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. 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 2020. These are the questionnaires administered during the 2020 calendar year.

The 2020 MCBS Questionnaire User's Guide is intended to accompany the 2020 MCBS Questionnaire specifications. For users less familiar with the MCBS Questionnaire, this document offers a publically available resource, which highlights questionnaire changes made in 2020 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.

Exhibit 1:   2020 MCBS Questionnaire Specification Sections

Section Group	Abbr.	Section Name	PDF Section File Name
Community Questionnaire			
Socio-Demographics	IAQ	Income and Assets	2020_Income_and_Assets_IAQ
	DIQ	Demographics/Income	2020_Demographics_Income_DIQ
Health Insurance	HIQ	Health Insurance	2020_Health_Insurance_HIQ

Section Group	Abbr.	Section Name	PDF Section File Name
Utilization	DVH	Dental, Vision, & Hearing Care Utilization	2020_Den_Vis_Hear_Care_Utl_DVH
	ERQ	Emergency Room Utilization	2020_Emergency_Utilization_ERQ
	IPQ	Inpatient Hospital Utilization	2020_Inpatient_Utilization_IPQ
	OPQ	Outpatient Hospital Utilization	2020_Outpatient_Util_OPQ
	IUQ	Institutional Utilization	2020_Institutional_Util_IUQ
	HHQ	Home Health Utilization	2020_Home_Health_Util_HHQ
	MPQ	Medical Provider Utilization	2020_Medical_Provider_Util_MPQ
	PMQ	Prescribed Medicine Utilization	2020_Prescribed_Med_Util_PMQ
	OMQ	Other Medical Expenses Utilization	2020_Other_Medical_Expense_OMQ
Cost	STQ	Statement Cost Series	2020_Statement_Cost_Series_STQ
	PSQ	Post-Statement Charge	2020_Post_Statement_Cost_PSQ
	NSQ	No Statement Charge	2020_No_Statement_Cost_NSQ
	CPS	Charge Payment Summary	2020_Cost_Payment_Summary_CPS
Experiences with Care	ACQ	Access to Care	2020_Access_to_Care_ACQ
	SCQ	Satisfaction with Care	2020_Satisfaction_Care_SCQ
	USQ	Usual Source of Care	2020_Usual_Source_Of_Care_USQ
Health Status	HFQ	Health Status and Functioning	2020_Health_Status_HFQ
Housing Characteristics	HAQ	Housing Characteristics	2020_Housing_Charcs_HAQ
Social Determinants of Health or Health Behaviors	CPQ	Chronic Pain	2020_Chronic_Pain_CPQ
	CMQ	Coginitive Measures	2020_Cognitive_Measures_CMQ
	MBQ	Mobility of Beneficiaries	2020_Mobility_MBQ
	NAQ	Nicotine and Alcohol Use	2020_Nicotine_Alcohol_Use_NAQ
	PVQ	Preventive Care	2020_Preventive_Care_PVQ
Knowledge and Decision Making	KNQ	Beneficiary Knowledge and Information Needs	2020_Beneficiary_Knowledge_KNQ
	RXQ	Drug Coverage	2020_Drug_Coverage_RXQ
Operational	INQ	Introduction	2020_Introduction_INQ
	ENS	Enumeration Summary	2020_Enumeration_Summary_ENS
	END	Closing	2020_End_END
	IRQ	Interviewer Remarks	2020_Interviewer_Remarks_IRQ

Section Group	Abbr.	Section Name	PDF Section File Name
Facility Instrument			
Facility Characteristics	FQ	Facility Questionnaire	Fac2020_Facility_Quex_FQ
Socio-Demographics	RH	Residence History	Fac2020_Residence_History_RH
	BQ	Background	Fac2020_Background_BQ
Health Insurance	IN	Health Insurance	Fac2020_Health_Insurance_IN
Utilization	US	Use of Health Services	Fac2020_Use_Health_Services_US
Cost	EX	Expenditures	Fac2020_Expenditures_EX
Health Status	HS	Health Status	Fac2020_Health_Status_HS
Operational	IR	Interviewer Remarks	Fac2020_Interviewer_Remarks_IR
Missing Data	FQM	Facility Questionnaire Missing Data	Fac2020_Facility_Missing_FQM
	RHM	Residence History Missing Data	Fac2020_Residence_Missing_RHM
	BQM	Background Questionnaire Missing Data	Fac2020_Background_Missing_BQM

WHAT'S NEW FOR THE QUESTIONNAIRE IN 2020?

There were a number of questionnaire sections that were revised in 2020. Below questionnaire users will note highlights and updates for the 2020 survey administration year.

COVID-19 Related Updates

Several changes were implemented in the 2020 Community and Facility instruments in response to the COVID-19 pandemic. CMS also added a MCBS COVID-19 Supplement to Summer and Fall 2020 data collection. See https://www.cms.gov/research-statistics-data-and-systemsresearchmcbsquestionnaires/2020-supplemental-covid-19-questionnaires for the questionnaire specifications and user's guide.

Community Questionnaire

In response to the COVID-19 pandemic, CMS expanded access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their health care providers without having to travel to a healthcare facility.[1] Due to expansion of telehealth coverage, a follow-up question was added to the Medical Provider Utilization (MPQ), Statement Section (STQ), and No Statement (NSQ) sections starting in Fall 2020 to capture if a medical provider event was a telephone or video visit. This item will allow data users to distinguish telemedicine vists from in-person provider visits.

