

Supporting Statement B
For Revision of Currently Approved Collection:
Medicare Current Beneficiary Survey (MCBS)

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B. Statistical Methods

The revision to this OMB package includes the following modifications to the Community instrument sections to improve measures, streamline content, and measure awareness and use of beneficiary-centric provisions of the Inflation Reduction Act (IRA):

- Add five new questions on beneficiary knowledge of IRA provisions to the Beneficiary Knowledge and Information Needs Questionnaire (KNQ).
- Streamline and enhance collection of immunization information via a new Immunization Questionnaire (IMQ) containing two existing items migrated from the Preventive Care Questionnaire (PVQ) and 16 new items about immunization uptake, location, and cost-sharing for the shingles, pneumonia, and RSV vaccinations.
- Redesign the existing Income and Assets Questionnaire (IAQ), which includes overarching changes to section structure to enhance analytic utility and respond to policy needs, deletion of 25 items which are no longer relevant, and the addition of three items related to other financial investments, 22 new items on medical and credit card debt, one new item related to financial liquidity, and four new items related to participation in and awareness of Federal assistance programs.
- The addition of one new item on financial assistance programs for medical bills (charity care) and the deletion of one item related to outstanding medical bills in the Health Status and Functioning Questionnaire (HFQ).
- Update respondent materials to increase understanding of the survey and improve participation.

B1. Universe and Respondent Selection

The target universe is current Medicare beneficiaries entitled to hospital and/or supplementary medical insurance and living in the 50 states or the District of Columbia. Both institutionalized and non-institutionalized beneficiaries are represented. Table B.1 summarizes the number of beneficiaries in the target universe based on CMS administrative records through 2023. The seven age groups shown in the table correspond to the primary sampling strata from which the samples for the MCBS are drawn. The age groups are defined by the beneficiaries' age as of December 31 of the given year for 2017 and later.

Table B.1: Universe Counts Broken Down by MCBS Age Groups (in thousands)

Age Interval	2017	2018	2019	2020	2021	2022	2023
Disabled <45	1,842.08	1,791.78	1,771.52	1,744.56	1,715.78	1,646.76	1,585.22
45 to 64	7,076.64	6,903.46	6,773.12	6,641.56	6,411.54	6,153.78	5,897.58
65 to 69	15,767.28	15,978.62	16,368.74	16,895.90	16,975.40	17,149.42	17,538.10
70-74	13,080.94	13,647.66	14,322.88	14,967.58	15,115.86	15,278.12	15,631.94
75-79	9,080.94	9,463.14	9,820.30	10,117.54	10,576.94	11,296.14	11,789.56
80-84	6,137.60	6,301.04	6,441.96	6,610.14	6,737.94	7,098.58	7,447.08
85+	7,021.14	7,001.80	7,052.58	7,099.28	6,902.06	6,966.30	7,062.08
Total (64 and under)	8,918.72	8,695.24	8,544.64	8,386.12	8,127.32	7,800.54	7,482.80

Age Interval	2017	2018	2019	2020	2021	2022	2023
Total (65 and over)	51,087.90	52,392.26	54,006.46	55,690.44	56,308.20	57,788.56	59,468.76
Total (All)	60,006.62	61,087.50	62,551.10	64,076.56	64,435.52	65,589.10	66,951.56

Source: Universe counts are based on a 5-percent extract of the Medicare administrative records and are computed as 20 times the extract counts.

Notes: Puerto Rico beneficiaries are excluded from counts beginning in 2017 by sample design.

Totals do not necessarily equal the sum of rounded components.

The target sample size of the MCBS varies slightly each year. Most recently, it has been designed to yield 8,218 completed cases providing Cost Supplement data per year (approximately 600-700 disabled enrollees under the age of 65 in each of two age strata, and 1,300-1,500 enrollees in each of five age strata for enrollees 65 and over) from 2023 onwards.

To achieve the desired number of completed cases, the MCBS selects new sample beneficiaries each year (referred to as the Incoming Panel) to compensate for nonresponse, attrition, and retirement of sampled beneficiaries in the oldest panel (referred to as the exit panel) and to include the current-year enrollees, while continuing to interview the non-retired portion of the continuing sample. The Incoming Panel is always added in the Fall round (also referred to as the Baseline interview); the retiring or exit panel occurs in the Winter round (and is the 11th and final interview for all respondents).

Each year, an analysis of non-response and attrition is conducted to determine the optimal sample size for the Fall round Incoming Panel. Through 2009, approximately 6,500 beneficiaries were added to the sample in the Fall (September – December) round each year to replace the exiting panel and to offset sample losses due to non-response and attrition. Beginning in the Fall round of 2010 and continuing through the decade, the number of beneficiaries included in the Incoming Panel sample release was gradually increased to compensate for declining response rates. Beginning in 2020 when interviewing shifted from in-person to telephone due to the COVID-19 pandemic, the Incoming Panel sample size was approximately 15,100. This increase is a reflection of the continued decline in response rates and the additional difficulty of locating respondents via telephone¹. The sample size results in over 34,000 interviews completed per year.

The methodology for drawing the samples is described later in this document. The number of cases to be selected each year for the Incoming Panel (designated sample sizes) are larger than the targeted number of completes to compensate for non-response, ineligibility, and attrition. Beginning in 2020 and through 2022, more sample was necessary to compensate for a switch from in-person interviewing to telephone interviewing and the expected lower response rates associated with that mode. With the reintroduction of in-person interviewing in late 2021, and the shift to multimode data collection, these additional increases have no longer been needed. To see an illustration of the extent of the compensation necessary in Fall 2021 Round 91 versus Fall 2023 Round 97 to achieve the desired number of cases providing annual data, see Table B.2.

Table B.2: Sample Size Needed to Compensate for Initial Non-Response and Ineligibility in the 2021 and 2023 Fall Rounds.

¹ Note that telephone numbers for beneficiaries are not available in the CMS administrative data used for sampling. Telephone numbers were appended to sampled addresses using vendor matching software; these numbers only sometimes reached the intended respondent. Additional manual locating was conducted by the field team to improve locating rates.

Table B.2: Sample Size Needed to Compensate for Initial Non-Response and Ineligibility

Age on December 31 of reference year	Desired average number of cases providing annual data	Number sampled at Fall 2021 Round 91	Number sampled at Fall 2023 Round 97
18-44	343	1,258	1,186
45-64	332	1,602	1,266
65-69	687	3,082	2,967
70-74	600	2,314	2,189
75-79	603	2,402	2,297
80-84	620	2,651	2,476
85+	648	2,641	2,714
Total	3,833	15,950	15,095

Proxy interviews are attempted for deceased sample persons. If data are collected through the date of death, then these cases are counted as completed interviews. Sampled beneficiaries remain in the survey when they are unavailable for an interview in a given round; that is, they are carried forward into the next round. For these individuals, the reference period for their next interview is longer as it covers the period since their last interview. This ensures that there will not be a gap in coverage of utilization and expenditure data. If a sampled beneficiary is not interviewed for two consecutive rounds, they are not scheduled for any further interviews and are removed from case management. Such cases are treated as nonresponding cases.

Cross-sectional sample sizes for other domains. There are multiple domains of interest in the MCBS, (for example, respondents with end-stage renal disease, persons residing in nursing homes, managed care enrollees, beneficiaries of various race and ethnic backgrounds, Medicaid recipients, and beneficiaries aligned to a provider participating in accountable care organizations). The MCBS will continue to maintain a minimum target of 8,000 to 9,000 completed responses in the annual Cost Supplement file to ensure that analysis can be performed on MCBS data for many domains of interest.

Sample sizes for longitudinal analyses. Beginning in 2018, under the rotating panel design specified for the MCBS, respondents remain in the sample for up to eleven rounds of data collection over a four-year period; prior to 2018, respondents remained in the sample for up to twelve rounds of data collection. The historical response rates and attrition rates observed in the MCBS are used to determine the rotational sample size and configuration of each new Incoming Panel. The rotational sample design attempts to achieve consistency in subgroup sample sizes across all panels comprising a particular calendar year.

Table B.3 (in section B2 below) presents the round-by-round conditional and unconditional response rates as of Round 91 (Fall round of 2021) for the samples (referred to in the table as “panels”) selected in 2015 through 2021. For example, from the bottom part of the table, it can be seen that by the 10th round of data collection for the 2018 panel, 19.0 percent of the 2018 panel were still in a formal responding status (that is, either the sampled beneficiary was alive and still participating in the study or had died but a cooperative proxy was found for the collection of data on the last months of life) or had participated in the survey until death, leaving enough data to estimate the last months of life. For the 2019 and 2020 panels, the unconditional response rates as of Round 91 were 21.9 percent (through the 7th round of data collection) and 22.8 percent (through the 4th round of data collection), respectively. The 2021 panel (the new

panel selected in Round 91) had an initial response rate of 38.1 percent in its first round of data collection.

