

# **SUPPORTING STATEMENT**

## **Part A**

*Medical Expenditures Panel Survey – Household and Medical Provider  
Components*

Revision of Previously Approved Information Collection – 0935-0118

**Version:** 6/27/2024

Agency of Healthcare Research and Quality (AHRQ)

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## **A. Justification**

### **1. Circumstances that make the collection of information necessary**

#### **About AHRQ:**

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see <https://www.ahrq.gov/policymakers/hrqa99a.html>), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting:

1. research that develops and presents scientific evidence regarding all aspects of health care; and
2. the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and
3. initiatives to advance private and public efforts to improve health care quality.

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

#### **Summary of Revision:**

This Information Collection Request (ICR) is for a revision to the Medical Expenditures Panel Survey – Household Component (MEPS-HC). These changes will be fielded in the Spring and Fall of 2025 and includes the addition of the Burdens and Economic Impacts of Medical Care Self-Administered Questionnaire (ESAQ), minor changes to questions in both the Core MEPS Interview and the Adult SAQ and removing the Cancer SAQ (CSAQ). These changes are discussed in detail below starting on page 8.

#### **Background of the MEPS:**

The MEPS consists of three main components: the Household Component, the Medical Provider Component (MEPS-MPC), and the Insurance Component (MEPS-IC). The MEPS-HC and MPC are linked and submitted together in the same ICR. The MEPS-IC is drawn from a different sample frame and submitted as a separate ICR. The OMB Control Number for the MEPS-HC and MPC is 0935-0118 and the current expiration date is November 30<sup>th</sup>, 2025. AHRQ is requesting a new expiration date, three years from approval.

The MEPS was initiated in 1996. Each year a new panel of sample households is selected. Recent annual MEPS-HC sample sizes average about 13,500 households. Data can be analyzed at either the person, family, or event level. The panel design of the survey, which includes 5 Rounds of interviews covering 2 full calendar years, provides data for examining person level changes in selected variables such as expenditures, health insurance coverage, and health status (see <https://www.ahrq.gov/policymakers/hrqa99a.html> for information on how the Covid-19 pandemic impacted this design). Using a combination of computer assisted personal interviewing (CAPI), computer assisted video interviewing (CAVI), and self-administered paper and web questionnaires, information about each household member is collected, and the survey builds on this information from interview to interview. CAVI is a new data collection technology and offers the best of both telephone and in-person interviewing, while offering opportunities for cost savings and more accurate reporting.

***The MEPS-HC and MPC have the following goals:***

- 1) To produce nationally representative estimates of health care use, expenditures, sources of payment, and health insurance coverage for the U.S. civilian noninstitutionalized population.
- 2) To produce nationally representative estimates of respondents' health status, demographic and socio-economic characteristics, employment, access to care, and satisfaction with health care.

***To achieve these goals the following data collections are currently approved by OMB:***

**Household Component** – The MEPS-HC consists of a core interview administered to all sampled households, supplemental interviews administered to selected individuals, permission forms and a validation interview:

- 1) **Core MEPS-HC Interview** – All sampled households are administered the Core MEPS interview which collects health, health insurance, and employment data on all household members. All data for a sampled household are typically reported by a single household respondent. During the interview individual household members are identified to complete a self-administered questionnaire. The interview also determines which permission forms need to be signed. The MEPS-HC Core Interview questions are included in Attachments 1 to 46 and interviewer showcards used during the interview are in Attachment 47.
- 2) **Adult Self-Administered Questionnaire (Adult SAQ)** – Completed by all adults 18 and older in the household in rounds 2 and 4 in odd years. Collects a variety of health status and health care quality measures of adults age 18 and older. The SAQ contains three measures of health status: the Veteran's RAND 12-item (VR-12), the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ-2). The health care quality measures in the SAQ were taken from the health plan version of CAHPS®, an AHRQ-sponsored family of

