

## INTRODUCTION

Medicare is the nation's health insurance program for persons 65 years and over and for persons younger than 65 years who have a qualifying disability. The Medicare Current Beneficiary Survey (MCBS) is a continuous, in-person, multi-purpose longitudinal survey covering a representative national sample of the Medicare population. Sponsored by the Centers for Medicare & Medicaid Services (CMS), the MCBS primarily focuses on economic and beneficiary topics including health care use and health care access barriers, health care expenditures, and factors that affect health care utilization. As a part of this focus, the MCBS collects a variety of information about the beneficiary, including demographic characteristics, health status and functioning, access to care, insurance coverage and out of pocket expenses, financial resources, and potential family support. The MCBS collects this information in three data collection periods, or rounds, per year. Over the years, data from the MCBS have been used to inform many advancements, including the creation of new benefits such as Medicare's Part D prescription drug benefit.

Each year, the MCBS Questionnaire specifications are made publically available on the MCBS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Questionnaires.html>. For each survey year, questionnaire users can view separate PDF files for each Community and Facility instrument section administered, including the question variable names and question text in each section. Exhibit 1 shows the PDF section specifications now available for 2019. These are the questionnaires administered during the 2019 calendar year.

The 2019 MCBS Questionnaire User's Guide is intended to accompany the 2019 MCBS Questionnaire specifications. For users less familiar with the MCBS Questionnaire, this document offers a publically available resource, which highlights questionnaire changes made in 2019 and explains the Community and Facility instruments more generally. For resources about MCBS data products, users can view documentation for each data year on the MCBS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Codebooks.html>.

**Exhibit 1:** 2019 MCBS Questionnaire Specification Sections

Section Group	Abbr.	Section Name	PDF Section File Name
<b>Community Questionnaire</b>			
Socio-Demographics	IAQ	Income and Assets	2019_Income_and_Assets_IAQ
	DIQ	Demographics/Income	2019_Demographics_Income_DIQ
Health Insurance	HIQ	Health Insurance	2019_Health_Insurance_HIQ
Utilization	DVH	Dental, Vision, & Hearing Care Utilization	2019_Den_Vis_Hear_Care_Utl_DVH

Section Group	Abbr.	Section Name	PDF Section File Name
	ERQ	Emergency Room Utilization	2019_Emergency_Utilization_ERQ
	IPO	Inpatient Hospital Utilization	2019_Inpatient_Utilization_IPO
	OPO	Outpatient Hospital Utilization	2019_Outpatient_Util_OPO
	IUQ	Institutional Utilization	2019_Institutional_Util_IUQ
	HHS	Home Health Summary	2019_Home_Health_Summary_HHS
	HHQ	Home Health Utilization	2019_Home_Health_Util_HHQ
	MPQ	Medical Provider Utilization	2019_Medical_Provider_Util_MPQ
	PMQ	Prescribed Medicine Utilization	2019_Prescribed_Med_Util_PMQ
	OMQ	Other Medical Expenses Utilization	2019_Other_Medical_Expense_OMQ
Cost	STQ	Statement Cost Series	2019_Statement_Cost_Series_STQ
	PSQ	Post-Statement Charge	2019_Post_Statement_Cost_PSQ
	NSQ	No Statement Charge	2019_No_Statement_Cost_NSQ
	CPS	Charge Payment Summary	2019_Cost_Payment_Summary_CPS
Experiences with Care	ACQ	Access to Care	2019_Access_to_Care_ACQ
	SCQ	Satisfaction with Care	2019_Satisfaction_Care_SCQ
	USQ	Usual Source of Care	2019_Usual_Source_Of_Care_USQ
Health Status	HFQ	Health Status and Functioning	2019_Health_Status_HFQ
Housing Characteristics	HAQ	Housing Characteristics	2019_Housing_Characs_HAQ
Social Determinants of Health or Health Behaviors	CPQ	Chronic Pain	2019_Chronic_Pain_CPQ
	MBQ	Mobility of Beneficiaries	2019_Mobility_MBQ
	NAQ	Nicotine and Alcohol Use	2019_Nicotine_Alcohol_Use_NAQ
	PVQ	Preventive Care	2019_Preventive_Care_PVQ
Knowledge and Decision Making	KNQ	Beneficiary Knowledge and Information Needs	2019_Beneficiary_Knowledge_KNQ
	RXQ	Drug Coverage	2019_Drug_Coverage_RXQ
Operational	INQ	Introduction	2019_Introduction_INQ
	ENS	Enumeration Summary	2019_Enumeration_Summary_ENS
	END	Closing	2019_End_END
	IRQ	Interviewer Remarks	2019_Interviewer_Remarks_IRQ

Section Group	Abbr.	Section Name	PDF Section File Name
<b>Facility Instrument</b>			
Facility Characteristics	FQ	Facility Questionnaire	Fac2019_Facility_Quex_FQ
Socio-Demographics	RH	Residence History	Fac2019_Residence_History_RH
	BQ	Background	Fac2019_Background_BQ
Health Insurance	IN	Health Insurance	Fac2019_Health_Insurance_IN
Utilization	US	Use of Health Services	Fac2019_Use_Health_Services_US
Cost	EX	Expenditures	Fac2019_Expenditures_EX
Health Status	HS	Health Status	Fac2019_Health_Status_HS
Operational	IR	Interviewer Remarks	Fac2019_Interviewer_Remarks_IR
Missing Data	FQM	Facility Questionnaire Missing Data	Fac2019_Facility_Missing_FQM
	RHM	Residence History Missing Data	Fac2019_Residence_Missing_RHM
	BQM	Background Questionnaire Missing Data	Fac2019_Background_Missing_BQM

## WHAT'S NEW FOR THE QUESTIONNAIRE IN 2019?

There were a number of questionnaire sections that were revised in 2019. Below questionnaire users will note highlights and updates for the 2019 survey administration year.

### Community Questionnaire

Changes implemented for the 2019 Community questionnaire generally included updates to question text, response options, programming logic, text fills, and the addition of new questionnaire items.

#### *General*

Two new Community questionnaire sections were introduced during 2019. The Dental Utilization Questionnaire (DUQ) section was expanded to ask respondents about vision and hearing care utilization and has accordingly been renamed the Dental, Vision, and Hearing Care Utilization Questionnaire (DVH). Additionally, the Chronic Pain Questionnaire (CPQ) has been introduced to capture MCBS beneficiary's experiences with pain.

#### *Section-Specific Changes*

Several item and section level changes were made to the Community questionnaire in 2019.

#### **Chronic Pain (CPQ)**

The new CPQ section was implemented in Summer 2019. This section begins with item CP1-PAINOFTN, which asks whether or not beneficiaries experienced pain within the last three months. If so, the section asks more detailed questions about the beneficiary's experience with pain and what types of services and activities they have used to manage their pain.

#### **Dental, Vision, & Hearing Care Utilization (DVH)**

Prior to Winter 2019, the MCBS collected information from beneficiaries about visits to vision and hearing professionals within the context of other medical provider visits in the Medical Provider Utilization Questionnaire (MPQ). However, given the structure of the MPQ, vision and hearing events were indistinguishable from other types of medical provider visits. To more effectively capture the occurrence, cost, and sources of payment for these types of events, the new Dental, Vision, & Hearing Care Utilization Questionnaire (DVH) section was created in 2019 to replace the existing Dental Utilization (DUQ) section. Existing items about dental utilization from DUQ remain within DVH and were used as a model for the vision and hearing care items to ensure capture of analogous details for dental, vision, and hearing care provider visits.

#### **Health Status and Functioning (HFQ)**

During the Baseline interview, Incoming Panel respondents are asked if they have ever been told they have a particular health condition, ever had a specific medical test or procedure, or

ever participated in certain health care screening activities. Some items then follow-up to ask the duration since the beneficiary's last medical test or screening. These items are also administered annually during the Continuing interview to update information since the last Fall round interview.

Previously, some of these items referenced time periods that were incongruous with their annual administration schedule in the Continuing interview. For example, during the Continuing interview, some of these items asked the respondent to recall if they "ever" had a particular diagnosis, test, or screening even though these items are administered each year. Further, some of these items asked the beneficiary to report the duration since their last medical test or screening and offered response categories using inconsistent time increments, often exceeding the time since the last interview one year prior.

To reconcile these inconsistent reference periods, several updates were made in the HFQ in Fall 2019. First, two versions of each item were created. During the Baseline interview, beneficiaries are asked the items that use "ever" as a reference period (e.g., item HFP17-DIAMNGE asks, "Have you ever participated in a diabetes self-management course or class, or received special training on how you can manage your diabetes?"). Then, in subsequent Continuing interviews, the beneficiary receives a second version of the item with an annual reference period (e.g., item CDIAMNGE-CDIAMNGE asks, "Since (DATE OF THE LAST FALL INTERVIEW), have you participated in a diabetes self-management course or class, or received special training on how you can manage your diabetes?").