Facility Instrument

Two changes were made to the Use of Health Services (US) section of the Faciltiy instrument in Fall 2020 in response to the COVID-19 pandemic:

- Due to the COVID-19 pandemic, some facilities had to temporarily or indefinitely suspend certain types of in-person health care services to prevent the spread of the virus. The US section asks if the beneficiary received health care services during the reference period for medical doctor visits, dental visits, mental health visits, physical therapist or other types of therapist vists, podiatrist visits, educational and habilitational services, and other types of health care provider visits. To measure the impact of suspension of health care services on the beneficiairy's health care utilization, a new response option was added throughout the US section for these health care services. In addition to responding "YES" or "NO", "SERVICE SUSPENDED DUE TO COVID-19" was added to these health care services to capture that a specific health care service type was suspended due to COVID-19.

- With the expansion of telehealth coverage due to the COVID-19 pandemic, additional question text at health care service questions and follow-up questions were added throughout the US section to measure whether any reported health care services were telehealth visits. The additional question text and new follow-up questions were added for medical doctor visits,

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[1] Centers for Medicare & Medicaid Services. (2020, March 17). *Medicare Telemedicine Health Care Provider Fact Sheet.* https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

dental visits, mental health visits, physical therapist or other types of therapist vists, podiatrist visits, educational and habilitational services, and other types of health care provider visits, in addition to already existing follow-up questions about the number of visits or duration of care.

Community Questionnaire

In addition to changes made in response to the COVID-19 pandemic, other changes implemented for the 2020 Community questionnaire generally included a new questionnaire section, updates to question text, response options, programming logic, text fills, and the addition of new questionnaire items.

General

■ The Community questionnaire contains several items that measure types of foregone health care. Previously, these items were fielded on inconsistent administration schedules. Some foregone care items were fielded every round while others were administered only during the Fall interview. Further, some were only administered to respondents who had reported a certain type of utilization. In Fall 2019, the administration schedule for these items was updated such that starting in Winter 2020, all foregone care items are administered annually in the Winter round and will be asked of respondents regardless of whether or not they report utilization. The table below summaries the sections and variables impacted by this change.

Section	Variables	Measures
DVH	DU15-DVNEED	Forgone Dental Care
	VU15-VUNEED	Forgone Vision Care
	HU20-HVNEED	Forgone Hearing Care
MPQ	MP33B-AFRDMT	Forgone Mental Health Care
	SC11-MCDRNSEE	Forgone Medical Provider Visits
PMQ	PMNOTGET-PMNOTGET	Forgone Prescribed Medicines

■ In 2020, the Home Health Utilization (HHQ) section was redesigned and modeled after the Medical Provider Utilization (MPQ) section to support the creation of a home health event-level segment in the Cost Supplement File Limited Data Set (LDS) release. This effort included many questionnaire changes including the following:

▶ To facilitate implementation of the redesigned HHQ and ease burden on analytic processing, the Home Health Summary (HHS) and HHQ sections were not fielded in the Winter or Summer 2020, thereby ensuring that all home health data collected in the 2020 data year will be from the redesigned HHQ.

▶ In Fall 2020, the HHS section was permanently deleted. Respondents receiving ongoing care from the same home health provider will record that information in HHQ as a new event, just as respondents do for other ongoing utilization.

▶ To mirror the structure of MPQ, questionnaire modifications in HHQ included text and variable name updates, new variables, deleted variables, and updated routing.

▪ In Winter 2020, a discrepancy in the code lists among the three items that collect provider speciality in the Access to Care (ACQ) and Usual Source of Care (USQ) sections was reconciled. The code lists at AC20-MDSPCLTY, US6A-MDSPEC, and AC34A-MHSPCLTY are now identical to ensure consistency across the items. Additionally, these variables were renamed; MDSPCLTY, MDSPEC, and MHSPCLTY became DRSPCLTY, PVSPEC, and MPSPCLTY, respectively, to reflect the updated code frames for these items.

Section-Specific Changes

Several item and section level changes were made to the Community questionnaire in 2020.

Access to Care (ACQ)

▪ In Winter 2020, two items measuring wait times for medical visits (AC16A and AC28A1) were updated with text fills to clarify that the response should only include the time beyond the beneficiary's appointment time. For beneficiaries without appointments, the question text remains unaltered. Since this new question text could alter the universe of responses at these items, the variables were renamed accordingly:

Old Variable Name	New Variable Name
AC16A-OWAITUNT	AC16A-HWAITUNT
AC16A-OWAITHRS	AC16A-HWAITHRS
AC16A-OWAITMIN	AC16A-HWAITMIN
AC28A1-MWAITUNT	AC28A1-DWAITUNT
AC28A1-MWAITHRS	AC28A1-DWAITHRS
AC28A1-MWAITMIN	AC28A1-DWAITMIN

Cognitive Measures (CMQ)

Measuring the prevalence of functional limitations in the Medicare population is important to gauging the impact of cognitive functioning on current and future health care costs. Mild cognitive impairment is linked with increased difficulties with activities of daily living (ADLs) and Instrumental Activities of Daily Living (IADLs), but the signs of cognitive impairment may be present before the respondent self-reports any functional limitations.[2] Therefore, in Fall 2020, a new Community questionnaire section, Cognitive Measures (CMQ), was added to the Community questionnaire to measure cognitive functioning. CMQ contains four well-established cognitive measures:

▪ Backwards Counting: Respondents are asked to count backwards starting at 20 or 86 for 10 continuous numbers.

▪ Date Naming: Respondents are asked to name today's date.