- survey instruments designed to measure quality of care from the consumer's perspective. The Adult SAQ is in Attachment 48.
- 3) **Preventive Care Self-Administered Questionnaire (PSAQ)** - Designed to collect a variety of person-level preventive health care data for adults. It is distributed to all eligible adults 18 years and older in rounds 2 and 4 in even years. In addition to questions about preventive care, the PSAQ also includes supplemental items on alcohol use, mental health counseling and treatment, exercise and sexual orientation and gender identity. The PSAQ is in Attachment 49.
  - 4) **Diabetes Care Survey (DCS)** - Respondents receive a DCS based on their response to a question in the Priority Condition section of the Core interview, which asks whether the respondent was ever told by a doctor or health professional that he/she had diabetes. The DCS is administered once a year in rounds 3 and 5. Included are questions about the number of times the respondent reported having a hemoglobin A1c blood test, whether the respondent reported having his or her feet checked for sores or irritations, whether the respondent reported having an eye exam in which the pupils were dilated, the last time the respondent had his or her blood cholesterol checked and whether the diabetes has caused kidney or eye problems. Respondents are also asked if their diabetes is being treated with diet, oral medications or insulin. The DCS is in Attachment 50.
  - 5) **Cancer Self-Administered Questionnaire (CSAQ)** – the National Cancer Institute (NCI) provided financial support to AHRQ for the Cancer SAQ in 2024. The Cancer SAQ will be removed from the MEPS-HC after the Fall 2024 data fielding. The NCI has collaborated in previous years with AHRQ to create the *MEPS Experiences with Cancer* Supplement, which oversampled households with cancer survivors from the prior year National Health Interview Survey (NHIS) and fielded a special survey about economic burden and access to care in cancer survivors. Due to a change in the NHIS sample design, MEPS will not be able to oversample cancer survivors in the 2024 data collection. The current effort will field an updated version of the *MEPS Experiences with Cancer* Survey in the Fall 2024 MEPS-HC. The new version of the survey will include most of the same questions as the earlier survey to allow comparisons of trends and will replace some survey items that are now less critical or available from other data sources with new questions on employment impacts and workplace accommodations; survivorship care; social determinants of health; and social isolation and support. The CSAQ is included in attachment 51.
  - 6) **Authorization Forms for the MEPS-MPC Provider and Pharmacy Survey** - As in previous panels of the MEPS, we will ask respondents for authorization to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies. The forms are in Attachments 52 and 53.

- 7) **MEPS Validation Interview** - Each interviewer is required to have at least 15 percent of his/her caseload validated to ensure that Core questionnaire content was asked appropriately, and procedures followed, for example the use of show cards. In excess of this requirement, all MEPS completes undergo validation efforts. Over 40% of cases are validated through the use of Westat's Eagle system which tracks GPS coordinates, matching them to respondent addresses and interview times. Computer Assisted Recorded Interview (CARI) review accounts for roughly 40% of MEPS case validation where EAGLE is not appropriate (CAVI interviews) or is not valid or available. The audio and screen capture from numerous questions is evaluated to ensure an interviewer and a respondent, proper question administration and show card usage. For cases that cannot be validated using CARI or GPS, phone validations are conducted to ensure proper procedures and administration. Mail validations are used as a final measure when other types of validation have not resulted in a validated case.

Home office and field management may also request that other cases be validated using any of the aforementioned methods throughout the field period. When an interviewer fails a validation all their work is subject to 100 percent telephone validation. Additionally, any case completed in less than 30 minutes is telephone validated. See Attachments 54a and 54b.

**Medical Provider Component** - Upon completion of the household interview and obtaining permission from the household survey respondents, a sample of medical providers are contacted by telephone to obtain information that household respondents cannot accurately provide. This part of the MEPS is called the Medical Provider Component (MPC) and information is collected on dates of visits, diagnosis and procedure codes, charges and payments. The MPC is not designed to yield national estimates. It is primarily used as an imputation source to supplement/replace household reported expenditure information. This ICR does not include any changes to the MPC. The MPC includes data collections for specific types of health care providers, outlined below:

- 1) **MPC Contact Guide/Screening Call.** An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS-MPC, the appropriate MEPS-MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of the seven provider types in the MEPS-MPC, except for the two home care provider types which use the same screening form. The Contact Guide is in Attachment 55.
- 2) **Home Health Care Providers Event Form** – The MPC collects data from different types of home health care providers. This includes: 1) **home health care agencies** that provide medical care services to household respondents. Information collected with this type of home health care providers includes types of personnel providing the care, hours or visits provided per month, and the

