

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

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Background

CMS is the largest single payer of health care in the United States. CMS plays a direct or indirect role in administering health insurance coverage for more than 120 million people across the Medicare, Medicaid, CHIP, and Exchange populations. A critical aim for CMS is to be an effective steward, major force, and trustworthy partner in supporting innovative approaches to improving quality, accessibility, and affordability in health care. CMS also aims to put patients first in the delivery of their health care needs.

CMS activities result in substantial data generation. Although administrative data are a critical resource for CMS and its partners, there remains an important need for self-reported data to obtain information that is not captured through other CMS operations. For example, a Medicare beneficiary's satisfaction with, access to, and quality of care are important pieces of information that can only be captured by obtaining the beneficiary's unique perspective. In addition, information on beneficiary insurance coverage and payments from non-Medicare sources (including beneficiary out-of-pocket spending) are collected by surveying beneficiaries because these data are currently not available to CMS from administrative sources. These survey-collected data elements, combined with CMS administrative data, complete the picture of a beneficiary's health care experience and provide a vital component in the development and evaluation of models and analysis conducted by CMS.

The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through operational or administrative data on the Medicare program. The MCBS is a continuous, multi-purpose longitudinal survey of Medicare beneficiaries that is sponsored by CMS and directed by the Office of Enterprise Data and Analytics (OEDA). The survey is conducted through a contract with NORC at the University of Chicago (NORC). Prior to the COVID-19 pandemic, interviews were traditionally conducted in-person using computer-assisted personal interviewing (CAPI). However, due to the COVID-19 pandemic, data collection switched to phone-only interviews in March 2020 and throughout most of 2021 with a gradual return to some in-person interviewing beginning in late 2021. MCBS data collection will continue to include both in-person and phone interviewing going forward to reduce costs, recognizing that in-person interviewing is necessary to improve response rates among selected populations and collect complex cost and utilization information while also retaining the benefit of reduced interviewer costs by collecting some data by phone. The respondent burden is the same regardless of mode of interview.

The MCBS has been continuously fielded since 1991, encompassing over 1.2 million interviews with more than 140,000 sampled beneficiaries. The MCBS respondents are interviewed up to three times per year over a four-year period; the rounds are referred to as Fall, Winter, and Summer. New beneficiaries always join in the Fall round; this panel's first round includes a Baseline interview and establishes a recall boundary for the next interview (the interview reference period is since the date of the previous interview). For the next 10 rounds (referred to as Continuing interviews), cost and utilization information and other health related questionnaire sections are administered to the panel. The panel exits the survey after its 11th interview which occurs in the Winter round.

The survey captures beneficiary information whether aged or disabled, living in the community or facilities, or serviced by managed care or fee-for-service. Questions are asked about beneficiaries' health care use, charges, insurance coverage, and payments over time. Respondents are asked about their sources of health care coverage and payment, their demographic and housing characteristics, their health and work history, and their experiences and perceptions of quality with their health care system. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g., fee-for-service claims, prescription drug event data, enrollment data, Medicaid payments and eligibility, and Medicare Advantage encounter records) to provide users with more accurate and complete estimates of total health care costs and utilization.

The primary goals of the MCBS are to:

- provide information on the Medicare beneficiary population that is not available in CMS administrative data and that is uniquely suited to evaluate or report on key outcomes and characteristics associated with beneficiaries treated in innovative payment and service delivery models;
- determine expenditures and sources of payment for all services (including services not covered by Medicare) used by Medicare beneficiaries, including copayments, deductibles, and non-covered services;
- ascertain all types of health insurance coverage among Medicare beneficiaries (e.g., Medigap coverage, retiree coverage) and relate this coverage to payment for specific services; and
- track changes in key beneficiary metrics over time, such as changes in health and functional status, spending down to Medicaid eligibility, access and satisfaction with the Medicare program and providers, and fluctuations in out-of-pocket spending.

The MCBS has been at the forefront of in-person (and now multimode) survey collection and data processing, most notably as one of the first surveys to successfully 1) implement a computer assisted personal interview (CAPI), 2) match survey and claims data to adjust and correct for underreporting in survey reported health care utilization and 3) conduct COVID-19 data collection. The CMS vision for the MCBS is to continue to provide policy-relevant, unique, high-quality, and high-value data in a timely manner, continue to break ground in innovative, efficient, and analytically powerful new areas of survey data administration, design, and development, and to increase the survey's ability to develop, monitor, assess, and evaluate the impact of CMS care delivery and payment models. To succeed in these areas, CMS is continuing to make improvements:

- increase response rates, understand and address non-response bias, and minimize burden;
- improve the integration of existing and new sources of administrative data with MCBS survey collected data;
- develop and implement more efficient, cost-effective, accurate, and innovative data collection strategies when possible;

- enhance the understanding of differences among racial and ethnic groups in their experiences; and
- enhance the understanding, usefulness, and promotion of MCBS through the dissemination of user tools and key scientific findings based on MCBS data.

This is a request for revision to the MCBS’s current OMB clearance (OMB No. 0938-0568, Ex. Date 8/31/2025). The purpose of this revision is to seek approval for CMS to add new items related to beneficiary-centric provisions of the Inflation Reduction Act (IRA) of 2022 to the MCBS Community Questionnaire beginning in 2025¹. The new items cover improved measures, streamlined content, and the addition of important IRA-related topics as requested by OMB in their terms of clearance specified in the approval of the 2024 MCBS. These items include:

- Five new questions on beneficiary knowledge of IRA provisions to be added to the Beneficiary Knowledge and Information Needs Questionnaire (KNQ),
- Improved immunization measures resulting in a new section (the 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, and
- A redesign to 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).

The estimated respondent burden is also updated to reflect a net increase of 6.4 minutes in annual burden. New respondent materials intended to address potential concerns about Medicare-related fraud and, thus, improve participation, have also been included in this request.

A. Justification

A1. Circumstances Making the Collection of Information Necessary

While the administrative data available to CMS via claims records are rich in breadth and accuracy, they do not contain important information that can only be obtained by interviewing beneficiaries. In particular, the current administrative information collected by CMS does not provide the complete picture needed for CMS to evaluate its programs and comply with legislative mandates found in both:

- a. Section 1115A of the Social Security Act, as established by Section 3021 of the Affordable Care Act (ACA) of 2010; and

¹ <https://www.congress.gov/117/plaws/publ169/PLAW-117publ169.pdf>

- b. Section 723 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.
- c. Section 1875 of the Social Security Act (42 United States Code 1395II)².