Round 91 (Fall 2021) is the latest round for which MCBS data have been fully processed. There were 2,068 interviews successfully completed at Round 91 with still-living members of the 2018 panel. For brevity, we refer to these 2,068 interviews as “live completes.” For the 2019 and 2020 panels there were 2,404 and 3,412 live Round 91 completes, respectively. For the first round of data collection for the 2021 panel, there were 5,789 completes at Round 91.

The MCBS has used a variety of techniques to maintain respondents in the survey and reduce attrition. These will be continued and adapted to comply with the time frames for initiating and implementing the continuing sample.

B2. Procedures for Collecting Information

This section describes the procedures used to select the samples for the national survey. It includes a general discussion of the statistical methodology for stratification and rotational panel selection, estimation procedures, and the degree of accuracy needed. This is followed by a presentation of how instrument sections are used to enhance the analytic potential of the MCBS data. Finally, there is a discussion of rules for allowing proxy response.

a. Statistical Methodology for Stratification and Sample Selection

This section opens with a description of the MCBS sample design. This is followed by a general discussion of the selection of the original and annual new incoming samples and the use of Medicare administrative enrollment data each year to reduce problems associated with duplication of samples across the years.

1. PSU and Census tract clustering. The MCBS employs a complex multistage probability sample design. At the first stage of selection, the sample consists of 104² primary sampling units (PSUs) defined to be metropolitan areas and clusters of nonmetropolitan counties. At the second stage of selection, samples of Census tracts are selected within the sampled PSUs. At the third and final stage of selection, stratified samples of beneficiaries within the selected Census tracts are sampled at rates that depend on age group and ethnicity.

The strata used for selection of the PSUs covers the 50 states and the District of Columbia. Since PSUs were selected randomly with probabilities proportionate to size, there are some states without any sample PSUs within their boundaries. Within major strata defined by region and metropolitan status, PSUs were sorted by percent of beneficiaries enrolled in HMOs and/or percent of beneficiaries who are minorities based on data in CMS administrative files. Substrata of roughly equal size were created from the ordered list for sample selection.

In 2014, within the PSUs, a sample of 703 second-stage units (SSUs) consisting of Census tracts or clusters of adjacent tracts was selected. There were several steps in the SSU sampling process. First, an extract of the entire Medicare administrative enrollment data was obtained, and all beneficiaries' addresses were geocoded to the tract level. A minimum measure of size was used to determine whether a Census tract was large enough (i.e., had enough Medicare beneficiaries) to stand on its own as an SSU or would need to be combined with one or more adjacent tracts. A frame of 24,212 SSUs was then constructed, and a

² Note that prior to 2017, 107 PSUs were used for sampling for the MCBS. These included three PSUs in Puerto Rico. Beginning in 2017, Puerto Rico was removed from the MCBS sampling frame.

sample of 703 SSUs was selected using systematic probability proportional to size. These SSUs have been used for sampling MCBS beneficiaries since 2014³ and were sized to be used for up to 20 years. An additional sample of 339 reserve SSUs was also selected to support an expansion of the sample or the study of special rare populations in future years. To date, these reserve SSUs have not yet been used for sampling for the MCBS.

Table B.3: Conditional and Unconditional Response Rates as of the 2021 Panel for Medicare Current Beneficiary Survey by Interview Round

Conditional Response Rates (%) for Medicare Current Beneficiary Survey by Interview Round							
Round	2015 Panel (n at R73= 8621)	2016 Panel (n at R76= 12145)	2017 Panel (n at R79= 11623)	2018 Panel (n at R82= 11523)	2019 Panel (n at R85= 11615)	2020 Panel (n at R88= 15952)	2021 Panel (n at R91= 15950)
Round 1	53.3	54.7	55.3	55.9	55.1	41.9	38.1
Round 2	83.2	81.4	79.9	80.9	73.4	78.3	
Round 3	82.7	83.9	83.1	82.2	83.5	82.2	
Round 4	80.0	84.2	85.1	84.7	83.9	81.9	
Round 5	88.3	87.9	88.1	74.9	84.4		
Round 6	88.0	87.7	85.7	89.3	89.1		
Round 7	87.7	88.1	89.4	88.9	86.1		
Round 8	91.5	90.9	80.3	89.9			
Round 9	92.0	89.2	92.7	92.4			
Round 10	91.9	93.2	91.4	89.7			
Round 11	96.8	91.4	95.7				

Unconditional Response Rates (%) for Medicare Current Beneficiary Survey by Interview Round							
Round	2015 Panel (n at R73= 8621)	2016 Panel (n at R76= 12145)	2017 Panel (n at R79= 11623)	2018 Panel (n at R82= 11523)	2019 Panel (n at R85= 11615)	2020 Panel (n at R88= 15952)	2021 Panel (n at R91= 15950)
Round 1	53.3	54.7	55.3	55.9	55.1	41.9	38.1
Round 2	44.2	44.3	43.7	44.8	40.2	32.5	
Round 3	31.7	38.1	37.7	37.6	37.9	27.2	
Round 4	32.9	33.3	33.7	34.3	32.1	22.8	
Round 5	31.3	29.0	28.2	26.7	28.0		
Round 6	28.1	27.5	27.3	27.6	25.2		
Round 7	25.6	25.5	26.2	24.5	21.9		
Round 8	23.0	21.9	21.6	22.5			
Round 9	22.7	22.1	22.7	21.0			
Round 10	21.7	21.8	20.7	19.0			
Round 11	21.7	20.4	20.3				

Note: In rounds where some cases are intentionally not fielded, unconditional response rates will be lower than they would have been if all eligible cases were fielded. For example, some cases were intentionally not fielded in Summer 2016 (Round 75) and Winter 2018 (Round 80). In Summer 2016 (Round 75), some cases were intentionally not fielded and instead were included in an early case release for Fall 2016 (Round 76). The resulting unconditional

³ Beginning in 2017, the 18 SSUs selected from the three Puerto Rico PSUs were removed from the sampling frame, leaving 685 SSUs for sampling for the MCBS.

response rate for the 2015 panel in its 3rd round was lower than it would have been had the cases been fielded, but increased again in the subsequent round. In Winter 2018 (Round 80), a group of 306 cases was intentionally not fielded as part of a strategic NIR experiment, affecting the 2015 and 2016 panels in their 8th and 5th rounds, respectively. In Winter 2019 (Round 83), a group of 600 cases was intentionally not fielded as part of a strategic NIR experiment, affecting the 2016 and 2017 panels in their 8th and 5th rounds, respectively.

2. Selection of beneficiaries. As described earlier, an annual Incoming Panel sample of beneficiaries is selected from the Medicare administrative enrollment data⁴. This sample is clustered within the selected PSUs and SSUs and is designed to achieve uniform sampling weights within each strata. Beginning in 2015, beneficiaries eligible *anytime* during the sampling year are also included in the Medicare administrative enrollment sampling frame (referred to as current-year enrollees). Also beginning in 2015, Hispanic beneficiaries living outside of Puerto Rico were oversampled. Nursing home residents are drawn into the sample in exactly the same manner as other beneficiaries residing in the community.

b. Estimation Procedure

To date, sampling weights have been calculated for each Fall round (1, 4, 7..., and 91) in order to produce the Survey File limited data sets (previously referred to as the Access to Care files), and for each calendar year in order to produce the Cost Supplement limited data sets (previously referred to as the Cost and Use files). In both cases, cross-sectional and longitudinal weights have been calculated. Some questionnaire sections fielded in the Winter or Summer rounds have specific cross-sectional weights calculated for them as well. In all cases, weights reflect differential probabilities of selection and differential nonresponse, and are adjusted to account for overlapping coverage of the panels included in the data files. Replicate weights were also calculated so that users can calculate standard errors using replication methods. In addition to the replicate weights, stratum and unit codes exist on each weight file for users who prefer to use Taylor Series methods to estimate variances.

