SUPPORTING STATEMENT

Part B

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

February 20, 2026

Agency for Healthcare Research and Quality (AHRQ)

Table of contents

B. Collections of Information Employing Statistical Methods

To fill in major data gaps identified by the Department of Health and Human Services, the Medical Expenditure Panel Survey (MEPS) is specified as a continuous survey. Each year, a new nationally representative MEPS sample will be selected from a subset of households that participated in the prior year's National Health Interview Survey (NHIS). A preliminary contact with the NHIS responding households selected for the MEPS study will take place to announce the MEPS survey and introduce records keeping activities.

The MEPS was initiated in 1996. Each year a new panel of sample households is selected. Recent annual MEPS-HC sample sizes average about 10,350 households (also defined as Reporting Units or RUs, see next section). 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. 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 newer data collection technology and offers the best of both telephone and in-person interviewing, while offering opportunities for cost savings and more accurate reporting.

1. Respondent universe and sampling methods

Household Component

The initial MEPS Household Component (HC) sample consists of households that responded to the prior year's NHIS. The basic analysis unit in the MEPS is defined as the person.

A Reporting Unit (RU) is a person or group of persons in the sampled dwelling unit that are related by blood, marriage, adoption or other family associations and for whom data are to be collected during the MEPS-HC interview. Typically, one adult family member provides information for the entire family although all adult family members are encouraged to participate. Each year's MEPS-HC sample will be surveyed to collect annual data for two consecutive years. Each new MEPS-HC sample will be a randomly selected subsample of households that responded to the prior year's NHIS. The NHIS is based on a stratified cluster sample design (see https://www.cdc.gov/nchs/nhis/about/ for more information about the NHIS).

NHIS implemented a new sample design in 2025, with the major change being the cycling of non-self-representing PSUs every two years. Otherwise, the design carries forward many of the features implemented in 2016 when the NCHS last revised the sample design for the NHIS. From a broad perspective, the 2016 and 2025 sample designs are similar to the previous pre-2016 design because clusters of households are still selected within PSUs which are still essentially formed at the county level. However,

within sampled PSUs, the clusters of addresses (households) that are sampled are not in the form of segments as in the pre-2016 design due to utilization of an address-based list of households. Also, the 2016 and 2025 sample designs use each of the 50 states as well as the District of Columbia as explicit strata with oversampling some of the smaller states with the intent of providing the capability of state-level NHIS estimates. However, the precision of estimates at the national level is expected to be very similar to the pre-2016 design. Although the PSUs in each new design were selected independently from previous designs, all large PSUs are selected in the sample with certainty in all designs which should contribute to the efficiency for trend analysis across designs. Moreover, the MEPS sample will continue to have the overlapping panels that will also be a major contributor to the efficiency of year to year estimates of change.

Another notable difference is that the current design does not involve oversampling any minority group (although it may in the future) that will reduce the number of minorities in the MEPS. See https://meps.ahrq.gov/data_stats/download_data/pufs/h233/h233doc.pdf for more detailed information about the MEPS-HC.

Beginning in 2019, NCHS implemented a new questionnaire for the NHIS. Under the redesigned questionnaire, only a few basic items will be collected about all household members (e.g., age, sex, race/ethnicity and education). Detailed demographic, family and health information will be collected only from a sample adult and a sample child (if available) in a household. This change in the NHIS questionnaire will have a minimal impact on the MEPS sample selection.

Table 1 shows the expected eligible sample sizes, response rates and number of respondents associated with producing calendar year estimates for the 2026 to 2028 MEPS-HC data collection components.

1. **MEPS-HC Core Interview** – The annual average sample size is 12,750 RUs. With an average response rate of 81.18% over 2.5 interviews per year, AHRQ expects 10,350 RUs to complete the Core MEPS-HC interview per year.

2. **Adult Self-Administered Questionnaire (Adult SAQ)** - Each RUs has an average of 1.75 adults making 18,113 adults eligible for the Adults SAQ. The Adult SAQ is administered only once, in the even years. The expected response rate is 68.43%, resulting in 12,395 adults completing SAQs.

3. **The Preventive Care Self-Administered Questionnaire (PSAQ)** – The PSAQ will be administered to all adults in the RU once, in the odd years. The expected response rate is 68.43%, resulting in 12,395 adults completing PSAQs.

