Medical Expenditure Panel Survey Medical Provider Component (MEPS MPC)

MPC 2023 Cycle Consolidated SBD Sample Development, Preparation, and Data Collection Plan

Deliverable OP3-8

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# Introduction and Overview

This document describes the data collection plan for the 2023 Medical Expenditure Panel Survey Medical Provider Component (MEPS MPC) for hospital healthcare providers not included in the hospital bill. For the MEPS MPC, these healthcare providers are also referred to as separately billing doctors (SBDs). Procedures are designed to maintain comparability with prior rounds of MEPS MPC and incorporate planned improvements for 2023.

This is a preliminary plan and includes enhancements to procedures used in 2022 in the areas of quality control in the confirmation of separately billing status and collection of SBD contact information***,*** the SBD training programs , and the plan for management of large SBD providers . Further discussion may be required on AHRQ’s objectives for SBD to refine the final SBD Data Collection Plan to those objectives. Following preliminary discussions with AHRQ, areas in which further discussion and revision for the 2023 cycle may be warranted include the following:

* Data collection schedule: Due to the scope of work for the 2023 SBD cycle, and the expected retention rate of Hospital, Home Health, Institution, and HMO staff, the MPC team expects SBD data collection will have sufficient DCSs and management staff from the 2023 non-SBD data collection effort to complete all planned activity. As such it will not be necessary to introduce any new-to-project staff as part of the 2023 SBD cycle. This is consistent with plans for the 2017-2022 cycles. However, staffing needs will be assessed throughout the data collection year and should a new-to-project training be necessary due to unforeseen staffing challenges for discussion with AHRQ.
* Large Provider: For the 2023 cycle, designations for Category 1 and 2 SBD providers/billers will be completed in similar fashion to the 2023 cycle non-SBD providers. Recategorization may take place based on 2022 nodes/pairs, participation status, and 2022 completion rates. Providers or billers are defined as a Category 1 or 2 band because they are among the largest providers or billers in the sample based on total number of nodes. A provider or biller is generally designated as Category 1 if it was among the largest bands (based on the number of nodes) and the previous cycle’s node completion rate was especially low (typically under 50%) or if working the band was especially complex or difficult. A provider or biller is generally designated as Category 2 if it was among the largest bands (again based on the number of nodes), but the completion rate was high (typically no lower than 50%) and working the band was straightforward. Bands defined as Category 1 or 2 may remain at their current designation despite higher completion rates or lower sizes though an established pattern over at least two cycles may be necessary, prior to recategorization to minimize the effects of anomalous cycles.

In addition, a glossary of frequently used MEPS MPC acronyms is included as Appendix A.

# Sample Development and Preparation

The SBD sample consists of physicians or other medical service providers, reported by hospitals or institutions as providing services during a hospital-based or institution-based event. These events often result in charges from physicians and other healthcare providers who may or may not have direct patient contact (e.g., pathologists or radiologists are often not seen by patients) and whose fees are not included in the hospital or institution charge. These charges are a key part of hospital or institution event costs, and this information can only be obtained from the MPC.

The sample of SBDs is created during the MEPS MPC non-SBD data collection, through the processes of completing event forms with Hospital and Institution providers, SBD coding, and subsequent deduplication and preparation of the SBD sample file. Below are key points of the generation and preparation of the SBD sample.

## Identification of Potential SBDs

As noted above, the MEPS MPC data collection specialists (DCSs) and abstractors generate the sample of SBDs when collecting data from hospitals or institutions during non-SBD data collection for the MEPS MPC.

First, the DCS will concurrently identify contacts for medical records (MR), patient accounts (PA), and administrative offices and record this information in the contact guide. As contacts are established, the DCS will then send authorization forms (AFs) to the MR department and PA department, confirm receipt of these AFs, and request copies of the medical, billing, and payment records.

Once records have been received, abstractors will record information from the records into electronic abstraction notes forms, recontact the points of contact about missing or ambiguous information, and then the data from the abstraction notes form is programmatically transferred into the event form.

In the MR section of the event form, the DCS or abstractor will record four key pieces of information from the hospital or institution MR: Date(s) of Service; Event Type (ER, outpatient, inpatient); Diagnoses (the International Classification of Diseases (ICD-10) codes); and information about any health professionals who saw the patient during the hospital or institution event and who charged for services separately from the hospital’s or institution’s billing (SBDs). This SBD information can include the provider’s name, the provider’s practice name, specialty, role, and National Provider Identifier (NPI), depending on the level of detail present in the records. In the PA section of the event form, the DCS will record the services provided, charges, and sources and amounts of payment as well as the reason for any discrepancy between charge and payment data for each event identified. Note that a few hospitals are excluded from the SBD identification process; appropriate steps will be provided to the DCS on how to handle this work.

Because it is critical that the MPC identify and contact all SBDs who provided care to the patient while in the hospital or institution but bill separately, the MPC team designed the Integrated Data Collection System (IDCS) to facilitate complete and accurate collection of this information. There are diagnoses for which certain SBDs would be expected. If one of these diagnoses is recorded, the system will review the types of SBDs captured, and if an SBD of that type was not captured it will prompt staff to ask about those specific types of SBDs. In addition to designing the event form to prompt the DCS or abstractor to enter complete and valid information as described above, the system performs a cross-check using the Current Procedural Terminology (CPT)-4 codes obtained from the billing records. CPT-4 codes make up a coding system for procedures and services performed by physicians and other providers which is widely used for reporting medical procedures for insurance billing and statistical purposes. Each procedure or service is identified with a unique five-digit code published in the Physicians’ Current Procedural Terminology – Fourth Edition (CPT-4). The system cross-checks the CPT-4 codes and an expected list of the type of SBDs associated with the procedures captured against the actual list of SBDs obtained. For example, a surgery procedure would cause the system to check for three SBDs: a surgeon, anesthesiologist and pathologist. If any of these types of SBDs were not recorded for the event, a data retrieval code is activated to indicate that MR needs to be recontacted to determine if SBDs are missing, and collect this information, as appropriate. This SBD triggering mechanism helps minimize missed SBD charges because the expected SBDs are identified as soon as the billing record data are entered. This is covered in depth in the Hospital and Institution provider abstraction training for the non-SBD data collection.

A random 10% of Hospital and Institution events and all high-dollar events are selected for reabstraction, as well as the first five completed events for each newly trained abstractor. Since the 2017 cycle, SBD errors have not been included in the overall error rate.

As Hospital events are collected, there is a possibility of collecting duplicate events between patient-provider pairs for the same patient. If these events have SBDs, then it is possible for duplicate SBD nodes to be created if the SBD sample is built before the duplicated events have been deleted. Since the 2012 cycle, duplicated Hospital events are identified and resolved to reduce the amount being built into the SBD sample.