Besides standard weighting and replicate weighting, another part of the estimation program includes the full imputation of the data sets to compensate for item non-response. Imputation of charges for non-covered services and sources of payment for covered services in the Cost Supplement files have been developed. Beginning with the 2015 data, unit-level imputation was also instituted to compensate for missing initial-round utilization and cost data⁵ for current-year enrollees. The weighting and imputation of data continue each year.

c. Degree of accuracy needed for the purpose described in the justification

A broad range of statistics are produced from the MCBS. There is no single attribute of beneficiaries and their medical expenses that stands out as the primary goal of the survey. Thus, there can be no simple criterion for the degree of reliability that statistics for each analytic domain should satisfy. Even with a larger sample size of 14,000 to 15,000 persons, there would be many small domains of interest for which it would be necessary to use modeling techniques or to wait several years for sufficient data to accumulate.

The MCBS will maintain a stratified approach to the selection of the sample. The sample will continue to be clustered by PSU and Census tract-based SSU and stratified by age domain and race/ethnicity; the tract-based SSU approach was an innovation first begun in 2014 which has resulted in greater efficiencies and increased analytic opportunities. We anticipate maintaining a

⁴ Note that the sample released was larger than most previous MCBS samples due to the continued reliance on telephone interviewing and the associated expected lower rates of locating and response.

⁵ Events and costs incurred after enrollment in Medicare but prior to the first interview.

total of 600-800 annual cases allocated to the two younger age categories for disabled beneficiaries who are not yet 65. The two age categories were selected because they indirectly reflect the means by which the disabled person becomes eligible for Medicare. Since the number of disabled sample persons per PSU and Census tract will be small, the effects of clustering on statistical precision should be mild for this subgroup. For example, depending on the prevalence of the characteristic being estimated, the MCBS has achieved standard errors for estimates of percentages ranging from 2-3% or lower for subgroup estimates based on 1,000 respondents.

Since many of the cost and reimbursement statistics derived from the MCBS may be heavily right-skewed (i.e., reflecting the higher end of the cost/reimbursement spectrum to a disproportionate degree), the accuracy may be lower in relative terms but still acceptable. For example, the relative standard error of the mean total Medicare reimbursements derived from the MCBS has generally ranged from 2.0-2.5% for the total sample, and 4.0-8.0% for subgroups.

Each of the age strata for the Medicare sample age 65 and over will be allocated 1,300-1,700 cases, with the oldest stratum (age 85 and over) being allocated about 1,900 cases with oversampling. A major reason for oversampling the very old is to obtain an adequate sample of nursing home stays. Variations in sampling weights across the age strata and clustering within PSU and Census tract will inflate sampling errors, but the resulting effective sample sizes should be adequate for most analyses.

d. Review of interview content for periodic data collection cycles to reduce burden.

1. Content and timing of instrument sections.

The primary variables of interest for the MCBS are the use and cost of health care services and associated sources and amounts of payment. While Medicare claims files supply information on billed amounts and Medicare payments for covered services, the survey provides important self-reported information on use of services not covered by Medicare and on payment sources and amounts for costs not reimbursed by Medicare. For both the Community and Facility components, the primary focus of the data collection is on use of services (dental, hearing and vision care, hospital, physician, medical providers, prescription medication and other medical services), sources and amounts of payment, and health insurance coverage. The MCBS interview collects continuous information on these items through thrice-yearly interviews; that is, once a new respondent completes their Baseline interview, they are asked utilization and cost questions each round.

Continuous data on utilization and expenditures are required for a number of reasons. First, several of the distinct expenditure categories involve relatively rare medical events (inpatient hospital stays, use of home health care, purchase of durable medical equipment, and so forth), so limiting the reference period would mean insufficient observations for annual estimates. Second, episodes of medical care often consist of a series of services over weeks or months; data collected several times a year allow examination of the grouping of services and costs around particular episodes of care. Third, payment for medical services often occurs considerably later than the utilization, so collection of complete information about a particular event can often only be obtained sometime after the event occurs.

The administration of the instruments will continue to follow the established pattern of data collection. Baseline interviews will be conducted in the initial interview with new Incoming Panel respondents. This will be followed with 10 interviews to collect utilization, cost and other important topics, referred to as Continuing interviews. Since the Baseline interview always occurs in the last four months of a calendar year, collection of utilization and

expenditure data in the second interview means the reference period will always begin prior to January 1st. This creates use and expenditure estimates on a calendar year basis.

The literature (initially reported by Neter and Waksberg in 1964⁶ and confirmed in subsequent research by other analysts) indicates that collection of behavioral information in an unbounded recall period can result in large recall errors. The Incoming Panel interviews covered in this clearance request - Fall 2024 (Round 100), Fall 2025 (Round 103), and Fall 2026 (Round 106) -prepares the respondent for the collection of utilization and expenditure information in subsequent rounds, thus “bounding” the recall period for the next interview. During the Baseline interview, the respondent is provided with a calendar and interviewers emphasize the importance of this tool for use in future interviews. This calendar marks the recall period for the respondent and serves as the means to record utilization as well as a prompt to retain statements and bills.

2. Content of the instruments, Rounds 101-109.

Nearly all of the instrument sections as currently approved by OMB are unchanged. Table B.4 presents the core and topical sections that comprise the MCBS Community instrument. As shown in the table, the content and order of administration varies based on season of data collection (Fall, Winter, Summer) and the type of interview (Baseline, Continuing). Those sections with an asterisk (*) include a revision contained in this clearance request (either adding or deleting questions). Occasionally an item may be moved from one questionnaire section to another to improve the flow and use of the data, or for other operational or analytic purposes.

Table B.4: Community Instrument Sections and Order of Administration

Section Listed in the order in which the section is administered.	Type of Section (Core or Topical)	Season of Administration (Rounds Administered)	Interview Type (Baseline, Continuing, Both)
Introduction (INQ)	Core	All (Round 101-109)	Both
Enumeration (ENS)	Core	All (Round 101-109)	Both
Housing Characteristics (HAQ)	Topical	Fall (Rounds 103, 106, 109)	Both
Health Insurance (HIQ)	Core	All (Round 101-109)	Both
Mobility of Beneficiaries (MBQ)	Topical	Fall (Rounds 103, 106, 109)	Both
Preventive Care (PVQ)*	Topical	All (Round 101-109)	Both
Health Status and Functioning (HFQ)*	Core	Fall (Rounds 103, 106, 109)	Both
Nicotine and Alcohol Use (NAQ)	Topical	Fall (Rounds 103, 106, 109)	Both
Satisfaction with Care (SCQ)	Core	Fall (Rounds 103, 106, 109)	Both
Cognitive Measures (CMQ)	Core	Fall (Rounds 103, 106, 109)	Both
Demographics and Income (DIQ)	Core	Fall (Rounds 103, 106, 109)	Baseline
COVID-19 (CVQ)	Topical	Winter (Round 101, 104, 107)	Continuing
Immunization (IMQ)*	Topical	Winter (Round 101, 104, 107)	Continuing
Beneficiary Knowledge and Information Needs (KNQ)*	Topical	Winter (Round 101, 104, 107)	Continuing

⁶ Neter J. Waksberg J. A Study of Response Errors in Expenditures Data from Household Interviews. Psychology. Journal of the American Statistical Association. March 1964.

Section Listed in the order in which the section is administered.	Type of Section (Core or Topical)	Season of Administration (Rounds Administered)	Interview Type (Baseline, Continuing, Both)
Usual Source of Care (USQ)	Core	Winter (Round 101, 104, 107)	Continuing
Telemedicine (TLQ)	Topical	Winter (Round 101, 104, 107)	Continuing
Chronic Pain (CPQ)	Topical	Summer (Rounds 102, 105, 108)	Continuing
Income and Assets (IAQ)*	Core	Summer (Rounds 102, 105, 108)	Continuing
Drug Coverage (RXQ)*	Topical	Summer (Rounds 102, 105, 108)	Continuing
Dental, Vision, and Hearing Care Utilization (DVH)	Core	All (Round 98-106)	Continuing
Emergency Room Utilization (ERQ)	Core	All (Round 101-109)	Continuing
Inpatient Utilization (IPQ)	Core	All (Round 101-109)	Continuing
Outpatient Utilization (OPQ)	Core	All (Round 101-109)	Continuing
Institutional Utilization (IUQ)	Core	All (Round 101-109)	Continuing
Home Health Utilization (HHQ)	Core	All (Round 101-109)	Continuing
Medical Provider Utilization (MPQ)	Core	All (Round 101-109)	Continuing
Access to Care (ACQ)	Core	Winter (Rounds 101, 104, 107)	Continuing
Prescribed Medicine Utilization (PMQ)	Core	All (Round 101-109)	Continuing
Other Medical Expenses (OMQ)	Core	All (Round 101-109)	Continuing
Statement Cost Series (STQ)	Core	All (Round 101-109)	Continuing
Post-Statement Cost (PSQ)	Core	All (Round 101-109)	Continuing
No Statement Cost Series (NSQ)	Core	All (Round 101-109)	Continuing
Cost Payment Summary (CPS)	Core	All (Round 101-109)	Continuing
Physical Measures (PXQ)^	Core	Winter (Rounds 101, 104, 107)	Continuing, Exit Panel Only
Physical Measures (PXQ)^	Core	Summer (Rounds 102, 105, 108)	Continuing, All Other Panels
End Section (END)	Core	All (Round 101-109)	Both

^Only conducted for in-person interviews.