The next change was made for follow-up questions asking when the last procedure or screening event occurred. In Fall 2019, the administration schedule of these follow-up items was changed such that they are only administered to Baseline cases. Since Continuing cases are asked if they had a particular diagnosis, test, or screening during the last 12 months, they no longer need to receive the follow-up question asking when the last procedure or screening event occurred.

Finally, to promote continuity across follow-up items during the Baseline interview, code lists were updated to contain response options in annual increments, up to ten years prior. During fielding, the questionnaire displays only those response options in line with standard of care guidelines for the specific item. For items with a standard of care guideline of less than five years, such as eye examinations, the five year scale was maintained to promote consistency across the items.

One additional change was made in HFQ in 2019 to expand the universe of item HFJ29B-OCDEMENT. Previously, beneficiaries who reported a diagnosis of Alzheimer's disease did not receive the item asking about whether they also have other types of dementia. Starting in Fall 2019, all beneficiaries receive HFJ29B-OCDEMENT, regardless of their Alzheimer's status.

### **Medical Provider Utilization (MPQ)**

Prior to Winter 2019, the question MP18-MPPRPRAC asked about the occurrence of medical events with other health practitioners (i.e., providers who are not a medical doctor), including acupuncturists, chiropractors, podiatrists, homeopaths, naturopaths, audiologists, and

optometrists. The reference to audiologists and optometrists has been removed from the question text for this item since all visits to vision and hearing care providers are now asked in DVH.

Additionally, the variable was renamed to MPHPRAC.

### **Nicotine and Alcohol Use (NAQ)**

In Fall 2019, two changes were made to the Nicotine and Alcohol (NAQ) section to align alcohol items with other federal surveys, notably the National Health Interview Survey (NHIS):

- Item ALCYEAR, which asks the respondent to report if they have ever had at least 12 drinks of any type of alcoholic beverage in any one year, was deleted. It was determined that the information gathered from ALCLIFE, which asks if the respondent had at least 12 drinks of any type of alcoholic beverage in their entire life met the criteria of classifying drinking status.
- The question measuring times the beneficiary has participated in binge drinking in the past month (i.e., 5 or more drinks for males on an occasion or 4 or more drinks for females on an occasion) was updated to mirror the parallel item in the NHIS. The variable name was also changed from ALC2HRS to ALCTIME.

### **Other Medical Expenses (OMQ)**

Prior to Winter 2019, data about the purchase of other medical items related to vision and hearing care, such as glasses, contact lenses, and hearing aids, were collected through the Other Medical Expenses Questionnaire (OMQ) section. These items were moved from OMQ to DVH in Winter 2019. Additionally, items about the purchase of hearing aids and hearing/speech devices were separated to capture more nuanced information about these event types.

### **Preventative Care (PVQ)**

Two changes were made to the PVQ section in 2019:

- For data collected in Summer 2019, routing logic in the PVQ was updated to ask all respondents who did not report a flu shot in the Winter round (PVF1-FLUSHOT) the reason for not receiving the flu shot (PV2-FLUCODE).
- Claims-based analyses have suggested very low uptake by beneficiaries of some important screening services including screening for HIV. Given the potential benefits of these preventive services to Medicare beneficiaries, questions from the National Health Interview Survey (NHIS) and the National HIV Behavioral Surveillance System (NHBS) were added to the survey in Fall 2019. The first item is administered to all respondents in Fall 2019 and asks whether the respondent has ever been tested for HIV. For those who respond yes, they are asked for the date of their most recent HIV test. For those who respond no, they are asked for the main reason they have not been tested. In future Fall rounds, Continuing respondents who have not previously been tested for HIV will receive a modified item asking if they have been tested for HIV since the date of the last interview.

## Drug Coverage (RXQ)

As part of the changes implemented in Summer 2018, two questions that ask about the drug coverage gap, or “donut hole,” were removed from the questionnaire since the information is available in administrative data (SC8I-DHPLAN and SC8L-DHTHISYR). These two deleted items served as filter questions to determine when follow-up items about the drug coverage gap are applicable to the beneficiary. With the removal of the filter questions in Summer 2018, all beneficiaries were asked follow-up items SC8M-DHSTART and SC8N-DHEND about the donut hole. However, some of these beneficiaries should have filtered out of these questions because they have not yet reached the start of the coverage gap or have private prescription drug coverage. In Summer 2019, the two questions about the coverage gap (SC8I-DHPLAN and SC8L-DHTHISYR) were added back to this series in their original form.

## Satisfaction with Care (SCQ)

In Fall 2019, PA3-PAINSTRC and PA4-PAMEDREC were added back into the questionnaire. These items were erroneously removed from the questionnaire when items from the Patient Activation (PAQ) section migrated to the Satisfaction with Care (SCQ) section in Fall 2017.

## Usual Source of Care (USQ)

Interviewers provided feedback indicating respondent confusion around items PP1-REMINDAPPT and PP2-PREPARE in the USQ section, which ask about communication from doctor’s offices prior to an upcoming appointment. The question text did not account for situations in which the respondent does not have an appointment (e.g., a walk-in visit to an immediate or urgent care facility). To account for these situations, a new response option of “(996) NOT APPLICABLE / R DID NOT HAVE AN APPOINTMENT” was added to each of these two items.

## Facility Instrument

Substantial changes were implemented for the 2019 Facility instrument to leverage administrative data, thereby shortening the Facility instrument for interviews conducted at Medicare- or Medicaid-certified facilities.

### *General*

## Incorporating Administrative Data to Reduce Respondent Burden

In Fall 2019, a number of changes were made to the Facility instrument to take advantage of existing CMS administrative data to reduce respondent burden.

During the Facility interview, interviewers collect data about MCBS facility-dwelling beneficiaries by administering CAPI instrument sections to facility staff and abstracting information from medical documentation. For interviews conducted at Medicare- or Medicaid-certified facilities, select questions in the MCBS Facility instrument are redundant with administrative data that are reported regularly to CMS. These data sources include the Long-Term Care Minimum Data Set

(MDS), which is a federally-mandated health assessment of residents living in Medicare- and Medicaid-certified nursing homes, and Certification and Survey Provider Enhanced Reports (CASPER), which contains certification data and provider characteristics for every facility in the United States that is qualified to provide services under Medicare or Medicaid. Importantly, CASPER and the MDS also include the CMS Certification Number (CCN), a unique identification number assigned to each facility certified to participate in Medicare and/or Medicaid.

Starting in Fall 2019, a small set of questions was added to the Facility questionnaire (FQ) section to verify whether the facility has a CCN and therefore is Medicare- or Medicaid-certified and required to report MDS and CASPER administrative data to CMS. If a facility's certification and reporting status is confirmed via the presence of a valid CCN, the Facility interview will skip more than 100 questionnaire variables contained in the Facility Questionnaire (FQ) and Health Status (HS) sections which are redundant with CASPER and MDS administrative data. For interviews conducted at facilities not certified by Medicare or Medicaid, the full Facility instrument is administered. During data processing, survey-collected data elements will be combined with CASPER and MDS administrative data to provide complete information for all MCBS facility-dwelling beneficiaries in MCBS data products. These changes to the Facility instrument will reduce burden for approximately 40% of annual facility cases, which are expected to reside in facilities meeting CMS' certification and reporting requirements.

### **Streamlining Collection of Medicaid and Marital Status Information<sup>1</sup>**

- Previously, three questions from the Health Status (HS), Expenditures (EX), and Insurance (IN) sections collected Medicaid number for a subset of beneficiaries as a means for determining if they had Medicaid coverage. In Fall 2019, these items were removed and questionnaire routing logic was updated to instead ask Medicaid coverage in the IN section for all beneficiaries.
- In Fall 2019, response options for the item collecting marital status were re-ordered to align with those used on the MDS.

### *Section-Specific Changes*

Several item and section level changes were made to the Facility instrument in 2019.

### **Facility Questionnaire (FQ)**

In Fall 2019, a number of changes were made to the FQ section to accommodate the integration of MDS and CASPER administrative data. These changes include:

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<sup>1</sup> For both of these changes, the items in question can be captured in different sections of the instrument depending on the case's interview type, season of administration, and order in which the field interviewer chooses to administer the survey, which explains why the items appear in multiple sections.

- The addition of one item to ask the facility respondent if the facility has a CMS Certification Number (CCN) and one item to collect the CCN using a lookup tool. The data source for the lookup tool is CASPER administrative data, thus allowing the instrument to validate the CCN value reported by the facility respondent.
- The addition of three items to confirm that a CCN reported in a prior round is still accurate.
- Routing was updated throughout the FQ section to allow for items captured by CASPER to be skipped once a valid CCN is collected. These items are on topics including certification status, the services the facility provides, and the total number of beds at the facility.
- Three questions were removed from the series that enumerates the services provided by the facility: help with correspondence or shopping, help with walking, and help with communications. This series is used to determine the eligibility of a facility to conduct the Facility instrument. These three items were confusing to facility respondents and were found to not be a deciding factor for facility eligibility in the MCBS. Further, it was found that these items were inconsistent with the definition of long-term care facility used by other federal surveys<sup>2</sup>.