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[2] Puente AN, Terry DP, Faraco CC, Brown CL, Miller LS. 2014. "Functional Impairment in Mild Cognitive Impairment Evidenced Using Performance-Based Measurement." Journal of Geriatric Psychiatry and Neurology, 27(4):253-258.

- Object Naming: Respondents are asked to answer two questions: "What do you usually use to cut paper?" and "What do you call the kind of prickly plant that grows in the desert?"

- President/Vice President Naming: Respondents are asked to name the current President/Vice President.

The new CMQ section will be administered annually in the Fall round to beneficiaries in all panels who are alive and not institutionalized. CMQ appears after the Satisfaction with Care (SCQ) section and is followed by the Demographics & Income (DIQ) section in the Baseline interview and the END section in the Continuing interview.

Demographic & Income (DIQ)

In Fall 2020, the code list at D12E-WHATLANG was expanded to include the languages that are most frequently entered at D12E-WHTLNGOS, when respondents indicate they speak a language other than English, Spanish, French, and German at home. Accordingly, the code list at D2E-WHATLANG was updated to include Italian, Tagalog, Chinese (Mandarin, Catononese, or Other), Polish, Korean, Russian, Greek, Filipino, Arabic, Japanese, Vietnamese, and Hindi.

Health Status and Functioning (HFQ)

A number of modifications were made to the Health Status and Functioning (HFQ) section in Fall 2020.

- On-screen help text at OCCANCER previously directed interviewers to include non-malignant tumors or growths in affirmative, "yes" responses at this item. However, the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES) both ask comparable items but exclude benign or non-malignant tumors. To align OCCANCER with the other federal surveys, the on-screen text was updated to read, "DO NOT INCLUDE BENIGN OR NON-MALIGNANT TUMORS OR GROWTHS."

  Since the universe of responses at OCCANCER was altered with the update described above, item OCCANCER was renamed EVRCANCR in Fall 2020. Similarly, variable OCCCODE, which captures on what part of the body the cancer reported at OCCANCER was found, was renamed CANCRSIT, as the responses at OCCCODE will no longer include site-specific information related to benign tumors.

- Prior to 2020, only beneficiaries with diabetes were asked whether they have chronic kidney disease. As a result, the universe of this item was not comparable to other chronic condition items asked of all Community respondents in the HFQ. In order to measure the prevalence of kidney disease, regardless of diabetes status, the universe of responses at these items was updated such that they are asked of all beneficiaries. Variable DIAKIDNY was renamed OCKIDNY and variable YRDKIDNY was renamed YRKID to reflect this universe change.

- Item HFPHQ10 is meant to capture the impact of depression on the respondent's day-to-day living as reported at items HFPHQ1 through HFPHQ8: "How difficult have these problems made it for you to do your work, take care of things at home, or get along with people?"

  Prior to Fall 2020, HFPHQ10 was asked of all respondents, even if they did not report being bothered by any of the mental health problems mentioned at items HFPHQ1 through HFPHQ8. In 2020, the questionnaire was modified to ensure that respondents who do not report being bothered by any mental health problems at items HFPHQ1 through HFPHQ8 skip question HFPHQ10.

  The variable name has been updated to PHQ9QS10, as this modification changed the universe of respondents receiving the question.

- In Fall 2020, existing colonoscopy questions in HFQ were revised to align with parallel items on the NHIS and provide more nuanced information about the type of colorectal cancer screening received by beneficiaries. Previously, colorectal cancer screening items HFR8-COLSCOPY and HFR8A-CCOLSCOP asked if the beneficiary had a sigmoidoscopy or a colonoscopy but did not capture which of these tests the beneficiary had completed. Therefore, these items were removed and replaced with two questions from the NHIS about colorectal cancer screening tests, COLORECT/CCOLOREC and CORECTYP/CCORECTP. The new items first capture whether the beneficiary had colorectal cancer screening and then, if yes, capture whether the beneficiary had a colonoscopy, sigmoidoscopy, or both tests. Due to the longitudinal nature of the MCBS, the survey will contain two versions of the colorectal cancer screening items, which will be administered once a year during beneficiary and proxy interviews. Respondents participating in their Baseline MCBS interview will be asked if the beneficiary has ever had colorectal screening; a second similar version will be administered to respondents participating in their Continuing interviews, which asks if the beneficiary has had colorectal screening in the past year.

- Item HEARSCOP asks the beneficiary whether, before today, they had have ever heard of a sigmoidoscopy or colonoscopy exam. If a beneficiary previously reported HEARSCOP=YES in a prior round, the question is skipped in the current round. However, if the beneficiary reports having a sigmoidoscopy or colonoscopy exam in the current round, they are still asked HEARSCOP. In Fall 2020, this item was modified to ensure that it is only administered to respondents who do not report a sigmoidoscopy or colonoscopy exam in the current round and have never reported having heard of the exam in a prior round. The variable name was changed to HEARSIG to reflect the change in the universe of responses.

Health Insurance (HIQ)

Four changes were made to the Health Insurance (HIQ) section in 2020:

- In Summer 2020, the question text at PRVRXCOV was updated to ensure respondents are now explicitly asked about prescription drug coverage through private insurance plans rather than "supplemental" plans, which can mistakenly be thought of as Medicare

Supplement plans. Help text was also included, instructing the interviewer to select "NO" if the private plan mentioned is a Medicare Supplement Plan.

- In Fall 2020, if-needed help text was updated at HIMC8-MHMOEYE to reflect current examples of services that may require a monthly premium under Medicare Managed Care Plans, including vision or hearing care.