The MCBS supports CMS' program evaluation and legislative mandate compliance by providing data to determine expenditures and sources of payment for all services used by Medicare beneficiaries, including co-payments, deductibles, and non-covered services; to ascertain all types of health insurance coverage and relate coverage to sources of payment; and to trace processes over time, such as changes in health status and "spending down" to Medicaid eligibility and the impacts of program changes, satisfaction with care, and usual source of care. These unique design features of the MCBS enable it to support a variety of CMS functional areas. For example, the MCBS is used by CMS researchers to assess the potential number of beneficiaries eligible for proposed new care and payment models, their Baseline utilization and patterns of usual care, and the factors that help determine when and where beneficiaries seek care. In addition, the MCBS panel design provides essential longitudinal data to measure change over time. Last, a unique feature of the MCBS—the capacity to follow individuals from the community into and out of nursing facilities and hospitals—provides critical data including the opportunity to estimate the total cost of episodes of illness and level and type of system interventions including home health care, as well as the care transitions that occur across the various care providers.

A2. Purpose and Use of Information Collection

The MCBS continues to provide unique insight into the Medicare program and helps both CMS and external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives. In the past, MCBS data have been used to assess potential changes to the Medicare program. For example, MCBS data were instrumental in supporting the development and implementation of the Medicare prescription drug benefit by providing a means to evaluate prescription drug costs and out-of-pocket burden for these drugs to Medicare beneficiaries.

Moving forward, the MCBS will continue to play a critical role in aiding policymakers in administering, monitoring and evaluating the Medicare program, with an emphasis on supporting CMS efforts to test innovative payment and service delivery models' ability to reduce costs and improve quality. For example, the longitudinal and comprehensive nature of the MCBS provides the opportunity for both pre/post and observational studies (with a control and comparison group) for beneficiaries involved with CMS models or other CMS programs. Other areas that can only be captured by using survey data along with the CMS administrative data include changes to beneficiaries' financial well-being in relation to Medicaid eligibility requirements, changes to cost sharing and premiums, and the use and knowledge of existing and new Medicare-covered preventive services.

MCBS data will continue to be used by CMS to assess the impact of major policy innovations and health care reform on Medicare beneficiaries (pre- and post-implementation). For instance, better MCBS data about historically underserved populations could help design more targeted outreach strategies to eligible beneficiaries. MCBS data users continue to monitor delivery of

² <https://www.hhs.gov/foia/privacy/sorns/09700519/index.html>

services, sources of payment for Medicare covered and non-covered services, beneficiary cost sharing and financial protection, satisfaction with and access to health care services, and integration of patient care. Researchers can relate the dynamics of future aging patterns to age-specific rates of use of health care services. MCBS data also allow accurate measurement of total health care expenditures for beneficiaries and changes in private health insurance benefits (including long-term care insurance). The capacity to follow individuals into and out of nursing facilities and hospitals provides researchers the opportunity to estimate the total cost of episodes of illness and level and type of system interventions including home health care.

Researchers can assess the aggregate cost of short stays and long stays in nursing homes, and of combined hospital/nursing home stays. In addition, the MCBS data can be used to forecast the need and settings for selected chronic condition care and long-term care services by examining trends in the use of health care services, linked with morbidity, disability, and mortality data.

The MCBS is also an important tool for assessing health disparities among Medicare beneficiaries. With the inclusion of new health equity measures in the survey in Fall 2023, researchers have expanded ability to assess differences in health status and functioning, health care utilization and cost, and experiences with care among historically underserved groups. Additional efforts conducted in collaboration with the CMS Office of Minority Health (OMH) piloted enhanced outreach to sampled Medicare beneficiaries who identify as Hispanic, Black, or Asian in Fall 2023, which improved response rates for these populations and will expand the data available for underserved Medicare beneficiaries.

The comprehensive nature of the MCBS makes its data appealing to a broad spectrum of users. In addition to CMS use, the MCBS consistently provides value and unique data to external users, as demonstrated by more than 4,500 research articles and citations using the MCBS to date, over 250 MCBS Limited Data Set (LDS) files purchased and shipped to researchers each year, and over 150 MCBS Microdata Public Use File (PUF) downloads per month. MCBS survey data are also vital in the production of highly regarded publications, including the Medicare Payment Advisory Commission's annual data book "Health Care Spending and the Medicare Program," the Federal Interagency Forum on Aging Related Statistics' chartbook "Older Americans: Key Indicators of Well-Being," and CMS' Annual Trustees Report.

- Within CMS. Survey results have been and will continue to be used by various organizations within the CMS. CMS researchers have frequently used the data collected by the MCBS for a variety of purposes, including to assess the potential number of beneficiaries eligible for proposed new care and payment models, their utilization and patterns of usual care over time, and the decisional factors that help determine when and where beneficiaries seek care. CMS also uses the MCBS to benchmark to other federal surveys, where appropriate, and uses the information to produce estimates of health care utilization, costs, and well-being for underserved populations. CMS uses lessons learned from these analyses to inform future outreach to these populations.

The MCBS is used by the CMS Office of the Actuary to track trends in out-of-pocket spending and monitor Medicare supplemental insurance (Medigap) and is a major source of information for the annual Trustees' Report. MCBS data have also been used to track beneficiary's knowledge and sources of information about Medicare, especially following the implementation of a new program or services (e.g., Part D, "Welcome to Medicare")

benefits, etc.). Self-reported MCBS data on immunizations and preventive screenings are used to track whether CMS is meeting population health objectives.

Analysis of the facility component also allows CMS to examine expenditures that are covered by Medicaid, the shifts between private pay and Medicaid, and the cost implications for both Medicare and Medicaid in the areas of spending down assets and spousal impoverishment.

