

Supporting Statement – Part A

Supporting Statement For Paperwork Reduction Act Submissions

A. Background

The Centers for Medicare & Medicaid Services (CMS) is the largest single payer of health care in the United States. With full implementation of the Affordable Care Act of 2010 (ACA), the agency will play 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 leading the transformation of the health care system. CMS also aims to provide Americans with high quality care and better health at lower costs through improvement. At the forefront of these initiatives is the newly formed Center for Medicare and Medicaid Innovation (CMMI).

The CMMI is authorized by Section 1115A of the Social Security Act, as established by Section 3021 of the ACA and was established to “test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished” to Medicare, Medicaid and CHIP beneficiaries. Implicit across all of CMMI activities is an emphasis on diffusion – finding and validating innovative models that have the potential to scale, facilitating rapid adoption, and letting them take root in organizations, health systems, and communities across America.

CMS activities result in data generation on a massive scale, and although administrative data are a critical resource for CMS, CMMI and its partners, there remains an important need for self-reported data and information that is not captured through other CMS operations. For example, a Medicare beneficiary’s satisfaction with, access to, and quality of care are all 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 in administrative data. These survey-collected data elements complete the picture of a beneficiary’s health care experience and provide a vital component in the development and evaluation of CMMI models.

The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through CMS operations. The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries that is sponsored by CMS and directed by the Office of Information Products and Data Analytics (OIPDA) in partnership with the CMMI. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g. fee-for-service claims, prescription drug event

data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years (encompassing over 1 million interviews), and consists of three annual interviews per survey participant.

The primary goals of the MCBS are to:

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

The core of the MCBS is a series of interviews administered to a stratified random sample of the Medicare population, including aged and disabled enrollees, residing in the community or in institutions. Questions are asked about enrollees' patterns of health care use, charges, insurance coverage, and payments over time. Respondents are asked about their sources of health care coverage and payment, their demographic characteristics, their health and work history, and their family living circumstances. In addition to collecting information through the core questionnaire, the MCBS collects information on special topics through supplements. Supplement topics include enrollees' income and assets, access to health care, health and functional status and satisfaction with care.

The MCBS respondents are interviewed three times per year using four-month recall periods. Round 1 for the survey, which is administered to new survey sample members, collects baseline information for the analysis of access to care and establishes a recall boundary for the next interview (the interview reference period is since the date of the previous interview). Subsequent rounds of the survey, including our proposed extension (i.e., Rounds 58-63) collect cost and utilization information (core) and administer selected supplements on income and assets and access to care. Supplemental samples of newly eligible enrollees are added in the fall round each year.

The MCBS has been at the forefront of in-person survey collection and data processing, most notably as one of the first surveys to successfully 1) implement a computer assisted personal interview (CAPI) and 2) match survey and claims data to adjust and correct for underreporting in survey reported health care utilization. The CMS vision for the MCBS is to continue to provide unique, high-quality and high-value data in a timely manner, continue to break ground in innovative, efficient and analytically powerful new areas of survey data administration, design

and development, and to increase the survey's ability to develop, monitor, assess and evaluate the impact of CMMI care delivery and payment models. To succeed in these areas, CMS aims to:

- capture high-value, unbiased, minimally burdensome, self-reported content that is multipurpose in use;
- improve the integration of existing and new sources of administrative data with MCBS survey collected data;
- develop and implement more efficient, cost-effective, accurate and innovative data collection strategies when possible; and
- enhance the understanding, usefulness, and promotion of MCBS through the dissemination of user tools and key scientific findings based on MCBS data.