- charges and payments for services received. 2) **home care for non-health care providers** that focuses on collecting information about services provided in the respondent home by non-health care workers because of a medical condition (e.g., cleaning or yard work; transportation; shopping; or childcare). The forms are included in Attachments 56 and 57.
- 3) **Office-Based Providers Event Form** – The MPC collects data from office-based physicians, including Doctor of Medicine (MDs) and osteopathy (DOs, as well as providers practicing under the care or supervision of an MD or DO (e.g., physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as staff model HMOs are included. The information collected includes date of the visit, time spent with the provider, types of treatment and services received, types of medicine prescribed, expenditures, and sources of payment associated with the visit. The form is in Attachment 58.
  - 4) **Separately Billing Doctors Event Form** – The MPC collects information from physicians identified by hospitals as providing care to household respondents during the course of an inpatient, outpatient, or emergency room care, but who will separately from the hospital itself. The information collected includes dates of visit, services provided, expenditures, and sources of payment. The form is in Attachment 59.
  - 5) **Hospital Event Form** – The MPC collects information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but the medical records and administrative departments as well. Medical records are contacted to determine the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also have to be contacted to determine whether the doctors identified by the medical records billed separately from the hospital itself. HMO hospitals are included as part of this data collection effort. The form is in Attachment 60.
  - 6) **Institutions (non-hospital) Event Form** – The MPC collects information on services and expenditures for household respondents who were admitted to a nursing home, rehabilitation center, or other non-hospital long-term health care facility. The form is in Attachment 61.
  - 7) **Pharmacies Event Form** – The MPC collects information from both corporate and non-corporate pharmacies, including drug stores, grocery stores, discount stores, mail order, online, clinics, HMOs, and Hospitals. The information collected includes a patient profile of the household respondent that reflects a listing of prescriptions given to the respondent, and includes dates prescriptions filled, medicine name, other drug characteristics, and sources and amounts of payments made. The form is in Attachment 62.

## Proposed Revisions for the Spring and Fall 2025 MEPS-HC:

- **MEPS Core Interview and Adult SAQ** – The Core interview and the Adult SAQ include four questions from the Consumer Assessment of Healthcare Providers and Systems 5.0 (CAHPS 5.0). These questions will have wording changes to update them to CAHPS 5.1. These wording changes will help identify telehealth utilization and access, as well as maintain consistency between CAHPS and MEPS-HC questionnaire items. Below are the four questions, both the current version and the proposed version:

Current: In the last 12 months, did {you/{PERSON}} have an illness, injury or condition that needed care right away in a clinic, emergency room, or doctor's office?

Proposed: In the last 12 months, did {you/{PERSON}} have an illness, injury, or condition that needed care right away?

Current: In the last 12 months, did you make any appointments for a check-up or routine care for {yourself/{PERSON}} at a doctor's office or clinic?

Proposed: In the last 12 months, did you make any in-person, phone, or video appointments for a check-up or routine care for {yourself/{PERSON}}?

Current: Looking at card CS-2, in the last 12 months, how often did you get an appointment for a check-up or routine care for {yourself/{PERSON}} at a doctor's office or clinic as soon as {you/he/she} needed?

Proposed: Looking at card CS-2, in the last 12 months, how often did you get an appointment for a check-up or routine care for {yourself/{PERSON}} as soon as {you/he/she} needed?

Current: Looking at card CS-3, in the last 12 months, not counting times {you/{PERSON}} went to an emergency room, how many times did {you/he/she} go to a doctor's office or clinic to get health care?

Proposed: Looking at card CS-3, in the last 12 months, not counting the times {you/{PERSON}} went to an emergency room, how many times did {you/he/she} get health care in person, by phone, or by video?

- **Burdens and Economic Impacts of Medical Care Self-Administered Questionnaire (ESAQ)** - The Office of the Secretary – Patient Centered Outcomes Research Trust Fund is funding this SAQ to expand the collection of economic outcomes data for patient-centered outcomes research (PCOR) via the Medical Expenditure Panel Survey (MEPS). The ESAQ will be completed during Round 3, Panel 30 and Round 5, Panel 29 (Spring 2025) by adult household members (aged 18 and over). The ESAQ will be administered in a mixed-mode of paper and online. Respondents will be offered a \$20.00 monetary incentive to complete the ESAQ. This is a one-time data collection and the ESAQ will be

removed from the MEPS after the 2025 fielding. The goal of the ESAQ is to enhance the MEPS data by adding new domains related to the economic burdens of seeking and receiving health care, to study economic outcomes in patient-centered outcomes research. The questionnaire is in Attachment 63.