4. **Authorization forms for the MEPS-MPC Provider and Pharmacy Survey** - An estimated 24,840 persons will have a medical or pharmacy event that will make them eligible to sign at least one permission form. The expected response rate is

70.00% resulting in an estimated 17,388 persons that will sign at least one form annually.

5. **MEPS-HC Validation Interview** - Each year 15% of completed Core MEPS-HC interviews are selected for a validation interview, resulting in an average of 1,553 RUs selected annually. The response rate for the validation interview is 96.00% giving an average of 1,491 completed interviews.

Table 1. MEPS-HC expected annual sample for 2026 to 2028

Data collection component	Unit	Sample count	Response rate[a]	Responding sample count
1. MEPS-HC Core Interview	RUs	12,750[a]	81.18[b]	10,350
2 & 3. Adult SAQ (even years); The Preventive Care SAQ (PSAQ) (odd years)	Adults	18,113[c]	68.43	12,395
4. Authorization forms for the MEPS-MPC Provider and Pharmacy Survey	Persons with health care events	24,840[d]	70.00	17,388
5. MEPS-HC Validation Interview	RUs	1,553[e]	96.00	1,491

[a] Expected RU sample size from the NHIS. Average number of persons per RU is about 2.4

[b] Average annual expected response rate over all interview rounds each year.

[c] 10,350 * 1.75 = 18,133; 10,350 responding RUs, 1.75 adults per RU.

[d] 10,350 * 2.4 = 24,840; 10,350 responding RUs, 2.4 persons with health care events per RU.

[e] 10,350 * 0.15 = 1,553; 10,350 responding RUs, 15% selected for validation interview.

The overall MEPS-HC response rate is a product of the response rate for each round of data collection in the MEPS and the response rate for the previous year NHIS survey from which the MEPS-HC sample was drawn.

The sample size specifications for the MEPS-HC are designed to meet specific precision requirements. However, due to a consistent decline in response rates, the precision requirement has been adjusted. For each estimation year, the relative standard error (RSE) for a person-level population estimate of 30 percent is targeted to average about 3 percent or less. For example, in 2020–2021, the national estimate of the percentage of persons with no usual source of care was about 30 percent, with an average RSE of 2.7 percent.

Medical Provider Component

The sample for the MEPS Medical Provider Component (MPC) is designed to provide data on events for which household respondents are unlikely to know, such as charges and payments, to enrich the sample of events available as donors for imputation, and to

provide a basis for methodological analysis of household reported charges and payments for all types of events.

Table 3 below shows the eligible sample sizes, completion rates and number of respondents for the MEPS-MPC, by provider type. The weighted ‘overall’ full completion rate is 54.29%, based on expected response rates for the 2023 data collection.

Table 3. MEPS-MPC expected annual sample by provider type for 2026 to 2028

Provider type	Eligible Sample Size	Full Completion Rate	Number of Respondents (Full Completes)
Home care -- health care providers	630	80.16%	505
Office-based providers	12,871	62.73%	8,074
Separately billing doctors	10,773	51.74%	5,574
Hospitals	5,672	61.39%	3,482
Institutions (non-hospital)	119	86.55%	103
Pharmacies	6,305	31.85%	2,008
Total	36,370	54.29%	19,746

All hospitals and home health care agency providers are "in-scope" for the MEPS-MPC. Other providers and sites of care are in-scope if the provider is either a Doctor of Medicine or osteopathy, or if the provider practices under the direction or supervision of a MD or DO. For example, physician assistants and nurse practitioners working in clinics are medical providers considered in scope for the MEPS-MPC. Chiropractors and dentists are out of scope (unless practicing in a hospital).

All office based physicians reported as providing care to persons in the MEPS-HC sample are eligible for inclusion in the MEPS-MPC sample (if permission provided). Unique person/provider pair combinations are sampled in a manner designed to achieve a general budgeted sample size while representing different sampling subgroups. In recent years the overall sampling rate has ranged from approximately 50 to 60%, with varying rates for different sample subgroups. The MEPS-MPC sample also includes 100 percent of hospitals identified as providers of care by household respondents (if permission provided), including all inpatient stays, emergency room, and outpatient department visits. All physicians identified by hospitals and/or households as providing care to sampled persons during the course of inpatient, outpatient department or emergency room care, but who bill separately from the hospital are included in the MPC sample. The physicians who bill separately from the hospital are sampled at different rates based on response propensity for predefined prioritization groups. This sampling rate for separately billing doctors has declined in recent years and was approximately 54% in 2023. All home health agencies that provided care to household sampled persons are also included in the MPC sample. Finally, all pharmacies that have dispensed prescribed medicines to sampled persons are included in the MPC.