In other examples, the CMS Office of Communication uses the MCBS to track beneficiaries' knowledge and sources of information about Medicare as well as population out-of-pocket spending in the Plan Finder tool. Within CMS, there is also collaboration with the CMS OMH to improve MCBS survey measures used to track social risk factors and health disparities. Following pilot testing of tailored outreach strategies in Fall 2023, OEDA and CMS OMH will prepare an "early look" data file that serves as an accelerated release of data collected during the Fall 2023 interview from all respondents. CMS and OMH will also collaborate on data products highlighting findings of interest for the Medicare population as well as key subgroups. CMS and OMH are evaluating interviewer training, tailored outreach, contacting strategies, and lessons learned to inform the feasibility of future methodological changes on the MCBS.

CMS provides an annual annotated bibliography that includes research using MCBS data. This publication highlights the breadth of research that is made possible by MCBS data and is a helpful resource to CMS staff, other government researchers, and the research community at large. The bibliography is available at [CMS MCBS Bibliography](#).

- Other Governmental / quasi-governmental, outside CMS. The MCBS is a major source of information for the Medicare Payment Advisory Commission (MedPAC) to monitor access to health care and beneficiary financial protection. The MCBS data have been routinely included in MedPAC's Annual Reports and data collected by the MCBS have been used both in descriptive statistics and simulation.

The MCBS is also a major source of information for the Government Accountability Office (GAO) to monitor the impact that different types of insurance coverage have on beneficiary health care expenses.

Several other agencies that have developed a partnership in using MCBS data include the Congressional Budget Office, Public Health Service, Centers for Disease Control and Prevention, National Institute of Mental Health, National Institute on Aging, NIH Office of Dietary Supplements, Consumer Financial Protection Bureau, and Advisory Council on Social Security. Foundations such as KFF, Robert Wood Johnson, and the Commonwealth Fund also use MCBS data for policy analyses.

- Other researchers. MCBS Limited Data Sets (LDS) are available to researchers with a data use agreement. Additionally, MCBS microdata public use files (PUFs), which include the annual Survey File PUF, the annual Cost Supplement File PUF, and the three COVID-19 Supplement PUFs are available free for download with accompanying documentation. Topics of other research found in annual annotated bibliographies of MCBS data include chronic conditions, effects of Medicare drug coverage, use of preventive services, underuse of medications, hospital readmission, out-of-pocket costs

and financial barriers to care, assistance with activities of daily living, obesity, quality of care, alcohol use, hospice and home health care, disability trends, treatments for dementia, depression, beneficiary knowledge, caregiving, use of durable medical equipment, falls, supplemental insurance coverage, and access to and use of telemedicine. These are just a few examples of actual uses of MCBS data for policy research; bibliographies by year can be found at [CMS MCBS Bibliography](#).

Requested Revisions to Currently Approved Collection:

This is a request to revise the existing MCBS clearance beginning in 2025, which will extend the collection for an additional three years as a result. This revised clearance request includes net additions to the Community Continuing instruments. This request also includes updated respondent materials intended to address potential concerns about Medicare-related fraud and increase participation in the survey; these materials have no impact on respondent burden.

The requested content additions are in response to OMB’s terms of clearance specified on the approved 2024 MCBS. These terms requested that CMS propose to add a set of questions focused on beneficiary-centric IRA policies in the 2025 survey. In its terms of clearance, OMB requested items related to beneficiary awareness and use of newly introduced benefits, such as the elimination of vaccine cost sharing, the annual out-of-pocket spending cap, and out-of-pocket smoothing.

When implemented, the revision to this OMB package will result in a **net increase** in respondent burden as compared to the current clearance. The new questions are projected to **add 6.4 minutes** to the Community questionnaire each year starting in 2025. This includes an increase in 6.9 minutes (2.8 minutes in the Winter round, 4 minutes in the Summer round, and 0.1 minutes in the Fall round) due to new content as well as a decrease in 0.5 minutes (0.1 minutes in the Winter round, 0.3 minutes in the Summer round, and 0.1 minutes in the Fall round) due to content migrations and deletions of multiple items that are no longer policy relevant. The current OMB clearance projects an annual respondent burden of 34,368 hours. This revision to the clearance increases the annual respondent burden by 976 hours, bringing the total annual respondent burden to 35,344 hours. The changes in estimated annual respondent burden are summarized in Table B-12 (under section A12 below). All these changes are described below and are referred to in Supporting Statement, Part B as well.

The proposed revisions are described below. Changes that will **increase** respondent burden are summarized in table A-1 by questionnaire section and administration schedule.

Table A-1: Summary of New Items by Questionnaire Section and Administration Schedule

Content Area	# of Items	Questionnaire Section	Administration Schedule
Immunization Prevalence, Location, and Cost-Sharing	16	Immunization Questionnaire (IMQ)	Annually, Winter Round
Beneficiary Knowledge of IRA Provisions	5	Beneficiary Knowledge and Information Needs Questionnaire (KNQ)	Annually, Winter Round

Content Area	# of Items	Questionnaire Section	Administration Schedule
Other Financial Investments	3	Redesigned Income and Assets Questionnaire (IAQ)	Annually, Summer Round
Medical Debt and Credit Card Debt	22	Redesigned Income and Assets Questionnaire (IAQ)	Annually, Summer Round
Financial Liquidity	1	Redesigned Income and Assets Questionnaire (IAQ)	Annually, Summer Round
Federal Assistance Program Participation and Awareness	4	Redesigned Income and Assets Questionnaire (IAQ)	Annually, Summer Round
Charity Care	1	Health Status and Functioning Questionnaire (HFQ)	Annually, Fall Round

These changes include:

- 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 (ACIP³) 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 forgone 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.

³ <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

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.

The IMQ will be fielded annually during the Winter round beginning in Winter 2025 Round 101. The migration of two items from the PVQ will result in a decrease of 0.2 minutes for the Summer round interview. The migration of these two items and addition of 16 new items in the IMQ will result in a net increase of two minutes for the Winter round interview.

- **Five new questions on beneficiary knowledge of Inflation Reduction Act (IRA) provisions.** 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 Poll⁴. 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.

These items will be added to the KNQ beginning in Winter 2025 Round 101 where they will be fielded annually during the Winter round; this will result in an increase of 0.8 minutes for the Winter round interview.

- **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^{5,6}. 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 had a retirement account, compared with 20 percent of Black non-Hispanic beneficiaries and 19 percent of Hispanic beneficiaries.

