

## 1. 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, 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. Over the years, data from the MCBS have been used to inform many advancements, including the creation of benefits such as Medicare's Part D prescription drug benefit.

The MCBS collects this information in three data collection periods, or rounds, per year. Most interviews were traditionally conducted in-person in households and facilities using computer-assisted personal interviewing (CAPI). Due to the COVID-19 pandemic, data collection switched to phone-only interviews in March 2020 and throughout most of 2021, with a gradual return to in-person interviewing beginning in late 2021. In 2022, multi-mode data collection was implemented as a design change and interviews were conducted both in-person and by phone. In 2023, Community interviews were conducted in-person and by phone, while nearly all Facility interviews were conducted over the phone. Going forward, MCBS data collection will continue to include both in-person and phone interviewing.

Each year, the MCBS Questionnaire specifications are made publicly 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 2023. These are the questionnaires administered during the 2023 calendar year.

The 2023 MCBS Questionnaire User's Guide is intended to accompany the 2023 MCBS Questionnaire specifications. For users less familiar with the MCBS Questionnaire, this document offers a publicly available resource, which highlights questionnaire changes made in 2023 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:** 2023 MCBS Questionnaire Specification Sections

<b>Section Group</b>	<b>Abbr.</b>	<b>Section Name</b>	<b>PDF Section File Name</b>
<b>Community Questionnaire</b>			
Socio-Demographics	IAQ	Income and Assets	2023_Income_and_Assets_IAQ
	DIQ	Demographics/Income	2023_Demographics_Income_DIQ
Health Insurance	HIQ	Health Insurance	2023_Health_Insurance_HIQ
Utilization	DVH	Dental, Vision, & Hearing Care Utilization	2023_Den_Vis_Hear_Care_Utl_DVH
	ERQ	Emergency Room Utilization	2023_Emergency_Utilization_ERQ
	IPQ	Inpatient Hospital Utilization	2023_Inpatient_Utilization_IPQ
	OPQ	Outpatient Hospital Utilization	2023_Outpatient_Util_OPQ
	IUQ	Institutional Utilization	2023_Institutional_Util_IUQ
	HHQ	Home Health Utilization	2023_Home_Health_Util_HHQ
	MPQ	Medical Provider Utilization	2023_Medical_Provider_Util_MPQ
	PMQ	Prescribed Medicine Utilization	2023_Prescribed_Med_Util_PMQ
	OMQ	Other Medical Expenses Utilization	2023_Other_Medical_Expense_OMQ
	Cost	STQ	Statement Cost Series
PSQ		Post-Statement Charge	2023_Post_Statement_Cost_PSQ
NSQ		No Statement Charge	2023_No_Statement_Cost_NSQ
CPS		Charge Payment Summary	2023_Cost_Payment_Summary_CPS
Experiences with Care	ACQ	Access to Care	2023_Access_to_Care_ACQ
	TLQ	Telemedicine	2023_Telemedicine_TLQ
	SCQ	Satisfaction with Care	2023_Satisfaction_Care_SCQ
	USQ	Usual Source of Care	2023_Usual_Source_Of_Care_USQ
Health Status	HFQ	Health Status and Functioning	2023_Health_Status_HFQ
	CMQ	Cognitive Measures	2023_Cognitive_Measures_CMQ
	PXQ	Physical Measures	2023_Physical_Measures_PXQ
Housing Characteristics	HAQ	Housing Characteristics	2023_Housing_Charcs_HAQ

<b>Section Group</b>	<b>Abbr.</b>	<b>Section Name</b>	<b>PDF Section File Name</b>
Social	CPQ	Chronic Pain	2023_Chronic_Pain_CPQ
Determinants of Health or Health Behaviors	MBQ	Mobility of Beneficiaries	2023_Mobility_MBQ
	NAQ	Nicotine and Alcohol Use	2023_Nicotine_Alcohol_Use_NAQ
	PVQ	Preventive Care	2023_Preventive_Care_PVQ
COVID-19	CVQ	COVID-19	2023_COVID_19_CVQ
Knowledge and Decision Making	KNQ	Beneficiary Knowledge and Information Needs	2023_Beneficiary_Knowledge_KNQ
	RXQ	Drug Coverage	2023_Drug_Coverage_RXQ
Operational	INQ	Introduction	2023_Introduction_INQ
	ENS	Enumeration Summary	2023_Enumeration_Summary_ENS
	END	Closing	2023_End_END
	IRQ	Interviewer Remarks	2023_Interviewer_Remarks_IRQ
<b>Facility Instrument</b>			
Facility Characteristics	FQ	Facility Questionnaire	Fac2023_Facility_Quex_FQ
Socio-Demographics	RH	Residence History	Fac2023_Residence_History_RH
	BQ	Background	Fac2023_Background_BQ
Health Insurance	IN	Health Insurance	Fac2023_Health_Insurance_IN
Utilization	US	Use of Health Services	Fac2023_Use_Health_Services_US
Cost	EX	Expenditures	Fac2023_Expenditures_EX
Health Status	HS	Health Status	Fac2023_Health_Status_HS
COVID-19	CV	COVID-19 Beneficiary	Fac2023_COVID_19_Bene_CV
	FC	COVID-19 Facility-Level	Fac2023_COVID_19_Fac_Level_FC
Operational	IR	Interviewer Remarks	Fac2023_Interviewer_Remarks_IR
Missing Data	FQM	Facility Questionnaire Missing Data	Fac2023_Facility_Missing_FQM
	RHM	Residence History Missing Data	Fac2023_Residence_Missing_RHM
	BQM	Background Questionnaire Missing Data	Fac2023_Background_Missing_BQM

## 2. WHAT'S NEW FOR THE QUESTIONNAIRE IN 2023?

Several questionnaire sections were revised in 2023. Below are highlights and updates for the 2023 survey administration year.