There is no other survey that is now or has been recently conducted that will meet the objectives of the ESAQ. The ESAQ will supplement MEPS data on direct care expenditures with data on major indirect costs, including time costs of getting care and administrative hassles; lost work productivity due to presenteeism, lost productivity in non-market activities, and time costs of informal care. With this new data, researchers will be able to better examine health care economic burdens and equity in health care access, utilization, and outcomes, for example to aggregate social costs of health care and poor health, examine indirect costs associated with common conditions, and analyze disparities and equity in indirect costs.

In developing the ESAQ, AHRQ consulted with several experts in the area and used their expertise to identify priority topics and questions that have already been tested and widely accepted. Nearly all items are either from Federal surveys, federally funded surveys, or adapted from instruments that have been carefully validated. Two questions related to affordability and access are from Kaiser Family Foundation surveys. One question about informal care was cognitively tested in a prior question development project. One question on the high-priority topic of administrative hassles of health insurance was developed from phrases from the carefully tested and widely accepted Consumer Assessment of Health Plans and Systems.

- **Cancer Self-Administered Questionnaire (CSAQ)** – The CSAQ will be removed from the 2025 MEPS-HC. The questionnaire is in Attachment 51.

This study is being conducted by AHRQ through its contractor, Westat, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness, and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

## ***2. Purpose and Use of Information***

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

- annual estimates of health care use and expenditures for persons and families
- annual estimates of sources of payment for health care utilizations, including

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

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

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

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

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

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

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

- outpatient departments, Medicaid recipients and expenditure estimates for pharmacies
- Allow for an examination of the level of agreement in reported expenditures from household respondents and medical providers

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

For over thirty years, results from the MEPS and its predecessor surveys (the 1977 National Medical Care Expenditure Survey, the 1980 National Medical Care Utilization and Expenditure Survey and the 1987 National Medical Expenditure Survey) have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses, and health policy.

Major changes continue to take place in the health care delivery system. The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment, income, health insurance and health status over two years. The use of the National Health Interview Survey (NHIS) as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

### **3. Use of Improved Information Technology**

#### MEPS-HC:

The MEPS-HC uses a combination of computer assisted personal interviewing (CAPI), computer assisted video interviewing (CAVI), and self-administered paper and web questionnaires. CAVI is a new data collection technology and offers the best of both telephone and in-person interviewing, while offering opportunities for cost savings and more accurate reporting. In 2022, the MEPS-HC began collecting signatures for authorization forms using one of three modes. Respondents can sign the form electronically, at the time of the in-person interview; sign electronically via DocuSign when the eligible respondent was not available in person and an email or textable cell phone number was available; or sign on traditional hard copy paper authorization forms. In 2023, the MEPS-HC allowed two modes for completion of the Adult SAQ, web and paper. A web survey was requested if an email or textable cell is available for the adult; otherwise, a paper survey was offered for completion.

#### MEPS-MPC:

The mode of administration for the MEPS-MPC (including the pharmacy component) varies based on the preferences of the provider and includes phone interviews, mail and electronic submission of information. Starting with the 2009 MEPS-MPC data collection, a computer-assisted system was developed for both interviewing and record abstraction. This Integrated Data Collection System (IDCS) supported the effort to recruit providers by telephone and to interview medical records and billing staffs of medical facilities. For providers that prefer to send hard copy records, the IDCS is used to abstract information from medical records and patient accounts. The IDCS consists of two main systems: 1) a Web component in ASP.Net in which the MEPS-MPC forms (Contact Guides and Event Forms) are programmed for either data entry either during telephone calls or record abstraction and 2) a Case Management System (CMS) that manages the medical providers and associated forms for call scheduling, contact information, appointment times, and event/status information

### **4. Efforts to Identify Duplication**

There is no other survey that is now or has been recently conducted that will meet all of the objectives of the MEPS. Some federal surveys do collect health insurance information from households (SIPP, NHIS); however, these surveys do not collect the depth of information on health care use and expenses available in the MEPS. Moreover, MEPS is the only survey which links information collected from households with information collected from medical providers to inform the estimation of expenditures.