This is a request to extend the existing Medicare Current Beneficiary Survey (MCBS) clearance for an additional three years. This request for continuation proposes no changes in burden. Clearances for the MCBS (OMB No. 0938-0568) were granted in October 1990 for the pilot, August 1991 for Round 1, January 1992 for Rounds 2-6, September 1993 for Rounds 7-10, November 1994 for Rounds 10-19, December 1997 for Rounds 20-28, April 2001 for Rounds 29-37, March 2004 for Rounds 38-47, August 2007 Round 49 – 57, December 2010 for Rounds 59-67. A Non-Substantive change was made to the MCBS March 13, 2012 to return facility data collection to a three round cycle per year. The present clearance request encompasses all aspects of the MCBS: the community baseline and core questionnaires, the facility screener, baseline and core questionnaires, and supplementary sections such as the income and assets supplement and the access to care supplement (i.e., usual sources of care, health status and functioning, satisfaction with care and the demographic questions).

B. Justification

1. Need and Legal Basis

As described in the **Background**, CMS collects administrative information on the Medicare population through its claims records. Unfortunately, the current administrative information collected by CMS fails to provide the complete picture needed for CMS to evaluate its programs and comply with legislative mandates found in both:

- a. Section 1115A of the Social Security Act, as established by Section 3021 of the Affordable Care Act (ACA) of 2010; and
- b. Section 723 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

The MCBS supports CMS' program evaluation and legislative mandate compliance by providing data to determine expenditures and sources of payment for all services used by Medicare beneficiaries, including co-payments, deductibles, and non-covered services; to ascertain all types of health insurance coverage and relate coverage to sources of payment; and to trace processes over time, such as changes in health status and "spending down" to Medicaid eligibility and the impacts of program changes, satisfaction with care, and usual

source of care. These unique design features of the MCBS enable it to support a variety of CMS functional areas in addressing both Section 3021 of ACA and Section 732 of MMA. For example, the MCBS is used by CMMI analysts to assess the potential number of beneficiaries eligible for proposed new care and payment models, their baseline utilization and patterns of usual care, and the decisional factors that help determine when and where beneficiaries seek care.

2. Information Users

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

Moving forward, the MCBS will continue to play a critical role in the monitoring and evaluation of key provisions of the Affordable Care Act (ACA), with an emphasis on supporting CMMI efforts to test innovative payment and service delivery models ability to reduce costs and improve quality. For example, the longitudinal and comprehensive nature of the MCBS provide the opportunity for both pre/post and observational studies (with a control and comparison group) for beneficiaries involved with CMMI models or new CMS programs (e.g., Accountable Care Organizations, Medical Homes). Other areas that will be covered include changes to Part D coverage, changes to cost-sharing and premiums, and the use and knowledge of new Medicare-covered preventive services.

MCBS data will also be used by CMS to continue to assess the impact of major policy innovations and health care reform on Medicare beneficiaries (pre and post implementation). MCBS users continue to monitor delivery of services, sources of payment for Medicare covered and non-covered services, beneficiary cost sharing and financial protection, and satisfaction with and the access to health care services. Analysts can relate the dynamics of future aging patterns to age-specific rates of use of health care services. MCBS data also allow accurate measurement of total health care expenditures for enrollees and changes in private health insurance benefits (including long-term care insurance). The capacity to follow individuals into and out of nursing homes and hospitals provides analysts the opportunity to estimate the total cost of episodes of illness and level and type of system interventions including home health care.

Analysts are able to assess the aggregate cost of short stays and long stays in nursing homes, and of combined hospital/nursing home stays. In addition, the MCBS data can be used to forecast the need and settings for selected chronic disease care and long-term care services by examining trends in the use of health care services, linked with morbidity, disability and mortality data. (A detailed analysis plan is included as Attachment 2. This plan discusses the analytic potential of the data and presents studies and data uses that exceed the budgetary

and staffing limitations of the MCBS.)

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 700 research articles published using the MCBS to date and over 300 MCBS files purchased and shipped to researchers each year. MCBS survey data are also vital in the production of highly regarded publications, including the Kaiser Family Foundation *Medicare Chartbook* and the Medicare Payment Advisory Commission's (MedPAC) annual *Data Book*. There are three separate categories of data users discussed below.

- a. Within CMS. Survey results have been and will continue to be used by various organizations within the CMS. CMMI analysts, for example, 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 baseline utilization and patterns of usual care, and the decisional factors that help determine when and where beneficiaries seek care.