## Collecting Contact Information and Confirming Billing Status

As abstractors identify potential SBDs in the medical and billing records, they are trained to record any contact information that is contained within these records in the data retrieval form. Next, staff will check the host hospital website to collect contact information that may not have been present in the records including NPI; business practice name; business practice address, city, state, and zip. Staff will record this information in the Administrative Office (AO) portion of the contact guide. Staff will then contact the hospital to clarify whether or not the provider bills separately. If the provider does bill separately or if their billing status cannot be determined, staff will confirm or collect the business practice contact information, determine and record whether or not the provider uses a billing service, and record billing service contact information (billing service name, phone number, street, city, state, and zip), if applicable. If the provider does not bill separately, no further action is taken; the provider will not be fielded in the SBD sample.

As in the previous cycles, the production team has established weekly production goals for the collection and finalization of billing status and contact information for SBDs. This ensures that staff will keep up with the AO work throughout the field period, maximizing the proportion of the SBD sample that will be available to be selected and fielded in the first two months of the field period. The MPC team will monitor AO production against goals both at a project level and at the individual DCS level. In addition, due to the importance of getting clear feedback from the point of contact (POC) on the separately billing status of each potential SBD, the MPC team will monitor the percentage of each DCS’ weekly abstraction work that they finalized as separately billing status unknown. DCS are expected to achieve a clear yes or no for at least 85% of their weekly AO work and will receive performance counseling and retraining if they fail to consistently achieve on this metric.

Both web searches and interactions with POCs are subject to silent monitoring. Monitors will evaluate staff on the following dimensions:

* When researching providers, used only project-approved websites, including the host hospital’s website, the NPI Directory, and WebMD.
* Organized physicians by specialty in order to work them most efficiently.
* Confirmed findings with a live call to the appropriate POC.
* Used the exact Location of Service in probing - "Do you handle billing for Dr. Jones when he provides services at General Hospital?"
* Used the actual doctor's name, rather than specialty, when confirming that a POC handles their billing (e.g., "Do you handle radiology billing for Dr. Smith when he provides services at General Hospital?").
* Confirmed that the POC handled the physician's billing for the entire correct year. If they did not handle it for the entire year, determine which month(s) they handled it.

The SBD contact information collected in the contact guide will be reviewed by editors for completeness and quality before it is finalized. Please see ***Exhibit 1*** for additional detail on the QC process.

**Exhibit 1 QC Process**

* Review SBD Comments to determine if anything further needs to be done with the information collected.
* Presence of a Phone Number (SBD or Billing Service): If there is no phone number associated with the string, the editor will suggest obtaining the contact information associated with the NPI or Group name (if applicable). If no phone number can be identified, data collection staff are instructed to document the steps they took to obtain a phone number.
* SBD Name: SBD names are reviewed to ensure that if a group name was recorded in the individual SBD name variable, it is moved to the SBD Group Name variable. If an SBD Name is “don’t know” and an NPI exists, data collection staff are instructed to identify the name associated with the NPI. Once the Group Name is captured in the Group name variable, then the SBD name is recorded as DK.
* SBD Phone Number & SBD Address: If the SBD phone number and address are the same as the host hospital or institution, and there is no billing service phone number, there must be a Group Name or department information recorded in the Group Name field.
* SBD Phone Number & Billing Service Phone Number cannot be the same.
* Billing Separately Status: The number of “Don’t Know” responses at the billing separately question is tracked by interviewer. Supervisors follow-up with data collection staff who have a high rate (>10%) of “Don’t Knows”.

## SBD Coding

There are two types of coding involved in preparation of the SBD sample, namely SBD NPI coding and SBD specialty coding. The following sections describe both in detail.

## SBD NPI Coding

The next step in the SBD sample generation process is SBD coding, a process through which provider IDs are assigned to each collected SBD. When possible, SBDs are coded to an appropriate group and/or individual-level NPI using NPIs created through the National Plan and Provider Enumeration System (NPPES). The NPI is a unique 10-digit identification number required by [HIPAA](http://searchdatamanagement.techtarget.com/definition/HIPAA) for all healthcare providers in the United States. Both individual providers (doctors, nurses, dentists) and healthcare organizations (hospitals, clinics, nursing homes) are required to obtain an NPI. This number’s primary purpose is to facilitate organization and create national standards within HIPAA transactions.

In the MPC, there are three main purposes in coding SBD to a valid NPI:

1. To identify and obtain the most up-to-date contacting information.

2. To group providers as needed for the purposes of contacting and gathering MR and billing information that has not already been obtained in some other way.

3. To assist in deduplication of SBDs who are identified by multiple hospitals or institutions that sometimes provide slightly different contact information for the SBD.

The only step of the coding process is autocoding. This is a batch computer process used to identify SBD matches to the Provider Directory. This process looks at information in SBD strings (NPI, name, phone number) compared to information in the NPI Registry to programmatically identify matches. If a provider can be matched to an existing SBD, then it is auto-coded to that existing NPI record and finalized as a match. Similarly, if a provider group/facility can be matched to an existing SBD provider group/facility, then it is autocoded to that existing NPI record and finalized as a match. If after exhausting all possibilities a provider cannot be matched, it is added to the Provider Directory to potentially be matched against in later waves.

## SBD Specialty Coding

The SBD specialty variable has three uses. It is used in imputation of SBD data, it is used to establish the relative priority the node will be given during the SBD field period, and it is used by SBD DCSs in communicating with the POC, “Do you have charges for a radiologist for patient X, on June 3 at ABC Hospital?” The specialty of the potential SBD is collected from the records by Hospital and Institution abstractors. If the DCS/abstractor is not able to choose from the specialty menu list, then the SBD specialty is recorded as “other” and a text string entered.

SBD Specialty Coding is comprised of assigning both a “speccode” as well as a “specialty” code. First, a combined autocoding and de-duplication procedure is run on the strings using a SAS specialty dataset as a reference. Remaining strings are sent to the Coding Task Leader and a data collection team member for manual coding. Coders utilize the coding rules received from AHRQ and the Household Component (HC) contractor as well as the table of SBD specialties used in the Event Form. After the strings are coded, any discrepancies are adjudicated.

## Building the SBD Sample and Creating Nodes

The first step in building the SBD sample is generating and loading provider records that have completed the SBD coding process (including those strings that could not be autocoded to the directory and were instead added to the directory). The provider record includes the SBD ID (called “PDDIRID”). The PDDIRID is the SBD’s individual-level NPI, when this can be identified. The provider record also includes SBD name, contact information, and sample wave number. Since multiple SBD strings can be coded to be the same NPI, the SBD providers are also de-duplicated during this step so that each provider record has a unique PDDIRID.

The second step is to create and load the pair and “node” records for each of the provider records into the IDCS. The pair record consists of the SBD, patient, and AF. Each pair record retains a link back to the SBD string that prompted its creation, including details such as specialty and any group practice and/or billing service affiliations. The “node” provides a link between the Hospital or Institutional provider and the SBD, and consists of the event type (Location of Service), event begin and end dates, and the SBD node identifier. Each node is associated with a single patient-provider pair. The node record also includes the SBD role (e.g., pathologist or radiologist) and specialty. The node is sometimes referred to as the “event” record since at least one SBD event form is administered for each node and SBD data are collected at the node level; some nodes from inpatient stays can have multiple event forms (encounters) associated with them. The node is critical for tracking the progress of the SBD sample during data collection and is used to link the SBD data back to the original Hospital or Institutional provider during the matching process.