- In Fall 2020, PRVOPEYE-PRVOPEYE was created to measure whether a beneficiary's private insurance plan offers optical or vision coverage for eye exames, eyeglasses, or contact lenses. This information is already collected for Medicare Managed Care plans via existing item HIMC8-MHMOEYE.

- In Fall 2020, the universe of respondents was updated for HIT11-MTFCOVER, so that Baseline respondents who report having served in the armed forces are asked whether they received health services or prescribed medicines at a Military Treatment Facility (MTF).

Income and Assets (IAQ)

In Summer 2020, new routing was added before the IAQ3 items so that respondents who have already reported the date they started receiving Social Security will not be asked the question again. Additionally, since the universe of respondents who receive these questions changed, the variable names at these items were updated to IAQ3-MSTRTSOC and IAQ3-YSTRTSOC.

Beneficiary Knowledge and Information Needs (KNQ)

In Winter 2020, five new items were added in the Beneficiary Knowledge and Information Needs (KNQ) section. The items ask whether the respondent reviewed their insurance coverage during the most recent open enrollment period to see if there were any expected changes in monthly premiums, deductibles, and other expenses; whether they reviewed their insurance to see if the treatment and services covered their needs; whether they compared their plan with other plans that are available; and the different types of Medicare plans they may have compared. The five new items appear between KN57-KCPHINFO and KN59- KCSUGGST. These items are being added to obtain information for the CMS Administrator's cost transparency initiative, and were developed by the CMS Office of Communications.

Mobility of Beneficiaries (MBQ)

In Fall 2020, the administration schedule of the Mobility of Beneficiaries (MBQ) section was updated from all rounds to annually each Fall round. To accommodate the annual administration schedule of the MBQ, the reference period at all six questions were updated from the date of the previous interview (REFERENCE DATE) to that of a year ago (TODAY'S DATE - 12 MONTHS, MONTH AND YEAR).

Preventative Care (PVQ)

In Summer 2020, the question text at PNEUSHOT was updated to align with new guidelines and specify the two different types of pneumonia shots currently available: polysaccharide, also known as Pneumovax®23, and conjugate, also known as Prevnar13®.

Drug Coverage (RXQ)

In Summer 2020, the questions pertaining to the donut hole were deleted as the coverage gap closed by 2020. Therefore, the following eight variables were deleted in RXQ: DHEVHEAR, DHPLAN, DHTHISYR, DHSTART, DHSTAROS, DHEND, DHWORRY, and PDOPTGAP.

Usual Source of Care (USQ)

Four changes were made to the Usual Source of Care (USQ) section in Winter 2020:

- Two items on Care Coordination and Patient Centered Care were added in the USQ. These items ask whether the respondent needed help from anyone in their healthcare provider's office to manage their care among their different providers and services, and whether they received the help they needed. The two new items, PP58A-DOCCARE and PP58B- GETHELP appears between PP58 - MNGCARE and PP59-ONEDOC, which also ask about care coordination.

- One item on provider participation in innovative health care initiatives was added in the USQ. The new item, INNOVATE, appears just after the series of items that identify and characterize the usual source of care (US1-PLACEPAR to US6A-MDSPECOS). Respondents are asked whether their healthcare provider is associated with an innovative health care initiative such as an accountable care organization or a patient centered medical home. The goal of the item is to measure provider communication about innovative model participation, i.e., whether the provider told the respondent that they are part of an innovative model at a visit, or to measure beneficiary knowledge of providers' innovative model participation, i.e., whether the respondent knows if their provider participates, irrespective of where they got the information.

- Starting in Winter 2020, eleven items were added to USQ to measure provider use of computers and Electronic Health Records (EHRs). The items are designed to capture critical feedback from Medicare beneficiaries on their experience and perception of the use of the EHRs during their office visits. Specifically, the new questions measure where there is beneficiary-identified value attributed to the clinician's use of EHRs, and where there is a perception of lack or loss of value. The new items were placed around the one existing question in the section that asks about EHRs, US37K-EMEDREC.

- Items PP1-REMINDAPPT and PP2-PREPARE in the USQ section ask the respondent if their health care provider's office sent them a reminder about their upcoming appointment and if the doctor's office instructed them how to prepare for their upcoming appointment. In Winter 2020, the routing was updated at PP1-REMINDAPPT to skip PP2- PREPARE when the respondent did not have an appointment. Additionally, the variable name was updated to PP2-PREAPPT from P2-PREPARE since the distribution of responses changed.

Facility Instrument

In addition to changes made in response to the COVID-19 pandemic, changes implemented for the 2020 Facility instrument included updates to question text, programming logic, text fills, and the addition of new questionnaire items.

Section-Specific Changes

Several item and section level changes were made to the Facility instrument in 2020.

Facility Questionnaire (FQ)

In Fall 2020, a number of changes were made to the Facility Questionnaire (FQ) section to align the Baseline and Continuing pathways in the collection of the total number of long-term care beds.

Previously, within the Baseline FQ pathway the total number of long-term beds in the facility was calculated using multiple questions (FA12-BEDSNUM, FA24-ANYBEDUL, and FA25-ULBEDS). Whereas, within the Continuing FQ pathway, the total number of long-term care beds in the facility was collected from a single question (FB18-TOTELBED). The changes to align these pathways include:

- The addition of one item FA12A-TOTLBEDA to the Baseline FQ pathway to collect the number of long-term care beds, which mirrors the exisiting item FB18-TOTELBED in the Continuing FQ pathway.