### 2.1 Community Questionnaire

Changes implemented for the 2023 Community questionnaire included the addition of new questionnaire items, the removal of items, and updates to question text, response options, and respondent universes.

#### 2.1.1 Section-Specific Changes

##### **COVID-19 (CVQ)**

Three changes were made to the COVID-19 Questionnaire (CVQ) section in 2023.

- In Winter 2023, the question text and code list were updated at VACNME, which collects the name of the COVID-19 vaccine the beneficiary received. This item was revised to include the vaccine Novavax after the Food and Drug Administration (FDA) granted its emergency use authorization in July 2022<sup>1</sup>. The question text was also modified so that it no longer requires the field interviewer to read aloud every vaccine name to the beneficiary.
- In Fall 2023, the text fill at the variable that collects whether a COVID-19 test found that the beneficiary had COVID-19 (COVRSLT) was updated to display the reference period of the prior year.
- Also in Fall 2023, the code list at LONGCVD, which collects if the beneficiary had COVID-19 symptoms lasting 3 months or longer, was updated to include a new response option to account for beneficiaries who were recently diagnosed with COVID-19: "(03) NOT APPLICABLE, RECENTLY DIAGNOSED WITH COVID-19 (LESS THAN THREE MONTHS)".

##### **Demographics and Income (DIQ)**

The DIQ section is normally administered to Baseline cases only. In Fall 2023, select items were administered to all cases, including Continuing cases. This required updating routing throughout DIQ to accommodate fielding to Continuing cases. In Fall 2024, the DIQ section will return to its typical administration schedule.

##### **Health Insurance (HIQ)**

In Winter 2023, several updates were made to improve the Health Insurance Questionnaire (HIQ). The purpose of these changes was three-fold:

1. Align collection of health insurance information across different plan types:

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<sup>1</sup> <https://ir.novavax.com/press-releases/2022-07-13-U-S-FDA-Grants-Emergency-Use-Authorization-for-Novavax-COVID-19-Vaccine%2C-Adjuvanted-for-Individuals-Aged-18-and-Over>

- Across Medicare Advantage, Medicare Prescription Drug Plan (MPDP), Medicaid, TRICARE, public and private plans, several question sequences were updated to collect beginning (COVBEGMM/COVBEGYY) and ending (COVENDMM/COVENDYY) dates for plan coverage.
  - To accommodate this change, two new variables were added to pathways collecting information about Medicare Advantage and MPDP pathways:
    - COVTIME, an item that asks whether the beneficiary had coverage the “whole time” or “part of the time” during the reference period.
    - CURRCOV, an item that asks whether the beneficiary was currently covered during the current round.
  - For MPDP plans, the questionnaire previously collected whether the plan was current via a different variable than for other plan types (PDPCURR instead of COVNOW/CURRCOV). In Winter 2023, the variable name was updated to CURRCOV to align with other plan types. Additionally, the question text was updated to include a text fill that would populate the name of the MPDP that covers the beneficiary.
  - Previously, the questionnaire collected specific services and items (e.g., prescription drugs, eye care, dental care, etc.) covered by the beneficiary’s plan via 12 separate items. These questions were replaced with one check-all item to capture the services provided by Medicare Advantage (MHMOCVR/ MHMOCVOS), TRICARE (TRICOV/TRICOVOS), public (PUBCOV/ PUBCOVOS), and private plans (PRIVSERV/ PRIVSVOS). The check-all item is administered for newly entered plans and annually in the Fall for current, existing plans. In addition to covering services such as prescription drugs, eye care, and dental care, the list of services collected was expanded to include behavioral health care (e.g., counseling, psychotherapy, mental health and substance use disorder services, etc.).
2. Reduce respondent burden by discontinuing collection of detailed information with limited analytic utility:
- It was determined that the exact day that health insurance coverage began or ended no longer needed to be collected; only the month and year are required. Therefore, all instances of COVBEGDD and COVENDDD were removed.
  - Prior to Winter 2023, beneficiaries with existing plans were asked COVTIME, which collected whether the plan was still current the “whole time” or “part of the time” during the reference period, and then asked COVNOW, which asked if the beneficiary was now covered by the same plan. In Winter 2023, it was determined that those who reported their plan was covered “the whole time” at COVTIME did not need to be asked COVNOW as it can be inferred that the beneficiary is now covered by the same plan. Since the universe of respondents changed to exclude existing plans at COVNOW, the variable was renamed CURRCOV.
  - The administration schedule for items PPRVGET and PPRVGOS, which collect how the beneficiary obtained their private insurance coverage, was updated from annual to once per plan since this information should not change over time. To accommodate the

change in universe at these items, the variables were renamed PRIVOBTN and PRIVOBOS, respectively.

### 3. Improve quality of information collected:

- Prior to Winter 2023, the exact dollar amount spent on insurance coverage was collected at MIPPAMT for Medicare Advantage plans and MHMOUNT for private plans. In Winter 2023, range follow-up items were added to the Medicare Advantage and private plan series to accommodate respondents who do not provide an exact dollar amount.
- The text fills within questions across the Medicare Advantage, MPDP, TRICARE, public and private plans were modified to display the past tense for pathways where the plan being added for the first time in the current round is no longer current.

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

Three new oral health items were added to the Health Status and Functioning Questionnaire (HFQ) in Fall 2023:

- TEETHGUM asks the beneficiary how they would rate the health of their teeth and gums. This item was sourced from the National Health and Nutrition Examination Survey (NHANES)<sup>2</sup>.
- To measure how frequently the beneficiary has experienced dry mouth (DRYMOUTH) and tooth sensitivity to hot or cold food or drinks (TOOTHSEN) were added to the survey and created by combining items from the National Health Interview Survey (NHIS) 2008 Oral Health Supplement<sup>3</sup> and World Health Organization (WHO) Oral Health Survey<sup>4</sup>.