## Grouping the SBD Sample for Data Collection

Collapsed SBD contact groups will be formed by starting with the original contact group assignment and combining groups that are similar with respect to certain provider ID fields and provider name and address fields. Combinations of the following fields will be used to form the groupings:

* PDDIRID (which includes the NPI when it is available)
* Phone number
* Name
* Street address
* City and state

This collapsing of contact groups will be done independently for two groups: SBDs not affiliated with a billing service and SBDs belonging to a billing service. The MPC team has developed an algorithm for each of these groups which involves making several passes through the data, collapsing groups based on various combinations of the above variables. These passes will vary for the two independent groups. SBDs that are affiliated with a billing service have additional address fields that will be used to form the collapsed groups. In addition, the passes will likely differ for each of the groups since certain address fields may be more appropriate to use for one group but not the other.

As the SBD sample is built, the MPC team will examine the groups that are being formed in order to prevent over-grouping or under-grouping by the algorithm; based on these observations, the algorithm will be tweaked accordingly. Since collapsing based on text fields is never an exact science, the final groupings will be reviewed by project management staff. A spreadsheet will be set up for review by the data collection team which displays all final groupings. If groups are identified during this QC step that need to be broken apart or combined, this will be indicated in the spreadsheet and these changes will be made as the last step of the grouping process.

For Waves 2 and later, the MPC team will start with the final contact group assignments from the previous wave and use the process outlined above to assign contact groups for the current wave. The grouping algorithm will not break apart the initial contact groups which were assigned at the previous wave. However, due to the addition of the new wave, the algorithm may attempt to combine one or more SBD nodes from the current wave with 2 or more groups that were formed at the previous wave. When this occurs, these groupings will be manually reviewed and split apart to combine the new SBD node(s) with the most appropriate contact group from the previous wave. The ultimate goal is for the SBD nodes from the current wave to be either in their own contact groups or combined with the “best” contact group from the previous wave.

## Anticipating and Tracking the Size of the SBD Sample

SBDs are identified as part of the Hospital data collection, AO, and coding activities. As in the 2012 through 2022 MPC cycles, SBD sample will again be built regularly. By providing feedback on the current size of the sample, this improves the quality of estimates of the ultimate sample size, in turn informing staffing decisions and subsampling. The first build will be in July. From August through the middle of October, sample will be built approximately every four weeks.

Between builds, the estimated size of the SBD sample is revised as activities progress. The sample is tracked on several levels: nodes (medical events), doctors, pairs, and “strings.” A string consists of the contact information for a potential SBD, sometimes with billing service information, that is recorded in association with a Hospital or Institution pair. Multiple strings from various pairs may be found to represent the same doctor. The events associated with the strings are potential SBD nodes.

The deduplication which occurs at several steps reduces the number of unique doctors represented by the strings, and therefore the sample size estimate. A determination is made whether a string represents a doctor who does indeed bill separately. If not, the string is ineligible as an SBD and its nodes are ineligible. Potential nodes can be orphaned when the associated Hospital or Institution event is found to be a duplicate. These kinds of nodes will be dispositioned appropriately so that they are excluded from estimates. If orphaned prior to building the sample, they are excluded from the sample build. Like all potential nodes, though, they are nonetheless tracked and reported.

Reports are run daily which count the potential SBD nodes associated with the SBD strings overall and at each step of SBD processing, from the time they are identified to the time the unique, eligible pairs are built into the sample. This includes their progress through AO, autocoding, tracing, and finally sample creation.

In addition to frequent sample builds, as discussed at the beginning of this section, the number of unique SBDs and SBD nodes yet to be identified are further estimated based on the current counts compared with the percentage of the Hospital and Institution pairs that have completed the AO process, and the percentage of AO-completed strings that have resulted in nodes to date and historically.

## Finalizing a Plan for the Selection and Release of SBD Nodes

SBD providers in the fielded pairs have been confirmed by the AO POC as possibly having charges and payments that are not included in the Hospital/Institution financial records. Although the final count of fielded SBD nodes cannot be confirmed until all AOs have been contacted, the MPC team carefully monitors the results of the AO protocol in terms of the ratio of SBD nodes to Hospital/Institutions pairs for pairs for which AO is complete. By projecting this ratio, the MPC team will estimate the final number of SBD nodes based on the estimated number of completed Hospitals/Institutions pairs. The MPC team will share these estimates with AHRQ as AO is completed.

SBD nodes are assigned a priority status based on the likelihood that the node will yield charge or payment data and high versus low charge and payments. Nodes are subsampled for fielding, with higher sampling rates used for node more likely to yield data. The definitions used to define the priority, counts of nodes in each priority group, and sample allocation will be provided to AHRQ for approval.

Four strata were defined for the 2019-2022 MPC SBD node subsamples; these strata were High, Medium, Low, and Extra Low, with nodes in the High and Medium strata more likely to be SBDs and more likely to have higher SBD charges and payments, and nodes in the two lowest strata were much less likely to be an SBD. These four strata were defined using Hospital Location of Service, Physician Specialty, Physician Role, and pathology CPT codes.

High

“High” priority was assigned when the physician’s role was “Active Physician/Providing Direct Care,” “Don’t know,” blank or missing, and the Physician Specialty and Hospital Location of Service was one of the following combinations:

* Anesthesiology or Surgery, with any Location of Service;
* General/Family Practice, Internal Medicine, Psychiatry, or missing specialty with Hospital Inpatient or Institution Location of Service; or
* OB/GYN or Pediatrics with Hospital Inpatient Location of Service

Medium

“Medium” priority was assigned when the physician’s role was “Active Physician/Providing Direct Care,” “Don’t know,” blank or missing and the Physician Specialty, Location of Service, and Hospital event CPT codes were one of the following combinations:

* OB/GYN or Pathology (excluding pathology with pathology CPT codes for the event only in the range 80000-84999), with Outpatient Location of Service;
* “Other” specialty with Emergency Room (ER), Hospital Inpatient, or Institution Location of Service;
* Pathology with Hospital Inpatient or Institution Location of Service;
* Pediatrics, Psychiatry, or missing specialty with ER Location of Service; or
* Radiology with any Location of Service

Low

“Low” priority was assigned when the physician’s role was “Active Physician/Providing Direct Care,” “Don’t know,” blank or missing and the Physician Specialty, Location of Service, and Hospital event CPT codes were one of the following combinations:

* General/Family Practice or Internal Medicine, with ER or Outpatient Location of Service;
* Pediatrics, Psychiatry, Other specialty, missing specialty, or Pathology (with pathology CPT codes for the Hospital event in the range 80000-84999 only), with Outpatient Location of Service; or
* OB/GYN or Pathology with ER Location of Service

“Low” priority was also assigned for all other roles where the Physician Specialty was Surgery,

Radiology, OB/GYN, or Anesthesiology.

Extra Low

“Extra Low” priority was assigned for all other roles and specialties (that is, the physician role was something other than “Active Physician/Providing Direct Care,” “Don’t know,” blank or missing and the Physician Specialty was “Pathologist,” “Internal Medicine,” “Psychiatry,” “Pediatrics,” “General/Family Practice,” or” Other”).