### Facility Questionnaire Missing Data (FQM)

For items in the FQ section that are critical to determining eligibility for the Facility interview, if the response is recorded as “Don’t Know” or “Refused”, the item is asked again later in the FQM section. One of these items is the total number of beds in the facility, which will now be skipped in the FQ section if a CCN is reported. Therefore, the FQM was updated in Fall 2019 such that if the total number of beds item is skipped in the FQ as a result of reporting a CCN, the FQM will not be required.

### Health Status (HS)

In Fall 2019, two changes were made to the HS section to accommodate the integration of administrative data. These changes include:

- For beneficiaries residing in Medicare- or Medicaid-certified facilities where facility staff did not report a CCN in the FQ section, the instrument will include two new items in the HS section asking facility respondents to report if the facility has a CCN using the lookup tool. Since the HS section is often completed with a different facility staff member from the FQ section, and since facility staff often reference documentation containing the CCN to complete the HS section, these items will allow for another opportunity to collect the CCN in rare situations when the CCN is likely available but not reported during the FQ section.
- Routing was updated throughout the HS section to allow for items redundant with the MDS to be skipped once a valid CCN is collected in either the FQ or HQ sections.

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<sup>2</sup> Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. National Center for Health Statistics. VitalHealth Stat 3(38). 2016.

In addition, two changes were made to better align the HS with the MDS:

- The item collecting information about intellectual or developmental disabilities was updated to align with the MDS. This item now contains a list of conditions and asks the interviewer to select all conditions that apply.
- Capacity for reporting diagnoses of additional health conditions, beyond those already reported in the Facility instrument, has been expanded to align with the MDS. These items have been updated to allow for up to ten other/specify diagnoses, an increase from the previous limit of four. In addition, corresponding new variables have been added to collect these new responses.

### **Prescribed Medicine (PM)**

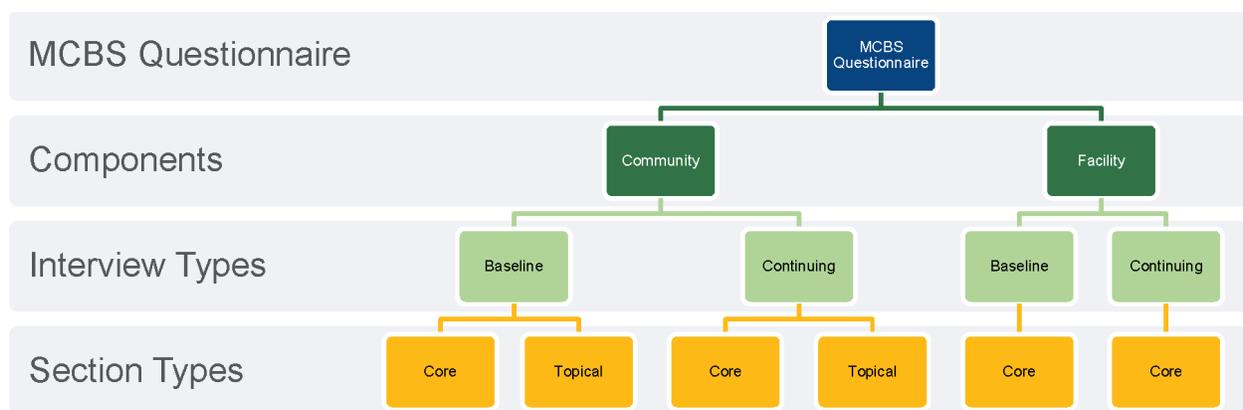
In Fall 2019, the PM section was removed from the Facility instrument. The data collected in this section had never been incorporated into the final data products as facility Medication Administrative Records (MAR) provide prescription medicine data by dose, rather than by prescription fill. A review of administrative data revealed that survey-reported prescription data were accounted for in the available administrative data. While this section will no longer be fielded, data from Medicare Part D claims will continue to be used to provide data users with prescribed medicine data for beneficiaries residing in facilities.

## QUESTIONNAIRES

The MCBS Questionnaire structure features two components (Community and Facility), administered based on the beneficiary's residence status. Within each component, the flow and content of the questionnaire varies by interview type and data collection season (fall, winter, or summer). There are two types of interviews (Baseline and Continuing) containing two types of questionnaire sections (Core and Topical). The beneficiary's residence status determines which questionnaire component is used and how it is administered. See Exhibit 2 for a depiction of the MCBS Questionnaire structure.

- **Community Component:** Survey of beneficiaries residing in the community at the time of the interview (i.e., their residence or a household). Interviews may be conducted with the beneficiary or a proxy.
- **Facility Component:** Survey of beneficiaries residing in facilities such as long-term care nursing homes or other institutions at the time of the interview. Interviewers conduct the Facility component with staff members located at the facility (i.e., facility respondents); beneficiaries are not interviewed if they reside at a facility. This is a key difference between the Community and Facility components.

**Exhibit 2:** MCBS Questionnaire Overview



Interviews are conducted in one or both components in a given data collection round, depending on the beneficiary's living situation.

Within each component, there are two types of interviews – an initial (Baseline) interview administered to new beneficiaries, and an interview administered to repeat (Continuing) beneficiaries as they progress through the study.

- **Baseline:** The initial questionnaire administered to beneficiaries new to the study; administered in the fall of the year they are selected into the sample (interview #1).
- **Continuing:** The questionnaire administered to beneficiaries as they progress through the study (interviews #2-11).

Depending on the interview type and data collection season (fall, winter, or summer), the MCBS Questionnaire includes Core and Topical sections. See Exhibits 6 and 8 for tables of the 2019 Core and Topical sections.

- **Core:** These sections are of critical purpose and policy relevance to the MCBS, regardless of season of administration. Core sections collect information on beneficiaries' health insurance coverage, health care utilization and costs, and operational management data such as locating information.
- **Topical:** These sections collect information on special interest topics. They may be fielded every round or on a seasonal basis. Specific topics may include housing characteristics, drug coverage, and knowledge about Medicare.

## Community Questionnaire Content

The section that follows provides an overview of the Community component of the MCBS questionnaire. The actual content administered varies based upon several factors, including the questionnaire administration season or round, the type of interview which reflects the length of time the respondent has been in the MCBS, and the component of the most recent interview.

### *Interview Type*

As MCBS is a panel survey, the type of interview a given beneficiary is eligible for depends on his or her status in the most recent round of data collection. Interview type (also referred to in this report by its Community Questionnaire variable name, INTTYPE) is a key determinant of the path followed through the Community Questionnaire. For example, the Baseline interview is an abbreviated interview that includes many Core and Topical sections but does not include questionnaire sections that collect health care utilization and cost information. For the purposes of administering the Community Questionnaire, there are eight interview types, summarized in Exhibit 3 below. Several of these interview types are applicable only in a certain season. For example, the Baseline interview (INTTYPE C003) is always conducted in the fall.

**Exhibit 3:** Community Questionnaire Interview Types

INTTYPE*	Description	Seasons
C001	Standard Continuing interview, meaning the most recent interview was in the community during the last round.	All
C002	Facility "crossover," meaning the most recent interview was in a facility. No prior community interview.	All
C003	Baseline interview. First round in the sample.	Fall
C004	Standard community "holdover," meaning the last round interview was skipped. Most recent interview was in the community.	All
C005	Facility "crossover," meaning the most recent interview was in a facility. Last community interview was two rounds ago.	All