## **Interviewer Remarks (IRQ)**

In Summer 2023, the operational variable MULTMODE, which captures the interview mode and whether multiple interview modes were used, was replaced by MODETYPE. New text at MODETYPE provides clarification to field interviewers on how to select the correct interview mode by instructing interviewers to consider only interview mode, as opposed to gaining cooperation mode, when responding.

## **Beneficiary Knowledge and Information Needs (KNQ)**

Four items were added to the Beneficiary Knowledge and Information Needs (KNQ) section in Winter 2023:

- Items USEMSP and APPLYMSP were added to gather information about beneficiary participation in the Medicare Savings Program (MSP). The first item (USEMSP) provides a

<sup>2</sup> Centers for Disease Control and Prevention. (2022). *NHANES 2021-2022 Oral Health Questionnaire*. <https://wwwn.cdc.gov/nchs/data/nhanes/2021-2022/questionnaires/OHQ-L-508.pdf>

<sup>3</sup> Centers for Disease Control and Prevention. (2008). *2008 NHIS Survey Description*. [https://ftp.cdc.gov/pub/health\\_statistics/nchs/Dataset\\_Documentation/NHIS/2008/srvydesc.pdf](https://ftp.cdc.gov/pub/health_statistics/nchs/Dataset_Documentation/NHIS/2008/srvydesc.pdf)

<sup>4</sup> World Health Organization. (2013). *Oral Health Surveys: Basic Methods – 5<sup>th</sup> edition*. <https://www.who.int/publications/i/item/9789241548649>

definition of the MSP program and asks if the beneficiary receives assistance from the program. For those who say no, a second item (APPLYMSP) asks if the beneficiary applied to their state Medicare office for help with medical expenses. These items are formatted in a way similar to existing MCBS Drug Coverage Questionnaire (RXQ) items about the Low-Income Subsidy (LIS) program.

- Item RGHTAPL was added to understand beneficiary knowledge about the Medicare appeal process and asks the beneficiary if they would know how to file a complaint or an appeal with Medicare if they had concerns about the quality of care they received. This item was drafted by the Beneficiary and Family Centered Care Quality Improvement Organization Program (BFCC-QIO).
- INTERNET, which quantifies beneficiary access to the internet, was added back into the KNQ section in Winter 2023. This item had previously been fielded as part of the MCBS COVID-19 Supplements. The addition of INTERNET changes the universe of respondents for the subsequent existing questions. Therefore, the variable names of KNETPERS, KNETFRND, and KNETOFTN were changed to USENET, SOMELNET, and OFTNNET, respectively. Additionally, the text fills at KVSTITE, KCOMINTE, KCOMPRES, KCOMAPPO, and KCOMCOMM were updated to reflect the variable name changes.

### **Physical Measures (PXQ)**

In Winter 2022, physical measures were incorporated into the MCBS via a new questionnaire section. The PXQ contains six physical measures: gait speed, chair stand, balance test, measured height, measured weight, and measured grip strength. PXQ was initially fielded in Winter 2022 as a pilot, administered to only a subset of exit round cases by trained interviewers. The PXQ section is administered at the end of the interview and only during interviews conducted in person with the beneficiary. For interviews conducted with the proxy, the PXQ is skipped.

An expanded pilot of PXQ was conducted in Summer 2022 and Summer 2023 with a subset of respondents from all Continuing panels.

### **Preventive Care (PVQ)**

In Fall 2023, item HYSTEREC, which collects whether the beneficiary has ever had a hysterectomy, was moved to precede item PAPSMEAR, which collects if the beneficiary has had a pap smear in the prior year. As a result of this change, the code list at the variable that collects the reason why the beneficiary has not had a recent pap smear, PAPCODE, was updated to remove hysterectomy as a response option. To reflect the corresponding change in the universe of respondents at these items, HYSTEREC was renamed HYSTER, PAPSMEAR was renamed PAPTEST, PAPCODE was renamed PAPREASN, and PAPNOTHS was renamed PAPOTHR.

### **Cost Series (STQ, NSQ, CPS)**

To coincide with the changes made in the HIQ in Winter 2023, the Statement Questionnaire (STQ), No Statement Questionnaire (NSQ), and Cost Payment Summary (CPS) were updated so that new plans entered in the cost series follow the same revised flow for new plans entered in

the modified HIQ section. Additionally, items that asked about the beneficiary's current Medicare Advantage or MPDP coverage were removed from STQ (STSOPCURR1 and STSOPCURR2), NSQ (NSSOPCURR1 and NSSOPCURR2), and CPS (CPSOPCURR and CPSOPCURR2) as that information is now collected via COVTIME in HIQ.

At the start of wide-scale telephone interviewing in 2020, a skip mechanism was added throughout the cost series to allow interviewers to route out of the cost series at various points in rare situations of extreme respondent burden or fatigue. Due to very limited use and the increased availability of in-person and hybrid interviewing, these skips were removed in Summer 2023.

### **Usual Source of Care (USQ)**

During Winter 2022 data collection, field interviewers reported that PRVNOMED, which asks if there was one provider who knew about all the medicines the beneficiary was taking, does not apply to respondents who did not take any medications within the past year. To clarify the intent of this item and assist with administration, interviewer on-screen help text was added to PRVNOMED in Winter 2023 instructing interviewers to probe whether the beneficiary's provider knew they were not taking any medicines.

## **2.2 Facility Instrument**

Changes implemented for the 2023 Facility instrument included updates to question text, response options, programming logic, and the removal of one questionnaire item.

### *2.2.1 Section-Specific Changes*

Several item and section level changes were made to the Facility instrument in 2023.

### **Background Questionnaire (BQ)**

In Fall 2023, the "COLLEGE GRADUATE" response option at BQ9-EDLEVELF, which collects the beneficiary's highest level of education in the Background Questionnaire (BQ) section, was replaced with "ASSOCIATE'S DEGREE" and "BACHELOR'S DEGREE" to align with a similar question in the Community questionnaire's Demographics and Income Questionnaire (DIQ) section.