### **5. Involvement of Small Entities**

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

## **6. Consequences if Information Collected Less Frequently**

The design of the MEPS-HC in which households are contacted 5 times over the course of 2 years enables the gathering of medical use data at the event level and permits the estimation of expenditures and payments for persons by event type (see [https://meps.ahrq.gov/mepsweb/survey\\_comp/hc\\_data\\_collection.jsp](https://meps.ahrq.gov/mepsweb/survey_comp/hc_data_collection.jsp)) for information on how the Covid-19 pandemic impacted this design). Reducing the number of rounds in which the data are collected would hamper the availability and quality of information due to long recall periods.

MEPS-MPC respondents are contacted at least once during the calendar year for the preceding data collection year. Sometimes a follow up contact is necessary to clarify ambiguous or collect missing information. Contacts on a less frequent basis than the envisioned timetable jeopardizes the access of the study to information from records that could otherwise be destroyed or archived.

## **7. Special Circumstances**

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

## **8. Federal Register Notice and Outside Consultations**

### **8.a. Federal Register Notice**

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on April 19<sup>th</sup>, 2024 page 28784, for 60 days (see Attachment 62), and again on July 1st page 54466, for 30 days. No comments were received. The Federal Register Notice is included in Attachment 64.

### **8.b. Outside Consultations**

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

**Table 1. MEPS Consultants**

<b>Name</b>	<b>Affiliation</b>
Jill Jacobsen Ashman, Ph.D.	Centers for Disease Control and Prevention National Center for Health Statistics
Brenda G. Cox, Ph.D	Independent Consultant
Judith H. Mopsik, M.H.S.	Vice President for Business Development, Abt Associates Inc.
Constance F. Citro, Ph.D.	Committee on National Statistics Division of Behavioral and Social Sciences and Education
Sarah Q. Duffy, Ph.D.	National Institute on Drug Abuse, National Institutes of Health

Llewellyn Cornelius, Ph.D.	University of Maryland
Michael L. Cohen, Ph.D.	Committee on National Statistics
Joan S Cwi, Ph.D.	Independent Consultant

### **9. Payments/Gifts to Respondents**

MEPS-HC respondents will be offered a monetary gift as a token of appreciation for their participation in the MEPS. A gift has been offered to respondents at the end of each round since the inception of MEPS in 1996; the current amount of \$50 per round has been in place since 2011 (OMB approval obtained January 26, 2010 version 1). For household respondents, participation includes not only time being interviewed, but also keeping track of their medical events and expenditures between interviews. Household respondents will be informed of the gift at the first in-person contact and all eligible respondents will be given the same amount. Respondents to the Burdens and Economic Impacts of Medical Care SAQ will be offered a \$20.00 monetary incentive to improve response rates and mitigate perceived additional burden. Currently no gift is offered to respondents to the Adult SAQ, Diabetes Care SAQ, Cancer SAQ or PSAQ.

### **10. Assurance of Confidentiality**

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

In accordance with 5 CFR § 1320.8(b)(3) the following Privacy Act statement is printed on the MEPS data collection forms. The “x” will be replaced with the number of minutes required to complete the form:

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and the confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average x minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The data provided will help AHRQ’s mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (OMB control number 0935-0118) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857, or by email to REPORTSCLEARANCEOFFICER@ahrq.hhs.gov.

## **11. Questions of a Sensitive Nature**

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

## **12. Estimates of Annualized Burden Hours and Costs**

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

### **MEPS-HC:**

1. *MEPS-HC Core Interview* - completed by 12,683 "family level" respondents. Since the MEPS-HC typically consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS-HC core requires an average response time of 88 minutes to administer.
2. *Adult SAQ* - completed once during the 2-year panel, in rounds 2 and 4 during odd numbered years, making the annualized average 0.5 times per year. The Adult SAQ will be completed by 15,600 adults and requires an average of 7 minutes to complete.
3. *PSAQ* - completed once during the 2-year panel, in rounds 2 and 4 during even numbered years, making the annualized average 0.5 times per year. The PSAQ will be completed by 15,600 adults and requires an average of 7 minutes to complete.
4. *DCS* - completed by 1,398 persons with diagnosed diabetes each year and requires 3 minutes to complete.
5. *Burdens and Economic Impacts of Medical Care SAQ* - completed by 16,170 and is estimated to take 10 minutes to complete. This SAQ will be completed only once in 2025 and will be removed in 2026; to annualize the burden hours the number of responses per respondent is 0.5 times per year.
6. *Authorization forms for the MEPS-MPC and Pharmacy Survey* - completed by 7,386 respondents. Each respondent will complete an average of 5.2 forms each year, with each form requiring an average of 3 minutes to complete.
7. *Validation interview* - conducted with approximately 1,826 respondents each year and requires 5 minutes to complete.