- Three questions in the Baseline FQ pathway that ask about the number and types of beds in the facility (FA12-BEDSNUM, FA24-ANYBEDUL, and FA25-ULBEDS) were removed from the questionnaire as the intent and calculations behind these variables was previously used to determine the total number of long-term care beds in the Baseline FQ pathway, but will now be captured in new item FA12A-TOTLBEDA.

- On-screen interviewer help text was added to instruct interviewers to include certified ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) beds in the total count of long-term care beds in both the Baseline and Continuing FQ pathway (FA12A-TOTLBEDA and FB18-TOTELBED).

- Routing was updated throughout the FQ section to accommodate the addition and removal of the items in the Baseline FQ pathway.

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 Facility Questionnaire Missing Data (FQM) section. One of these items is the total number of beds in the facility. Thus to accommodate the changes being made in the FQ for Fall 2020, the parallel FQM variables were updated. These changes include:

- The addition of one item FQM6B-MSTOTLBA as the equivalent of the FQ variable FA12A-TOTLBEDA.

- The removal of one item FQM6A-MSBEDSNU, which was the FQM equivalent of FA12-BEDSNUM in the FQ.

- Routing was updated throughout the FQM section to accommodate the addition and removal of the items in both FQ and FQM.
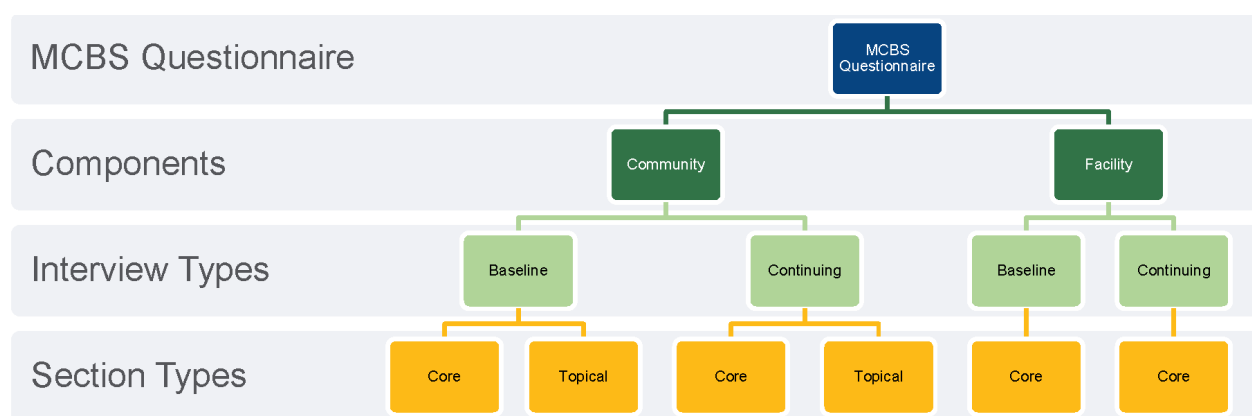
Health Status (HS)

- In Winter 2020, to align with changes made in Fall 2019 that leverage CMS administrative data, a text fill was updated at item HA1PRE1T2-HA1PRE1C, an introductory screen to a question series at the end of the HS section that collects additional health status information for beneficiaries admitted to a new Facility more than 90 days prior. The updated text fill clarifies the appropriate source to abstract information from for this item series, depending on whether or not the Facility reported a CMS Certification Number (CCN).

- Items FLUSHOT-HA43DC and PNUESHOT-HA43DD had header text that point the interviewer to reference similar questions on the Long-Term Care Minimum Data Set (MDS) to assist in answering these questions. However, there is a slight variation in reference periods for these items in the Facility instrument items when compared to the parallel MDS items, as the Facility instrument items have reference periods aligned with similar items in the Community questionnaire. In Fall 2020, the header text that referenced the MDS was removed for these items to de-emphasize its utility as a reference. Instead, on-screen interviewer help text was added that indicates if the respondent is unsure of how to answer, and there is no record of these vaccines in the medical chart, the interviewer can reference the applicable MDS items, if available.

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 2020 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.
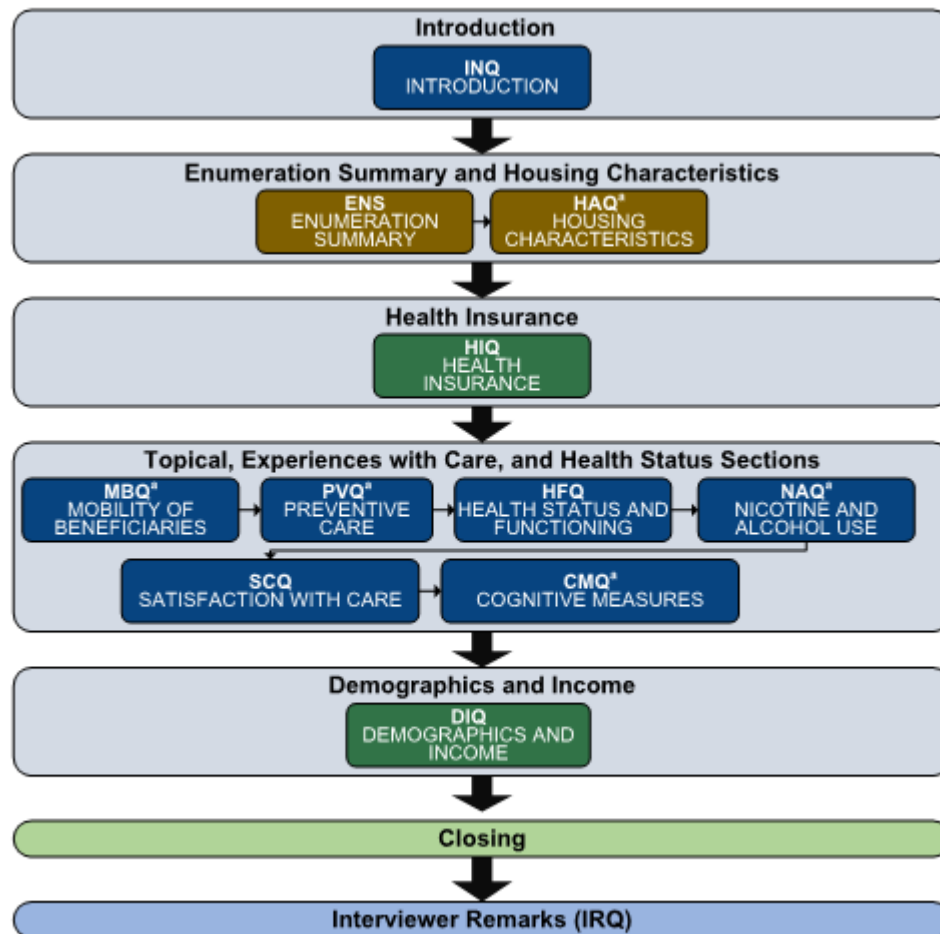
Exhibit 3:   Community Questionnaire Interview Types