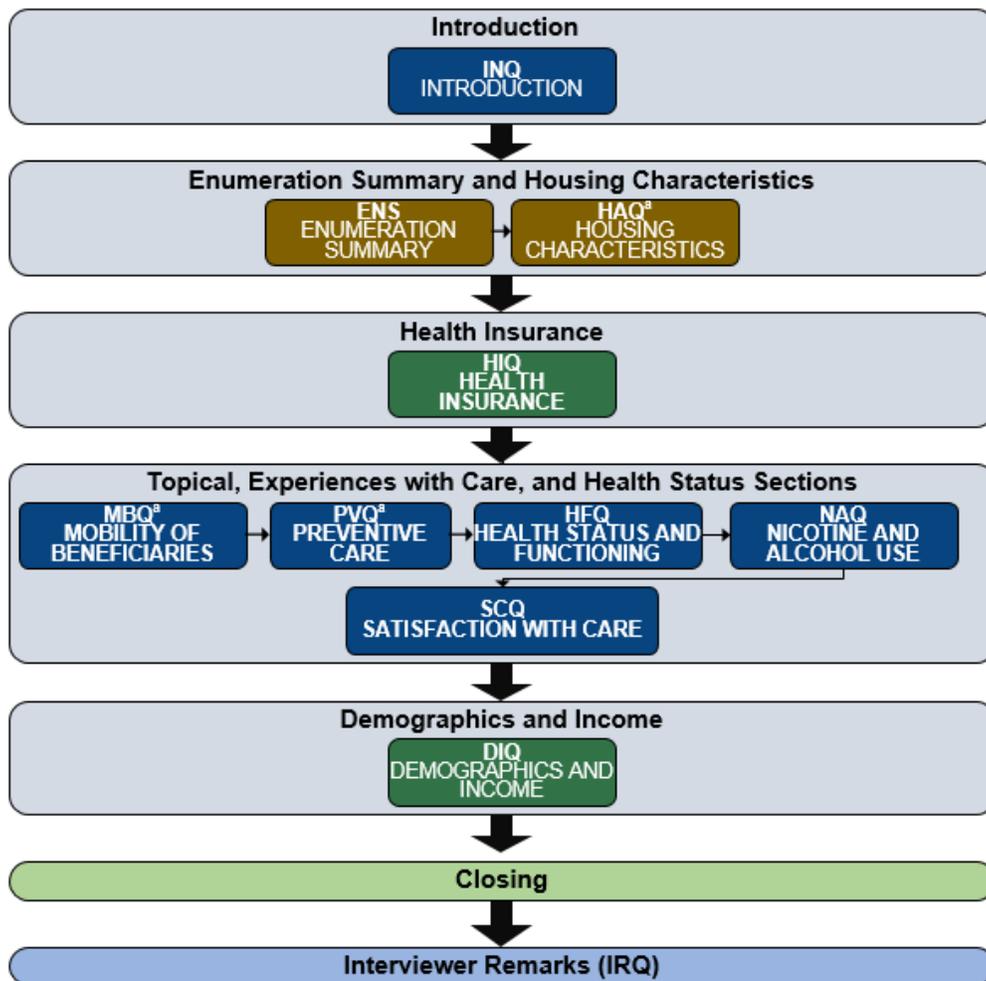
INTTYPE*	Description	Seasons
C006	Facility "crossover," meaning the most recent interview was in a facility. Last community interview was three or more rounds ago.	All
C007	Second round interview. Most recent interview was the fall Baseline interview. The second round interview is the first time utilization and cost data are collected.	Winter
C010	Second round "holdover," meaning the winter interview was skipped. Most recent interview was the fall Baseline interview. The third round interview is the first time in which utilization and cost data are collected.	Summer

\*Interview types for exit panel Community cases in the Summer round (INTTYPEs C008 and C009) were removed from the questionnaire specifications in 2018.

### *Community Questionnaire Flow*

Interview type and data collection season (fall, winter, or summer) are the two main factors that determine the specific sections included in a given interview. Further factors include whether the interview is conducted with the beneficiary or with a proxy and, for proxy interviews, whether the beneficiary is living or deceased. The Baseline interview contains an abbreviated flow which does not include the utilization or cost sections of the questionnaire. Exhibit 4 shows the flow for the Baseline interview.

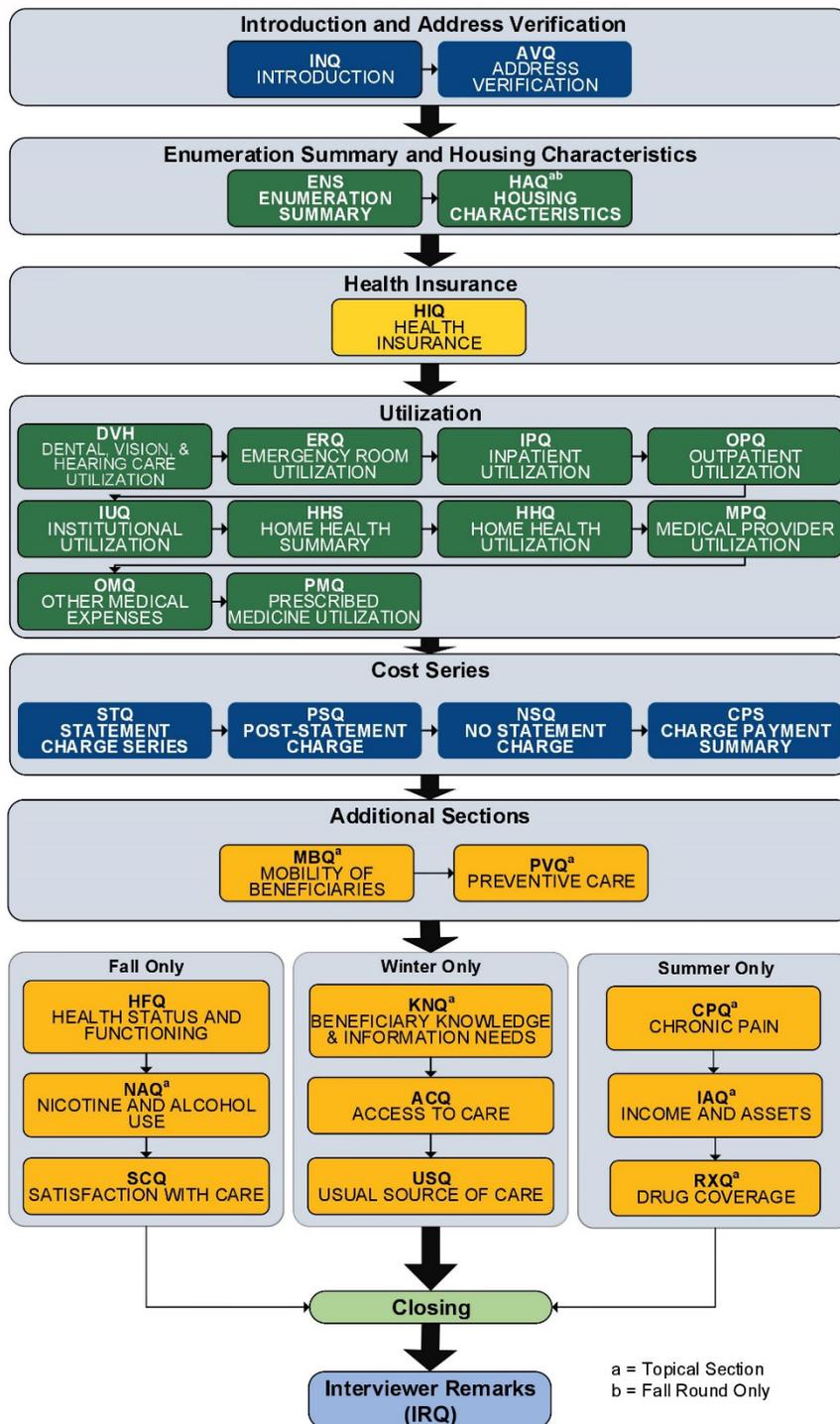
**Exhibit 4:** 2019 MCBS Community Questionnaire Flow for Baseline Interview



a = Topical Section

Exhibit 5 shows the most common Community Questionnaire flow for standard Continuing community sample.

**Exhibit 5:** 2019 MCBS Community Questionnaire Flow for Continuing Interview



## Core Section Content

Core survey content is grouped into questionnaire sections that collect data central to the policy goals of the MCBS. These sections collect information related to socio-demographics, health insurance coverage, health care utilization and costs, beneficiary health status and experiences with care, as well as operational and procedural data. Many of the core sections are administered each round. The following pages describe core sections of the Community Questionnaire, organized by topic of information collected. Exhibit 6 lists the core sections of the Community Questionnaire and the seasons in which they are administered.

**Exhibit 6:** 2019 MCBS Community Core Sections by Administration Schedule

Section Group	Abbr.	Section Name	Administrative Season
<b>Socio-Demographics</b>	IAQ	Income and Assets	Summer**
	DIQ	Demographics/Income	Fall, Baseline Interview
<b>Health Insurance</b>	HIQ	Health Insurance	All Seasons
<b>Utilization</b>	DVH	Dental, Vision, & Hearing Care Utilization	All Seasons
	ERQ	Emergency Room Utilization	All Seasons
	IPQ	Inpatient Hospital Utilization	All Seasons
	OPQ	Outpatient Hospital Utilization	All Seasons
	IUQ	Institutional Utilization	All Seasons
	HHS	Home Health Summary***	All Seasons
	HHQ	Home Health Utilization	All Seasons
	MPQ	Medical Provider Utilization	All Seasons
	PMQ	Prescribed Medicine Utilization	All Seasons
	OMQ	Other Medical Expenses Utilization	All Seasons
	<b>Cost</b>	STQ	Statement Cost Series
PSQ		Post-Statement Charge	All Seasons
NSQ		No Statement Charge	All Seasons
CPS		Charge Payment Summary***	All Seasons
<b>Experiences with Care</b>	ACQ	Access to Care	Winter
	SCQ	Satisfaction with Care	Fall
	USQ	Usual Source of Care	Winter
<b>Health Status</b>	HFQ	Health Status and Functioning	Fall

**SOURCE:** 2019 MCBS Community Questionnaire

\*Certain procedural or operational management sections are collected specifically to manage the data collection process (e.g., Introduction (INQ), Enumeration (ENS), and Interview Remarks (IRQ)).