In 2019-2022 with four sampling priority strata, all of the High and Medium priority nodes and subsamples of the Low and Extra Low priority nodes were fielded. The MPC team expects that the 2023 SBD nodes will be subsampled similarly to the prior four years’ nodes, unless AHRQ provides different direction. ***Exhibit 2*** provides the 2022 cycle numbers of nodes in each priority status by wave.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Exhibit 2. 2022 Number of Nodes Released by Wave** | | | | | |  |  |  |  |
|  | |  |  | |  |  |  |  |  |
|  | |  |  | **Subsample Released** | | | |  |  |
|  | |  | **Wave 1** | | **Wave 2** | **Wave 3** | **Wave 4** | **Total** | **% of Total** |
| 1. High Priority | |  | 2,458 | | 657 | 546 | 2,123 | 5,784 | 26.17 |
| 2. Medium Priority | |  | 5,608 | | 1,755 | 1,190 | 4,417 | 12,970 | 58.69 |
| 3A. Low with H or M | |  | 627 | | 284 | 161 | 776 | 1,848 | 8.36 |
| 3B. Low without H or M | |  | 327 | | 0 | 41 | 0 | 368 | 1.67 |
| 4A. XLow with H or M | |  | 260 | | 142 | 52 | 388 | 842 | 3.81 |
| 4B. Xlow without H or M | |  | 224 | | 0 | 60 | 2 | 286 | 1.29 |
| Total Released | |  | 9,504 | | 2,838 | 2,050 | 7,706 | 22,098 | 100.00 |
| Notes excluded\* | |  | 138 | | 34 | 56 | 122 | 350 |  |
|  | |  |  | |  |  |  |  |  |
|  | \* Nodes determined to duplicate an OBD were excluded from the Wave 1/2/3 subsamples. | | | | | | | | |
|  | In addition, nodes for HC nonrespondents were excluded from the Wave 4 subsample. | | | | | | | | |

The MPC team looks forward to working with AHRQ staff to determine a plan for selection and release of SBD nodes. Because of the schedule for SBD data collection, the MPC team suggests that a final plan be in place by June 28, 2024 so that the final plan can be implemented from the beginning of SBD data collection, scheduled for August 14, 2024.

## Resolving Overlaps between SBD Nodes and OBD Events

It is possible that an SBD identified through record abstraction is also identified by the HC respondent and is included in the sample of OBD developed during the HC. The potential overlap of the SBD and OBD samples is assessed to minimize double-counting medical expenditures and to avoid contacting providers in SBD data collection who have already been contacted during OBD data collection. Overlap of the two samples is assessed through a combination of computer-assisted matching programs and manual review of possible matches in the two samples. For the 2014-2022 cycles, the MPC team used additional rules for algorithmic and manual processing of potential overlaps, and the MPC team will continue to do so for the 2023 cycle.

## Schedule for SBD Sample Development, Preparation, and Fielding

|  |  |
| --- | --- |
| 3/18/2024 | Start AO and AO QC |
| 7/9/20234 | Cut off for Wave 1 AO QC |
| 7/10-11/2024 | Wave 1 Autocoding |
| 7/12-16/2024 | Build Wave 1 sample |
| 7/17-30/2024 | Prepare contact groups and identify overlaps |
| 7/31-8/6/2024 | Merge groups, apply overlaps, code out, etc. |
| 8/7-8/14/2024 | Release Wave 1 for case assignments |
| 8/14/2024 | Begin Wave 1 data collection |
| 8/8/2024 | Cut off for Wave 2 AO QC |
| 8/9-12/2024 | Wave 2 Autocoding |
| 8/13-15/2024 | Build Wave 2 sample |
| 8/16-29/2024 | Prepare contact groups and identify overlaps |
| 8/30-9/6/2024 | Merge groups, apply overlaps, code out, etc. |
| 9/6-11/2024 | Release Wave 2 for case assignments |
| 9/11/2024 | Begin Wave 2 data collection |
| 9/10/2024 | Cut off for Wave 3 AO QC |
| 9/11-12/2024 | Wave 3 Autocoding |
| 9/13-17/2024 | Build Wave 3 sample |
| 9/18-10/1/2024 | Prepare contact groups and identify overlaps |
| 10/2-8/2024 | Merge groups, apply overlaps, code out, etc. |
| 10/9-11/2024 | Release Wave 3 for case assignments |
| 10/11/2024 | Begin Wave 3 data collection |
| 10/11/2024 | End of Hospital data collection |
| 10/18/2024 | Cut off for Wave 4 AO QC |
| 10/21-22/2024 | Wave 4 Autocoding |
| 10/23-25/2024 | Build Wave 4 sample |
| 10/28-11/8/2024 | Prepare contact groups and identify overlaps |
| 11/11-15/2024 | Merge groups, apply overlaps, code out, etc. |
| 11/18-20/2024 | Release Wave 4 for case assignments |
| 11/20/2024 | Begin Wave 4 data collection |
| 11/19-25/2024 | Review overlap spreadsheet and key results |
| 11/27/2024 | Update CMS based on review of spreadsheet |
| 12/2/2024 | Begin assigning cases with remaining (non-overlapping) nodes for DCS to collect data, as needed |
| 1/10/2025 | End SBD data collection |
| 1/13/2025 | Submit to HC Contractor matched and rolled up data test files for SBD and disavowal file |
| 1/14/2025 | End SBD reabstraction of randomly selected events |
| 1/14/2025 | End SBD reabstraction of batches over 2% |
| 1/14/2025 | End SBD Edit Shop and Managerial Review |
| 1/16/2025 | End coding |
| 1/24/2025 | Submit to HC contractor MPC raw data production files and Linked IDs from MPC production files |
| 1/27/2025 | Receive comments from HC Contractor on SBD test files |
| 1/31/2025 | Submit raw SBD file to AHRQ |
| 2/12/2025 | Submit to HC Contractor MPC matched and rolled up production data file for SBD and disavowal file |

# Instruments and Materials

This chapter provides an overview of the instruments and materials that will be used to collect data for the SBD sample.

The MPC team will continue to use the computer-based Integrated Data Collection System (IDCS) that allows data collection through either telephone or through record abstraction directly into one central database.

Additional detail is provided in the following subsections on the different components of the instrument and materials that will be used to assist the DCSs, abstractors, and providers during MEPS MPC data collection. These include the contact guide, provider materials, event forms, and the Case Management System.

## POC Module and Contact Guide

The POC module that contains the contact guide is one part of the combined POC/CMS component of the IDCS for SBD, as for other provider types. The POC Module and the contact guide are used by the DCS to initiate contact with the SBD provider. Using the contact guide, the DCS identifies the appropriate person(s) within the provider setting who should be sent the provider. These individuals are also the contacts for subsequent calls to complete data collection with the event forms. More specifically, it is during this contact that the DCS introduces her/himself and the study, explains the MEPS MPC request for data, collects relevant contact information to fax (or deliver by mail, electronic portal, or email) provider materials, and documents steps for proceeding with data collection.