The Facility instrument collects information that is similar in content to the Community instrument. Table B.5 presents the core and topical sections that comprise the MCBS Facility instrument. As with the Community instrument, the content and order of administration varies based on season of data collection (Fall, Winter, Summer) and the type of interview (Baseline, Continuing). Those sections with an asterisk (*) include a revision contained in this clearance request (either adding or deleting questions).

Table B.5: Facility Instrument Sections and Order of Administration

Section	Type of Section (Core or Topical)	Season of Administration (Rounds Administered)	Interview Type (Baseline, Continuing, Both)
Facility Questionnaire (FQ)	Core	All (Round 98-106)	Both
Residence History (RH)	Core	All (Round 98-106)	Both
Background Questionnaire (BQ)	Core	Fall (Rounds 100, 103, 106)	Baseline
Health Insurance (IN)	Core	Fall (Rounds 100, 103, 106)	Both
Use of Health Services (US)	Core	All (Round 98-106)	Continuing
Expenditures (EX)	Core	All (Round 98-106)	Continuing
Health Status (HS)	Core	Fall (Rounds 100, 103, 106)	Both
COVID-19 Beneficiary (CV)	Topical	Winter (Rounds 98, 101, 104)	Continuing
Facility Questionnaire Missing Data [^]	Core	All (Round 98-106)	Both
Residence History Missing Data [^]	Core	All (Round 98-106)	Both
Background Questionnaire Missing Data [^]	Core	Fall (Rounds 100, 103, 106)	Baseline

[^]Section only activated and available for administration when critical data points from the FQ, RH, or BQ sections are marked as missing, Don't Know, or Refused.

The revision to this OMB package includes the following content changes to the Community questionnaire.

Summary of instrument changes beginning in Winter 2025 Round 101 through Fall 2027 Round 109:

- Add five new questions on beneficiary knowledge of IRA provisions to the Beneficiary Knowledge and Information Needs Questionnaire (KNQ).
- Streamline and enhance collection of immunization information via a new Immunization Questionnaire (IMQ) containing two existing items migrated from the Preventive Care Questionnaire (PVQ) and 16 new items about immunization uptake, location, and cost-sharing for the shingles, pneumonia, and RSV vaccinations.
- Redesign the existing Income and Assets Questionnaire (IAQ), which includes overarching changes to section structure to enhance analytic utility and respond to policy needs, deletion of 25 items which are no longer relevant, and the addition of three items related to other financial investments, 22 new items on medical and credit card debt, one new item related to financial liquidity, and four new items related to participation in and awareness of Federal assistance programs.
- The addition of one new item on financial assistance programs for medical bills (charity care) and the deletion of one item related to outstanding medical bills in the Health Status and Functioning Questionnaire (HFQ).
- Update respondent materials to increase understanding of the survey and improve participation.

Streamline and expand immunization content via a new Immunization Questionnaire (IMQ). The Inflation Reduction Act (IRA) of 2022 expands access to vaccines recommended by

the Advisory Committee on Immunization Practices (ACIP⁷) by eliminating cost-sharing for certain vaccine types. Although the MCBS currently asks beneficiaries about whether they receive flu, shingles, pneumonia, and COVID-19 vaccines in the Preventive Care Questionnaire (PVQ) and COVID-19 Questionnaire (CVQ), respectively, these items are administered during different seasons and contain inconsistent follow-up questions. For example, for beneficiaries who report receiving the flu vaccine, additional questions are asked about vaccine cost-sharing and vaccination site. For beneficiaries who have ever received a shingles or a pneumonia vaccine, no information on the timing or cost of vaccination is currently collected. Further, information on whether a beneficiary has ever received a particular vaccine, where the vaccine was administered, whether the beneficiary had to pay a portion of the cost for their vaccine, and why a beneficiary may have foregone vaccination is not available from existing administrative data. As a result, CMS is currently unable to evaluate the impact changes to vaccine cost-sharing due to IRA provisions have on vaccine uptake. CMS is also currently unable to identify characteristics of beneficiaries who may benefit from additional outreach or areas of focus during any vaccination outreach effort. CMS will fill this important data gap by streamlining the current collection of immunization information in existing questionnaire sections and forming a dedicated IMQ for better administration. Starting in Winter 2025, the IMQ will standardize and expand collection of vaccine data on the MCBS to include vaccines made accessible by IRA. The series will migrate two existing items on the prevalence of pneumonia and shingles vaccines from the PVQ and will include a new item about the prevalence of the respiratory syncytial virus, or RSV. Age requirements for the existing shingles vaccine item will be removed to account for beneficiaries who may have received the vaccine due to increased risk for shingles.

For each of the three vaccine types (RSV, pneumonia, shingles), beneficiaries will receive a standard flow of questionnaire items. First, beneficiaries will be asked if they have *ever* received the vaccine. If they have, follow-up questions will ask about the timing of vaccination (before January 1, 2013, for first time IMQ respondents), where the beneficiary received the vaccine, and whether the beneficiary had to pay “some or all of the cost” for the vaccine they received. If the respondent indicates they have never received a vaccine, one follow-up question on the reason for not getting vaccinated will be asked. Beneficiaries who never reported receiving a vaccine will be asked if they have ever received a vaccine since their last Winter round interview; follow-up questions on vaccination site and cost-sharing will be asked if they have received one. These items were adapted from existing MCBS items and revised to align with corresponding items on the National Health Interview Survey (NHIS).

Standardizing data collection for existing vaccine types and extending data collection to the RSV vaccine will enable CMS to measure changes in vaccine uptake related to IRA. The addition of follow-up items that capture reasons for not getting vaccinated, the timing of each vaccination, and vaccination cost-sharing will allow CMS to evaluate beneficiary experiences with cost-sharing implementation after IRA went into effect. Rationalizing and modifying data collection for these items will also help to satisfy OMB’s 2024 Terms of Clearance directing CMS to propose a set of IRA focused items on vaccine cost sharing.

These data will also inform CMS’ efforts to improve access to care for vulnerable population groups. CMS Part B previously added additional payment for COVID-19 vaccines administered in-home. To further expand access for vulnerable population groups, CMS will use the new IMQ to evaluate reasons for not getting vaccinated, as well as to identify places where vulnerable population groups currently get vaccinated.

⁷ <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

Five new questions on beneficiary knowledge of Inflation Reduction Act (IRA) provisions.

Redesign Income and Assets Questionnaire. Five new questions assessing knowledge and awareness of beneficiary-centric IRA provisions will be added to the Beneficiary Knowledge and Information Needs Questionnaire (KNQ) in Winter 2025. Collecting these data will help the Department of Health and Human Services (DHHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) and other CMS stakeholders better understand beneficiaries' overall awareness of key IRA provisions, evaluate changes in beneficiaries' awareness over time, as well as assess whether awareness of these provisions varies by the health and/or demographic characteristics of beneficiaries. Understanding the extent to which Medicare enrollees are aware of these provisions will provide the federal government with valuable data on whether additional outreach should occur and if these efforts can be specialized for different parts of the Medicare populations. Certain demographic groups may be less aware of the various provisions and may benefit from tailored outreach and education efforts.

Three of the proposed items were sourced from the Kaiser Family Foundation (KFF) Health Tracking Poll⁸. Respondents are asked if they are aware of a federal law that requires the federal government to 1) negotiate certain prescription drug prices for people with Medicare, 2) places an annual limit on out-of-pocket prescription drug costs, or 3) caps the cost of insulin to \$35 per month for people with Medicare. In addition, ASPE recommended inclusion of two additional items to measure awareness of 1) the removal of out-of-pocket costs for Part D recommended vaccines and 2) the Medicare Prescription Payment Plan, which allows Medicare Part D enrollees to spread their out-of-pocket prescription drug costs out over the year. All five proposed items will appear together in the KNQ. The inclusion of these items helps to satisfy OMB's 2024 Terms of Clearance directing CMS to propose a set of Inflation Reduction Act (IRA) focused questions, including items on beneficiary awareness of the annual out-of-pocket spending cap and out-of-pocket smoothing.