The total annual burden hours for the respondent's time to participate in the MEPS-HC is estimated to be 51,814 hours.

### **MEPS-MPC:**

1. *Contact Guide/Screening Call* - conducted with 38,683 providers and pharmacies each year and requires 5 minutes to complete.
2. *Home Health Care Providers Event Form* - completed by 540 providers, with each provider completing an average of 5 forms and each form requiring 3 minutes to complete.
3. *Office-based Providers Event Form* - completed by 9,300 providers. Each provider will complete an average of 2.8 forms and each form requires 3 minutes to complete.

4. *Separately Billing Doctors Event Form* - will be completed by 4,676 providers, with each provider completing 1.2 forms on average, and each form requiring 3 minutes to complete.
5. *Hospital Event Form* - completed by 3,935 hospitals or HMOs. Each hospital or HMO will complete 5.9 forms on average, with each form requiring 3 minutes to complete.
6. *Institutions (non-hospital) Event Form* - completed by 86 institutions, with each institution completing 1.3 forms on average, and each form requiring 3 minutes to complete.
7. *Pharmacy Event Form* - completed by 6,112 pharmacies. Each pharmacy will complete 31.3 forms on average, with each form requiring 3 minutes to complete.

The total burden hours for the respondent's time to participate in the MEPS-MPC is estimated to be 15,674 hours. The total annual burden hours for the MEPS-HC and MPC is estimated to be 67,488 hours.

**Exhibit 1. MEPS-HC and MPC estimated annualized respondents and burden hours, 2025 to 2027**

Form Name	Number of Respondents <sup>a</sup>	Number of responses per respondent	Hours per response	Total Burden hours
<b>MEPS-HC</b>				
1. MEPS-HC Core Interview	12,683	2.5	88/60	46,504
2. Adult SAQ*	15,600	0.5	7/60	910
3. Preventive Care SAQ (PSAQ)**	15,600	0.5	7/60	910
4. Diabetes Care Survey (DCS)	1,398	1	3/60	70
5. Burdens and Economic Impacts of Medical Care SAQ	16,170	0.5	10/60	1,348
6. Authorization forms for the MEPS-MPC Provider and Pharmacy Survey	7,386	5.2	3/60	1,920
7. MEPS Validation Interview	1,826	1	5/60	152
Subtotal for the MEPS-HC	70,663	--	--	51,814
<b>MEPS-MPC</b>				
1. Contact Guide/Screening Call	38,683	1	5/60	3,224
2. Home Health Care Providers Event Form	540	5.0	3/60	135
3. Office-based Providers Event Form	9,300	2.8	3/60	1,302
4. Separately Billing Doctors Event Form	4,676	1.2	3/60	281
5. Hospitals & HMOs (Hospital				

Event Form)	3,935	5.9	3/60	1,161
6. Institutions (non-hospital) Event Form	86	1.3	3/60	6
7. Pharmacies Event Form	6,112	31.3	3/60	9,565
Subtotal for the MEPS-MPC	63,332	--	--	15,674
<b>Grand Total</b>	133,995	--	--	67,488

\* The Adult SAQ is completed once every two years, on the odd numbered years.

\*\* The PSAQ is completed once every two years, on the even numbered years.

<sup>a</sup> See the Supporting Statement Part B, Table 1 and Table 3, for information on the sample size and number of respondents.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection. The annual cost burden for the MEPS-HC is estimated to be \$1,631,105 and the annual cost burden for the MEPS-MPC is estimated to be \$326,612. The total annual cost burden for the MEPS-HC and MPC is estimated to be \$1,957,716.