### **COVID-19 Beneficiary (CV)**

There were two updates to the COVID-19 Beneficiary (CV) section in Winter 2023:

- As of Winter 2023, the CV section was considered a topical section within the Facility instrument rather than a supplemental section. Therefore, "Supplement" was removed from the title of the section in the navigation screen. In addition, "supplement" was removed from on-screen text at CVEND-CVENDCT.
- The question text and code list were updated at CV8-VACNME, which collects the name of the COVID-19 vaccine the beneficiary received. This item was revised to include the Novavax vaccine after the FDA granted its emergency use authorization in July 2022. The question text was also modified so that it no longer requires the field interviewer to read

aloud every vaccine name to the Facility respondent. The aligns with updates made in the Community Questionnaire's COVID-19 Questionnaire (CVQ) section.

### **COVID-19 Facility-level (FC)**

As of Winter 2023, the COVID-19 Facility-level (FC) section was considered a topical section within the Facility instrument rather than a supplemental section. Therefore, "Supplement" was removed from the tile of the section in the navigation screen. In addition, "supplement" was removed from on-screen text at FCEND-FCENDCT.

### **Health Insurance (IN)**

The Health Insurance (IN) reference date for deceased beneficiaries, who passed before September 1<sup>st</sup>, would set to September 1<sup>st</sup> of the current year for multiple variables (IN13A-ICAREPTD, IN18-IGAPCOV, IN20-ILTCCOV, IN22-ICHACOV, IN23-IDVACOV, IN24-IPUBCOV). In Fall 2023, the logic was updated to set the reference date of deceased cases, where the beneficiary passed before September 1<sup>st</sup> of the current year, to the reported date of death.

### **Health Status (HS)**

There were two updates made to the Health Status (HS) section in Fall 2023:

- Item HA43B-PAPSMEAR, which asks if the beneficiary has had a pap smear test, was moved to be administered after confirming whether the beneficiary has had a hysterectomy (HA43C-HYSTEREC or HA43D- EVERHYST). As a result of this change, HA43B-PAPSMEAR was renamed to HA43O-PAPTEST due to a change in respondent universe. In addition, the routing logic was updated to skip over HA43O-PAPTEST if it was reported that the beneficiary has had a hysterectomy. This is in alignment with the Community Questionnaire's Preventive Care Questionnaire (PVQ).
- The "COLLEGE GRADUATE" response option at HA51B- HEDULEV, which collects the beneficiary's highest level of education if it has not already been reported in BQ, was replaced with "ASSOCIATE 'S DEGREE" and "BACHELOR'S DEGREE to better align with the Community questionnaire and updates made to the BQ section.

### **Use of Health Services (US)**

Two items were updated in the Use of Health Services (US) section in Summer 2023:

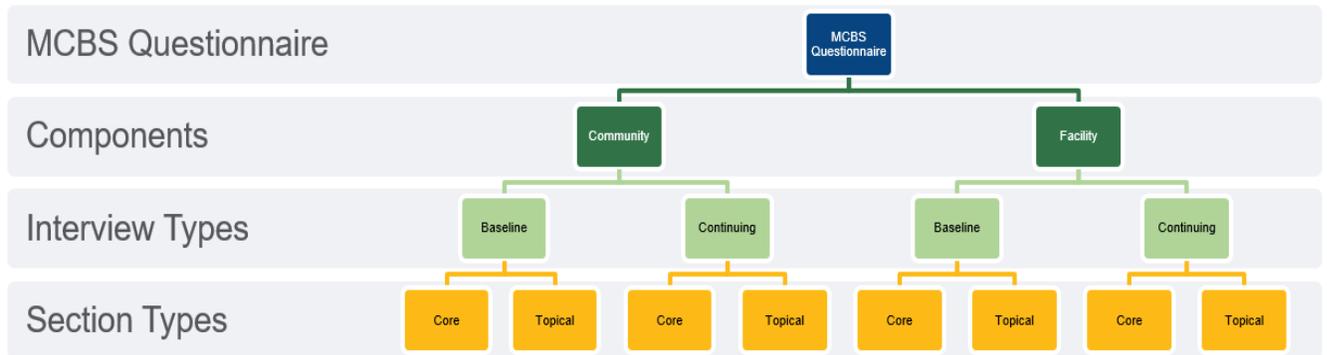
- The "DISPOSABLE DIAPERS" and "CLOTH DIAPERS" response options were replaced with a new response option, "INCONTINENCE BRIEFS", at item US40-USEEQUIP, which collects supplies, equipment, or other types of medical services the beneficiary received.
- Item US43-MSRESTR, which collects if the beneficiary received restraints, was removed.

### 3. 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, 8, 10, and 11 for tables of the 2023 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.

### 3.1 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.

#### 3.1.1 Interview Type

As the 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.

### *3.1.2 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:** 2023 MCBS Community Questionnaire Flow for Baseline Interview