## Provider Materials

Prior to data collection and using the contact information collected in the initial contact, providers are sent (by fax, mail, electronic portal, or email) the following materials:

* Cover sheet.
* Cover letter providing general information about the study from the U.S. Department of Health and Human Services.
* A confidential patient checklist of all HC respondents who reported receiving services from a Hospital or Institution that may have included services provided by an SBD, with step-by-step guidance to the point of contact.
* AF for each patient. This is the same AF that was sent to the Hospital or Institution provider, and also authorizes the SBD to report patient data to the MEPS MPC study. This form is compliant with the Health Insurance Portability and Accountability Act (HIPAA) implemented in 2003.
* Document that addresses commonly asked questions about the MPC study.
* Fax/mail return form to be used by the respondent if they prefer to fax or mail their billing records. The fax return cover sheet contains pre-printed information for faxing records. The mail return form includes a pre-printed mailing label for the provider to send records via mail.
* An instruction sheet on how to upload data for respondents using the electronic portal.

## Event Form

Once the provider has received materials with the AFs, the DCS or abstractor will use the SBD event form to collect data for care provided to the patient by the SBD for the corresponding hospital or institution event reported during Hospital or Institution data collection. Data will either be collected directly from the provider over the telephone or an abstractor will enter the relevant data from records received from the provider. The event form will be accessible to the DCS and abstractor through the IDCS.

Different event forms are used for each of the six provider types in the study (Office-Based Doctors, Hospitals, Institutions, Home Health Care, SBDs, and Pharmacies). While the forms will collect a common set of data items for each event, adaptations have been made to each form as needed to collect the core set of MEPS MPC data items in different provider settings. **Exhibit 3** identifies the data items to be collected from the SBD provider type with the relevant event form.

## Case Management System (CMS)

The node ID, event date, event type, and location of the event (i.e., name of hospital or institution where services were provided) are preloaded into the CMS for each patient. The preloaded information is used during the interview to identify the patient event for which data are being collected and to verify that data have been recorded for the correct events. The DCS can view all needed nodes for the entire contact group with a single click of a button which facilitates communications between the DCS and the POC.

An SBD query tool is used to assist in identifying SBD contact groups that require merging. This tool is part of the IDCS and DCSs are trained to utilize this tool to look for additional cases with the same POC or phone number prior to contacting a POC. The tool includes a query to search for specific POC types and a query that DCSs utilize when attempting to dial a number that has been contacted in the past 32 hours. The use of both queries led to a reduced number of multiple contacts with SBD POCs and improved the ability to group SBD cases within the CMS prior to additional phone contacts.

Exhibit 3. Data Items Collected during MEPS MPC SBD Data Collection

|  |  |
| --- | --- |
| Data Item | SBDs |
| Dates of services | 1 |
| Setting of care | 1 |
| Medical condition (ICD10 or DSM-V code) |  |
| Type of personnel seen |  |
| Type of prescribed medicine (NDC) |  |
| Amount of medicine dispensed (quantity and dosage/form) |  |
| Procedures/services provided (CPT4, DRG, revenue codes) |  |
| Full established charge by service |  |
| Total charge |  |
| Payment amount by source of payment (if capitation, copayment amount and payer sources) |  |
| Total payment |  |
| Reason(s) for any discrepancy between total charge and total payment |  |
| Identification of SBDs |  |
| Comparison of total number of MPC-reported events vs. total number of HC-reported events and explanation if discrepancy cannot be resolved | 2 |

1 These items are obtained from the hospital or institution and are used to identify the specific events about which the SBD is to report.

2 For SBDs, each event reported by the hospital or institution is accounted for.

# Staffing and Training

Staffing and training plans have been designed to ensure that data collection specialists (DCS) and abstractors (ABS) meet the workload needed for the study.

## Staffing

The team of SBD DCSs and ABSs will include a mixture of veterans from the 2022 SBD data collection, and staff who were hired earlier in the 2023 data collection cycle and have been working other provider types.

Negotiators, along with a couple of additional experienced staff, will begin work on contacting groups of Large Provider SBDs in mid-August, while continuing to finalize non-SBD assignments. Other staff will transition to SBD data collection in October as non-SBD caseloads diminish, and all staff will fully transition to SBD by the third full week of October. Negotiators and other data collectors working a mixed caseload of SBD and other provider types will be instructed to prioritize the other provider types, as necessary. When possible, the MEPS MPC team will look for flexibility within the cycle to move a subset of staff to SBD earlier, if non-SBD progress has been sufficient to do so.

## Training

Following the initial negotiator training in August, staff will transition from Hospital and OBD data collection to a full-time SBD caseload over the course of several weeks, from the beginning of October through the week following the end of the non-SBD field period in mid-October.

Veteran staff attended a more comprehensive SBD refresher training: 16 hours of content on topics from the previous half-day training model with a full refresher for staff on SBD procedures, given the 8-to-9-month gap between SBD cycles for these staff. This lengthier training has proven more successful in bringing veteran staff up to speed prior to SBD data collection, and this approach will be used again for the 2023 cycle.

MPC staff who were hired to work other provider types earlier in the 2023 cycle will also receive the 16-hour SBD DCS training and may be selected to attend a 16-hour SBD abstraction training. While there are no current plans for hiring new-to-project staff for SBD in the 2023 cycle, should that be necessary to maintain appropriate staffing levels, those new staff would first attend an 8-hour basic training prior to attending SBD training.

For the 2023 cycle, the SBD training agenda will be reassessed, including the development of mocks to specifically address common performance issues encountered in the 2022 SBD cycle. For the 2023 cycle, those staff in need of additional assistance following training will be identified and asked to participate in additional coaching.

In addition, enhancements specific to SBD that included more practice in ensuring an appropriate SBD POC has been reached (someone who handles billing for the physician *when he or she provides services at a particular hospital*) will be used, as well as more practice in probing disavowals.

The core training team will be responsible for the overall success of each training session and will ensure all trainees receive identical training. Trainers are selected based on those who have “hands on” experience gained through participation in data collection (records abstraction and telephone data collection). This experience contributes to the learning environment as trainers can draw on real life situations to illustrate training points. The experience also adds to the credibility of trainers.

For the 2023 cycle, a core training team will again be used to avoid regularly pulling the same individuals away from their technical and supervisory responsibilities. Training teams include a mix of staff from project management, data quality, supervisors, utility specialists, team leads, Large Provider negotiators, and higher performing production staff. Project management staff will serve in a primary trainer role leading lecture and walkthrough content and organizing individual trainings. They will be supported by staff from other roles who will help monitor staff engagement or assist trainees in labs or study hall, with the number of trainers active in the training dependent on the method of content delivery and size of training class.

Staff will have access to a reference manual for SBD.

# Data Collection Specialist Procedures

The following sections discuss SBD data collection work processes.

## Basic Case Flow

Prior to contacting a provider, DCSs will use POC queries to determine if the case has been contacted by another DCS. The first query will be run automatically when the number is entered in the phone system. If the number has been contacted in the past 32 hours, the DCS will receive a message and the instruction to follow up with their supervisor for direction on how to proceed. A second query will be used when a DCS accesses the POC screen in the CMS. The DCS will click on the POC phone number displayed in the system so a real-time check can be run to determine if the POC has been contacted previously in SBD data collection. If the POC has been contacted before, the DCS informs her/his supervisor who determines if a contact group merge is needed.