\*\*The IAQ is administered in the Summer round following the current data year.

\*\*\*Summary sections: Updates and corrections are collected through the summary sections. The respondent is asked to verify summary information gathered in previous interviews. Changes are recorded if the respondent reports information that differs from what was previously recorded.

## Socio-Demographics

Two sections in the Community Questionnaire capture key socio-demographic characteristics of the beneficiary. The Demographics and Income section is administered for each Community beneficiary once during the Baseline interview. Income and Assets is administered to all Continuing beneficiaries once per year.

The **Demographics and Income (DIQ)** section includes traditional demographic items such as Hispanic origin, race, English proficiency, education, and a total household income. This section is administered during the Baseline interview.

**Income and Assets (IAQ)** collects detailed information about income and assets of the beneficiary and spouse or partner (if applicable). IAQ covers beneficiary (and spouse/partner) income from employment, Social Security, Veteran's Administration, and pensions. The respondent is also asked to indicate the value of the beneficiary's (and spouse's/partner's) assets including retirement accounts, stocks, bonds, mutual funds, savings accounts, businesses, land or rental properties, and automobiles. Also included is homeownership or rental status, and food security items. The Income and Assets section is asked in the summer round to collect income and asset information about the previous calendar year.

## Health Insurance

The Community Questionnaire captures health insurance information each round.

**Health Insurance (HIQ)** records all health insurance plans that the beneficiary has had since the beginning of the reference period. The survey prompts for coverage under each of the following types of plans: Medicare Advantage, Medicaid, Tricare, non-Medicare public plans, Medicare Prescription Drug Plans, and private (Medigap or supplemental) insurance plans. Detailed questions about coverage, costs, and payment are included for Medicare Advantage, Medicare Prescription Drug, and private insurance plans.

## Utilization

The utilization sections of the questionnaire capture health care use by category. Generally, four types of health care utilization are recorded: provider service visits, home health care, other medical expenses, and prescribed medicines. Provider service visits includes visits to dental, vision, and hearing providers, emergency rooms, inpatient and outpatient hospital departments, institutional stays, and medical providers. In these sections, visits are reported as unique events by date, although in cases where there are more than five visits to a single provider during the reference period, the events are entered by month with the number of visits specified. A slightly different reporting structure is used for home health care, other medical expenses, and prescribed medicines.

All utilization sections are administered in all Continuing interviews; these sections are not part of the Incoming Panel's Baseline interview. Additional detail is provided on each of the four types of health care utilization collected by the community survey below.

## Provider Service Visits

The utilization sections collecting provider service dates are as follows.

**Dental, Vision, & Hearing Care Utilization (DVH)** collects information about dental, vision, and hearing care visits during the reference period. DVH collects the name and type of dental, vision, and/or hearing care providers, dates of visits, services performed and/or medical equipment purchased (e.g., glasses, hearing aids), and medicines prescribed during the visits.

**Emergency Room Utilization (ERQ)** records visits to hospital emergency rooms during the reference period. ERQ collects the names of the hospitals, dates of visits, whether the visit was associated with a particular condition, and medicines prescribed during the visits. If a reported emergency department visit resulted in hospital admission, an inpatient visit event is created, with follow up questions asked in the Inpatient Utilization section.

**Inpatient Hospital Utilization (IPQ)** collects information about inpatient stays during the reference period. IPQ collects the names of the hospitals, beginning and end dates of the stays, whether surgery was performed, whether the visit was associated with a particular condition, and medicines prescribed to be filled upon discharge from the hospital (medicines administered during the stay are not listed separately). Inpatient stays resulting from emergency room admissions are also covered.

**Outpatient Hospital Utilization (OPQ)** prompts for visits that the beneficiary may have made to hospital outpatient departments or clinics during the reference period. OPQ collects the name of the outpatient facility, dates of visits, whether surgery was performed, whether the visit was associated with a particular condition, and medicines prescribed during the visits.

**Institutional Utilization (IUQ)** collects information about stays in nursing homes or any similar facility during the reference period. IUQ collects the name of the institution(s) and the dates the beneficiary was admitted and discharged from the institution(s).

**Medical Provider Utilization (MPQ)** collects information about medical provider visits during the reference period. In addition to physicians and primary care providers, this includes visits with health practitioners that are not medical doctors (acupuncturists, chiropractors, podiatrists, homeopaths, naturopaths), mental health professionals, therapists (including speech, respiratory, occupational, and physical therapists), and other medical persons (nurses, nurse practitioners, paramedics, and physician's assistants). MPQ collects names and types of providers, dates, whether the visit is associated with a particular condition, and medicines prescribed during the visit.

## Home Health Care Visits

A second type of health care utilization captured by the community survey are home health care visits. For Continuing beneficiaries that reported home health events during the prior round, **Home Health Summary (HHS)** reviews those providers and confirms whether the same providers were visited during the current round. These visits are recorded not by date, but by

the number of visits. In addition, the length of visits and services performed are recorded.

**Home Health Utilization (HHQ)** then collects information about home health provider visits, both professional and non-professional, during the reference period. HHQ collects names and types of home health providers, number and length of visits, and services performed during visits.

## Prescribed Medicines

The **Prescribed Medicine Utilization (PMQ)** section collects details about prescribed medicines obtained during the reference period. For medicines recorded in the provider service visit sections (in the context of those visits), PMQ collects the medicine strength, form, quantity, and number of purchases. Medicines that are not previously reported during the course of the provider service visit utilization sections, including those that are refilled or called in by phone, are also collected in this section. Unlike for provider service visits, event dates are not collected for prescribed medicines. Instead, the interviewer records the number of purchases or refills. Information about non-prescription medicines and prescriptions that are not filled are not recorded.

## Other Medical Expenses

The community survey also records other medical expenses. These expenses are reported using a slightly different reporting structure within the questionnaire.

**Other Medical Expenses Utilization (OMQ)** collects information about medical equipment and other items (excluding prescriptions) that the beneficiary purchased, rented, or repaired during the reference period. Other medical expenses includes hearing and speaking devices, orthopedic items (wheelchairs, canes, etc.), diabetic equipment and supplies, dialysis equipment, prosthetics, oxygen-related equipment and supplies, ambulance services, other medical equipment (beds, chairs, disposable items, etc.) and alterations to the home or car. For each item the date(s) of rental, purchase or repair are recorded. For disposable medical items (e.g., bandages), the number of purchases is collected, rather than a date.

## Cost Series

Once all utilization sections are completed, the questionnaire flows to the cost series, wherein the costs of all reported visits and purchases are recorded, along with the amount paid by various sources. Importantly, additional visits and purchases not reported in the utilization sections of the questionnaire could be recorded within the cost series, and all corresponding data for those events are collected within the cost series.

The cost series consists of four sections: Statement, Post-Statement, No Statement, and Charge Payment Summary. Each is described below.

The **Statement section (STQ)** collects medical cost information directly from Medicare Summary Notices (MSNs), insurance explanations of benefits (EOB), Prescription Drug Plan statements, and TRICARE or other insurance statements. In cases where the beneficiary had

more than one payer (e.g., Medicare and private insurance), interviewers organize statements into charge bundles, which are driven by the claim total on a MSN or EOB and may include one or more utilization events (visits, medicines, or purchases). Each charge bundle is entered separately, and all previously-reported events associated with the charge bundle are linked to the cost record. Payment details are entered from the statements and any remaining amount not accounted for is confirmed with the respondent. This process is repeated for all available, not previously recorded insurance statements containing events that occurred within the survey reference period (roughly the past year).