Over the last three years a number of lessons have been learned and incorporated into the MPC data collection strategy. Specific areas of focus are as follows:

1. As more hospitals have been acquired by large healthcare systems, the patient account records have become more specialized. For example, for many hospitals there are now multiple points of contact to gather data for facility expenditures (including the in-patient room, operating or other treatment room, supplies, prescriptions) and professional fees (all healthcare providers included in a hospital bill). As a result data collection strategies that address obtaining records from multiple sources in order to compile a complete record of inpatient expenditures for identified events have been developed.
2. For office-based doctors, a larger proportion of providers now contract with billing services rather than staffing that have administrative function within their office. Similarly, hospitals not housed within a larger healthcare system more frequently use third-party record management vendors. In such cases a key to efficient data collection is the development of procedures that identify the billing services and/or record vendor initially so that data collection resources can be used more effectively and are not expended on contacts directly to the provider.

2. Information Collection Procedures

Household Component

Preliminary Contact. Households responding to the NHIS and subsampled as part of a MEPS-HC panel will be contacted by mail prior to their first interview. The mailing contains an advance letter and brochure. Senior interviewing staff contact the households by telephone as a follow up to the mailing. The purpose of the advance telephone call is to verify the arrival of the materials, answer questions about MEPS, and obtain the best times for conducting the round 1 interview. Additional informational and record keeping materials are available to the respondent to assist them in preparing for their first interview. See Attachment 63 for all the core instrument respondent materials.

After the advance contact, households with a tentative appointment or a favorable rating obtained during the advance contact will be contacted by phone to secure or verify an appointment. The remaining households will be contacted in-person for the first of five interviews. The first two interviews are conducted primarily in person with the option to conduct interviews by video for respondents who are reluctant to be interviewed in person; telephone interviews are available in very limited circumstances. Later interviews may be conducted more often by video once the respondent is familiar with the study and trained to maintain and use medical records to answer questions about their health care events.

The MEPS brochure will introduce the study. The Assurance of Confidentiality is covered in both the letter and the brochure, and the Reporting Burden statement appears in the brochure. Five interviews (rounds 1-5) will be conducted with each sampled

household at 4-6 month intervals over a 30 month time period. Round 1 will ask about the period since January 1 to the date of the interview. Round 2 will ask about the time since the Round 1 interview through the date of the Round 2 interview. Round 3 and Round 4 interviews cover the interview to interview interval. The Round 5 interview covers the period from the Round 4 interview to December 31, the end of a household's second calendar year of MEPS participation.

All interviewers use the same computer assisted personal interview (CAPI) instrument. The instrument is organized as a core instrument that will be unchanged in each of the rounds. Additional sections are asked for only once a year and provide greater depth. Dependent interviewing methods in which respondents are asked to confirm or revise data provided in earlier interviews will be used to update information such as employment and health insurance data after the round in which such data are initially collected.

Questionnaires for these field periods are largely parallel to those used in prior MEPS interviews. The instruments contain items that are asked for once in the life of the study, items that are asked for in each round, and items that are updated from round to round. Items only asked for once include basic sociodemographic information. Core questions asked include health status, health insurance coverage, employment status, medical utilization, hospital admissions, and purchase of medicines. For each health encounter identified, data will be obtained on the nature of health conditions, the services provided, the associated charges and sources (and amounts) of payments. Authorization forms for contacting medical providers and pharmacies will be collected in the field. Self-Administered Questionnaires (SAQs) including topics such as health and preventive health will be collected in the field as well.

Medical Provider Component

The MEPS-MPC survey begins with the selection of the sample during the household interview. For those medical events and prescribed medicines reported in a household interview that meet the targeting criteria described above, a permission form is generated for each provider of the sampled person/provider pairs involved. This form describes the purpose of the survey and the information that is being collected and authorizes the provider to release that information. The form is signed by the patient (or parent or guardian if person is under 18 years of age, or witness or proxy if patient is disabled or deceased). To expedite the identification of providers and assist with the preparation of an unduplicated provider list for the fielding of the MEPS-MPC, interviewers use a computerized database of medical providers, the National Provider Identifier (NPI) Provider Directory, which has been loaded onto the laptop. The NPI database is directly from the National Plan and Provider Enumeration System (NPPES) and Centers for Medicare & Medicaid Services. The NPI is a unique identification number for covered health care providers and uniquely identifies a health care provider. If a match is found with a provider identified by the household respondent, the matched directory record will be associated with the household event. The NPI directory records include, for each provider: a unique provider ID, the provider's name, and the provider's practicing address

and phone number(s). The MPC is conducted by telephone and record abstraction. The data collection process contains three basic steps:

1) an initial telephone screening to confirm provider eligibility and determine the appropriate person to whom the survey materials should be sent.