Redesigning the Income and Assets Questionnaire (IAQ). The MCBS Income and Assets (IAQ) questionnaire is administered once per year during the Summer round. The redesigned IAQ will be implemented in Summer 2025 and will include a number of changes to align the collection of income and assets data to more accurately reflect the needs of policy makers and CMS stakeholders.

The IAQ collects detailed information on the financial well-being of Medicare beneficiaries that is not available elsewhere in enrollment or claims data. The section asks questions on employment, sources of income, as well as home and asset ownership. These data make it possible for CMS to understand the financial setting in which Medicare beneficiaries make decisions about their healthcare, as well as to evaluate whether beneficiaries with certain characteristics may be differentially impacted by policy changes. CMS regularly publishes estimates from the IAQ; the table package on *Financial Well-Being of Medicare Beneficiaries* is an annual Public Use File that provides estimates on labor force participation, asset ownership, and median value of assets owned by Medicare beneficiaries^{9,10}. These estimates are used to illustrate subpopulation differences in income and access to housing and other resources among Medicare beneficiaries. For example, according to the *Financial Well-Being of Medicare Beneficiaries*, there are significant differences in asset ownership rates among Medicare beneficiaries. In 2021, 58 percent of White non-Hispanic beneficiaries living in the community

⁸ <https://files.kff.org/attachment/Topline-KFF-Health-Tracking-Poll-November-2023.pdf>

⁹ <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-tables/2021-mcbs-puf-financial-well-being-medicare-beneficiaries>

¹⁰ [Financial Assets \(norc.org\)](https://www.norc.umd.edu/financial-assets)

had a retirement account, compared with 20 percent of Black non-Hispanic beneficiaries and 19 percent of Hispanic beneficiaries.

The redesigned IAQ contains several overarching changes to increase analytic utility for researchers and meet the needs of key CMS stakeholders, including ASPE and the Consumer Financial Protection Bureau (CFPB).

- While the previous version of the IAQ included both spouses and unmarried partners in the “household” definition, the redesigned IAQ will define “household” as the beneficiary and their spouse, if the beneficiary and spouse live together. This definition will align the data collected from the redesigned IAQ with eligibility rules for Medicare and Social Security programs, which do not count the income, assets, or debts of unmarried partners. This change will support ASPE’s evaluation of beneficiaries who may be impacted by provisions of the Inflation Reduction Act (IRA) of 2022 using data from the redesigned MCBS IAQ. This change will also allow CMS to more accurately estimate the number of beneficiaries who may be eligible for different Medicare programs but not currently enrolled.
- The redesigned IAQ will include follow-up ranges to collect approximate asset amounts when exact dollar amounts are unknown. This change will improve the quality of post data collection processing and resulting data by enhancing reporting at income and asset amount items and mitigating non-response. Where possible, the ranges were constructed using historical MCBS data for each asset. The credit card and medical debt ranges were modeled after similar items sourced from the Census Bureau’s Survey of Income and Program Participation (SIPP)¹¹.
- The redesigned IAQ will continue to collect information about beneficiary assets, such as retirement accounts, stocks, and savings accounts. Three new items sourced from SIPP will be added to the series to collect ownership and worth of any other financial investments not already discussed, such as a business, real estate, and boats. The objective of this change is to capture more comprehensive data on assets used by Medicare and Social Security beneficiaries to determine eligibility for different programs, thereby allowing CMS to more accurately assess impact of any future policy changes.

The redesigned IAQ will include several new items to collect information related to beneficiary experiences with IRA provisions, which will support the analytic needs of CMS, ASPE, and CFPB as well as address OMB’s terms of clearance requesting that CMS add IRA-related items to the 2025 questionnaires. Data on debt, financial liquidity, and Federal assistance program participation and awareness, not currently available from other CMS data sources, will enable CMS and stakeholders to evaluate financial relief provided by the IRA to Medicare beneficiaries. These content additions will include:

- **22 new items on medical and credit card debt.** Although debt is an important component of beneficiaries’ financial well-being, the MCBS does not currently collect any information on this topic, with the exception of a question on debt against beneficiary’s primary residence. The redesigned IAQ will include 19 new items on medical debt adapted from the KFF Health Care Debt Survey¹². Respondents will first be asked to report prevalence of medical debt by creditor type, including medical or dental bills a)

¹¹ <https://www.census.gov/programs-surveys/sipp.html>

¹² <https://files.kff.org/attachment/TOPLINE-KFF-Health-Care-Debt-Survey-March-2022.pdf>

being paid off over time directly to a provider, b) being paid off over time via a credit card, c) owed to a bank, collection agency, or other lender, d) owed to a family member or friend, and/or e) any other medical or dental bills that the respondent is unable to pay. Respondents will then be asked to estimate the amount of debt owed by each debt type they endorsed. If the respondent is not able to report a numeric amount, they will be asked to provide the closest range category. Respondents who report any type of medical debt will also receive four follow-up items collecting additional details. These follow up items will ask if the medical bills leading to debt were bills for the beneficiary's care or someone else's care; enumerate what types of medical events contributed to medical debt; clarify if the medical bills were for a short- or long-term medical expense; and approximate the time range of the beneficiary's medical debt. The redesigned IAQ also will include three items sourced from SIPP that collect prevalence of credit card debt and, if applicable, the amount of debt owed.

By collecting comprehensive and nuanced information on the amount and source of medical debt, the proposed items on medical and credit card debt will fill an important gap in policymakers' understanding of the relationship between the Medicare program and beneficiaries' well-being. Analysis of these new items in combination with existing MCBS questions on access to care, health status, and forgone care, will also enable CMS and its stakeholders to evaluate financial relief provided by the IRA over time, better understand barriers to care, and get a comprehensive understanding of how beneficiaries pay for their care. This new series will shed light on the heterogeneity and degree of debt burden experienced by Medicare beneficiaries across creditor type. These items will also support the CFPB's ongoing study of the role of medical debt in consumer financial products and services, including its relevance to credit underwriting and impact on consumer financial health since the CFPB began operations¹³. Credit reporting data has become a limited source to measure medical debt among Americans, as increasingly medical bills are paid with credit cards or are excluded from credit reports. Therefore, data collected on large and representative surveys such as the MCBS are increasingly important in tracking patterns, trends and issues in unpaid medical bills and collections.

- ***One new item on financial liquidity.*** The redesigned IAQ will add one new item on financial liquidity sourced from the Federal Reserve Board Survey of Consumer Finances (SCF)¹⁴. The new item will capture the relationship between income and spending by asking if the beneficiary's family spending exceeded, met, or was less than their income over the past year. Household financial stability is a key priority of the CFPB and other federal regulators. The proposed question provides a way to identify Medicare beneficiaries living in households with positive cash-flow which is key to building and maintaining liquidity. The proposed question has been used on the SCF to understand households' response to income and expense shocks such as depleting assets and savings, taking on debt, or reducing/delaying spending (including on food, housing, and medical care)¹⁵. Understanding financial stability among Medicare beneficiaries is key to the CFPB's Office for Financial Protection of Older Americans¹⁶. This Office is tasked, among other things, with conducting research to educate older adults about personal finance management with a focus on planning for retirement and long-term care. Prior research commissioned by the CFPB found that positive cash-flow is a predictor of

¹³ https://files.consumerfinance.gov/f/201405_cfpb_report_data-point_medical-debt-credit-scores.pdf

¹⁴ <https://www.federalreserve.gov/apps/scfcb/detail/-/1/10235/X7510>

¹⁵ <https://www.federalreserve.gov/publications/files/scf17.pdf>

¹⁶ <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title12-section5493&num=0&edition=prelim>

retirees' ability to maintain their standard of living in retirement, and ability to afford long-term care costs¹⁷.

- **Four new items on Federal assistance program participation and awareness.** The redesigned IAQ will consolidate existing MCBS items regarding Federal assistance program participation into a single series at the end of the IAQ. This series will measure participation in Section 8 housing, the Supplemental Nutrition Assistance Program (SNAP)¹⁸, the Low-Income Subsidy (LIS)¹⁹, and the Medicare Savings Programs (MSP)²⁰ via existing items that have been migrated to the IAQ from various questionnaire sections including the Drug Coverage Questionnaire (RXQ) and KNQ. One new item will be added to this series to assess beneficiary participation in the Low-Income Home Energy Assistance Program (LIHEAP) from the Current Population Survey's (CPS) 2023 Annual Social and Economic (ASEC) Supplement²¹.