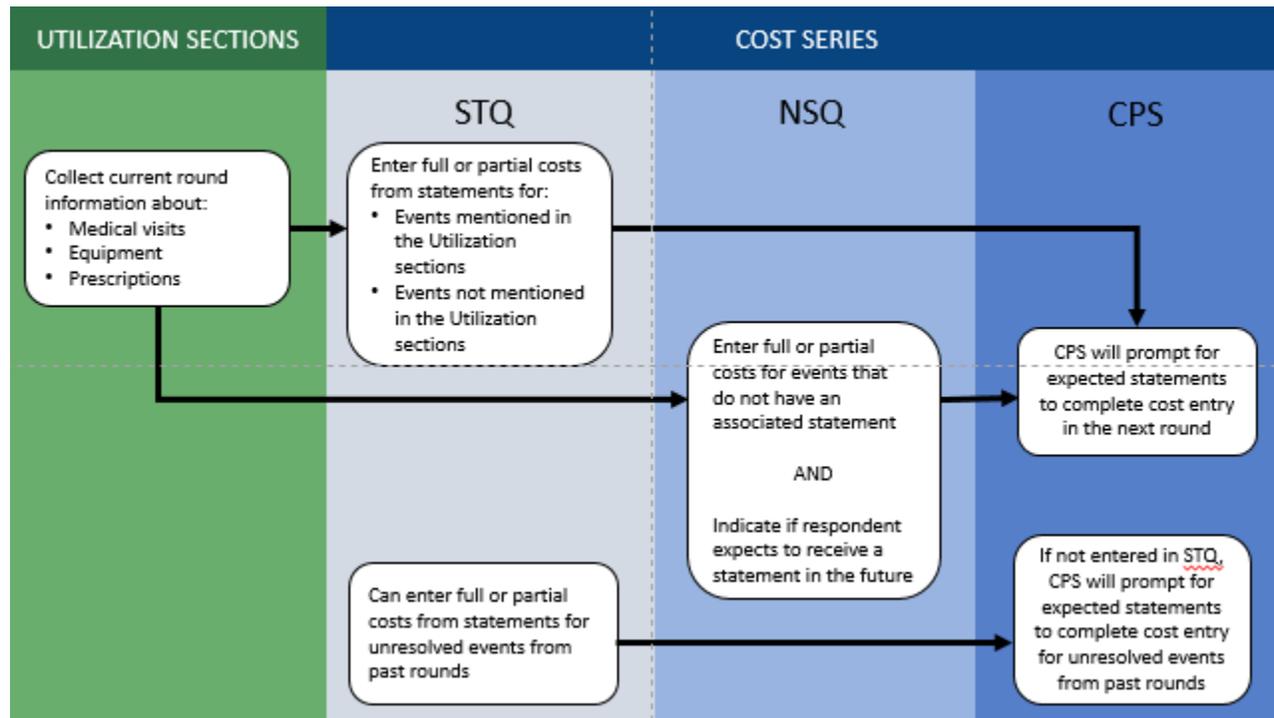
The **Post-Statement section (PSQ)** facilitates cost data collection for rental items that span multiple rounds of interviews (such as a long term wheelchair rental) and for which cost data has not yet been reported.

The **No Statement section (NSQ)** prompts for cost data for all events that do not have a Medicare, insurance, or TRICARE statement reported in the current round. This section attempts to capture cost data even in absence of insurance statements. The respondent may refer to non-statement paperwork such as bills or receipts to help collect accurate cost information. NSQ loops through a series of cost verification items for each event or purchase reported during the current round utilization but not already linked to a cost record via the Statement section. If respondents indicate a statement for the event is expected, then the NSQ items are bypassed.

The final cost series section, the **Charge Payment Summary (CPS)** reviews outstanding cost information reported from previous rounds. For example, if the respondent reported in the previous interview that he/she expected to receive an insurance statement for a particular event, then this event is carried forward to the next round CPS. Any charge bundle for which costs are not fully resolved is asked about in the next round CPS section. There are a variety of reasons a cost record might qualify to be asked about in CPS (referred to as “CPS Reasons”). For example, a respondent may have been expecting to receive a statement related to the event or may have reported payments that account for only part of the total charge. The amount of information collected in CPS and the path through the section is determined by the CPS reason for the cost record. One case can have multiple cost records flagged for CPS with a variety of CPS reasons. The questionnaire loops through each eligible cost record in an attempt to collect further cost data.

The flow of sections and questions within the Cost series varies depending on data collected in the current round (e.g., whether the beneficiary had a health insurance statement for a visit reported in the current round) and data collected in prior rounds (i.e., whether there was outstanding cost information reported from a prior round). Exhibit 7 illustrates how paths through these sections may vary depending on health care utilization and cost information collected in the current and previous rounds.

**Exhibit 7:** Utilization and Cost Section Flow



**Experiences with Care**

Three sections cover the beneficiary’s experience with care in various medical settings.

**Access to Care (ACQ)** is administered in the winter round interview for Continuing respondents and focuses on the beneficiary’s experience with particular types of medical encounters (hospital emergency room, hospital clinic or outpatient department, long-term care facility, or medical doctor visits) during the reference period. If the beneficiary had one or more of a particular type of medical encounter, additional items collect information about services received and waiting times associated with the most recent encounter.

**Satisfaction with Care (SCQ)** is part of the fall round interview for Incoming Panel and Continuing respondents and collects the respondent’s opinions about the health care that the beneficiary had received. The questions refer to medical care received from all medical providers, including both doctors and hospitals.

The **Usual Source of Care (USQ)** section is administered in the winter round interview for Continuing respondents and collects specific information about the usual source of health care for the beneficiary as well as any specialists seen during the reference period.

**Health Status**

**Health Status and Functioning (HFO)** collects information on the beneficiary’s general health status and needs. This includes specific health areas such as disabilities, vision, hearing,

and preventive health measures. HFQ includes measures of the beneficiary's ability to perform physical activities, moderate and vigorous exercise, health care maintenance and needs, and standard measures of Instrumental Activities of Daily Living (using the telephone, preparing meals, etc.), and Activities of Daily Living (bathing, walking, etc.). In addition, HFQ asks about medical diagnoses for common conditions (cancer, arthritis, hypertension, etc.). Finally, the section covers mental health conditions, falls, urine loss, and a more extensive series of questions for beneficiaries with high blood pressure and diabetes.

## Operational and Procedural

These sections help guide the interviewer through the interview, providing scripts for introducing and ending the interview. They also facilitate collection of address and household information to augment sample information for the purposes of locating respondents for follow-up interviews.

**Introduction (INQ)** introduces the survey and records whether the interview was completed by the beneficiary or a proxy. For interviews completed by a proxy, the introduction collects the proxy's name and relationship to the beneficiary and determines if the proxy is a member of the beneficiary's household. The introduction is part of every community interview.

The **Closing (END)** section is administered to close the interview for all respondents. During the exit interview, this section contains additional scripts to thank the respondent for participation over the four years of the MCBS.

**Enumeration (ENS)** collects household information and a roster of persons living in the household. For each household member added to the roster, his/her relationship to the beneficiary, sex, date of birth, age and employment status are collected. ENS is administered in all rounds.

The **Interviewer Remarks Questionnaire (IRQ)** captures additional metadata about the interview, as recorded by the interviewer. This includes the length of the interview, assistance the respondent may have received, perceived reliability of the information provided during the interview, and comments the interviewer had about the interviewing situation. IRQ is administered after every interview, but is generally completed after leaving the respondent's home, as none of the questions are directed to the respondent.

### *Topical Section Content*

In addition to the core content, there are several topical questionnaire sections that capture data on a variety of key topics that relate to the beneficiary's housing characteristics, health behaviors, knowledge about Medicare, and health-related decision making. Each topical section is described below, organized by information collected. Exhibit 8 lists the topical sections and administration schedule.

**Exhibit 8:** 2019 MCBS Community Topical Sections by Administration Schedule

Section Group	Abbr.	Section Name	Administrative Season
Housing Characteristics	HAQ	Housing Characteristics	Fall
Social Determinants of Health or Health Behaviors	CPQ	Chronic Pain	Summer
	MBQ	Mobility of Beneficiaries	All seasons
	NAQ	Nicotine and Alcohol Use	Fall
	PVQ	Preventive Care	All seasons
Knowledge and Decision Making	KNQ	Beneficiary Knowledge and Information Needs	Winter
	RXQ	Drug Coverage	Summer

**Housing Characteristics**

**Housing Characteristics (HAQ)** collects information on the beneficiary's housing situation. This includes the type of dwelling, facilities available in the household (e.g., kitchen and bathrooms), accessibility, and modifications to the home (e.g., ramps, railings, and bathroom modifications). This section also records if the beneficiary lives in an independent or assisted living community (distinct from a nursing or long-term care facility) where services like meals, transportation, and laundry may be provided. HAQ is administered in the fall for all beneficiaries in the Community component.

**Health Behaviors**

Three questionnaire sections record additional information about health behaviors, specifically prevalence and management of pain, mobility, preventive care, and nicotine and alcohol use.

**Chronic Pain (CPQ)** measures whether the beneficiary has experienced pain within the last three months. If so, the section asks about the beneficiary's experience with pain and what types of services and activities they have used to manage their pain.

**Mobility of Beneficiaries (MBQ)** determines the beneficiary's use of available transportation options, with a focus on reduced mobility and increased reliance on others for transportation.

The **Preventive Care (PVQ)** section collects information about beneficiaries' preventive health behaviors. Questions administered in this section vary by data collection season. In the winter round, the PVQ focuses on the influenza vaccine while in the summer round, the PVQ asks about the shingles and pneumonia vaccines. In the fall round, the PVQ asks whether the beneficiary has received various types of applicable preventive screenings or tests, such as a mammogram, Pap smear, or digital rectum exam.

**Nicotine and Alcohol Use (NAQ)** collects information on beneficiaries' smoking and drinking behavior, including past and current use of cigarettes, cigars, "smokeless" tobacco, and e-cigarettes. It also asks about past and current drinking behavior.

## Knowledge and Decision-Making

Respondent knowledge of Medicare and health-related decision making is captured in two topical sections.