2) the mailing, faxing, or secure electronic submission of an advance package to the provider which describes the survey and the types of information that will be collected and also includes the permission forms for each patient; and

3) a phone call to actually collect the data. However, many providers prefer to send records rather than provide information over the telephone. The information is abstracted from the records when records are sent in; when necessary, follow-up phone calls are made to the providers to clarify items in the records or to retrieve critical data items not contained in the records.

The majority (97 percent) of hospital providers choose to mail, fax or electronically submit records and approximately 45 percent of office based providers' mail or fax records. The rest are obtained by telephone or submitted electronically via web portal or secure email.

For office-based physicians, home health agencies, clinics, and separately billing doctors the data collection call is directed to the person who handles the billing for the provider. Often this is not someone in the provider's office, but an outside billing organization.

In the case of hospitals, data are collected not only from the billing department but from the medical records department and administrative office. Previous experience has shown that the names of the separately billing doctors usually cannot be obtained from the hospital's billing department. Consequently, there is an additional call to the medical records department to determine the names of all the doctors who treated the patient during a stay or visit. Moreover, in some cases the hospital's administrative office must be contacted to determine whether or not the doctors identified by medical records bill separately from the hospital itself.

Although experience has shown that telephone interviewing tends to be a very efficient method of collecting MEPS-MPC data and imposes minimal burden on providers, the MEPS-MPC data collection process has been designed to be as flexible as possible to accommodate the needs of respondents. Procedures for self-administration are available, should respondents prefer that mode of data collection. More recently, Secure File Transfer (FTP), submission to a secure electronic portal, and secure email have also been provided as an option to MPC providers.

The pharmacy data collection process -- for individual, non-chain pharmacies -- consists of: (1) an initial phone call to the pharmacy to solicit cooperation and determine how to send the survey materials; (2) materials are faxed, mailed, or electronically submitted to the pharmacy; (3) pharmacies respond by sending in, by fax, mail, or electronic

submission, patient profiles. Sometimes the pharmacist is willing to give the information over the phone, and the data is collected into an Integrated Data Collection System (IDCS) on a secure web portal; (4) pharmacies are followed up to prompt for response or if data items in submitted profiles are not clear. The process for the larger chains that have requested centralized corporate contacts can vary, depending on the preferences of the chain. All begin with a telephone contact and include a step in which the authorization forms are sent to the company, but then data collection proceeds as desired by the chain: some respond in electronic format (approximately 10 percent); many send in (hard copy) profiles (approximately 90 percent reply by mail (~60%) or fax (~30%)).

3. Methods to Maximize Response Rates

Household Component

Households in the MEPS-HC sample are interviewed in person or by video by trained interviewers using a CAPI application to record the respondent's answers to the survey questions. In addition to providing information on family composition, health status, employment, and health insurance, household respondents are asked to report details on health events for all members of the family. The interviews vary in length depending upon the number of persons in the family and the number of health care events the family has to report.

Over time, the MEPS-HC has refined a series of activities and procedures designed to build and maintain response rates. These activities begin with a sequence of advance mailings that provide a first introduction to the study and continue through concerted follow up efforts to gain the participation of the households that are difficult to contact or reluctant to participate. These efforts are particularly concentrated in the first round of a new panel's participation but continue with efforts to maintain cooperation through the full five rounds of interviewing. The standard practices include:

- Round 1 pre-interview contacts - Before an interviewer makes the first attempt to contact a sampled household in person, the household receives a series of two mailings and one advance telephone contact. The first mailing notifies the family of its selection for the survey and includes a brochure explaining the study and the nature of participation. The second mailing is a brief reminder of the coming interview, timed to arrive shortly before the interviewer's first attempt to contact the family to conduct an interview. Shortly following the first mailing, respondents are contacted by telephone to verify their receipt of the package and to answer their questions about the study. These calls serve to provide an early indication of the households that have moved since the NHIS and require tracking and an early assessment of the likelihood of the household's participation when contacted.