To support CMS' efforts to expand participation in certain Medicare assistance programs, this series will also feature revisions to existing items on LIS and MSP. Beneficiaries will first be asked two new items about awareness of LIS and MSP programs; those who respond affirmatively will be asked if they participate in the respective program(s). The purpose of these revisions is to improve measures of program awareness among beneficiaries who are not currently enrolled. In combination with rich demographic data and other data available from the MCBS, this information can be used by CMS stakeholders to estimate the number and characteristics of beneficiaries who may be eligible for existing programs but not currently enrolled²². Previous IAQ data has been used by the Office of Communications and others within CMS to improve their outreach strategies and make additional resources available to CMS partners and stakeholders²³. The inclusion of the consolidated Federal program participation and awareness series in the redesigned IAQ will provide CMS with a more comprehensive understanding of various non-CMS programs that Medicare beneficiaries rely on. Data provided by this expanded series will align with, and build on, aspects of the Supplemental Poverty Measure (SPM), which helps to determine the effects of government policies and determine the size and composition of the population whose basic needs are going unmet²⁴. Extensive research from the Census Bureau indicates that accounting for noncash government benefits and living expenses in determining who is in poverty provides a deeper understanding of economic conditions and policy effects^{25,26}.

Finally, the redesigned IAQ will include the deletion of 22 items, which are no longer policy relevant, including extensive follow-up items about employment, several items related to car ownership, and when the beneficiary started collecting Social Security. These updates will help

¹⁷ https://www.rand.org/pubs/working_papers/WR1224.html

¹⁸ Items on Section 8 housing and SNAP participation were sourced from the previous version of the MCBS IAQ

¹⁹ Item moved from the MCBS Drug Coverage Questionnaire (RXQ)

²⁰ Item moved from the MCBS Beneficiary Knowledge and Information Awareness Needs Questionnaire (KNQ)

²¹ Item sourced from Census [Current Population Survey, 2023 Annual Social and Economic \(ASEC\) Supplement](https://www.census.gov/research-statistics-data-and-systems/research/mcbs/data-tables/744519414/mcbs-puf-characteristics-medicare-beneficiaries-low-income-subsidy-enrollment-status-2021)

²² <https://www.cms.gov/research-statistics-data-and-systems/research/mcbs/data-tables/744519414/mcbs-puf-characteristics-medicare-beneficiaries-low-income-subsidy-enrollment-status-2021>

²³ <https://www.hhs.gov/about/news/2023/06/12/fact-sheet-biden-harris-administration-announces-new-tools-lower-prescription-drug-costs-low-income-seniors-people-disabilities.html>

²⁴ National Academies of Sciences, Engineering, and Medicine. 2023. An Updated Measure of Poverty: (Re)Drawing the Line. Washington, DC: The National Academies Press

²⁵ <https://www.census.gov/topics/income-poverty/supplemental-poverty-measure/about.html>

²⁶ https://www.census.gov/library/visualizations/2021/demo/poverty_measure-how.html

to offset the increase in respondent burden stemming from new items related to IRA provisions. In addition, this change results in the deletion of two items about LIS program applications from the RXQ and one item about MSP program application from the KNQ; these items are no longer necessary given the shift in focus to program eligibility vis-à-vis participation.

One new item on charity care. Many consumers struggle to afford the cost of medical services²⁷, and there are ongoing concerns amongst policymakers about the affordability of hospital care and the growing burden of medical debt. Building on the addition of new medical debt items in the redesigned IAQ, CMS seeks to add a new item on financial assistance programs for medical bills (referred to hereafter as charity care) in the Health Status and Functioning Questionnaire (HFQ) in Fall 2025 Round 103.

Federal law requires that nonprofit hospitals—which account for nearly three-fifths (58%) of community hospitals—provide some level of charity care as a condition of receiving tax-exempt status, and many state governments require all or a subset of hospitals to extend eligibility for charity care to certain groups of patients²⁸. It is unclear what proportion of patients are eligible for hospital charity care, what proportion of eligible patients benefit from these programs, and what share of their costs are covered. The available research indicates that not all patients eligible for financial assistance receive it and that inequities exist in the availability and supply of charity care, with hospitals serving low income and rural communities offering the least relief to patients^{29,30}.

Federal and state regulations do not consistently define or set minimum standards for hospitals to determine who is eligible for charity care or the level of assistance to be provided. Slightly over half of all states (26 states and DC), for example, require all or a subset of hospitals to extend eligibility for charity care to certain groups of patients. Medicaid and Medicare both provide supplemental payments to hospitals that are intended, at least in part, to offset the costs of charity care and other uncompensated care (e.g., disproportionate share hospital payments). From the available data, it appears that the total amount of tax relief for non-profit hospitals greatly exceeds the level of financial assistance hospitals provide in any given year³¹. Access to financial assistance can provide significant relief to the patients and families impacted by medical bills and collections, but financial assistance for medical care appears to be underused.

In the context of ongoing concerns about the affordability of hospital care and the growing burden of medical debt, several policy ideas have been initiated at the federal and state level to strengthen hospital charity care programs. To inform these initiatives and support the ongoing research of CFPB, CMS, and ASPE, it is important to better understand the patterns of use of charity care programs amongst Medicare beneficiaries.

²⁷ <https://www.consumerfinance.gov/data-research/research-reports/understanding-required-financial-assistance-in-medical-care/>

²⁸ <https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/>

²⁹ Dranove, D., Garthwaite, C., Ody, C. “A Floor-and Trade Proposal to Improve the Delivery of Charity Care Services by U.S. Noprofit Hospitals,” The Hamilton Project, Discussion Paper 2015-0, October 2015; O’Toole, T, Arbelaez, J, Lawrence, The Baltimore Community Healthy Consortium, “Medical Debt and Aggressive Debt Restitution Practices, Predatory Billing Among the Urban Poor, J. Gen Intern Med, 19:772-778, 2004.

³⁰ Mose, J., “A multilevel mixed-effects regression analysis of the association between hospital, community and state regulatory factors, and family income eligibility limits for free and discounted care among U.S. not-for-profit, 501 (c)(3), hospitals, 2010 to 2017,” BMC Health Services Research, 21:230, 2021

³¹ <https://www.consumerfinance.gov/data-research/research-reports/understanding-required-financial-assistance-in-medical-care/>

The new charity care item will be sourced from the 2022 Health Reform Monitoring Survey³² and will be added to an existing three-item series on trouble paying for medical bills and debt collection in the HFQ. This item will be fielded beginning in Fall 2025 Round 103 and will be fielded annually during the Fall round. At the same time, an existing item on outstanding medical bills will be removed from the HFQ starting in Fall 2025 Round 100, given its redundancy with the new medical debt series planned for the redesigned IAQ.

Update Respondent Materials. To maximize outreach, CMS is adding one new item to the suite of existing respondent material (see Attachment 7). The new refusal conversion letter is designed to address potential concerns about Medicare-related fraud, which has been cited as a reason for non-participation. Interviewers may request this letter to be sent to beneficiaries to establish legitimacy and motivate participation.

Rounds 98 through 106 Data Collection Procedures

1. Interviews with Incoming Panel sample persons in community. In the Fall rounds (Round 103, 106, 109), all newly selected beneficiaries will be mailed a Community Advance Letter from the Centers for Medicare and Medicaid Services (Attachment 1). Advance mail materials have been developed to accommodate interviews conducted in person and phone. Outreach with Incoming Panel beneficiaries is conducted by telephone and in-person visits following a process to identify viable phone numbers for beneficiaries.
2. When conducting in-person interviews, field interviewers will carry copies of the advance materials (e.g., advance letter, frequently asked questions) for respondents who do not recall receiving them in the mail, as well as a copy of the MCBS Community Brochure and At the Door Sheet (Attachments 1). Additional reminder letter, thank you letters acknowledging participation, and tailored refusal conversion letters provide additional ways to build rapport and gain cooperation with beneficiaries and further improve response rates.
3. The Community interviews (Rounds 101-109) will be administered to the respondent or a designated proxy using a CAPI program on a laptop computer. Attachment 2 includes a copy of all questionnaire sections administered in the Baseline interview, the Continuing interview, and the Showcards used by the interviewer to assist in the interviewing process.