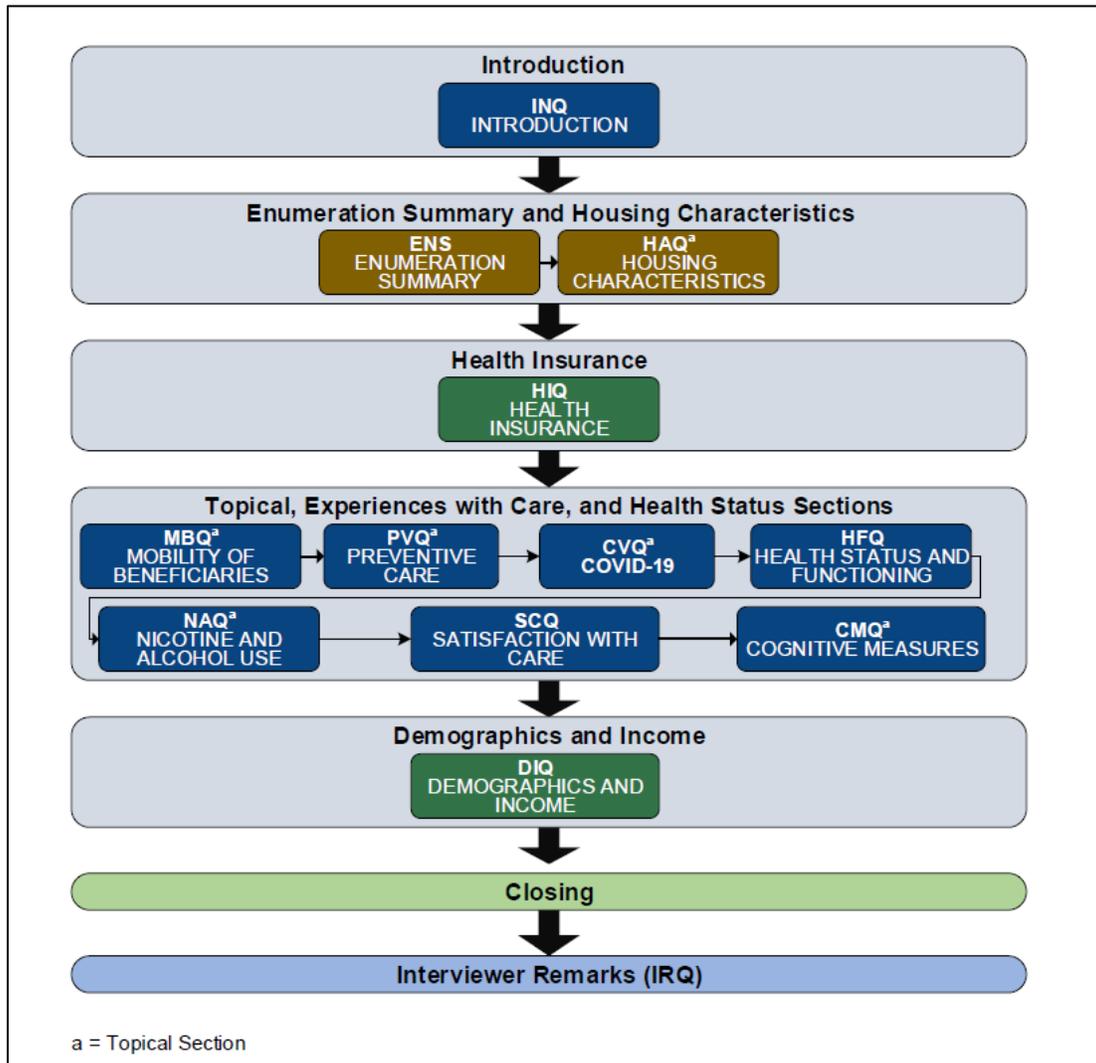
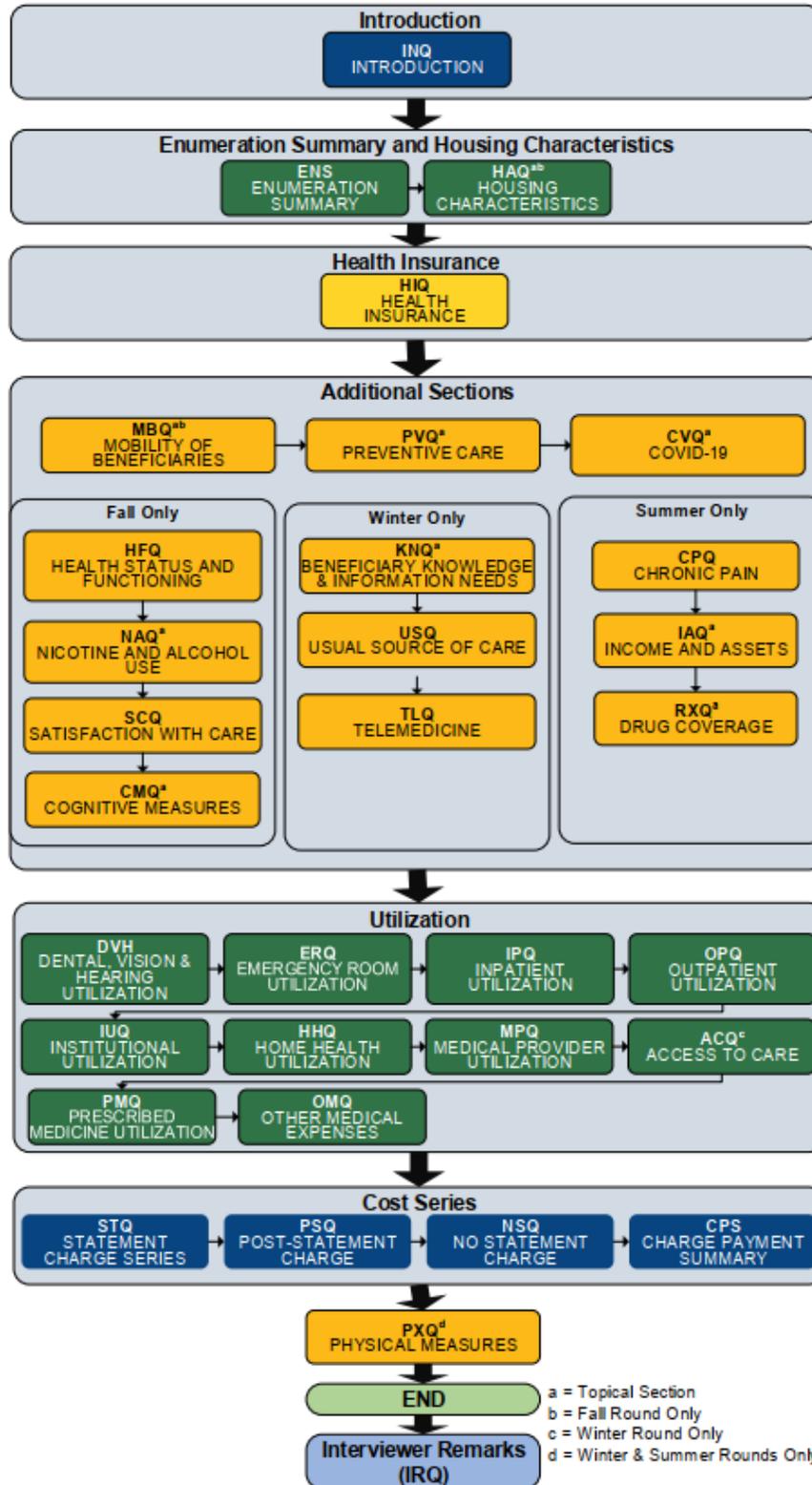