CMMI also uses the managed care supplement to the MCBS to compare fee-for-service with alternative delivery systems and to assess beneficiary satisfaction and access to alternative delivery systems. Also, MCBS provides information on health promotion and disease prevention from the core instrument. Additional information on these areas can be obtained by the development of supplements.

The MCBS is also 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 is currently 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.

The 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. The Office of Financial Management and Office of Clinical Standards and Quality use immunization data to track whether CMS is meeting GPRA objectives.

- b. Other Governmental / quasi-governmental, outside CMS. The MCBS is a major source of information for the Medicare Payment Advisory Commission (MedPAC) to monitor

access to health care and beneficiary financial protection. The MCBS data have been routinely included in MedPAC's Annual Reports and data collected by the MCBS have been used both in descriptive statistics and simulation.

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

Several other agencies that have developed a partnership in using MCBS data include the Congressional Budget Office, Public Health Service, Centers for Disease Control and Prevention, National Institute of Mental Health, National Institute on Aging, and Advisory Council on Social Security. Foundations such as Kaiser Family Foundation, R W Johnson, and the Commonwealth Fund also use MCBS data for policy analyses.

- c. Other researchers. Data are available to academic researchers through data use agreements. Topics of their research include: chronic disease, effects of Medicare drug coverage, racial and ethnic disparities in service use, use of preventive services, underuse of medications, hospital readmission, body mass and aging, assistance with activities of daily living, obesity, quality of care, medication use in nursing homes, alcohol use, home care, veterans' care, disability trends, treatments for dementia, depression, beneficiary knowledge, informal assistance, use of durable medical equipment, falls, depression, and self-management for chronic disease. These are just a few examples of actual uses of MCBS data for policy research.

3. Use of Information Technology

The MCBS takes full advantage of advances in survey methodology by administering the survey electronically. Respondents living in the community are administered a personal, face to face interview using computer-assisted personal interviewing (CAPI). Though respondents residing in long-term care facilities are not administered a personal, face-to-face interview, the CAPI instrument is used in interviewing the designated proxy (i.e., facility staff). CAPI, which functions with programmed edit checks, reduces respondent burden by minimizing the potential for double reporting and inconsistent responses. CAPI enables the interviewer to move through complex skip patterns quickly, which reduces respondent burden by shortening the interview and eliminating the need for call backs to correct errors. CAPI also greatly increases the efficiency of the interview in the following ways:

- a. CAPI tailors the sequence of questions to the responses of the interviewee, resulting in few – if any – interviewer skip errors. The natural flow of the interview is maintained even when the pattern of questions is complex.
- b. CAPI automatically provides “fills”, or word choices within questions. One keystroke can insert “you”, “he”, or “she”, as appropriate, for the duration of the interview. The sample person's name, date of the last interview, and other items can also be filled as needed.
- c. CAPI maintains rosters or lists created during the interview, such as household

- members, health insurance plans, medical conditions, providers, visit dates, prescription drugs, and people who help with daily activities. These rosters can be used to structure questions, e.g., cycling through a series of doctor visits and checking for missing information. Interviewers can select items from a roster, add items, or correct them. Rosters are carried over from one interview to the next.
- d. CAPI edits entries for range and consistency. The interviewer can make corrections immediately. Information missing from a previous round can be inserted in the questionnaire.
 - e. CAPI allows instantaneous calculations to be made, such as the amount remaining to be paid on a medical bill after totaling several payments.
 - f. Interviewers use the computer to electronically transmit completed cases to the central office over the telephone.

CAPI has strategic implications for survey design and planning, some of which are not easily predicted. CAPI also strongly influences the shape of the questionnaire itself: it can be more complex, more tailored to the characteristics of respondents, with more cross-references and rosters, and have more error checks. MCBS does not require a signature from the respondent(s).

4. Duplication of Efforts

This information collection is unique and does not duplicate any other effort and the same information cannot be obtained from any other source.