These two queries avoid unnecessary multiple contacts to a POC. While efforts are made to group cases prior to data collection, SBDs and billing groups are constantly evolving. The use of these queries allows DCSs to avoid burdening POCs with multiple contacts.

The contact guide is designed to facilitate communication with both SBDs who do their own billing and SBDs that use off-site billing services. The DCS will access the SBD contact guide in the Integrated Data Collection System (IDCS) to contact the provider. If the DCS is unable to reach the POC on the first contact, the information gained from each contact is recorded in the Contact Block of the contact guide and the outcome of each contact is noted in the CMS. Results from each contact will become part of the overall history of the case and will be readily available for review in the CMS the next time the DCS attempts to make contact.

Once the DCS establishes a POC, the DCS will introduce the study, confirm the provider groupings that were initially assigned, obtain the fax number or mailing or e-mail address to which the packet of materials will be faxed, mailed, emailed, or shared via electronic portal, and negotiate the manner in which data collection will proceed.

Once this information has been gathered, cooperation has been obtained, AFs have been sent, and the provider has acknowledged receipt of the AFs, the DCS will attempt to collect information while speaking with the POC on the telephone using the SBD event form instrument. Unlike OBD, SBD data collection will only request data or records that match with a corresponding Hospital or Institution event. All data for SBDs should be available from the provider’s billing records. If the provider is unable to participate by telephone, the DCS will request the POC send a copy of the billing records for abstraction.

Disavowals occur frequently during SBD data collection with more wide-ranging reasons than for any other provider type. Disavowals on SBD also differ from those on other provider types because disavowal status can differ by node within the same pair on SBD. Disavowals will be determined and recorded when the DCS completes the patient verification process as well as when the DCS reviews each node during completion of the SBD event forms. The DCS will probe to determine to which of the following disavowal categories the node should be coded:

* Knows patient but no participation/charge for this node—*Referring/Copied doc*
* Does NOT know patient—*Department Head/Follow-up Doc*
* No participation/charge for this node—*No additional information*

The different types of disavowals noted above will be tracked in the system for easy access for reporting and analysis; however, all SBD disavowals are treated as out of scope in completion rate calculations.

# Document Handling and Abstraction Procedures

Typically, about 25% of SBD nodes are collected via records, while the remaining approximately 75% of SBD nodes are collected via phone. Procedures for receipting and processing PA for SBDs mirror those used for other provider types. However, determining how to receipt records for SBD can be more challenging. First, records for a patient may include events with more than one provider within a particular group practice; thus they may need to be parsed among more than one patient-provider pair. Second, while the protocol is to request professional fees, the DCS may again receive the same facility fees received during Hospital and Institution data collection; these are not receipted as PA. Third, for SBD data collection, the emphasis is on particular events; if these events do not all appear to be present in the records received, the records are receipted as partial PA, and a note is left in the system for the DCS to follow up with additional prompts for full PA records. Fourth, POCs often send a disavowal note indicating they have no records for the patient; these documents are receipted as “miscellaneous” records.

After records are receipted, they are reviewed to ensure the accuracy of receipting and to determine next steps. For the SBD provider type, instead of comparing records received to the expected events from the HC, staff will compare the events in records received to the nodes collected from the MPC Hospital and Institution events. If the events in the SBD records do not appear to fill all nodes, staff will instruct the DCS to recontact the POC to probe about the missing nodes, determine an alternate POC who could have those records, or ascertain if no records are available because the provider was a referring doctor, copied doctor, follow-up doctor, or department head. Likewise, if the documents received contain a disavowal note, the supervisor will have the DCS contact the POC to probe and verify that a disavowal code is the most appropriate resolution of the node(s). If staff determine the records contain the necessary nodes, the abstractor will record the data into an electronic abstraction notes form, and the data are programmatically transferred into the SBD event form. After the event form has been populated, the system will evaluate the completeness of each node and the case will either be finalized or submitted for data retrieval. To minimize burden to the provider, re-contacts to collect any missing information will be made in an efficient manner.

For those difficult and sensitive cases requiring a negotiator to maintain contact with the POC throughout completion, production supervisors will team negotiators and skilled abstractors together. When appropriate, negotiators and abstractors will work together to allow the negotiator to continue contact with the POC after records have been received and to work with the abstractor to follow up on any retrieval items. Allowing the negotiator and abstractor to work together for difficult cases maintains consistency when working the case and rapport with sensitive POCs because they only communicate with one person throughout the life of a case.

# Management Plan

## Management

The MPC Project Director will be actively engaged in every aspect of SBD data collection from sample preparation through data collection operations and data file delivery. The Project Director regularly attends, and is actively involved in, the weekly production meeting, data quality meetings, monthly financial review meetings with team leaders, meetings of supervisory staff, and quality circle meetings with DCSs. The Project Director has the ultimate authority and responsibility for decision making related to SBD data collection operations, as with all other tasks on the project. The Associate Project Director will assist the Project Director with management of the project and will also assist the Data Collection Team Leader with technical oversight.

The data collection team will be led by the Data Collection Team Leader, who, with deference to the Project Director, will provide overall direction and supervision for all aspects of data collection, including instrumentation, training, coding, and data collection production and quality.

The Production Manager, who works under the Data Collection Team Leader in support of data collection operations, will work with the project supervisors to make certain clear directives and messaging is provided to production team supervisors and DCSs/abstractors.

The Training Manager manages the project training team and is responsible for continuing and improving the overall training program and its integration into data collection production and works with the quality control staff to make sure data quality standards are maintained and oversees the review of anomalous cases to ensure data are being collected correctly. For SBD, this managerial review includes duplicate events (SBD/SBD and SBD/Hospital), SBD/OBD overlaps, and events with extreme charges or payments. The Training Manager works under the Data Collection Team Leader.

Production Shift Supervisors coordinate day-to-day activities and provide specific logistical instructions to the team supervisors consistent with directives provided by the Data Collection Team Leader and Production Manager. The Production Shift Supervisors work with the Production Manager to propose specific protocols and procedures that enhance production. These proposals are reviewed for feedback and approval by the Production Manager and Data Collection Team Leader. The Production Manager is also responsible for approving all meeting agendas for supervisors and data collection staff, and reviews all meeting notes and memos before distribution. The Production Manager and Data Collection Team Leader are in attendance at production meetings and provide feedback to supervisors and data collection staff, as appropriate. DCSs and abstractors also know that, regardless of the project hierarchy, they can go to anyone on the project team to address questions and concerns. This hands-on approach provides consistency across teams and also assists in determining priority shifts, as necessary.