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.
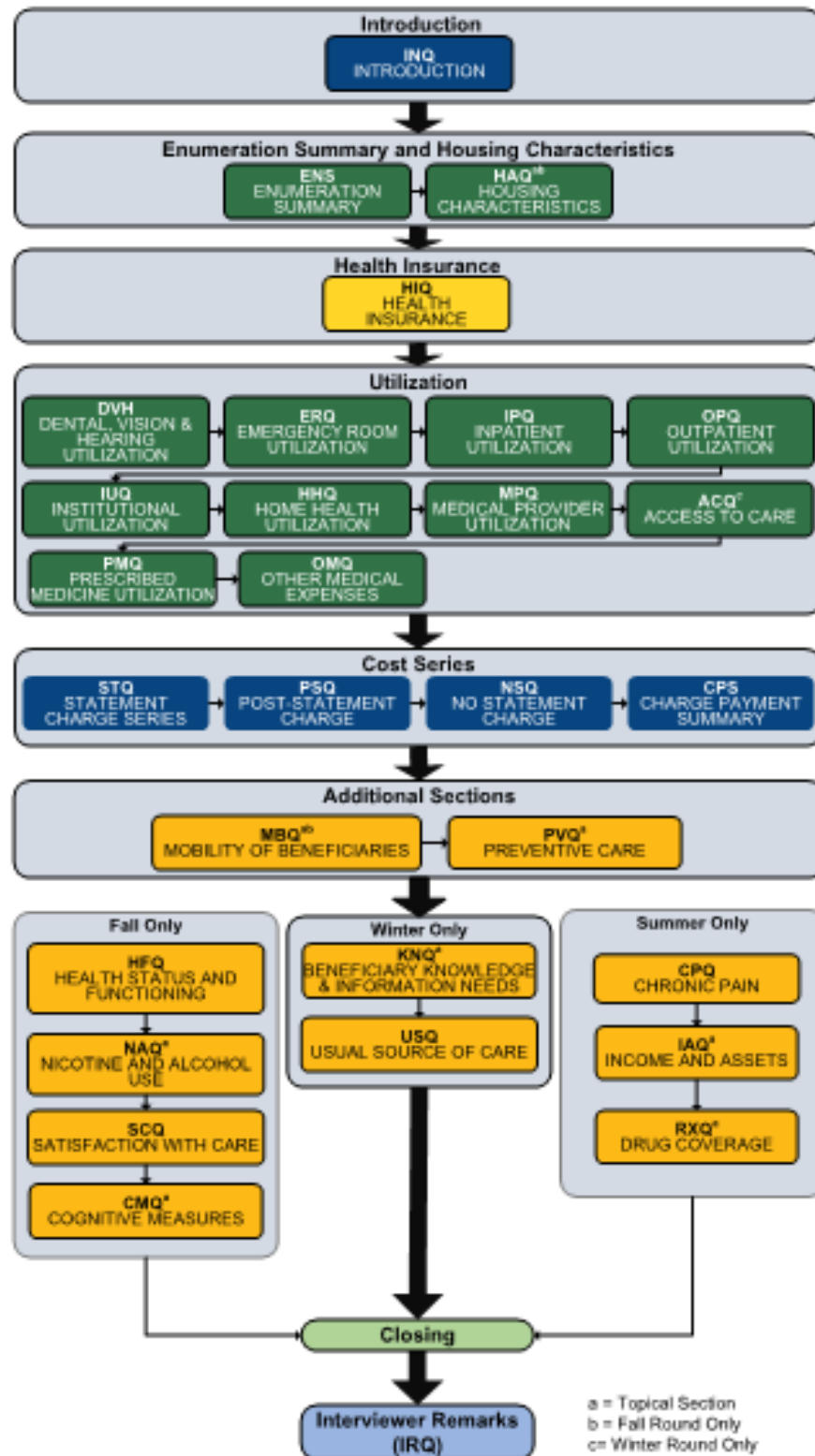
Community Questionnaire Flow

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:   2020 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:   2020 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:   2020 MCBS Community Core Sections by Administration Schedule

Section Group	Abbr.	Section Name	Administrative Season
Socio-Demographics	IAQ	Income and Assets	Summer**
	DIQ	Demographics/Income	Fall, Baseline Interview
Health Insurance	HIQ	Health Insurance	All Seasons
Utilization	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
	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
Cost	STQ	Statement Cost Series	All Seasons
	PSQ	Post-Statement Charge	All Seasons
	NSQ	No Statement Charge	All Seasons
	CPS	Charge Payment Summary***	All Seasons
Experiences with Care	ACQ	Access to Care	Winter
	SCQ	Satisfaction with Care	Fall
	USQ	Usual Source of Care	Winter
Health Status	HFQ	Health Status and Functioning	Fall

SOURCE: 2020 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 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).