⁴ <https://files.kff.org/attachment/Topline-KFF-Health-Tracking-Poll-November-2023.pdf>

⁵ <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-tables/2021-mcbs-puf-financial-well-being-medicare-beneficiaries>

⁶ [Financial Assets \(norc.org\)](https://www.norc.umd.edu/financial-assets)

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)⁷.
- 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

⁷ <https://www.census.gov/programs-surveys/sipp.html>

items on medical debt adapted from the KFF Health Care Debt Survey⁸. Respondents will first be asked to report prevalence of medical debt by creditor type, including medical or dental bills a) 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' financial 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 operations⁹. 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)¹⁰. 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

⁸ <https://files.kff.org/attachment/TOPLINE-KFF-Health-Care-Debt-Survey-March-2022.pdf>

⁹ https://files.consumerfinance.gov/f/201405_cfpb_report_data_point_medical-debt-credit-scores.pdf

¹⁰ <https://www.federalreserve.gov/apps/scfcb/detail/-/1/10235/X7510>

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)¹¹. Understanding financial stability among Medicare beneficiaries is key to the CFPB's Office for Financial Protection of Older Americans¹². 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 retirees' ability to maintain their standard of living in retirement, and ability to afford long-term care costs¹³.

- ***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)¹⁴, the Low-Income Subsidy (LIS)¹⁵, and the Medicare Savings Programs (MSP)¹⁶ via two 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) Supplement¹⁷.

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 enrolled¹⁸. 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 stakeholders¹⁹. The

¹¹ <https://www.federalreserve.gov/publications/files/scf17.pdf>

¹² <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title12-section5493&num=0&edition=prelim>

¹³ https://www.rand.org/pubs/working_papers/WR1224.html

¹⁴ Items on Section 8 housing and SNAP participation were sourced from the previous version of the MCBS IAQ

¹⁵ Item moved from the MCBS Drug Coverage Questionnaire (RXQ)

¹⁶ Item moved from the MCBS Beneficiary Knowledge and Information Awareness Needs Questionnaire (KNQ)

¹⁷ Item sourced from Census [Current Population Survey, 2023 Annual Social and Economic \(ASEC\) Supplement](#)

¹⁸ <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>

¹⁹ <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>

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 unmet²⁰. 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^{21,22}.

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 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.

The new IAQ will be fielded beginning in Summer 2025 Round 102 and will be fielded annually during the Summer round; this will result in a net increase of 4.0 minutes for the Summer round interview. Given the migration and deletion of items related to MSP and LIS, the Winter and Summer round interviews will experience a reduction in 0.1 and 0.1 minutes, respectively.

- **One new item on charity care.** Many consumers struggle to afford the cost of medical services²³, 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 patients²⁴. 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

²⁰ National Academies of Sciences, Engineering, and Medicine. 2023. An Updated Measure of Poverty: (Re)Drawing the Line. Washington, DC: The National Academies Press

²¹ <https://www.census.gov/topics/income-poverty/supplemental-poverty-measure/about.html>

²² https://www.census.gov/library/visualizations/2021/demo/poverty_measure-how.html

²³ <https://www.consumerfinance.gov/data-research/research-reports/understanding-required-financial-assistance-in-medical-care/>

²⁴ <https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/>

hospitals serving low income and rural communities offering the least relief to patients^{25,26}.

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 year²⁷. 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.

The new charity care item will be sourced from the 2022 Health Reform Monitoring Survey²⁸ 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; this addition will result in an increase of 0.1 minutes for the Fall round interview. 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. This removal will result in a reduction of 0.1 minutes for the Fall round interview. Together, these changes result in a burden neutral change to the HFQ. Changes that will **have no impact to** respondent burden include:

- **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.

²⁵ 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.

²⁶ 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

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

²⁸ <https://www.urban.org/sites/default/files/2022-10/HRMS-June-2022-survey.pdf>

Table A-2 summarizes the new content requested to be added to the Community instrument and their associated effect on burden (minutes).

Table A-2: Increased Burden Associated with New Content Revisions to the Community Instrument

Community Additions	Section	Winter 2025 Round 101	Summer 2025 Round 102	Fall 2025 Round 103	Total Annual Increase
Immunization Questionnaire	IMQ	2.0	-	-	2.0 minutes
Beneficiary Knowledge of IRA Provisions	KNQ	0.8	-	-	0.8 minutes
Income and Assets Questionnaire Redesign	IAQ	-	4.0	-	4.0 minutes
Charity Care	HFQ	-	-	0.1	0.1 minutes
Total Minutes Added		2.8 minutes	4.0 minutes	0.10 minutes	6.9 minutes
Net Annual Effect Increase in Community Burden					6.9 minutes

Table A-3 summarizes the decrease in burden associated with the migration of existing immunization items to the IMQ and the migration and deletion of LIS and MSP program application items associated with the IAQ redesign.

Table A-3: Decreased Burden Associated with Migration and Deletion of Items from the Community Instrument*

Community	Section	Winter 2025 Round 101	Summer 2025 Round 102	Fall 2025 Round 103	Total
Pneumonia and Shingles Vaccine Prevalence	PVQ	0	0.2	0	0.2 minutes
MSP Program Participation and Application	KNQ	0.1	0	0	0.1 minutes
LIS Program Participation and Application	RXQ	0	0.1	0	0.1 minutes
Outstanding Medical Bills	HFQ	0	0	0.1	0.1 minutes
Net Annual Effect Decrease in Community Burden		0.1	0.3	0	0.5 minutes

*The deletion of 22 items from the IAQ is included in the net increase to respondent burden already calculated above in Table A-2.

CMS conducts continuous round-by-round review of survey content for data quality, policy relevance, and usability. This effort ensures that the survey content is regularly reviewed and that low performing items, or items that are no longer of relevance to CMS, are removed or are

considered for less frequent administration, as is appropriate. Any changes resulting from these reviews are documented via CMS' full clearance revision packages.