After the completion of the Baseline interview (Rounds 103, 106, 109), each new respondent is offered an MCBS calendar (Attachment 1), on which he or she is encouraged to record health care events. The same calendar is offered to all Continuing Community respondents on a yearly basis. The calendar may be provided either during an in-person interview or by mail following a phone interview.

4. Interviews with sample persons in institutions. Regardless of mode of administration, all Facility interviews are administered to facility staff by field interviewers who use a CAPI program on a laptop computer. For all facility residents, the Facility Eligibility Screener is administered each time a respondent is found to have entered a facility, or in the case of Baseline respondents, is currently in a facility (Attachment 3). The Facility instrument to be used in Rounds 101-109 is shown in Attachment 4.

An advance letter is sent to all facilities prior to an interview contacting the facility for an interview (Attachment 5). CMS has also developed additional materials to gain cooperation including providing information on how to prepare for the interview, introducing the study to

³² <https://www.urban.org/sites/default/files/2022-10/HRMS-June-2022-survey.pdf>

staff at third-party billing offices who may provide additional survey responses, and thanking the facility staff for participation.

Some facility administrators will require consent of the sample person or a next of kin before releasing any information. The data collection contractor will offer to obtain such written consent, using the Resident Consent Form, and Next of Kin Consent Form. These forms as well as a HIPAA letter are included in Attachment 5.

e. Proxy rules.

For Community respondents, the preferred mode is self-response. Respondents are asked to designate proxy respondents. These are individuals who are knowledgeable about the respondent's health care. In the MCBS, only those individuals who are designated by the respondents can serve as proxy respondents. In addition, a proxy is utilized if a beneficiary had been reported as deceased during the current round's reference period or if a beneficiary who was residing in the community in the previous round had since entered into a long-term care facility. Proxy interviews are only used for the Community interview, as the Facility interview is conducted with a staff member located at the facility.

Upon screening a facility where a sampled beneficiary is determined to be living, the interviewers determine the appropriate staff at the facility best able to respond. MCBS interviewers do not interview residents in a facility. Instead, interviewers are trained to determine and seek out the appropriate staff for the interview. If a respondent is incarcerated, we do not seek response. Other institutions will be treated on a case-by-case basis.

B3. Methods for Maximizing Response Rates and Dealing with Issues of Non-Response

The sample for the MCBS is a heterogeneous population that presents a unique challenge for maximizing response rates. The survey selects respondents from two Medicare groups—those age 65 and over and those younger than 65 who have disabilities. Increasing age, poor health or poor health of a family member are common reasons for refusal. On the other hand, older persons are the least mobile segment of the population and thus, for a longitudinal survey, this population has a reduced likelihood of failing to locate the respondent.

Because this is a longitudinal survey, it is essential that we maximize the response rates. To do so, data collection staff undertake an extensive outreach effort each round. This includes the notification of government entities about the survey including CMS regional offices and hotline, carriers and fiscal intermediaries, and Social Security Offices, national organizations including AARP and various community groups (e.g., social service and health departments, home health agencies, state advocates for the elderly, and area agencies on aging). These efforts are undertaken to answer questions or concerns that respondents may have to increase the likelihood that respondents would participate in the MCBS and remain in the survey panel.

Further, with the integration of telephone outreach and interviewing, additional methods have been introduced to maximize participation among new Incoming Panel members. Prefield locating activities (including electronic database searches using LexisNexis[®] Accurint[®], Infutor[®] PowerFlex[®], and TransUnion[®] TLOxp batch processing) are used to verify or update selected sample addresses and to obtain telephone numbers when available. Additional mailings include reminder letters and use of FedEx priority mailings, along with intensive locating and tracing efforts to maximize response.

Efforts to maximize response rates include: 1) informing authoritative sources to whom respondents are likely to turn if they question the legitimacy of the MCBS; 2) giving interviewers resources to which they can refer to reassure respondents of the legitimacy/importance of the survey; 3) generally making information about MCBS available through senior centers and other networks to which respondents are likely to belong or reach out (such as the 1-800-Medicare hotline); 4) mailing reminder or refusal conversion letters to respondents to encourage their participation in the survey, and 5) prioritize in-person outreach and interviewing for certain case groups.

CMS intensively monitors both unconditional and conditional response rates. The unconditional response rate is the percentage of sample that were released during the fall round of the selection year and responded to the survey in a given year. The unconditional response rates, also called cumulative response rates, use the original selected sample size as the baseline in their calculation. Conditional response rates are the percentage of sample that were *eligible* at the beginning of the Fall round of a particular year and responded during that year. Conditional response rates use the sample who are eligible to participate in the survey (a subset of the sample released in the Fall round of the selection year) as the baseline in their calculation. In other words, they are conditioned on eligibility. Both indicators are very important for understanding trends about response rates and where interventions should optimally be targeted. These trends are monitored over the full historical span of the survey, providing important insights in changes to response rates over time.

Response is also tracked throughout each round by a host of key indicators including panel, HHS region, age, race, ethnicity, residential status (community or facility), current year Medicare enrollees or not-current year enrollees. In addition, performance by field interviewers is also tracked to identify any staff who need additional training or support to improve their interview completion rates. CMS continually analyzes response rates, particularly for the subpopulations with the lowest propensity to respond and is fully committed to finding ways to stem declining response rates.

In addition to outreach, the following efforts remain in place to maintain a sense of validity and relevance among the survey participants.

- a. An advance letter is sent to both sampled beneficiaries and facility administrators from CMS with the CMS Survey Director's signature. This includes an informational brochure answering anticipated questions. Reminder mailings are also sent to encourage response (Attachment 1 and 5).
- b. A handout with Privacy Act information and an appeal to participate is given to the respondent at the door by the interviewer (Attachment 1).
- c. Interviewer training emphasizes techniques and approaches effective in communicating with older adults and those with disabilities and ways to overcome difficulties respondents may have in participating.
- d. Individualized non-response letters are sent to respondents who refuse to participate (example included in Attachment 1). These letters are used when deemed appropriate by the field management staff.
- e. NORC field management staff are specialized to follow up with respondents who express concerns about participating due to privacy or confidentiality questions.
- f. Proxy respondents are sought for respondents unable to participate for themselves in order to keep respondents in the survey over the life of the panel.
- g. Non-respondents are re-contacted by a refusal conversion specialist.

- h. A dedicated project email address (mcbs@norc.org) and toll-free number (1-844-777-2151) is available to answer respondent's questions. This information is contained on various materials provided to the respondent.
- i. An MCBS website (mcbs.norc.org) contains information for respondents on the project and has recently been updated to include a short explanatory video. Respondents are also informed about the CMS MCBS Project Page – www.cms.gov/mcbs.
- j. Respondents receive an annual MCBS newsletter, which includes information about the survey as well as seasonal topics such as winter safety tips for seniors. Attachment 1 contains an example of a recent newsletter.
- k. Whenever possible, the respondent is paired with the same interviewer throughout the survey. This maintains rapport and establishes continuity of process in the interview.
- l. Interviewers are trained to utilize personal touches such as thank you notes and birthday cards to maintain contact with respondents.
- m. A Community Authority Letter (Attachment 1) is sent to community organizations in advance of the Fall rounds (Rounds 100, 103, 106) to inform community representatives, such as state-level departments of aging, insurance, and state senior Medicare patrol officers, about the MCBS.
- n. A language insert will be included with the Community Advance Letter for the Incoming Panel sample to provide an explanation of the survey for respondents who do not speak English or Spanish (Attachment 1).

In Fall 2023, OEDA and the CMS Office of Minority Health piloted enhanced outreach to sampled Medicare beneficiaries who identify as Hispanic, Black, or Asian. These efforts included updating interviewer training materials to include additional content on culturally specific issues or concerns respondents may have as well as tailoring outreach and contacting strategies, with an emphasis on in-person interactions with sample members predicted to be Hispanic, Black, or Asian. CMS will closely monitor the success of outreach and interviewing strategies and data collection progress amongst underserved minority groups. Analysis of response rates, level of contacting effort required to complete interviews, modes of outreach and mode of completed interviews will inform the feasibility of future efforts to expand the data available for underserved Medicare beneficiaries. Initial analyses indicate that the enhanced outreach and training contributed to a substantial increase in the number of interviews completed among beneficiaries who identify as Hispanic, Black or Asian, demonstrating that these strategies are an effective way to increase sample sizes for disparities research. CMS will continue to look for ways to increase participation in the MCBS amongst these beneficiaries.