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. None of the people contacted were aware of duplicative information, nor were they aware of any other survey that duplicates the efforts of MCBS. In addition, both CMS and its data collection contractor have 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.

While continuing interagency collaboration has helped insure against the likelihood of duplicative data collection processes in the past, in early 2013 the CMS contracted with MITRE and RAND to conduct an unbiased comprehensive assessment of the MCBS. This evaluation will assess the current survey design (e.g., mode of collection, survey content). By mid-2014 CMS will have a report of recommendations as well as an advisory board.

5. Small Business

Most of the data collected for the MCBS will be from individuals in households. However, in any given round about 1,000 sample persons will reside in government-sponsored, non-profit, and for-profit institutions such as nursing and personal care homes. Some of these institutions qualify as small businesses. All data collected on sample persons in these

institutions will be collected from small businesses, their employees serve as proxies for each sample person in their care.

Interviewers in long-term settings 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 all respondents, with skip instructions so that respondents will be asked only questions that apply to them. Facility proxies are not asked question on beneficiary attitudes and perceptions, which they would be unlikely to know.

All enrollees will be selected from the Medicare Enrollment Database and sample persons residing in nursing homes will be randomly distributed. Therefore, the burden for the collection of this information will be proportional to the size of nursing homes (on average), thereby reducing the burden on small nursing homes.

6. Less Frequent Collection

Only a continuous survey can fully meet CMS' information needs for operating the Medicare program and also address many of the limitations of existing databases collecting information on the elderly and disabled, including the oldest old portion of the population (85+). Large changes in Medicare delivery systems and programs have been occurring with increasing frequency, (e.g., The Medicare Prescription Drug, Improvement, and Modernization Act, Patient Protection and Affordable Care Act). While such extensive changes as contained in MMA and ACA are the exception rather than the rule, adjustments to the Medicare program continue to remain an ongoing part of the program administration. Only a continuous survey will produce the data that support accurate evaluation of the effects of such changes.

By re-interviewing the same respondents and replenishing the sample annually, the MCBS will continue to support longitudinal as well as cross-sectional analyses. Longitudinal data provide the material for models that analyze quantitative change over time. Longitudinal data are needed for causal analyses, such as the relationship between legislative and program changes and their effects on enrollees, providers, and costs. Longitudinal data can also help clarify the relationship between changes in health status and functioning and levels of health care service use and expenditures (i.e., analysis of temporal relationships).

While it is necessary to conduct a continuous survey as outlined above, the frequency of collection in a given year can differ across community and institutional settings, while retaining the same outcome.

Research on survey methodology shows that as the length of time between community interviews grows, there is a marked decline in the quality of the data reported (Cohen and Burt, 1985; Cohen and Cohen, 1986). The literature supports spacing interviews for a continuous survey of medical care use up to four months apart. The Current Medicare Survey employed a one-month recall period, the 1977 National Medical Care Expenditure Survey an average of three months, and the 1987 National Medical Expenditure Survey an

average of four months. In the first round of interviewing in the MCBS, the sample person in the community is provided with a calendar and asked to record all visits to health care providers, expenditures and to retain all statements including private insurance and Medicare statements/bills. Thus after the initial round, the recall period for the MCBS is since the time of the last interview. Making MCBS community rounds any farther apart would significantly jeopardize the quality of the results, because of the strong potential for recall problems with the elderly. In addition, less frequent data collection may negate the opportunity to obtain additional information by using supplements; more time spent on repetition of the core items might not allow time for the inclusion of proposed supplements questions to assess legislative and program changes.

7. Special Circumstances

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

8. Federal Register/Outside Consultation

The 60-day Federal Register Notice was published on July 26, 2013. Since this collection is not new, we have not gone out to solicit outside consultation; however, during the 60-day Federal Register Notice the public was free to comment; however, there were no comments received.

9. Payments/Gifts to Respondents

The MCBS does not provide payments or gifts as incentives to respond. The most important incentive we use is to persuade the respondent that his or her participation is a service to the future of Medicare. We use standard refusal conversion techniques, letters, and newsletters.