The **Beneficiary Knowledge and Information Needs (KNQ)** section is administered in the winter round. These items measure the respondent's self-reported understanding of Medicare and common sources of information about health care and Medicare.

The **Drug Coverage (RXQ)** section is a summer round section that focuses on the Medicare Prescription Drug benefit, including respondent knowledge of the benefit, and opinions of the beneficiary's drug coverage, whether through a Medicare Prescription Drug Plan, a Medicare Advantage plan with prescription drug coverage, or a private insurance plan that covers prescription drugs.

## Facility Instrument Content

The following section provides an overview of the content of the Facility component of the MCBS questionnaire. The content of the Facility Instrument varies based upon several factors, including the season of data collection, the type of interview (which reflects the length of time the beneficiary has been in the facility), and the component of the most recent interview.

### *Interview Type*

Similar to the Community Questionnaire, the Facility Instrument uses interview type as a key determinant of which questionnaire sections to administer during a facility interview.

The MCBS uses five interview types, also known as sample types, to describe MCBS beneficiaries who reside in a facility, summarized in Exhibit 9.

**Exhibit 9:** Facility Instrument Interview Types

INTTYPE	Description	Season
CFR	Continuing Facility Resident. Beneficiary for whom the previous round interview was a facility interview and who currently resides at the same facility.	Any
CFC	Community-Facility-Crossover. Beneficiary who was interviewed in the community previously and has now moved to a long-term care facility.	Any
FFC	Facility-Facility-Crossover. Beneficiary for whom an interview was previously interviewed in a long-term care facility and has now moved to a different facility.	Any

INTTYPE	Description	Season
FCF	Facility-Community-Facility Crossover. Beneficiary whose last interview was in the community and for whom a facility interview has been conducted in a previous round, and who has been admitted to a new facility or readmitted to a facility where the beneficiary had a previous stay. This sample type is rarely encountered.	Any
IPR	Incoming Panel Respondent. Beneficiary who was just added to the MCBS sample (fall round only) and currently resides in a facility.	Fall

NOTE: Interview type (INTTYPE) is typically referred to as Sample Type in the Facility Instrument section specifications.

### *Facility Screener*

The Facility screener is administered to a facility staff member when a beneficiary moves to a new facility setting. The Facility screener confirms whether the beneficiary is currently living at the facility (or lived at the facility at some point during the reference period) and determines whether the facility is a public or private residence.

### *Facility Instrument Flow*

The Facility Instrument collects similar data to the Community Questionnaire. However, the Facility Instrument is administered to facility staff and not to the beneficiary; that is, the beneficiary does not answer questions during a Facility interview – instead, facility administrators and staff answer questions on behalf of the beneficiary.

Just like the Community Questionnaire, the sections administered in a given facility interview vary by interview type and data collection season (fall, winter, or summer). The Baseline interview administered to Incoming Panel Respondents contains an abbreviated flow which does not include the utilization or cost sections of the questionnaire. Exhibit 10 shows the flow for the Baseline interview.

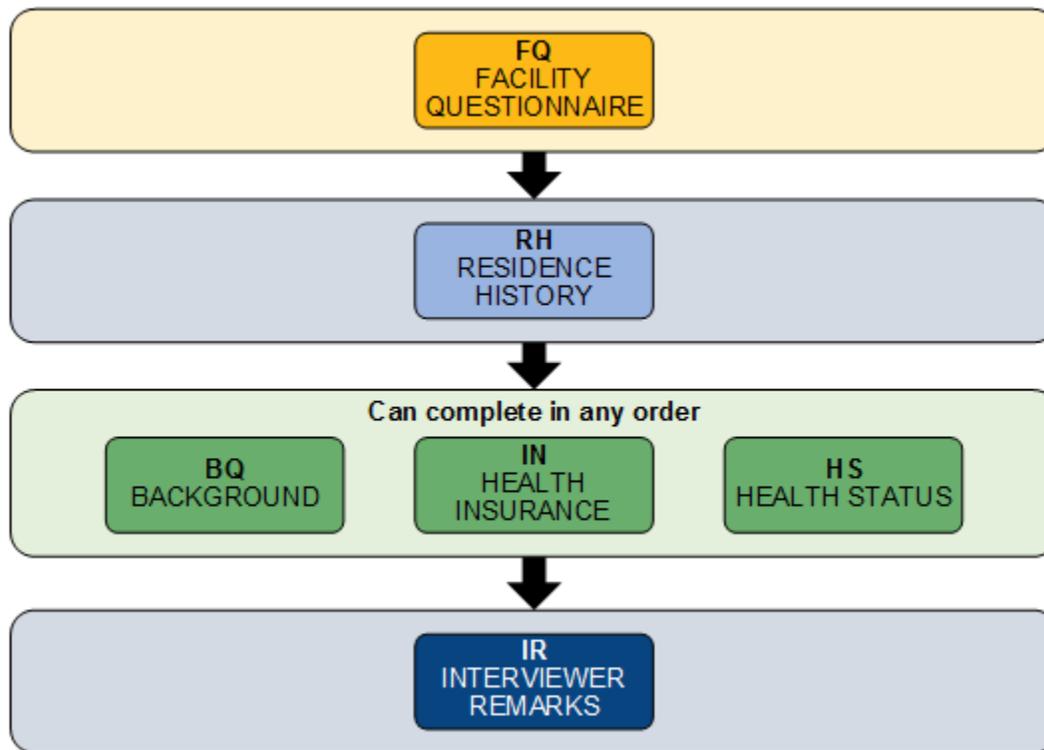
**Exhibit 10:** 2019 MCBS Facility Instrument Flow for Baseline Interview

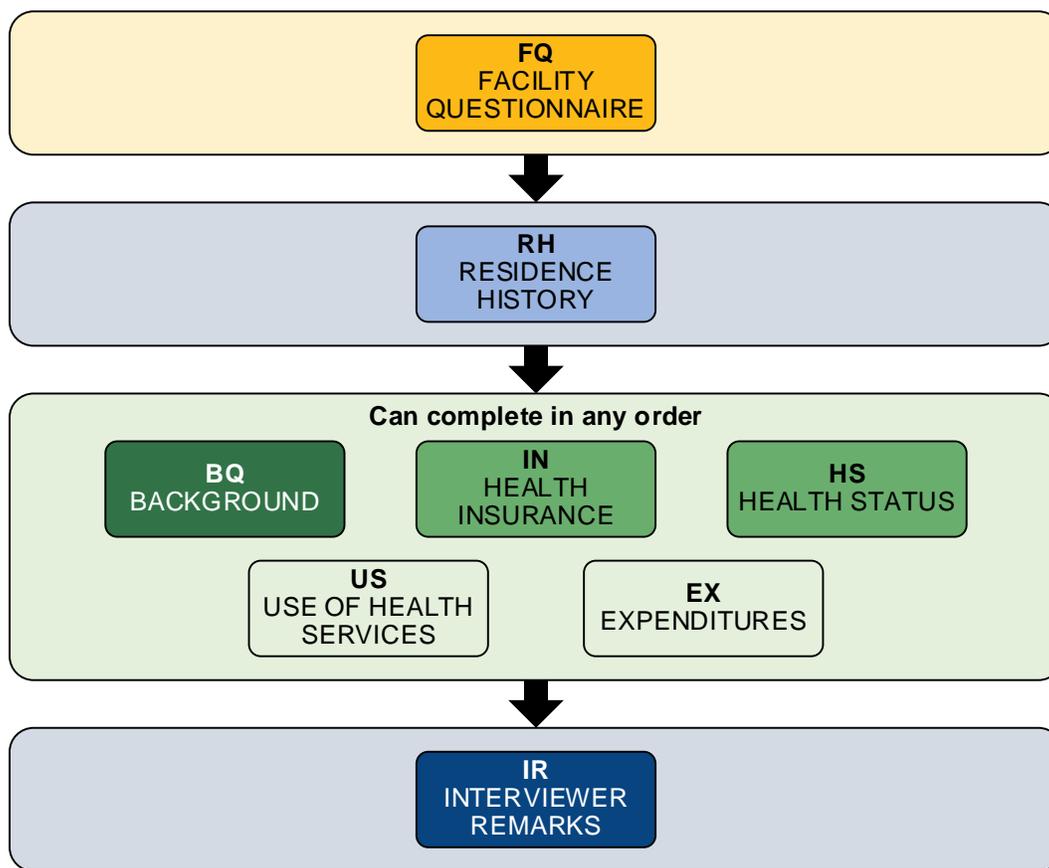
Exhibit 11 shows the flow for the Continuing and crossover interview types.

Because the Facility Instrument is administered to facility staff and not directly to the beneficiary, the Facility Instrument is designed to have a modular, flexible flow. The interviewer first completes the Facility Questionnaire (FQ) section. Next, the interviewer administers the Residence History (RH) section. The remaining sections may be completed in any order. Interviewers are instructed to conduct the sections in the order most suitable to the facility structure and the availability of facility staff. For example, the interviewer may conduct three sections with the head nurse and then visit the billing office to complete the remaining sections. Interviewers complete the Interviewer Remarks (IR) section at the end of the interview.