Exhibit 5 shows the most common Community Questionnaire flow for standard Continuing community sample.

**Exhibit 5:** 2023 MCBS Community Questionnaire Flow for Continuing Interview<sup>5</sup>



### 3.1.3 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:** 2023 MCBS Community Core Sections by Administration Schedule

Section Group	Abbr.	Section Name	Administrative Season
<b>Socio-Demographics</b>	DIQ	Demographics/Income	Fall, Baseline Interview
	IAQ	Income and Assets	Summer**
<b>Health Insurance</b>	HIQ	Health Insurance	All Seasons
	DVH	Dental, Vision, & Hearing Care Utilization	All Seasons
<b>Utilization</b>	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
<b>Cost Series</b>	STQ	Statement Cost Series	All Seasons
	PSQ	Post-Statement Cost	All Seasons
	NSQ	No Statement Cost	All Seasons
	CPS	Charge Payment Summary	All Seasons
<b>Experiences with Care</b>	ACQ	Access to Care	Winter
	SCQ	Satisfaction with Care	Fall
	TLQ	Telemedicine	Winter
	USQ	Usual Source of Care	Winter
<b>Health Status</b>	HFQ	Health Status and Functioning	Fall
	CMQ	Cognitive Measures	Fall
	PXQ	Physical Measures	Summer

**SOURCE:** 2023 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.

<sup>5</sup> The administration schedule of DIQ was changed in Fall 2023 to facilitate a one-time administration of select items to all cases.

## **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, total household income, and religious preference. 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 and detailed questions about 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.

## **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 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 questionnaire 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 Cost Series (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).

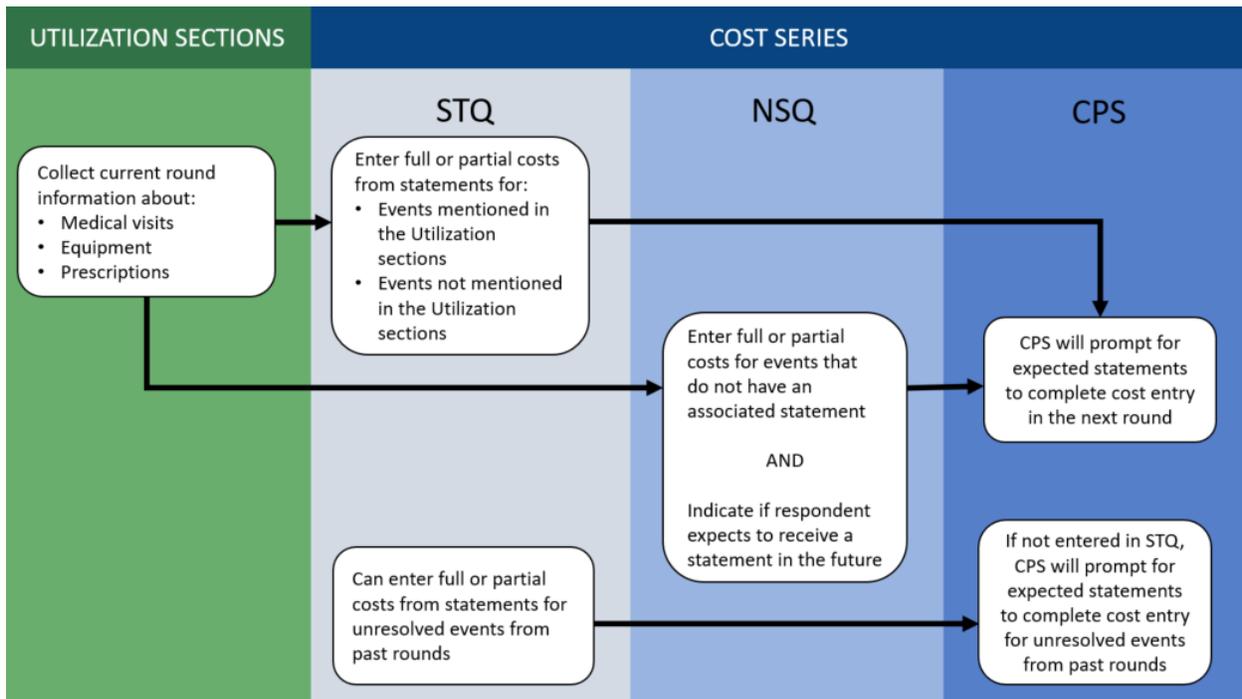
The **Post-Statement Cost section (PSQ)** facilitates cost data collection for rental items that span multiple rounds of interviews (such as a long-term wheelchair rental) and for which cost data has not yet been reported.

The **No Statement Cost 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



\*The Post-Statement Series Questionnaire (PSQ) occurs very rarely to collect cost information for respondents with certain “rent-to-buy” items. If the PSQ section is prompted, it would appear after the **Statement section (STQ)**.