#### Exhibit 2. Estimated annualized cost burden

Form Name	Total burden hours	Average hourly wage rate	Total cost burden
<b>MEPS-HC</b>			
1. MEPS-HC Core Interview	46,504	\$31.48*	\$1,463,946
2. Adult SAQ*	910	\$31.48*	\$28,647
3. Preventive Care SAQ (PSAQ)**	910	\$31.48*	\$27,082
4. Diabetes Care Survey (DCS)	70	\$31.48*	\$2,204
5. Burdens and Economic Impacts of Medical Care SAQ	1,348	\$31.48*	\$42,435
6. Authorization forms for the MEPS-MPC Provider and Pharmacy Survey	1,920	\$31.48*	\$60,442
7. MEPS Validation Interview	152	\$31.48*	\$4,785
Subtotal for the MEPS-HC	51,814	--	\$1,631,105
<b>MEPS-MPC</b>			
1. Contact Guide/Screening Call	3,224	\$20.85**	\$67,220
2. Home Health Care Providers Event Form	135	\$20.85**	\$2,815
3. Office-based Providers Event Form	1,302	\$20.85**	\$27,147
4. Separately Billing Doctors Event Form	281	\$20.85**	\$5,859
5. Hospitals & HMOs (Hospital Event Form)	1,161	\$20.85**	\$24,207

6. Institutions (non-hospital) Event Form	6	\$20.85**	\$125
7. Pharmacies Event Form	9,565	\$20.83***	\$199,239
Subtotal for the MEPS-MPC	15,674	--	\$326,612
<b>Grand Total</b>	67,488	--	\$1,957,716

\* Mean hourly wage for All Occupations (00-0000)

\*\* Mean hourly wage for Medical Secretaries (43-6013)

\*\*\* Mean hourly wage for Pharmacy Technicians (29-2052)

Occupational Employment Statistics, May 2023 National Occupational Employment and Wage Estimates United States, U.S. Department of Labor, Bureau of Labor Statistics.

### **13. Estimates of Annualized Respondent Capital and Maintenance Costs**

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

### **14. Estimates of Annualized Cost to the Government**

Exhibit 3 shows the remuneration paid to providers. Exhibit 4 shows the total and annualized costs associated with the design and data collection of the MEPS-HC and MEPS-MPC is estimated to be \$64,851,222 in each of the three years covered by this ICR. Exhibits 5 and 6 show the total and annualized cost of MEPS-HC and MEPS-MPC oversight, respectively.

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

Provider Type	Number of Records with Payment	Average Payment	Total Remuneration
Hospital	1,350	\$52.16	\$70,423
Office Based Providers	455	\$28.21	\$12,835
Institutions	1	\$1002.47	\$1,002
Home Care Provider (Health Care Providers)	1	\$200.08	\$200
Home Care Provider (Non-Health Care Providers)	0	\$0	\$0
Pharmacy	11,040	\$32.02	\$353,553
Separately Billing Doctors	53	\$192.37	\$10,196
Total MPC	12,900	---	\$448,209

#### **Exhibit 4. Estimated Total and Annualized Cost for Data Collection**

Cost Component	Total Cost	Annualized Cost
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Sampling Activities	\$2,896,508	\$965,503
Interviewer Recruitment and Training	\$11,299,464	\$3,766,488
Data Collection Activities	\$125,493,877	\$41,831,292
Data Processing	\$16,482,407	\$5,494,136
Production of Public Use Data Files	\$17,367,154	\$5,789,051
Project Management	\$21,014,256	\$7,004,752
<b>Total</b>	\$194,553,666	\$64,851,222

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

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost
Management Support: GS-15, Step 5 average	2	\$185,824	50.0%	\$185,824
Survey/Statistical Support: GS-14, Step 5 average	3	\$157,982	33.3%	\$157,824
Research Support: GS-13, Step 5 average	4	\$133,692	50.0%	\$267,384
Research Support: GS-12, Step 5 average	2	\$112,425	75.0%	\$168,638
<b>Total</b>	11	---	---	\$779,670

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

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost
Management Support: GS-15, Step 5 average	2	\$185,824	33.3%	\$123,759
Survey/Statistical Support: GS-14, Step 5 average	2	\$157,982	50.0%	\$157,982
Research Support: GS-13, Step 5 average	1	\$133,692	50.0%	\$66,846
Research Support: GS-12, Step 5 average	1	\$112,425	33.3%	\$37,438
<b>Total</b>	6	---	---	\$386,025

Annual salaries based on 2024 OPM Pay Schedule for Washington/DC area:

## **15. Changes in Hour Burden**

The burden estimate for the MEPS-HC and MPC is reduced by 9,011 hours in this ICR. This reduction comes primarily through a reduction in sample size.