Reporting to the Production Shift Supervisors are Production Team Supervisors, who are each responsible for a team of DCSs and abstractors. Production Team Supervisors are responsible for assigning work to team members in a manner appropriate to each DCS’ skill level and serving as the DCS’ first line of contact with questions about working their assignment. Supervisors use performance indicators, relative to each DCS’ assignment, to prioritize weekly one-on-one case review, coaching, and mentoring activities with the individuals on their team. In addition, support specialists, utility specialists, and team leads are responsible for providing support to production supervisors, helping as needed in any area of the project, and assisting with certain tasks that previously were distributed across supervisors. The purpose of the support staff during SBD data collection is to focus on the review of problem reports, disavowals, case merges or case banding. These specific activities will prevent distraction for production team supervisors and allow them to truly focus on their team’s case review and production.

## Team Organization

Rather than integrating a third provider type into the existing teams, RTI plans to reorganize the teams as DCSs complete SBD trainings, creating several teams that have only SBD work. As the staff continue to transition from Hospital and OBD (non-SBD) to SBD, more SBD-only teams will be created, and the Hospital and OBD work will be consolidated into fewer teams. Organizing into provider-specific teams (Hospital-OBD and SBD Only) will allow overlap of the SBD field period with the non-SBD field period with minimal distraction to DCS and supervisors who are involved in closing out data collection on non-SBD providers. Negotiators who have a caseload that includes Large Providers from both non-SBD and SBD samples will continue to be organized into one team and meet weekly with their assigned manager to discuss Large Provider bands from both samples.

## Remote and On-site Management

Current plans for the 2023 cycle reflect staff will continue working in a hybrid environment, with some staff working on-site and others continuing to work from home. For 2023, all DCSs will get an opportunity to work on-site in the weeks following a training session of a new task to get additional in-person coaching. As the cycle progresses, project managers will carefully consider the mix of on-site staff and management to best meet project needs. While in a hybrid setting, managers continue to meet virtually with staff at various levels of the project, including a weekly “floor” meeting, and managers troubleshoot and problem solve with the Production Shift Supervisors. Managers are also active in various discussions and team huddles that are held remotely via MS Teams and use this access to anticipate and research potential production, workflow, and quality issues and to detect and correct drift in implementation of procedures.

When on-site operations are taking place without restrictions due to COVID-19, the Project Director typically spends 2 days a month at the ROC. The Associate Project Director typically spends 2 days a month at the ROC. The Data Collection Team Leader, Data Quality Manager and Training Manager will typically spend 4-5 days weekly at the ROC during the SBD field period. The Production Manager typically spends 5 days onsite per week. Managers also conduct periodic visits to SUBCONTRACTOR’s call center.

Time on-site is spent on management activities including meeting with staff at various levels of the project, troubleshooting and problem solving with the project supervisors, walking the floor, gathering information, providing feedback, and reviewing problem cases, as needed. This active approach gives project management an up-close opportunity to anticipate and research potential production, case flow, and quality issues and to detect and correct drift in implementation of procedures. When off-site work is being conducted, remote tools will be utilized to accomplish the same management tasks.

## Data Collection Schedule

To use the full SBD data collection schedule, the production team anticipates an overlap with non-SBD data collection at the beginning of SBD data collection. In August, most DCSs will continue to clean up Hospital, OBD, and Pharmacy, while seasoned negotiators and some experienced DCS begin contacting Wave 1 SBDs. Four SBD samples releases are expected: one in mid-August, the second in mid-September, the third in mid-October, and the last wave to follow in November. SBD data collection will end in early January.

As with Hospital and OBD, edit shop activities for SBDs are scheduled to run concurrent with SBD production. Full SBD abstraction and reabstraction is expected to start in November.

# Field Cost and Progress Reports

The ***MPC Consolidated Data Collection Plan*** reviews Field Cost and Progress Reports available for all provider types. In addition, there are two reports unique to the SBD provider type: an SBD Node Report provides the current status of all nodes, and an SBD pair-level report provides finer detail about ineligible pairs than is available in the main production report.

Exhibit 6. MPC SBD Pair Report—Overall

|  |  |  |
| --- | --- | --- |
| Category | Value | % of Original N |
| Original N |  |  |
| Merge |  |  |
| Abstracted in Error |  |  |
| Included in another SBD |  |  |
| Included in Hospital Charges |  |  |
| Disavowal 1 |  |  |
| Not Treated for event, Disavowal 2 |  |  |
| Referred/Copied Physician |  |  |
| Department Head/Follow-up Doctor |  |  |
| Current N |  |  |
| Complete |  |  |
| Partial complete |  |  |
| General refusal. |  |  |
| PF refusal |  |  |
| Unlocatable |  |  |
| Refuses to retrieve records |  |  |
| No data, info purged |  |  |
| Any other non-response |  |  |
| Pending |  |  |
| Completion Rate |  |  |
| Response Rate |  |  |

# Response Rates

In this chapter, a multi-faceted approach to maximizing completion rates for the 2023 MEPS MPC is described.

## Careful Assignment/Reassignment of Work

Workload assignments are kept at a moderate level. DCSs are encouraged to thoroughly work their assignments, while maintaining enough nodes to continue meeting goals if some of their nodes get put on hold due to issues, such as review of overlaps. Counts of providers, pairs, and nodes may vary among the assignments because of the varying amounts of work required at different stages of data collection.

Assignments to DCSs are made thoughtfully so challenges presented by the provider type and data collection are matched with the skills and experience of the DCS. Factors considered in SBD assignments include:

* size of the contact group;
* priority of pairs associated with the provider contact group;
* prior provider resistance to participating in the MPC;
* stage of data collection (e.g., initial contacts, prompting for records, records abstraction/data collection, data retrieval);
* data collection mode (records abstraction or telephone);
* experience, skills, and training of the DCS

While, in many cases, all of the nodes associated with a contact group may be completed by a single DCS, transferring work to a different DCS with different skills and experience or more availability may be the most effective way to address a particular challenge that has been encountered. Transfers involve updating the case assignment system in order to keep track of nodes. Again, this is to assure that the current status and location of provider contact groups, pairs, and nodes is known, encouraging assigned work to be handled effectively.

## Setting Weekly Production and Intermediate Goals

The production team has set up the staffing and production projections to not only set goals and monitor weekly production, but to set goals and track interim measures of workflow such as the number of AFs sent, AFs confirmed, and records received during each week of data collection. These measures assist with workload and staffing management throughout the field period. They will be especially useful at the beginning of the SBD field period when it is critical to start strong in order to gain cooperation early with large and difficult providers.

## Goal-Focused Messaging

Messaging to DCSs and ABSs will continue to be upbeat and motivational, while conveying the urgency of staying on or ahead of production goals. Weekly virtual or on-site floor meetings will be held to share updates with the group on progress made, recognize top performers, and communicate expectations for the coming days or weeks. Progress towards cumulative and weekly goals will be posted on colorful boards around the production floor, or shared with staff electronically. When project goals are not met, Quality Circle meetings will be held with staff to convey that the goal is to help them be successful, and ask for their insight in how the team can help remove barriers or streamline processes; this communication approach conveys the urgency of the goal in a way that also helps the DCS feel heard and supported.