A3. Use of Information Technology and Burden Reduction

The MCBS takes full advantage of advances in survey methodology by administering the survey electronically. Whether by phone or in-person, the MCBS is administered by trained field interviewers using computer-assisted personal interviewing (CAPI), which functions with programmed edit checks, reduces respondent burden by minimizing the potential for double reporting and inconsistent responses. CAPI enables the interviewer to move through complex skip patterns quickly, which reduces respondent burden by shortening the interview and eliminating the need for call backs to correct errors. CAPI also greatly increases the efficiency of the interview in the following ways:

- a. CAPI tailors the sequence of questions to the responses of the interviewee, resulting in few – if any – interviewer skip errors. The natural flow of the interview is maintained even when the pattern of questions is complex.
- b. CAPI automatically provides “fills”, or word choices within questions. For example, the sample person’s first name can be filled for the duration of the interview when the interview is conducted with a proxy, rather than filling with “you/yours” as it would for an interview with the sample person. The date of the last interview and other items can also be filled as needed.
- c. CAPI maintains rosters or lists created during the interview, such as household members, health insurance plans, medical conditions, providers, visit dates, prescription drugs, and people who help with daily activities. These rosters can be used to structure questions, e.g., cycling through a series of doctor visits and checking for missing information. Interviewers can select items from a roster, add items, or correct them. Rosters are carried over from one interview to the next.
- d. CAPI displays questions with identical question stems and response options in a grid-style format instead of displaying each question on separate screens.
- e. CAPI edits entries for range and consistency. The interviewer can make corrections immediately. Information missing from a previous round can be inserted in the questionnaire.
- f. CAPI allows instantaneous calculations to be made, such as the amount remaining to be paid on a medical bill after totaling several payments.
- g. CAPI allows for the instrument to be pre-loaded with responses recorded from previous data collection rounds and from administrative records to reduce respondent burden and provide for more accurate reporting of subsequent responses.
- h. Interviewers use the computer to electronically transmit completed cases to the central office, and the central office uses automated management processes to balance interviewer caseload in order to provide for data collection efficiency in the field.

MCBS data collection also takes advantage of sophisticated technologies for efficient sampling as well as data editing and processing. Additionally, locating of respondents utilizes available technologies that have reduced on-the-ground searches.

A4. Efforts to Identify Duplication and Use of Similar Information

This information collection is unique and does not duplicate any other effort and the same information cannot be obtained from any other source. This is especially true due to the unique panel design which follows respondents over a four-year period both in the community as well as in long term care facilities. This design enables CMS to capture more complete data associated with costs and utilization of health care.

During the development and initial administration of the MCBS, a number of people inside and outside the Federal government were consulted. This consultation included issues of design, content, and statistical methodology and analysis. This effort was reexamined in 2013 using an independent contractor. In both instances, none of the people contacted were aware of duplicative information, nor were they aware of any other survey that duplicates the efforts of MCBS.

Further, in 2015-2016, the DHHS underwent an intensive review of health surveys to align like questions, reduce duplication, and ensure that official estimates were being provided by the appropriate survey²⁹. The DHHS review determined that data collected by the MCBS are unique even though similar topics are asked by the National Health Interview Survey (NHIS), the National Health and Nutrition Examination Survey (NHANES), and other federal surveys. Although NHIS, for example, asks similar questions about health insurance coverage, the usage of MCBS data is different, particularly given the ability to link MCBS survey data to Medicare administrative data and cost related data. Unlike other federal surveys, CMS uses health insurance information collected by the MCBS to determine the cost burden of premiums paid by beneficiaries as well as to determine the cost of additional supplemental plans paid for the Medicare covered and non-covered medical expenses. Using the MCBS, CMS examines the cost of reported medical events, and determines with Medicare administrative data and cost information collected from the beneficiary what the true out of pocket costs are to the beneficiary. CMS also uses the information to see whether private plans such as employer provided plans are paying for the Medicare premiums for Part D and/or Part C for currently employed beneficiaries as well as retired beneficiaries.

In addition, CMS has undertaken exhaustive reviews of the literature and other data sources. In no instance have we identified another source of data that would be an effective substitute for the MCBS.

A5. Impact on Small Businesses and Other Small Entities

Most of the data collected for the MCBS will be from individuals in households. However, in any given round, approximately 800 to 1,100 sample persons will reside in government-sponsored, non-profit, and for-profit institutions such as nursing and personal care homes. Some of these institutions likely qualify as small businesses. For data collected on sample persons in these institutions, their employees serve as proxies for each sample person in their care.

²⁹ HHS Data Council Co-Chairs memorandum to the Secretary of the Department of Health and Human Services, May 11, 2016

Interviewers who collect data on beneficiaries living in facilities make every effort to determine, for each type of question, which staff members are most able to answer them. The data collection procedures are designed to minimize the burden on facility staff by utilizing as much administrative data as possible to streamline the data collection process.

A6. Consequences of Collecting the Information Less Frequently

As part of the currently approved clearance, CMS revised the longitudinal design in 2018 by reducing the number of rounds respondents participate in from 12 interviews to 11 interviews. Analysis of data collected in the 12th interview revealed that this ‘exit’ interview did not provide essential cost and use information and therefore, was eliminated.

By re-interviewing the same respondents a total of 11 times during a four-year period, the MCBS supports longitudinal as well as cross-sectional analyses. Longitudinal data provide the basis for models that analyze quantitative change over time. Policy changes can only be effectively understood by modeling the consequences of those changes on the same individuals over time. For example, the MCBS data allow us to understand how changes in copays or coverage affect the type of physicians a beneficiary may choose or the type of services a beneficiary seeks. Additionally, three interviews a year that collect full cost and event data allow CMS to assess rapid individual changes in health and wellbeing in an elderly population.

In the first round of interviewing in the MCBS, the respondent is provided with a calendar and asked to record all visits to health care providers and health care expenditures; they are also asked to retain all statements including private insurance documents, prescription drug documents and Medicare statements/bills. After the initial Baseline interview, the recall period for the MCBS is since the time of the last interview (usually not greater than four months).

In addition, the MCBS administers some sections only once a year which allows for important information to be collected but reduces respondent burden by collecting the information less frequently. As an example, in this clearance, we retained important metrics while reducing burden by only asking COVID-19 items in the Community and Facility instruments once annually instead of three times per year.

A7. Special Circumstances Relating to Guidelines of 5 CFR 1320.5

None of the special circumstances listed by OMB apply to the MCBS.