10. Confidentiality

The cover letter to the respondent and a handout presented at the beginning of the interview contain the following disclosure statement:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0568. The time required to complete this information collection is estimated to average 1½ hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Additionally, a randomly selected 10 percent of the respondent population (per round) are contacted for a validation interview averaging 10 minutes. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

(Attachment 3) is a copy of the advance letter and MCBS brochure and introduction to the MCBS sheet for the household.

This is a person-based survey. The cover letter to the respondent contains a reference to the Privacy Act of 1974, as amended. A handout sheet (provided to the household respondent at the door and the nursing home administrator and proxy respondents) contains a statement of confidentiality consistent with the Privacy Act of 1974 and the Paperwork Reduction Act of 1995. In fielding selected supplements, (e.g., Income and Assets) an additional handout sheet is provided explaining the purpose of the supplement and restating the Privacy Act. Interviewer training stresses the importance of maintaining confidentiality. The household interviewer's manual specifically addresses this and it is part of the training for the interviewers (both household and nursing home). Procedures have been established to maintain and ensure confidentiality. These include computer security procedures (password protection for each interview and interviewer), electronic mail submission and next of kin consent forms for following nursing home people (discharged residents).

In addition, the administration of the facility component is preceded by a statement that CMS will collect only the information necessary to perform the system's functions. 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 confidentiality agreements. Furthermore, all MCBS patient-level data are protected from public disclosure in accordance with the Privacy Act of 1974, as amended.

11. Sensitive Questions

None of the data to be obtained by this study are considered to be sensitive.

12. Burden Estimates (Hours & Wages)

Table B-12 shows estimates of the annual respondent burden. The annual burden for the MCBS is based on three interviews per respondent. We currently estimate that our annual burden will be 58,450 hours for the survey. A community interview should take roughly an hour and a half to complete and a facility interview roughly an hour.

Table B-12: Estimates of the Annual Respondent Burden

	Time per Response	Number of Interviews	Expected Number of Completed Per Round	Burden Hours
Community Rounds 68-70				
-Fall Rd Supplemental Interview	1.0 hour	1	5,250	5,250
-Fall Round Continuing Interview	1.5 hour	1	9,250	13,875
-Winter Round Interview	1.5 hour	1	13,900	18,900
-Summer Round Exit Interview	15 minutes	1	3,000	750
-Summer Rd Continuing Interview	1.5 hour	1	10,600	15,900
Validation per 10% of Population	10 minutes	3	1,550	775
Facility Rounds 68-70	1.0 hour	3	1,000	<u>3,000</u>
Total Annual Hours				58,450
Total Estimate – Rounds 68-76 (3 Years)				172,350

Note: 1. During the Winter Round interview the Round 67 supplemental panel and the Round 69 exiting panel time per response is 1.25. This is a result of a utilization start and end point that deviates from the standard Continuing Interview reference point. The regular reference point is from the last interview. The Round 67 supplemental panel (4,800 completes) use January 1 as the start date in the Winter Round. The Round 69 exiting panel (3,000 completes) use December 31 as the end date in the Winter Round.

The MCBS oversamples both the under 65 and the 85 and over populations. Consequently, the U.S. minimum wage (\$7.25 for 2013) was multiplied to the Total Annual Hours for

Rounds 68-70 (58,450) for a Total Annual Cost Burden in terms of dollars of roughly \$423,762.50. The minimum wage was used because of the impact created by the oversampled populations. It is possible that the under 65 population would include minors and the 85 and over could be well below the poverty line, having spent down all assets and institutionalized.

The MCBS survey methodology is designed to reduce burden on the survey respondents in the community and facility setting. In the community setting logical skip patterns and rotating supplements limit the time per response. In the facility setting, questionnaire flow designed around likely respondents in addition to reduction in data collection rounds help reduce burden.