- Round 2-5 Pre-interview contacts - The household receives an advance mailing reminding the family that a field interviewer will be calling to schedule the next interview shortly before the interviewer's first attempt to contact the family for that round.

- Careful attention to the selection and training of data collection staff. Training sessions are designed to prepare interviewers to be knowledgeable about the study, comfortable in using study materials, and prepared with answers to common respondent questions. In recent years, as the level of effort required to obtain cooperation has increased, more attention has been given to training interviewers in techniques for avoiding refusals. For some segments of the training, bilingual interviewers meet separately to practice introducing and administering the survey in Spanish.

- Attention to the appropriate assignment of cases to interviewers. As the MEPS-HC is a subset of households that participated in the prior year's NHIS, information available from the NHIS interview and from the advance contact calls is considered by field supervisors when making assignments and by individual interviewers when planning their first contact attempts. When the NHIS information indicates that a case was only "partially completed" it usually indicates that the NHIS household was reluctant to participate and only willing to complete part of the NHIS interview. These cases are assigned to interviewers who have demonstrated skill with refusal aversion techniques. Similarly, if the interviewer conducting the advance contact call indicates that the household seems hesitant to participate, the case is also assigned to an interviewer skilled in refusal aversion.

- Close monitoring of the field data collection effort by field supervisors and project managers. Paradata documenting every interviewer attempt to contact a household is made available to supervisors to guide interviewers' timing of contact attempts. In weekly calls, supervisors and interviewers discuss work plans and alternative approaches for contacting and gaining cooperation of individual cases. Weekly calls among the managers of the field operation allow discussion of solutions to common response problems, planning and coordination of efforts to follow-up non-responding households, and efficient allocation of field resources.

- Determining where to place resources to build the response rate requires reliable data on production and response rates, contact efforts, interviewer availability, location of pending work, and dispositions of remaining cases. All of this information is contained within the MEPS-HC management database and available in reports and electronic dashboards. A number of 'real time' reports using paradata are available to field management staff for daily use. In addition, weekly reports are generated throughout the field period to monitor production and response rates by domain, primary sampling unit (PSU), and region to ensure the work is progressing toward schedule and response rate goals. The key to the approach is early identification of response rate issues that allows sufficient time to formulate and implement plans for conversion. Recent history regarding MEPS-HC unweighted response rates for MEPS only (i.e., rates that are conditional on response to NHIS) are as follows:

MEPS Year & Panel	Response Rates
MEPS 2017	
Panel 21	61.50%
Panel 22	64.30%
MEPS 2018	
Panel 22	61.10%
Panel 23	64.10%
MEPS 2019	
Panel 23	60.20%
Panel 24	60.00%
MEPS 2020	
Panel 23*	41.70%
Panel 24	44.80%
Panel 25	39.40%
MEPS 2021	
Panel 23*	32.80%
Panel 24*	32.10%
Panel 25	29.90%
Panel 26	40.10%
MEPS 2022	
Panel 24*	27.20%
Panel 26	34.00%
Panel 27	46.50%
MEPS 2023	
Panel 27	40.40%
Panel 28	49.80%
MEPS 2024	
Panel 28	43.90%
Panel 29	44.60%

*Panels 23 and 24 were invited to continue participating in MEPS during the pandemic.

- Interviewers are provided with a variety of materials to support their efforts to gain cooperation: handouts printed in English and Spanish that explain different aspects of the study and research highlights and news items reporting findings from MEPS data are provided for the interviewers to use as needed to address concerns expressed by respondents. These are also available online at MEPSdocs.org and meps.ahrq.gov.

- In return for the time respondents spend preparing for the MEPS-HC interview, households receive a gift of $50 per interview. The $50 gift has been in place since the start of Panel 16 in 2011 (OMB approval obtained January 26, 2010, version 1).

- The project has developed a number of letters that address areas of concern commonly raised by respondents who do not respond when initially contacted by an interviewer. Supervisors can request mailing of the specific letter (available in English and Spanish) that is most appropriate for a given household.

- For households that are difficult to contact, interviewers make multiple contact attempts, at different times of day and days of the week, using information from the NHIS and their own prior contact attempts to determine the best time for each successive attempt. A module in the Interviewer Management System (IMS) presents contact day, time, and mode information to better inform the timing and type of next contact attempt.

- For households that refuse an initial request to participate, the interviewer and supervisor decide on an approach for attempting to convert the refusal, considering all information available from the NHIS and prior contact efforts. Depending on the specifics of each case, one of the refusal conversion letters may be sent before another attempt is made in person, points to be made to address the reasons for the refusal are discussed, and frequently, a different interviewer skilled in conversion will be assigned to make the next attempt.