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside Agencies

The 60-day Federal Register notice was published on April 26, 2024 (89 FR 32435). One comment was received from The American Cancer Society Cancer Action Network (ACS CAN) expressing support for the addition of new items on medical and credit card debt to the redesigned IAQ. The commenter provided additional information and data specific to the issue of medical debt among cancer patients, survivors, caregivers, and family members. CMS appreciates the commentor’s support.

A second comment was submitted jointly by Community Catalyst, Justice in Aging, and the National Consumer Law Center supporting the addition of new items on medical and credit card debt to the MCBS. The commenters suggested that CMS include additional questions to measure

whether the debt was incurred due to specific plan, provider, and billing issues. The commenters also suggested that CMS use administrative sources or questionnaire items to assess the connection between participation in low-income assistance programs, including Medicaid and the Medicare Savings Program (MSP), and medical debt. Additionally, the commenters encourage CMS to report on trends related to medical debt and access to care among Medicare Advantage beneficiaries. CMS appreciates the commenters' support of the inclusion of these items as well as the suggestions for additional survey questions. CMS is expanding the proposed medical debt series to include items on the type of creditor to whom debt is owed and the amount owed by creditor type and will consider the additional suggestions from the commenters for future inclusion. CMS appreciates the suggestion related to federal assistance program participation and is pleased to note that existing administrative variables and survey items related to Medicaid and MSP enrollment and eligibility will continue to be included in MCBS data releases. Once data on the new medical debt items are available, CMS plans to disseminate findings and will consider the important topics suggested by the commenters.

CMS also regularly solicits input on questionnaire content from an extensive list of stakeholders as well as notification of opportunities to comment on the website ([CMS.gov/MCBS](https://www.cms.gov/MCBS) and [Research Statistics Data and Systems MCBS](#)). Also, CMS participates in interagency working groups as well as research conferences to consult with a wide variety of data users and policy officials interested in MCBS data.

The 30-day Federal Register notice was published on July XX, 2024 (XX FR XXXXX).

A9. Explanation of Any Payment or Gift to Respondents

The MCBS does not provide payments or gifts as incentives to respond. The most important incentive we use is to persuade the respondent that his or her participation is a service to the future of Medicare. Respondents are provided with a calendar to record all health events and provider visits for easy reference during future interviews.

A10. Assurances of Confidentiality Provided to Respondents

On February 14, 2018, CMS published in the Federal Register a notice of a modified or altered System of Record (SOR) (System No. 09-70-0519). The notice was published in 83 Federal Register 6591.

The Community Advance Letter (Attachment 1) mailed to the respondent for in person and telephone interviewing includes the following statement regarding confidentiality of data:

“...your information will be kept private to the extent permitted by law, as prescribed by the Federal Privacy Act of 1974.”

The Community brochure (Attachment 1), which is mailed to all newly added sample members each Fall round, contains the following on respondent rights and privacy:

“The information you provide will be kept private to the extent permitted by law, as prescribed by the Privacy Act of 1974. The information you give will only be used for research and statistical purposes.”

The At the Door Sheet (Attachment 1) provided during in person interviews to the Community respondent at the door and the facility administrator and proxy respondents contains a statement of privacy protection consistent with the Privacy Act of 1974. In fielding the Community questionnaire Income and Assets module, an additional handout (Attachment 1) is provided explaining its purpose and restating the Privacy Act.

Interviewer training stresses the importance of maintaining confidentiality and project protocols is documented within the Field Interviewer manual. Field outreach and contacting procedures have been established to maintain and ensure confidentiality. These include the utilization of standard computer security procedures (dual authentication password protection for each interviewer laptop) and prohibitions on submitting personally identifiable information through electronic mail submission.

The Facility Advance Letter (Attachment 5), sent to any new facility participating in the MCBS via in person or telephone interviews, includes the following statement:

“No residents of your facility will be contacted directly. All of the information your organization provides will be kept private to the extent permitted by law, as prescribed by The Federal Privacy Act of 1974. Your participation is voluntary, and your relationship with programs administered by CMS will not be affected in any way by whether or not you participate.”

Participating facilities also receive a HIPAA Letter (Attachment 5), which includes the following regarding the Health Insurance Portability and Accountability Act (HIPAA) regulations:

“I am writing to address any concerns you may have about your facility’s participation in the Medicare Current Beneficiary Survey (MCBS) as it relates to the Health Insurance Portability and Accountability Act (HIPAA) regulations. Please be assured that the standards of privacy of protected individually identifiable health information implemented under the HIPAA privacy regulation do not affect the data being collected for MCBS. Specifically, your cooperation with the MCBS will not violate the HIPAA privacy regulations. Nor will it require any additional privacy disclosure record keeping.

Under the HIPAA regulations, your facility does not need an individual’s authorization to disclose their protected health information to a health plan, such as the Medicare program, when the information is being disclosed for receiving organization’s health care operations activities. This holds if both your facility and the Medicare program has or had a relationship with the individual whose protected health information is being requested, and the protected information pertains to such relationship. See 45 CFR § 164.506(c) (4).

Furthermore, participating in the MCBS will not impose additional disclosure record keeping burdens on your facility. Disclosures under 45 CFR § are explicitly exempt from the HIPAA disclosure accounting provisions. See 45 CFR § 164.528 (a) (1) (i).”

The Resident Consent Form (Attachment 5) contains the following statement:

“The information collected for MCBS will be protected by NORC at the University of Chicago, the contractor collecting the data, and by CMS. It will be used only for the purposes stated for this study. Identifiable information will not be disclosed or released to

anyone except those involved in research without the consent of the individual or the establishment except as required under the Privacy Act of 1974 (Public Law 93-579).”

Any data published will exclude information that might lead to the identification of specific individuals (e.g., ID number, claim numbers, and location codes). CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to the individual privacy or other personal or property rights of the individual.

All MCBS survey staff directly involved in MCBS data collection and/or analysis activities are required to sign a Non-Disclosure Agreement as well as a NORC confidentiality agreement.

A11. Justification for Sensitive Questions

In general, the MCBS does not ask sensitive questions. However, for a small number of respondents, there may be some questionnaire items that are considered to be sensitive. All interviewers are trained on how to handle respondent concerns about questions being sensitive.