13. Capital Costs

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

14. Cost to Federal Government

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

The estimated cost for the planning, sampling, data collection and analysis for the MCBS in each year is: (The following estimated costs per Fiscal Year are approximated amounts based on the current MCBS contract and include the cost associated with conversion from a DOS based platform to a Windows based platform.)

FY 2014: Data collection and analysis	\$18,500,000
FY 2015: Data collection and analysis	\$18,500,000
FY 2016: Data collection and analysis	\$19,000,000

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 pay grade in Table B-14.

Table B-14: CMS Personnel

Grade	FTE	2013 Annual Salary	Cost to Government
GS12 step 1	1.0	\$74,872	\$74,872
GS13 step 6	7.0	\$103,872	\$727,104
GS14 step 5	2.0	\$119,238	\$238,476
GS15 step 3	1.0	\$132,009	\$132,009
			<hr/> \$1,172,461

CMS staff costs are approximately \$1,172,461. In addition, staff travel is budgeted for \$8,000. The MCBS releases its documentation on CD Rom thus eliminating its printing budget. Thus, in-house CMS cost will be \$1,180,461.

15. Changes to Burden

There are no changes to the burden contained in this clearance request.

16. Publication/Tabulation Dates

A number of published methodological studies have been conducted (Attachment 2). In addition, data files will continue to be prepared over the course of the survey, see Table B-16.

Table B-16: Schedule for information collection and dissemination

01/01/2014	Data collection begun for MCBS Round 68.
05/01/2014	Data collection begun for MCBS Round 69.
09/01/2014	Data collection begun for MCBS Round 70.
10/01/2014	Public Use File available for 2013 Access to Care series.
12/01/2014	Public Use File available for 2011 Cost and Utilization series.
01/01/2015	Data collection begun for MCBS Round 71.
05/01/2015	Data collection begun for MCBS Round 72.
09/01/2015	Data collection begun for MCBS Round 73.
10/01/2015	Public Use File available for 2014 Access to Care series.
12/01/2015	Public Use File available for 2012 Cost and Utilization series.
01/01/2016	Data collection begun for MCBS Round 74.
05/01/2016	Data collection begun for MCBS Round 75.
09/01/2016	Data collection begun for MCBS Round 76.
10/01/2016	Public Use File available for 2015 Access to Care series.

10/01/2016 Prepare clearance package for Rounds 77 – 85.
 12/01/2016 Public Use File available for 2013 Cost and Utilization series.

There are two special reports being issued on an annual basis by CMS, Health and Health Care of the Medicare Population: Data from the Medicare Current Beneficiary Survey and Characteristics and Perceptions of the Medicare Population: Data from the Medicare Current Beneficiary Survey. These reports or “chartbooks” contain a comprehensive set of statistical tables describing 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. The tables, which were created from Access to Care and Cost and Use files released to the public, are intended as references for persons interested in using MCBS data to analyze the health and health care of the Medicare population.

CMS posts these chartbooks online at www.cms.hhs.gov/mcbs. The data in these tables are being updated as new files become available, and are released to the public in the two series of chartbooks. In addition to providing statistics from the annual MCBS releases, the chartbooks can be used to follow trends and measure change in the Medicare population. Subsequent chart books have illustrated the types of longitudinal analysis that can be performed with MCBS data.

Annual updates to the two chartbooks are available for the following years. (For years where the chartbooks are still unavailable an asterisk is used as a denotation and an estimated date of completion follows.)

Health and Health Care of the Medicare Population: Data from the MCBS
 1992 – 2009, 2010* (December 2013), 2011* (December 2014), and 2012* (December 2015)

Characteristics and Perceptions of the Medicare Population: Data from the MCBS
 1995 – 2011, 2012* (May 2014), 2013* (May 2015), and 2014* (May 2016)

17. Expiration Date

CMS would like an exemption from displaying the expiration date as the collection of the MCBS is an ongoing endeavor with rotating panels of respondents. Therefore, an expiration date would cause unnecessary confusion on the part of the respondent and is therefore not practical.

18. Certification Statement

There are no exceptions to this certification statement.