As of Fall 2019, the Facility instrument flow has been updated such that a shorter interview is administered for interviews conducted at Medicare- or Medicaid-certified facilities. Prior to Fall 2019, for facilities certified by Medicare- or Medicaid, select questions in the MCBS Facility instrument were redundant with administrative data that are reported regularly to CMS. These administrative data sources include the Long-Term Care Minimum Data Set (MDS), which is a federally-mandated health assessment of residents living in Medicare- and Medicaid-certified nursing homes, and Certification and Survey Provider Enhanced Reports (CASPER), which contains certification data and provider characteristics for every facility in the United States that is qualified to provide services under Medicare or Medicaid.

Importantly, CASPER also includes the CMS Certification Number (CCN), a unique identification number assigned to each facility certified to participate in Medicare and/or Medicaid. If a facility’s certification and reporting status is confirmed via the presence of a valid CCN, the Facility interview will skip more than 100 Fvariables in the Facility Questionnaire (FQ) and Health Status (HS) sections which are redundant with CASPER and MDS administrative data. For interviews conducted at facilities not certified by Medicare or Medicaid, the full Facility instrument is administered. During data processing, survey- collected data elements will be combined with CASPER and MDS administrative data to provide complete information for all MCBS facility-dwelling beneficiaries in MCBS data products.

**Exhibit 11:** 2019 MCBS Facility Instrument Flow for Continuing and Crossover Interviews



- Administered only for Community to Facility interviews
- Administered to all sample types in Fall round. Otherwise, administered only for Community to Facility, Facility to Facility, and for beneficiaries residing in a Facility whose last interview was a Community interview and who completed a Facility interview in a prior round.
- Administered for all Facility interviews

## Core Section Content

The Facility Instrument consists of only core sections with no topical content. The following pages describe core sections of the Facility Instrument, organized by topic of information collected. Exhibit 12 shows the core sections of the Facility Instrument and the seasons in which they are administered.

**Exhibit 12:** Facility Core Sections by Administration Schedule

Section Group	Abbrev	Section Name	Administrative Season
<b>Facility Characteristics</b>	FQ	Facility Questionnaire	All seasons
<b>Socio-Demographics</b>	RH	Residence History	All seasons
	BQ	Background	Fall*
<b>Health Insurance</b>	IN	Health Insurance	Fall**
<b>Utilization</b>	US	Use of Health Services	All seasons
<b>Cost</b>	EX	Expenditures	All seasons
<b>Health Status</b>	HS	Health Status	Fall**

SOURCE: 2019 MCBS Facility Instrument

NOTE: Certain procedural or operational management sections are collected specifically to manage the data collection process (e.g., Interview Remarks (IR)).

\*The BQ section is also administered to Community-to-Facility crossover cases each season.

\*\*The IN and HS sections are also administered to Community-to-Facility and Facility-to-Facility crossover cases each season.

## Facility Characteristics

The Facility Characteristics core section contains the **Facility Questionnaire (FQ)** section of the Facility Instrument. The FQ section collects information on the number, classification, and certification status of beds within the facility; sources of payment for facility residents; and facility rates. Interviewers typically conduct the FQ with the facility administrator. Interviewers are not allowed to abstract this section of the interview; it must be conducted with a facility staff member.

For interviews conducted in Medicare- or Medicaid-certified facilities, the FQ section collects the CMS Certification Number (CCN), which indicates that a facility is required to report MDS and CASPER administrative data to CMS. The CCN facilitates the linking of MCBS data to these administrative data sources during data processing. For interviews that report a valid CCN, the FQ skips items that are redundant with CASPER.

## Socio-Demographics

The Socio-Demographics core sections capture key characteristics of the interview and the beneficiary. These include residence history and demographics.

The **Residence History (RH)** section collects information about all of the places that the beneficiary stayed during the reference period. Information is collected about where the beneficiary was just before entering the facility and where he/she went if they had been discharged. For each stay, the interviewer collects the name of the place of residence, the type of place it is, and the start and end date for the period the beneficiary was living there.

The RH section creates a timeline of the beneficiary's whereabouts from the date the beneficiary entered the facility or the date of the last interview, through the date of interview, date of discharge, or date of death. The goal is to obtain a complete picture of the beneficiary's stays during the reference period, including any stays of one night or more in hospitals, other facilities, or any other place.

The **Background Questionnaire (BQ)** collects background information about the beneficiary such as use of long-term care before admission to the facility, level of education, race, ethnicity, service in the Armed Forces, marital status, spouse's health status, living children, and income. The BQ is completed only once for each beneficiary during their first interview in the Facility.

## Health Insurance

The Health Insurance core section contains the **Health Insurance (IN)** section of the Facility Instrument. The IN section collects information about the beneficiary's type(s) of health insurance coverage. This includes questions about all types of health insurance coverage the beneficiary had in addition to Medicare: private insurance, long-term care insurance, Department of Veterans Affairs eligibility, and TRICARE or CHAMPVA.

## Utilization

The Utilization sections collect data on the beneficiary's use of health care. This section is administered to all sample types except for the Incoming Panel.

The **Use of Health Care Services (US)** section collects information on the beneficiary's use of health care services while a resident of the facility. This includes visits with a range of providers including medical doctors, dentists, and specialists; visits to the hospital emergency room; and other medical supplies, equipment, and other types of medical services provided to the beneficiary.

The best facility respondent for this questionnaire section is usually someone directly involved with the beneficiary's care or someone who is familiar with the medical records.

## Cost

The Facility Cost component consists of the **Expenditures (EX)** section. The EX section collects information about bills for the beneficiary's care at a facility and payments by source for those charges. Data are only collected for the time period when the beneficiary was a resident of the facility at which the interview takes place. The EX section collects information by billing period (e.g., monthly semi-monthly, quarterly, etc.).

Unlike the Community Questionnaire which collects information for each service, the EX section collects information on the fees the facility bills for the beneficiary's care. The EX section collects information on the amount billed for the beneficiary's basic care and for any health related ancillary services. Typically the EX section is administered to facility staff located in the billing office.

## Health Status

The **Health Status (HS)** section collects information on the beneficiary's general health status, ability to perform various physical activities, general health conditions, Instrumental Activities of Daily Living, and Activities of Daily Living. For the small number of beneficiaries residing in Medicare- or Medicaid-certified facilities that did not report a CCN in the FQ, the HS section also presents the opportunity to collect the CCN. Since the HS section is often completed with different a facility staff member from the FQ section, and since facility staff often reference documentation containing the CCN to complete the HS section, these items will allow for another opportunity to collect the CCN in rare situations when the CCN is likely available but not reported during the FQ section.

Most of the information needed to conduct the HS section may be found in a medical chart. The Federal Government requires that all nursing facilities certified by Medicaid or Medicare conduct comprehensive and standardized assessments of each resident's health status when the resident is admitted to the nursing home and at regular intervals thereafter. These assessments are captured by the MDS and reported to CMS. Nursing homes use this information to assess each resident's health status, identify problem areas and, where problems exist, formulate care plans to address them.

The HS section is designed to mirror the flow and wording of the MDS items; it contains a subset of the MDS items. In addition, the HS section contains some questions that are not found on the MDS. Interviewers ask these questions of someone knowledgeable about the beneficiary's care or find the information in the medical chart.

For MCBS beneficiaries residing in facilities for which a CCN was collected, the HS section skips items that are redundant with the MDS. During data processing, MDS administrative data are incorporated for items skipped during the Facility interview.

## Operational and Procedural

The **Interviewer Remarks (IR)** section captures additional metadata about the interview, as recorded by the interviewer. This includes comments the interviewer may have about the interviewing situation and notes to themselves for use in gaining cooperation in the future.

## Missing Data Sections

There are three additional sections, called missing data sections, which are activated when essential survey information is coded as “don’t know” or “refused” in the FQ, RH, or BQ sections. The missing data sections prompt the interviewer for the specific piece of information that is missing. There are no new questions in the missing data sections, just repeats of questions initially asked in the FQ, RH, or BQ. Examples of the type of missing information that activate the missing data sections are the name of the facility or date of death.

The purpose of the missing data sections is to reduce item non-response for key variables in a highly modular, flexible format. If the interviewer is able to obtain the missing information from another facility staff member or from a different medical document, then the interviewer uses the missing data section to later capture a non-missing response for the key questionnaire item without modifying responses for the other already-completed items in the FQ, RH, and BQ sections. If the interviewer is unable to obtain the missing information, either “don’t know” or “refused” is entered in the missing data sections.

The missing data sections are:

- Facility Questionnaire Missing Data (FQM): collects data missing from the FQ section of the interview;
- Residence History Questionnaire Missing Data (RHM): collects data missing from the RH section; and
- Background Questionnaire Missing Data (BQM): collects data missing from the BQ section.