**Experiences with Care**

Four 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. This section collects the respondent’s opinions about the health care that the beneficiary had received.

The **Telemedicine (TLQ)** section is administered in the winter round interview for Continuing respondents who report a usual source of care in the USQ section. TLQ asks questions on the availability and utilization of telemedicine services.

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, autoimmune disease prevalence, 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, social isolation, falls, urine loss, and a more extensive series of questions for beneficiaries with high blood pressure and diabetes.

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

- **Backwards Counting:** Respondents are asked to count backwards starting at 20 for 10 continuous numbers.
- **Date Naming:** Respondents are asked to name today's date.
- **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 **Physical Measures Questionnaire (PXQ)** section collects six measures: gait speed, chair stand, balance test, measured height, measured weight, and measured grip strength. The PXQ section is administered in the summer round to Continuing respondents. The section appears at the end of the interview and only during interviews conducted in person with the beneficiary.

## **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 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.

### 3.1.4 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:** 2023 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	Fall
	NAQ	Nicotine and Alcohol Use	Fall
	PVQ	Preventive Care	All seasons
COVID-19	CVQ	COVID-19*	All seasons
Knowledge and Decision Making	KNQ	Beneficiary Knowledge and Information Needs	Winter
	RXQ	Drug Coverage	Summer

\*In Summer 2021, COVID-19 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, modifications to the home (e.g., ramps, railings, and bathroom modifications), as well as problems with their residence (e.g., pests, mold, lack of heat, etc.). 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, mobility, nicotine and alcohol use, and preventive care.

**Chronic Pain (CPQ)** measures whether the beneficiary has 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. Questionnaire items were developed by the National Pain Strategy (NPS) Population Research Working Group for inclusion in federal surveys.

**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.

**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.

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.

## **COVID-19**

The **COVID-19 (CVQ)** section collects vital information on how the Medicare population is impacted by the COVID-19 pandemic. CVQ spans a number of COVID-related topics, including presumptive vaccine uptake, vaccine utilization, viral testing, as well as medical care, severity of symptoms, and long-term symptoms for those who had a probable or confirmed diagnosis of COVID-19.

## **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 use of the Internet for accessing health care related information, self-reported understanding of Medicare and certain Medicare programs, self-reported use of certain Medicare programs, 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.

## 3.2 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.

### 3.2.1 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
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.

### 3.2.2 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.

### 3.2.3 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:** 2023 MCBS Facility Instrument Flow for Baseline Interview

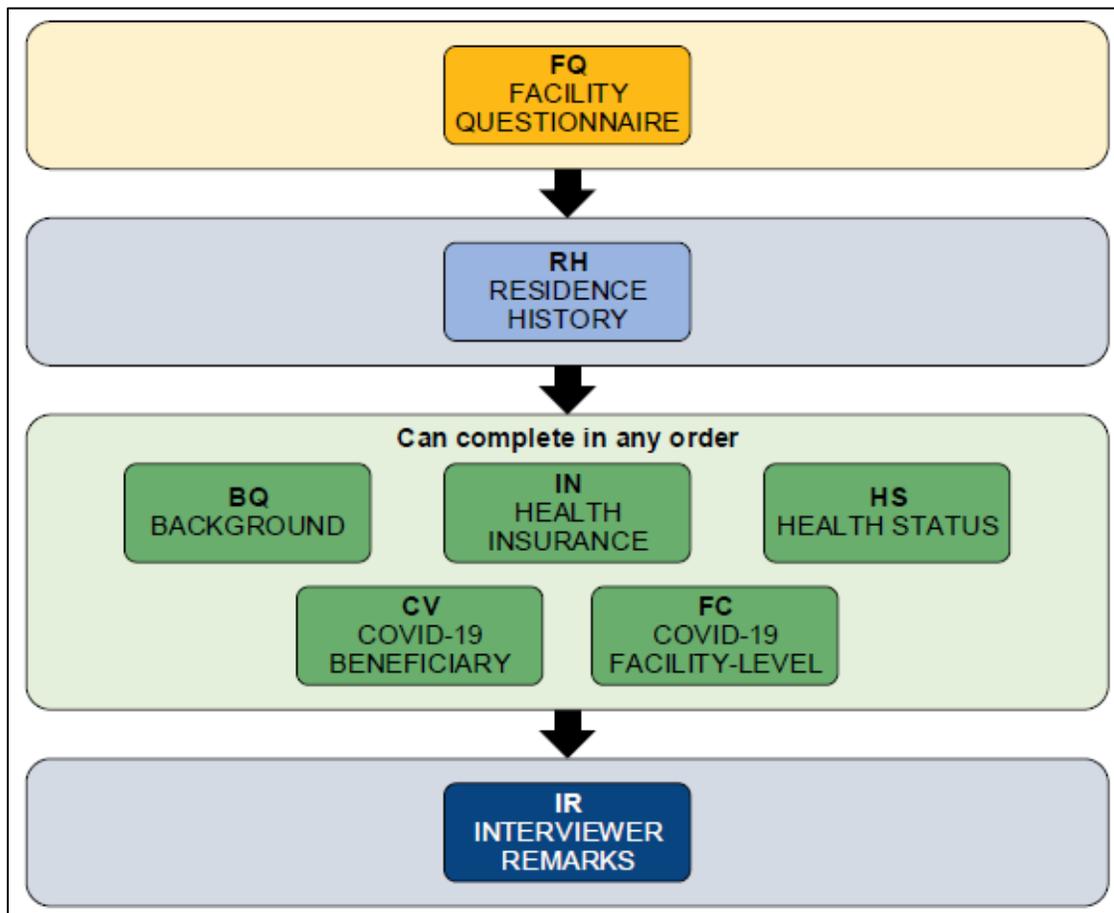


Exhibit 11 shows the flow for the Continuing and crossover interview types.