A non-response bias analysis for the MCBS is conducted every three years. The most recent non-response bias analysis for the MCBS was conducted based on the 2021 Panel and was released in the final 2021 Methodology Report³³. This analysis also included beneficiaries who participated in COVID-19 surveys. While non-response is carefully monitored every year, a complete non-response bias analysis is updated every three years to ascertain trends both annually and for subpopulations. The next non-response bias analysis for the MCBS will be conducted based on the 2024 Panel and released with the forthcoming 2024 Methodology Report in the Fall of 2026.

In the most recent non-response bias analysis, Fall 2021 respondents and non-respondents were compared on various measures, including frame characteristics, Medicare claims payments, and chronic conditions, in order to identify areas of potential bias. The effects of weighting on potential nonresponse bias were also investigated: unweighted and weighted proportions of

³³ <https://www.cms.gov/files/document/2021-mcbs-methodology-report.pdf>

respondents across select frame-level attributes were compared to corresponding benchmarks. Small but statistically significant differences were found across many of these measures. Among the demographic characteristics, Incoming Panel nonrespondents appeared more likely to be female and younger, but the differences were not large. Continuing Panel nonrespondents generally tended to skew older than the respondents and were more likely to be Hispanic. In all panels, there were proportionately more respondents than nonrespondents located in the Northeast. Some of these demographic differences, such as imbalances among the youngest age group of MCBS beneficiaries, are related to lower phone match rates which make it more difficult to conduct interviews by phone. Significant differences were also found across various claims payment measures but were minimal and not consistently in the same direction (i.e., sometimes respondents had higher claims payments in certain settings, and other times nonrespondents did). The same was true for beneficiaries with chronic conditions: Incoming Panel respondents in the Fall round were more likely to have a few of the chronic conditions than nonrespondents, but in later rounds and for the continuing panels, nonrespondents were more likely to have some of the chronic conditions than were respondents. While many differences were found, most were not large in a practical sense. Furthermore, across most of these measures, weighted respondent distributions were closer to benchmarks than unweighted respondent distributions, suggesting that the potential bias identified via these analyses is expected to be minimized by the weighting procedures. In contrast to most surveys, the MCBS has a large amount of information to characterize nonrespondents. This information, including Medicare claims data, can be used for imputation if necessary. While the nonresponse bias analysis excluded Medicare Advantage (MA) enrollees from many analyses, it has been noted in recent years that MA beneficiaries are more likely to respond to the MCBS than those enrolled in original Medicare. Beginning in 2017, CMS introduced additional nonresponse adjustments and calibration of the MCBS weights to match enrollment benchmarks by Fee-for-Service (FFS)/MA status, to reduce or eliminate any potential bias the differential response rates by enrollment status may have introduced.

Over the rounds, the following patterns of nonresponse have been observed, which have or have not changed over time. In the most recent three rounds for which a full analysis of response rates have been completed, the round-level response rates for continuing panels remains high, ranging from 78.3% for the 2020 panel in Round 89 to 95.7% for the 2017 panel in Round 89. Despite these high rates, each year continuing panels are subjected to a nonresponse adjustment based on new response propensity models by panel. Incoming Panels at the first interview (e.g., the 2021 panel at Round 91) show a larger propensity for nonresponse due to having never been reached prior to the first interview. In Round 91 the response rate for the 2021 Incoming Panel was 38.1%. Once again, we rely on cells derived from response propensity models to account for differential effects of demographic and geographic characteristics on the resulting data. By accounting for these characteristics in constructing the adjustment cells, we reduce the potential for nonresponse bias that could arise due to these differential factors.

Adaptive design methods have also been applied to measure the representativeness of the MCBS incoming sample. In 2017, CMS conducted a review of the Representativity Indicators (R-indicators) or metrics for the Fall 2017 Baseline interview to monitor the representativeness of the achieved sample. The R-indicators provided a quantitative assessment of which segments of the sample were over/under producing and causing the achieved sample to be imbalanced in terms of sample representativeness.

A sample R-indicator as well as two partial R-indicators (variable and category) are used to monitor representativeness of the panel. The variable R-indicator measures the

representativeness of the sample associated with each variable (looking at the strength of each co-variate subpopulation such as race, ethnicity, age, sex, region) to predict response propensity. The category R-indicator then looks at the categories of each variable to measure representativeness of the responding sample.

Since their inception, R-indicators have not been observed outside these thresholds; consequently, no data collection interventions were needed to improve the representativeness of the achieved sample. Use of R-indicators, along with a continual review of annual and historical response rates and non-response bias analysis are important tools in understanding response and ensuring that the sample as a whole, as well as subpopulations, are represented to produce high quality data. Future analysis will also focus on the R-indicators found in in-person data collection as compared to telephone data collection for the Baseline sample.

Multimode Survey Administration

Following the MCBS transition from in-person to phone data collection due to the COVID-19 pandemic in 2020, in-person interviewing was slowly reintroduced starting in late 2021. The MCBS is now multimode and includes both phone and in-person outreach and interviewing, and CMS has demonstrated that multimode MCBS data collection offers many advantages.

Results of several in-depth analyses along with feedback from field staff have shown that phone data collection works well for a majority of interviews, maintaining stability in representativeness and data quality. The phone mode also offers a cost-effective option for both contacting and interviewing. In-person interviewing is preferred for the collection of cost data from beneficiaries with large health care needs and for some subpopulations such as persons with sensory impairments. In addition, collection of physical measures must be done during an in-person interview. In-person outreach has also been shown to be effective at improving response, particularly among Incoming Panel beneficiaries for whom it is difficult to locate a working phone number or who have proven difficult to reach by phone.

NORC interviewers conduct phone or in-person interviewing depending on the needs of the respondent and taking into consideration operational constraints. CMS also assumes a majority of Facility interviews will take place over the phone with a small proportion conducted in-person. This is based on finding that for Facilities new to the MCBS, in person outreach and interviewing appear to be the most successful means of gaining cooperation.

MCBS Mode Assignments

Starting in Fall 2023, CMS implemented a new Community data collection protocol involving case-level mode assignments. These assignments are designed to provide guidance to field interviewers and simplify tradeoffs between the cost-effectiveness of phone interviewing and specific situations where conducting in-person interviews may mitigate respondent burden and increase data quality. A model-based approach was used to develop separate assignment protocols for the Incoming Panel and Continuing Panels. Models assessed relationships between specific beneficiary characteristics and potential benefits of in-person data collection.

For Incoming Panel beneficiaries, the protocol leverages model results to assign the mode of outreach for individual beneficiaries based on characteristics including age, gender, race / ethnicity, and residence in urban vs. rural areas. For beneficiaries in the Continuing Panels, who have already provided additional demographic and health-related information in prior interviews, the protocol assigns the mode of interview based on similar characteristics as well as income and

education levels, prior levels of health care utilization, and whether or not the beneficiary has indicated experiencing serious difficulty hearing.

For each beneficiary, characteristics are assessed in combination with one another with formulas that tally the predicted benefit of in-person data collection. Beneficiaries with the highest predicted benefit are most likely to receive in-person assignments. The mode assignments are also designed with embedded flexibility for field staff, such that it is possible to switch modes as needed to mitigate respondent burden and accommodate respondent preferences. This protocol was well received by field staff and was effective in controlling data collection costs for Fall 2023. It will continue to be used and refined for future rounds of the MCBS.

B4. Tests of Procedures or Methods

MCBS' generic clearance for Questionnaire Testing and Methodological Research for the MCBS was first approved by OMB in May 2015 and most recently received approval for revision on June 24, 2021 (OMB No. 0938-1275, expiration 06/30/2024). The generic clearance encompasses development and testing of MCBS questionnaires, instrumentation, and methodological experiments. It contains approval for six types of potential research activities:

1) cognitive interviewing, 2) focus groups, 3) usability testing, 4) field testing (both within and outside the MCBS production environment), 5) respondent debriefing questionnaire, and 6) research about incentives. Any future changes to the MCBS instrumentation, data collection methods, or procedures that require testing will be submitted as individual collection requests under the generic clearance.

In December 2023-January 2024, CMS conducted a small number of cognitive tests (nine) with respondents in English and Spanish to test the comprehension and of new questionnaire items in the redesigned IAQ, including new items on Federal assistance program participation and awareness and items on medical and credit card debt. The redesigned section performed well based on this small number of cognitive interviews.

B5. Individuals Consulted on Statistical Aspects of Design

The person responsible for statistical aspects of design is:

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