- For households that require tracking, the interviewer who determines that the household has moved makes initial, local attempts to obtain new locating information. When those local sources are not successful, the case is referred to senior field management staff for additional searching through approved internet resources.

Since resources—time, budget, and staff—are not limitless, selection of the areas and specific cases on which to concentrate effort is critical. To guide these decisions, the project draws on multiple sources of information: information from prior panels on the characteristics of responders and nonresponders, information from the NHIS on the characteristics of the sampled households, paradata from the project management system, and information on the location, experience level, and skill sets of the interviewing field force.

While planned upcoming NHIS sample design changes have the potential to affect MEPS response rates and data quality, it is not completely feasible at this juncture to assess any impact of these changes. The NHIS sample redesign was launched in January 2025.

Medical Provider Component

MEPS-MPC staff plans to maintain the high response rates for the MEPS-MPC by bringing forward to the current data collection effort the methods that have been successful in maintaining provider cooperation in the past. An initial telephone screening to confirm provider eligibility and determine the appropriate person to whom the survey materials should be sent and the mailing, faxing, or electronic submission of an advance package to the provider which describes the survey and the types of information that will

be collected (and includes the permission forms) helps to maintain the high response rates.

Data collection staff who appreciate the difficulty and importance of the task and who are capable of establishing good rapport with providers and placing as little burden on them as possible to accurately collect the data, will be recruited and retained. All data collection staff participate in an in-depth initial training as well as on-going performance improvement activities. MEPS-MPC identity and logos will be maintained so that providers who have participated in the past will recognize the study, but data collection materials will be customized to the current year's data collection, so providers understand what is currently being requested of them. Data collection protocols and instruments are also customized to the different types of providers to make it as easy as possible for providers to provide data in the manner in which it appears in their records. Providers with a previous history of being reluctant to participate will be assigned to data collection staff specializing in working with such respondents to maximize the possibility that they will participate. Providers with particularly large numbers of study patients will be assigned to staff capable of working out means of obtaining the large number of records with minimal burden to the provider. Finally, the use of an electronic data capture system, which allows real-time checking for the entry of complete and accurate information into the data collection forms while they are being filled out, helps minimize return calls to providers to resolve missing or confusing items and make it more likely that their cooperation will be maintained in future data collection efforts.

4. Tests of Procedures

Whenever major changes are made to the MEPS, they are pretested to ensure that data quality is not negatively impacted. In the Household Component, all updates to the CAPI instrument and web SAQs include continuous, iterative cycles of specification, testing, and evaluation by Westat and testing of alpha and beta versions of each instrument by AHRQ. Testing of the developing instrument is guided by increasingly sophisticated and complex testing scenarios. Test data preparation uses an iterative process that first yields data for round 1 interviews for the most common scenarios and then increases the breadth of scenarios within round 1 before moving into the preparation of data for later rounds. Test scripts cover all aspects of the design layout for each question within a section (e.g. adherence to conventions for display of question text, interviewer instructions, response categories, etc.) and cover the full range of routing instructions through each questionnaire section. Multiple rounds of usability testing are conducted with field staff with varying levels of technical skills when introducing new features. Before each field period, interviewers receive training including online training modules on changes to the CAPI instrument and field procedures.

Recent changes to the MEPS Household Component since 2020 include the introduction of video interviewing (CAVI), web SAQs, and electronic authorization forms. Web SAQs and electronic authorization forms (added to the traditional paper options) were tested similar to the procedures described in the paragraph above. Development of CAVI in fall 2021 included testing three different video platforms, first with Westat staff, then with friends and family of employees, and finally with a small number of live respondents. Throughout spring 2022 interviewers were trained in batches to set up and

use video interviews, and the use of video has been closely monitored for quality and assessed for improvements to the procedures and equipment setup.

There are currently no firm plans for implementation of significant additional changes to MEPS that would require pretesting. When adding new items to the study, MEPS uses well-established items from other national surveys if pretesting is not possible.

5. Statistical Consultants

The following are responsible for statistical aspects of the MEPS Study:

Sadeq Chowdhury, Ph.D.
Division of Statistical Research and Methods
Center for Financing, Access and Cost Trends
Agency for Healthcare Research and Quality
Sadeq.Chowdhury@AHRQ.hhs.gov
Phone: (301) 427-1666