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

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, whether an event was a telehealth visit, and medicines prescribed during the visit.

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,
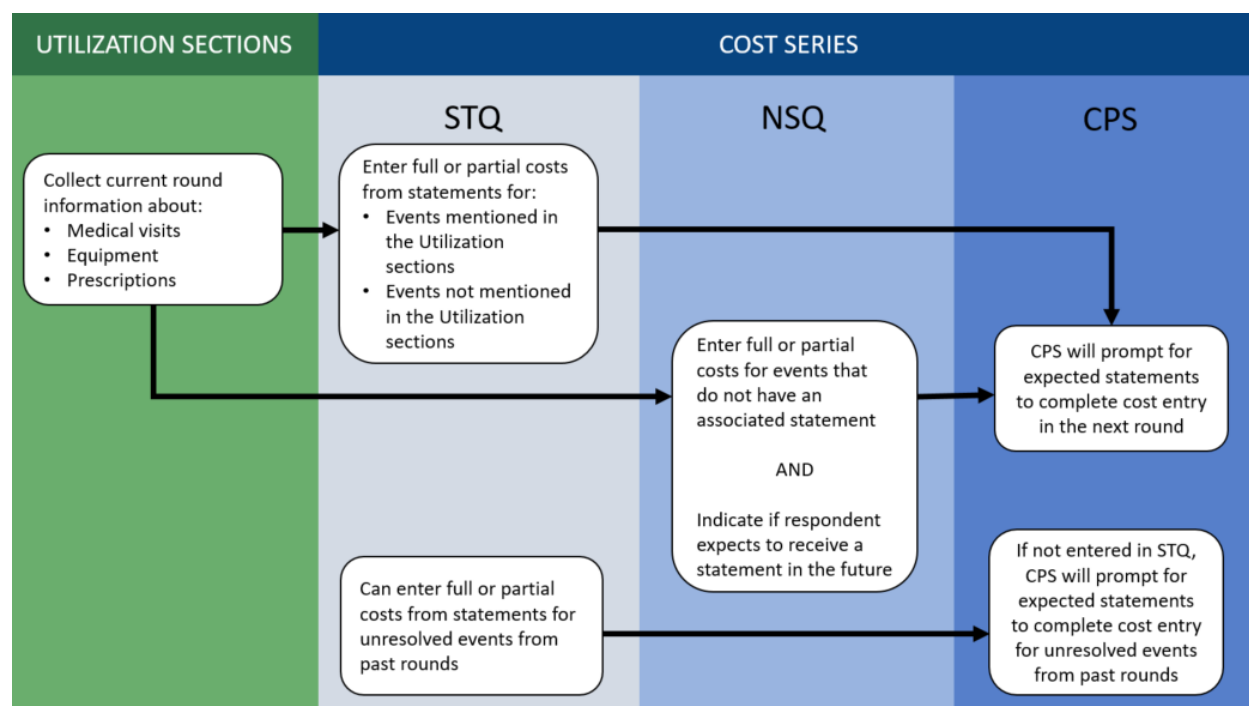
not previously recorded insurance statements containing events that occurred within the survey reference period (roughly the past year).

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 administered in the fall round interview for Baseline 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 (HFQ) 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 completed by the interviewer after every interview, usually 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:   2020 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
	CMQ	Coginitive Measures*	Fall
	MBQ	Mobility of Beneficiaries	Fall
	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

*In Fall 2020, Cognitive Measures was added to the Community questionnaire.

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.

Social Determinants of Health or Health Behaviors

Four questionnaire sections record additional information about health behaviors, specifically prevalence and management of pain, cognitive functioning, 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.

Cognitive Measures (CMQ) contains four well-established cognitive measures to assess signs of mild cognitive impairment among beneficiaries.

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 HIV, 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