## Case-Specific Strategy Development

Supervisors frequently review assignments with each DCS to assure that each assignment is receiving appropriate attention. Nodes that are not brought to an expected disposition (e.g., “ready for abstraction” or “data collection completed by telephone”) will be discussed to identify challenges and solutions. Supervisors will receive continuous mentoring on effective case review, including not only techniques for efficiently identifying nodes in need of in-depth review, but also ways of thinking about whether the node is being appropriately handled or if the DCS is chasing the wrong lead or otherwise spinning their wheels. (Filtering the case-aging report by supervisor is one way of identifying supervisors most in need of mentoring.) An ongoing focus will be given during the 2023 cycle to nodes dispositioned as a locating problem, a refusal, or a node that could potentially be finalized as an empty node. Continued scrutiny of nodes in these buckets could help identify the need for a change in strategy when certain situations are encountered.

Applications introduced in previous cycles will help supervisors more effectively identify contact groups and nodes that need review and will provide supervisors with reports to help them more efficiently identify DCSs who need coaching or mentoring.

Another part of developing effective case-level strategy includes encouraging DCSs to modify their general behaviors throughout the field period. For example, early in the field period, it is useful for staff to quickly churn through their caseload to gain cooperation from a large number of providers per day. Later in the field period, it will become more important for DCSs to invest the necessary time to break through to more difficult providers, which can include simple behavioral changes like waiting for longer periods of time “on hold” for a POC to answer.

## Focus on Large Providers

The MEPS MPC sample includes several hundred large SBD providers and SBD billing services that account for a significant portion of the nodes in the overall sample. Success with Large Providers is an essential component of meeting overall response rate goals. This section describes plans for handling the largest and most complex Large Providers (Category 1 and 2 Large Providers). These plans are consistent with plans for handling the largest and most complex Hospital and OBD providers.

*Advance Preparation*

For the 2023 cycle, designations for Category 1 and 2 SBD providers/billers will be revisited in a similar fashion to the 2023 cycle non-SBD providers. Providers/billers were originally designated as Category 1 and 2 based on the size of the bands, with the largest 30-40 bands (from the previous cycle) being assigned a critical band value (Category 1 or 2). The designation of Category 1 or 2 was made based on (a) completion rate from previous cycles, (b) difficulty of working the band, and (c) complexity of working the band. Revisiting the designations based on the 2021 cycle results maintains focus on the largest and most difficult providers/billers in the sample.

The largest providers/billers with a history of refusals or limited participation will generally be designated as Category 1, and those with a history of success or greater participation will generally be designated as Category 2. Prior to initiating contact, summaries of previous experience with each of these providers will be written, detailing the nature and success of contacts, what strategies were successful in gaining cooperation, what specific barriers were encountered during outreach efforts, and what types of behaviors may have led to unfavorable outcomes. These summary documents will include names and contact information of previous POCs as well as information about how the provider is organized. A final section of the summaries outlines a strategy for approaching and gaining cooperation from the POC. Plans will be drafted and submitted to AHRQ in time to have approval of Category 1 and 2 band plans in place for the beginning of SBD data collection.

*Assigning Work and Preparing Negotiators*

These Category 1 and 2 providers will then be divided amongst negotiators, based on each negotiator’s style, strengths and their previous experience with these and similar providers.

In August, each negotiator and the Large Provider supervisor will meet with a designated manager to review the AHRQ-approved plans, and to discuss the history and strategy of each provider prior to making initial contact.

*Overseeing the Large Provider Negotiations*

A designated supervisor assists data collection managers with overseeing the work for Category 1 and 2 Large Providers. This Large Provider supervisor is responsible for reviewing the negotiators’ call history notes, resolving problem reports for the Category 1 and 2 cases (banding, merging, disavowal tracing, etc.), preparing spreadsheets for providers and ensuring customized authorization-form packets are sorted in the order requested by the point of contact, and helping the negotiator stay organized.

The negotiator, the Large Provider supervisor, and their designated manager then meet weekly throughout the rest of the field period to discuss and strategize about new developments and document progress and next steps for a weekly report to AHRQ. The negotiator is expected to come to these meetings with detailed notes of interactions from the previous week. The Large Provider supervisor is expected to have verified this information through their independent case review.

*Reporting Progress on Category 1 and 2 Providers*

On a weekly basis, AHRQ will receive an update on Large Provider (broad definition) completion rates. A separate weekly summary of recent progress on each Category 1 and 2 provider is also provided, noting obstacles encountered and suggested approaches.

## Costs of Providing Records

Providers who participate in MPC data collection are offered reimbursement for reasonable charges for time spent, the copying of documents, or a standard charge for these services. Such protocols exist for specific situations that instruct DCS staff to determine if there is a set fee the provider charges for providing or patient information. This should facilitate cooperation and minimize break offs due to anticipated burden. Historical information from the 2022 MPC allows for anticipation of requests for remuneration from specific providers.

All provider payment requests are maintained using a Windows application database. The database will document the provider status and approval process for each contact group requiring payment. Data is available to AHRQ upon request.

DCSs offer to arrange and pay for FedEx pick-up and delivery of records, as needed.

**Appendix A: MEPS MPC Acronyms**

|  |  |
| --- | --- |
| AF | Authorization Form |
| AO | Administrative Office |
| AHRQ | Agency for Healthcare Research and Quality |
| ABS | Abstractor |
| ATS | Assignment Transfer System |
| BETOS | Berenson-Eggers Type of Service Codes (medical procedure and supply codes) |
| CCB | Change Control Board |
| CCSR | Clinical Classification Software Refined (coding scheme developed by AHRQ that converts ICD-10 codes into other codes used for matching, imputation, and analysis) |
| CHAMPVA | Civilian Health and Medical Program of the Department of Veteran’s Affairs |
| CMS | Case Management System |
| CPT-4 | Current Procedural Terminology 4th Edition (medical procedure and service codes) |
| CS | Control System |
| DCS | Data Collection Specialist |
| DPM | Document Processing Module |
| DQ | Data Quality |
| DR | Data Retrieval |
| eANF | Electronic Abstraction Notes Form |
| GPI | General Product Identifier (prescribed medication codes) |
| HCUP | Healthcare Cost and Utilization Project (AHRQ website checked for updated CCSR codes) |
| HIPAA | Health Insurance Portability and Accountability Act |
| HPC | Hours Per Case |
| ICD-10 | International Classification of Diseases 10th Revision (medical condition codes) |
| IDCS | Integrated Data Collection System |
| LOS | Location of Service |
| MEPS | Medical Expenditure Panel Survey |
| MEPS HC (HC) | Household Component of the MEPS |
| MEPS MPC (MPC) | Medical Provider Component of the MEPS |
| MR | Medical Records |
| NDC | National Drug Code |
| NPI | National Provider Identifier |
| NTP | New to Project |
| OBD | Office-Based Doctor |
| PA | Patient Accounts |
| PHI | Protected Health Information |
| PII | Personally Identifiable Information |
| POC | Point of Contact |
| PSS | Production Shift Supervisor |
| PSU | Primary Sampling Unit |
| QE | Quality Expert |
| RBCS | Restructured BETOS Classification System |
| ROC | Research Operations Center (RTI) |
| RU | Reporting Unit |
| SOP  SBD | Source of Payment  Separately Billing Doctor |
| TRC | Telephone Research Center |