## **16. Time Schedule, Publication and Analysis Plans**

Data collected from the MEPS will be used in a variety of descriptive analysis. AHRQs' website [www.meps.ahrq.gov](http://www.meps.ahrq.gov) contains examples of publications. Those publications include statistical briefs, research findings, chartbooks, and journal articles. In addition, tabular data is presented on the website. Special analytic reports will be issued on an ad-hoc basis, and other analyses will be presented at annual meetings of professional associations and in professional journals.

To the extent possible, given our commitment to respondent confidentiality, we have endeavored to release public use files from this project as soon as possible.

## **17. Exemption for Display of Expiration Date**

AHRQ does not seek this exemption.

### **List of Attachments:**

- Attachment 1 – Access to Care
- Attachment 2 – Additional Healthcare Questions
- Attachment 3 – Assets
- Attachment 4 – Calendar Section
- Attachment 5 – Closing Section
- Attachment 6 – Contacting Module Section
- Attachment 7 – Charge Payment Section
- Attachment 8 – Child Preventive Health Section
- Attachment 9 – Dental Visit Section
- Attachment 10 – Event Driver Section
- Attachment 11 – Event Enumeration Section
- Attachment 12 -- Event Follow-Up Section
- Attachment 13 -- Employment Section
- Attachment 14 -- Employment Driver Section
- Attachment 15 -- Emergency Room Section
- Attachment 16 -- Event Roster Section
- Attachment 17 -- Employment Wages Section
- Attachment 18 -- Flat Fee Section
- Attachment 19 -- Food Security Section
- Attachment 20 -- Global Section
- Attachment 21 -- Health Status Section
- Attachment 22 -- Home Health Section
- Attachment 23 -- Health Insurance Detail Section
- Attachment 24 -- Time Period Covered Detail Section
- Attachment 25 -- Hospital Stay Section
- Attachment 26 -- Health Insurance Section

Attachment 27 -- Institutional Care Stay Section  
Attachment 28 -- Income Section  
Attachment 29 -- Institutional Care Section  
Attachment 30 -- Medical Visit Section  
Attachment 31 -- Old Empl-Priv Related Ins Section  
Attachment 32 -- Off Path Navigation Section  
Attachment 33 -- Other Medical Expenses Section  
Attachment 34 -- Outpatient Department Section  
Attachment 35 -- Priority Condition Enumeration Section  
Attachment 36 -- Prescribed Medicines Section  
Attachment 37 -- Provider Probes Section  
Attachment 38 -- Old Public Related Insurance Section  
Attachment 39 -- Provider Roster Section  
Attachment 40 -- Quality Supplement Section  
Attachment 41 -- Reenumeration A Section  
Attachment 42 -- Reenumeration B Section  
Attachment 43 -- Respondent Forms Section  
Attachment 44 -- Review of Employment Section  
Attachment 45 -- Start-Restart Section  
Attachment 46 -- Telehealth Section  
Attachment 47 -- MEPS-HC Show Cards  
Attachment 48 -- Adult SAQ  
Attachment 49 -- PSAQ  
Attachment 50 -- Diabetes Care SAQ  
Attachment 51 -- Cancer SAQ (remove in 2025)  
Attachment 52 -- Permission Form for Medical Providers  
Attachment 53 -- Permission Form for Pharmacies  
Attachment 54a -- Validation Letter  
Attachment 54b -- Phone Validation Form  
Attachment 55 -- MPC Contact Guide & Screening Call  
Attachment 56 -- Home Healthcare for Healthcare Providers  
Attachment 57 -- Home Healthcare for Non-healthcare Providers  
Attachment 58 -- Office Based Provider Event Form  
Attachment 59 -- Separately Billing Doctors Event Form  
Attachment 60 -- Hospital Event Form  
Attachment 61 -- Institutions (non-hospital) Event Form  
Attachment 62 -- Pharmacies Event Form  
Attachment 63 -- ESAQ  
Attachment 64 -- Federal Register Notice