For example, some respondents might view questions on the Demographics and Income Questionnaire (DIQ) to be sensitive, such as items about race, ethnicity, sexual orientation, gender identity, and income and assets. Despite the potentially sensitive nature of these items, years of data collection on these topics on the MCBS, NHIS, and other Federal surveys indicates that respondents are willing to respond and do not report sensitivity concerns to interviewers.

The Community instrument asks for respondents’ perception of their health care, including any issues they may have experienced with their health care providers. These items may be considered sensitive for some respondents, depending on their health care experiences. It also includes some questions about activities of daily living, such as whether the respondent needs help bathing. Some respondents view these kinds of questions in a sensitive manner. In addition, there are a few questions that ask about alcohol use, obesity screening, mental health screening, and HIV testing that some respondents might perceive as sensitive.

A12. Estimates of Annualized Burden Hours and Costs

Table B-12 shows the estimates of the annual respondent burden, based on the projected number of completed interviews per round and the estimated length of each interview (including the net additions and deletions requested in this clearance). On average, the annual burden for the MCBS is based on three interviews (e.g., rounds) per respondent. The number of actual respondents who complete an interview changes every round and every year. Response rates per round and annually are carefully monitored and reviewed to determine the size of the next Incoming Panel. The size of the new panel is designed to provide a stable number of respondents across all panels participating in the survey annually and this size changes annually depending on prior year response rates and the number of active participants still engaged in the survey.

Table B-12: Estimates of the Annual Respondent Burden in 2025

Community Rounds 101-103	Time Per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
Winter 2025 Round 101 Continuing Interview	62.80 minutes	1	10,619	11,115
Summer 2025 Round 102 Continuing Interview	61.57 minutes	1	7,880	8,086
Fall 2025 Round 103 Baseline Interview	65.80 minutes	1	5,766	6,323
Fall 2025 Round 103 Continuing Interview	75.20 minutes	1	6,852	8,588
FM Follow-up with 5% of Completed Interviews	5 minutes	1	1556	130

Facility Rounds 101-103	Time Per Response	Number of Interviews	Expected Number of Completed Interviews Per Round	Burden Hours
Winter 2025 Round 101 Continuing Interview	21.84	1	799	291
Summer 2025 Round 102 Continuing Interview	21.70	1	593	214
Fall 2025 Round 103 Baseline Interview	42.00	1	209	146
Fall 2025 Round 103 Continuing Interview	40.50	1	249	168
Fall 2025 Round 103 Baseline Interview--Admin Data	30.20	1	225	113
Fall 2025 Round 103 Continuing Interview--Admin Data	38.00	1	267	169

Rounds 101-103	Expected Number of Completed Interviews Per Round	Burden Hours
Total Expected Number of Completed Interviews Annually	35,015	
Total Annual Burden Hours		35,344
Total Estimated Burden Hours – Rounds 101-109 (3 Years)		106,031

Below provides a summary of the annual burden change from the current clearance, reflecting the net increased burden of adding 52 new questions and deleting 26 items.

Total annual burden hours – current 2024 clearance	34,368
Total annual burden hours – revised 2025 clearance	35,344
Total annual burden hours – difference	976

To provide an estimate of the cost of participating in this survey, we must select an hourly rate to use which is then multiplied by the burden hours of the respondent. We selected the U.S. minimum wage (\$7.25 for 2024³⁰) and multiplied it to the Total Annual Hours for Rounds 101-103 (35,344), for a Total Annual Cost Burden in terms of dollars of roughly \$256,241.33.

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

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

A14. Annualized Costs to the Federal Government

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

The estimated cost for the annual planning, sampling, data collection and analysis for the MCBS is below.

Option Year 3 (May 1, 2024-April 30, 2025): Survey development, operations, processing and analysis: \$24,400,000.³¹

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

CMS personnel involved in MCBS include approximately 11 FTEs broken out by paygrade or paygrade range in Table B-14.

Table B-14: CMS Personnel

Grade	FTE	2024 Annual Salary	Cost to Government ³²
GS9-GS12	1.0	\$83,802	\$83,802
GS13 step 5	5.0	\$133,692	\$688,460
GS14 step 5	4.0	\$157,982	\$631,928
GS15 step 5	1.0	\$185,824	\$185,824
			\$1,590,014

CMS staff costs are approximately \$1,590,014. The MCBS releases its documentation as downloadable files on its public website and on CD Rom thus eliminating its printing budget. Thus, in-house CMS cost will be \$1,590,014.

A15. Explanation for Burden Changes (Program Adjustments)

This revision includes the addition of 52 items, the migration of four existing items, and the deletion of 26 items that result in a net burden increase of 6.4 minutes. Specifically, as noted earlier, the following changes are requested:

³⁰ <https://www.dol.gov/general/topic/wages/minimumwage>

³¹ Future awards are based on execution of option years and funding availability.

³² <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2018/DCB.pdf>

Changes that will **increase** respondent burden:

- 0.8 minutes of burden will be added to each Winter interview beginning in Winter 2025 due to the addition of five new items in KNQ related to beneficiary knowledge of IRA provisions.
- 2 minutes of burden will be added each Winter round starting in Winter 2025 due to the addition of a new Immunization Questionnaire which will collect prevalence of pneumonia, shingles, and RSV vaccines as well as follow-up vaccine details related to vaccine location, timing, cost sharing, and reasons for not vaccinating.
- 4.0 minutes of burden will be added each Summer round starting in Summer 2025 due to the addition of 30 items related to other financial investments, medical and credit card debt, financial liquidity, and Federal assistance program participation and awareness via the redesigned IAQ.
- 0.1 minutes of burden will be added to each Fall round starting in Fall 2025 due to the addition of one item in HFQ related to charity care.

Changes that will **decrease** respondent burden:

- 0.1 minutes of burden will be reduced from the Winter interview beginning in Winter 2025 due to the migration of one item about MSP participation and the removal of one item about MSP program application.
- 0.3 minutes of burden will be reduced from the Summer interview beginning in Summer 2025 due to the migration of two items about pneumonia and shingles vaccines from the PVQ to the IMQ, the migration of one item about LIS participation from RXQ to IAQ, and the removal of two items about LIS program application from RXQ.
- 0.1 minutes of burden will be reduced in the Fall interview beginning in Fall 2025 due to the removal of one item on outstanding medical bills in the HFQ.