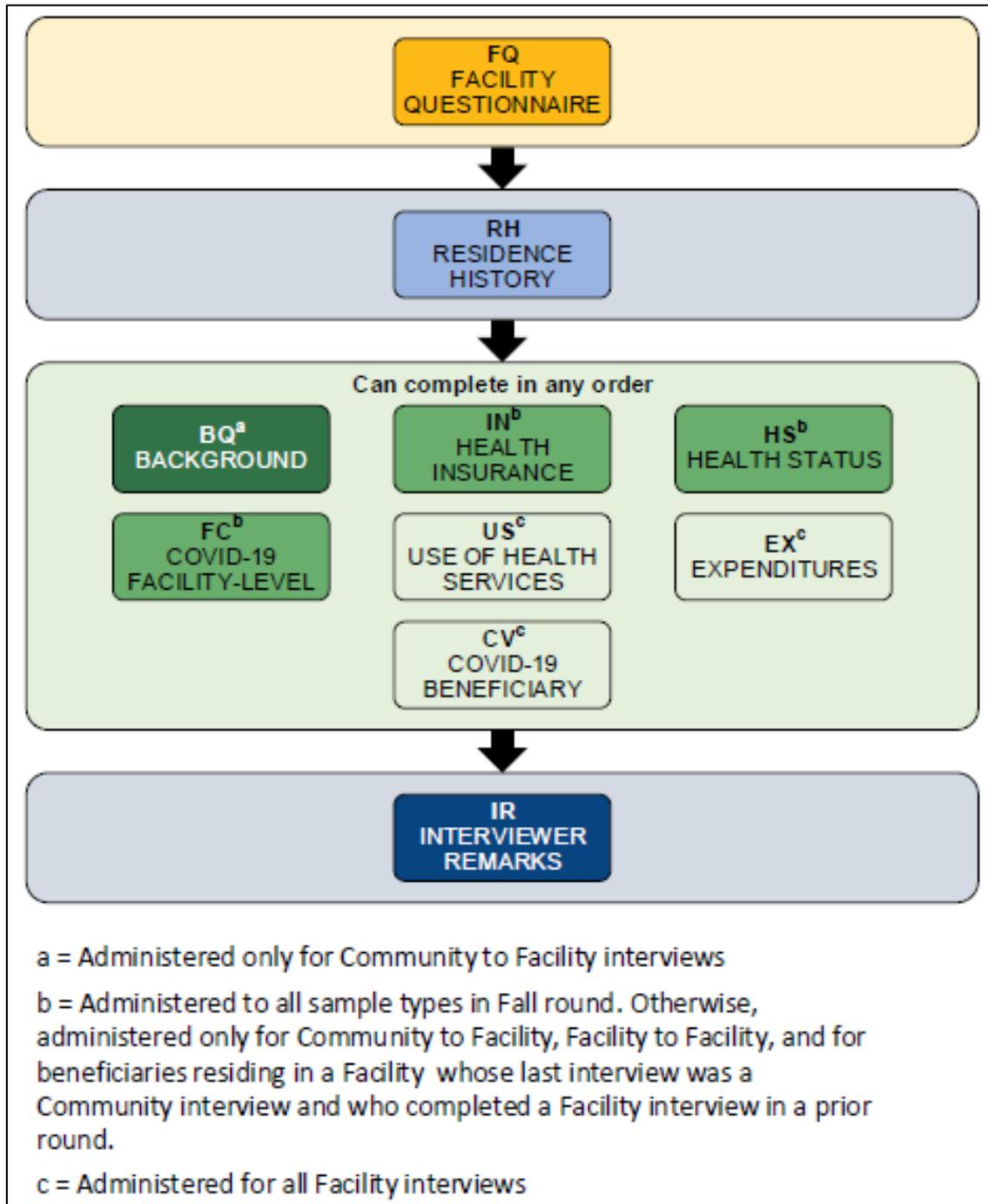
Because the Facility Instrument is administered to facility staff and not directly to the beneficiary, the Facility Instrument is designed to have a modular, flexible flow. The interviewer first completes the Facility Questionnaire (FQ) section. Next, the interviewer administers the Residence History (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:** 2023 MCBS Facility Instrument Flow for Continuing and Crossover Interviews



### 3.2.4 Core Section Content

The Facility Instrument consists primarily of core sections. 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

<b>Section Group</b>	<b>Abbrev</b>	<b>Section Name</b>	<b>Administrative Season</b>
<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: 2023 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.

### 3.2.5 Topical Section Content

In addition to the core content, there are a couple of topical questionnaire sections that capture data on COVID-19 topics at the facility- and beneficiary-level. Each topical section is described below, organized by information collected. Exhibit 13 lists the topical sections and administration schedule.

#### Exhibit 13: 2023 MCBS Facility Topical Sections by Administration Schedule

Section Group	Abbr.	Section Name	Administrative Season
COVID-19	CV	COVID-19 Beneficiary	All Seasons
	FC	COVID-19 Facility-Level	Fall*

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

### **COVID-19**

The COVID-19 topical sections capture key characteristics on the impact of the COVID-19 pandemic on long-term care facilities and Medicare beneficiaries.

The **COVID-19 Beneficiary (CV)** section collects information on topics related to the beneficiary’s utilization of COVID-19 testing, COVID-19 medical care, and COVID-19 vaccine utilization. The CV section is completed for each alive beneficiary in the facility.

The **COVID-19 Facility-Level (FC)** section collects information on topics that assess key ways in which COVID-19 has impacted facilities that serve Medicare beneficiaries. The FC section is separated into three main topics: availability of current telehealth services inside and outside of the facility, facility measures to prevent the spread of the flu and COVID-19, and mental health and social and recreational services offered inside and outside of the facility.

The FC section is completed for each beneficiary in the facility regardless of whether multiple beneficiaries reside in the same facility.