INTTYPE	Description	Season
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
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	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 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.
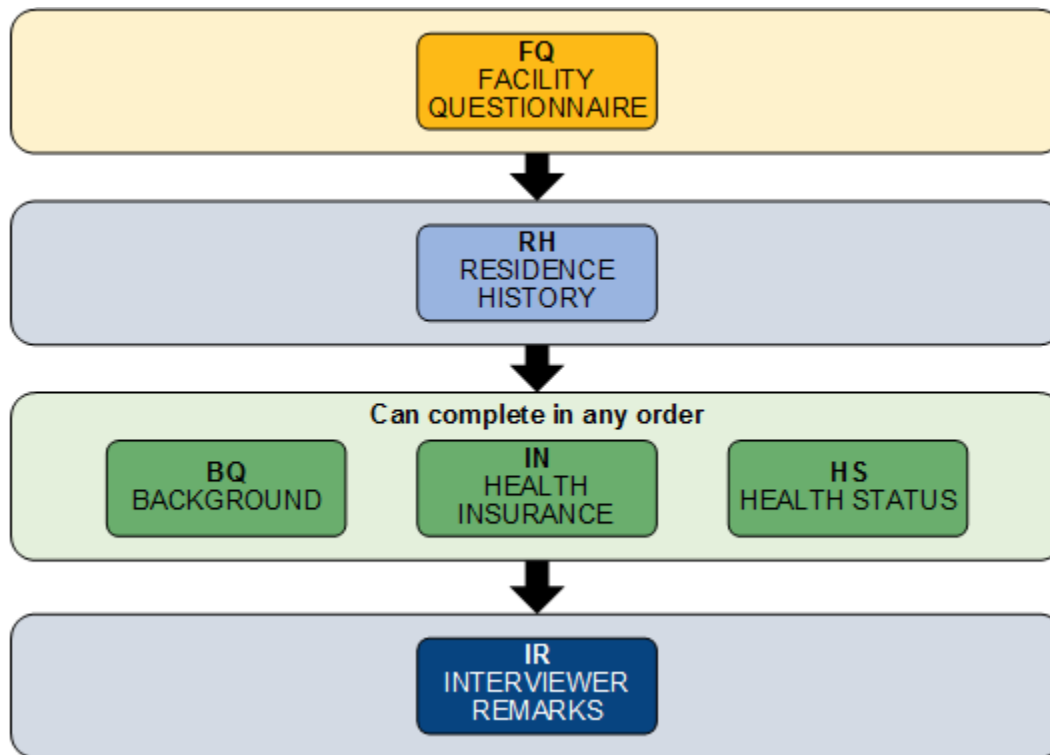
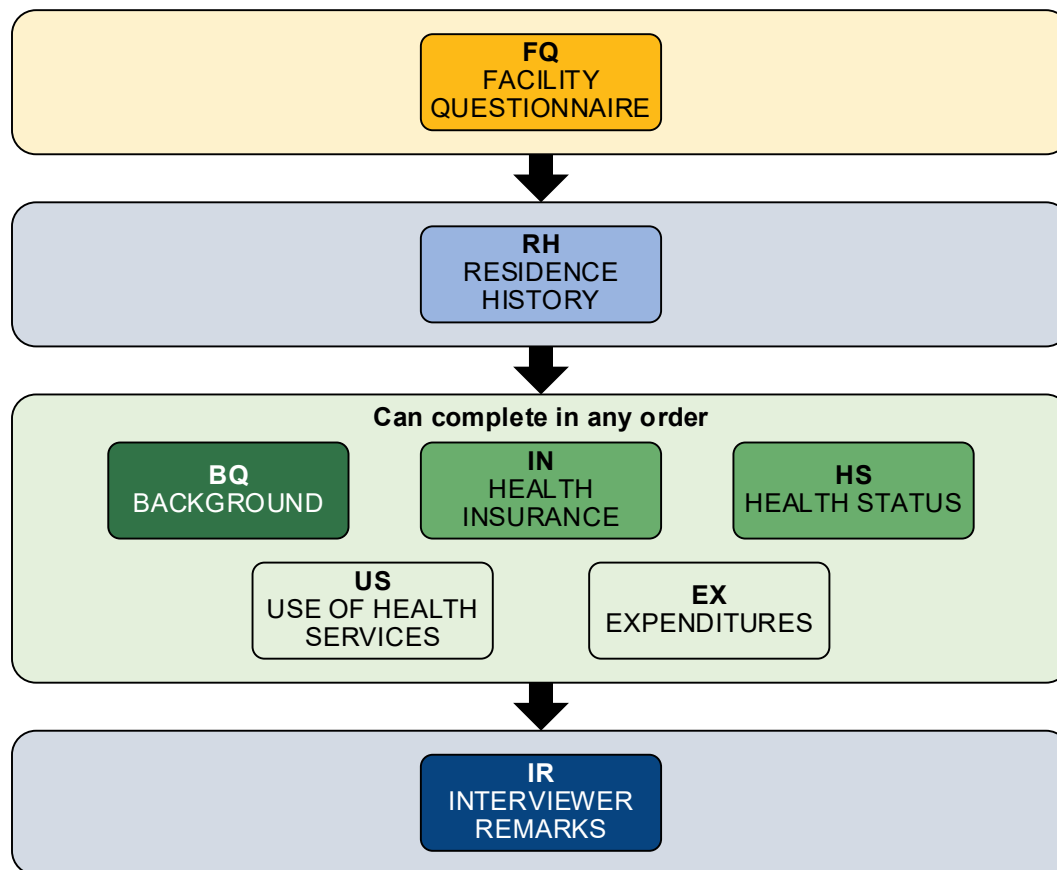**Exhibit 10:** 2020 MCBS Facility Instrument Flow for Baseline Interview

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 was 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 variables 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 are combined with CASPER and MDS administrative data to provide complete information for all MCBS facility-dwelling beneficiaries in MCBS data products.

Exhibit 11: 2020 MCBS Facility Instrument Flow for Continuing and Crossover Interviews

FQ FACILITY QUESTIONNAIRE

RH RESIDENCE HISTORY

Can complete in any order

BQ BACKGROUND

IN HEALTH INSURANCE

HS HEALTH STATUS

US USE OF HEALTH SERVICES

EX EXPENDITURES

IR INTERVIEWER REMARKS

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
Facility Characteristics	FQ	Facility Questionnaire	All seasons
Socio-Demographics	RH	Residence History	All seasons
	BQ	Background	Fall*
Health Insurance	IN	Health Insurance	Fall**
Utilization	US	Use of Health Services	All seasons
Cost	EX	Expenditures	All seasons
Health Status	HS	Health Status	Fall**

SOURCE: 2020 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 Baseline interview.

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 in-person and telehealth 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.