Net impact to respondent burden:

- As a result, the total burden has increased to 35,344 from the previously approved total burden of 34,368. This is a net increase of 976 burden hours annually.

A16. Plans for Tabulation and Publication and Project Time Schedule

Data files will continue to be prepared over the course of the survey. This clearance request covers data collection beginning in Round 101 (Winter 2025) through Round 109 (Fall 2027). See Table B-16a for data collection rounds and plans for data dissemination. CMS is continuously evaluating ways to compress the schedule for data dissemination (making the data available faster). This schedule may be revised as innovative plans for data dissemination and delivery are developed and implemented.

Table B-16a: Annual schedule for information collection and dissemination, January 2025 – January 2030.

Data collection schedule

01/08/2025	Data collection starts for Winter 2025 Round 101
05/07/2025	Data collection starts for Summer 2025 Round 102
07/21/2025	Data collection starts for Fall 2025 Round 103
01/07/2026	Data collection starts for Winter 2026 Round 104
05/06/2026	Data collection starts for Summer 2026 Round 105
07/20/2026	Data collection starts for Fall 2026 Round 106
01/06/2027	Data collection starts for Winter 2027 Round 107
05/05/2027	Data collection starts for Summer 2027 Round 108
07/19/2027	Data collection starts for Fall 2027 Round 109

Data dissemination schedule

01/25/2024	Cost Supplement File Microdata Public Use File for 2021 data.
07/15/2024	Limited Data Set available for 2022 Survey File.
10/15/2024	Limited Data Set available for 2022 Cost Supplement File.
10/15/2024	Survey File Microdata Public Use File for 2022 data.
01/15/2025	Cost Supplement File Microdata Public Use File for 2022 data.
07/15/2025	Limited Data Set available for 2023 Survey File.
10/15/2025	Limited Data Set available for 2023 Cost Supplement File.
10/15/2025	Survey File Microdata Public Use File for 2023 data.
01/15/2026	Cost Supplement File Microdata Public Use File for 2023 data.
07/15/2026	Limited Data Set available for 2024 Survey File.
10/15/2026	Limited Data Set available for 2024 Cost Supplement File.
10/15/2026	Survey File Microdata Public Use File for 2024 data.
01/15/2027	Cost Supplement File Microdata Public Use File for 2024 data.
07/15/2027	Limited Data Set available for 2025 Survey File.
10/15/2027	Limited Data Set available for 2025 Cost Supplement File.
10/15/2027	Survey File Microdata Public Use File for 2025 data.
01/15/2028	Cost Supplement File Microdata Public Use File for 2025 data.
07/15/2028	Limited Data Set available for 2026 Survey File.
10/15/2028	Limited Data Set available for 2026 Cost Supplement File.
10/15/2028	Survey File Microdata Public Use File for 2026 data.
01/15/2029	Cost Supplement File Microdata Public Use File for 2026 data.

- 07/15/2029 Limited Data Set available for 2027 Survey File.
- 10/15/2029 Limited Data Set available for 2027 Cost Supplement File.
- 10/15/2029 Survey File Microdata Public Use File for 2027 data.
- 01/15/2030 Cost Supplement File Microdata Public Use File for 2027 data.

The Survey File contains data collected directly from respondents and supplemented by administrative items plus facility (non-cost) information and Medicare Fee-for-Service claims. The Cost Supplement File contains both individual event and summary files and can be linked to the Survey File to conduct analyses on health care cost and utilization. The Survey File Microdata Public Use File (PUF) includes data on topics such as Medicare beneficiaries' access to care, health status, other information regarding beneficiaries' knowledge of, attitudes toward, and satisfaction with their health care, as well as demographic data and information on all types of health insurance coverage. The Cost Supplement File Microdata PUF includes data that links Medicare claims to survey-reported health care events and provides summarized expenditure and source of payment data on all health care services, including those not covered by Medicare. Disclosure protections have been applied to the PUFs, including de-identification and other methods. CMS posts the PUFs online at [CMS MCBS Public Use File](#).

An MCBS Chartbook is issued with each annual release of the data by CMS. It provides the public with a collection of charts and tables presenting estimates from both the Survey File and Cost Supplement File. The charts and tables in the Chartbook are cross-sectional and describe the Medicare population in terms of its demographic and socioeconomic characteristics, use of and expenditures on health care, perceived health and functional status, and access to and satisfaction with health care within a given year. The Chartbook is intended as a reference for persons interested in using MCBS data to analyze the health and health care of the Medicare population. Beginning with the release of 2021 MCBS data, the <https://chartbook.mcbs.org> website replaced the PDF version of the MCBS Chartbook. MCBS estimates from 2015 through 2020 can be found in both the current online version of the MCBS Chartbook at <https://chartbook.mcbs.org> and the previous MCBS Chartbook PDFs at [CMS MCBS Data Tables](#).

A series of policy-relevant MCBS PUF table packages and preliminary estimates are issued with each annual release of the Survey File Limited Data Set by CMS. These products present estimates on various topics of interest, such as beneficiaries' financial well-being, telemedicine, usual source of care, internet access, diabetes prevalence, preventive care, and oral health, as well as for key subpopulations, such as dually eligible beneficiaries, beneficiaries living in metropolitan versus non-metropolitan areas, and beneficiaries who speak a language other than English at home. CMS posts these products online at [CMS MCBS Data Tables](#) as well as accompanying infographics at [CMS MCBS Data Briefs](#).

Researchers can also use interactive tools developed with MCBS data to explore trends for variety of topics on the Medicare population, including beneficiary health and well-being, health care access and expenditures, and COVID-19 impact. These tools can be found at [MCBS Interactives](#) and [MCBS Chartbook](#).

A17. Display of OMB Expiration Date

The OMB expiration date is displayed on the hardcopy respondent materials, including advance mail materials. It is also displayed on the MCBS website. When conducting in person interviews, the OMB expiration date is displayed in the CAPI instrument on the first screen (introductory script and consent) and on the last screen (thank you script), as displayed in Attachment 6. There is no hard copy questionnaire or document to display the OMB expiration date.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to this certification statement.