U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Evaluation of the Medicare Recovery Audit Contractor Demonstration

RAC Provider Satisfaction Survey

Request for Clearance
Supporting Statement
And Data Collection Instruments

September 23, 2008

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A. Justification

A.1. Circumstances Requiring the Collection of Information

This is a request for OMB approval of a Provider Satisfaction Survey to assess the impact of Medicare Recovery Audit Contractors (RACs) on the provider community. The Centers for Medicare and Medicaid Services (CMS) has contracted with Econometrica, Inc. to conduct an independent evaluation of the Medicare RAC demonstration. The results, which will be summarized in a report to Congress, will be used to assess the financial impact of the demonstration on the Medicare program and to make recommendations for the demonstration's extension or expansion. Previous research by the U.S. Government Accountability Office found that RACs have the potential to burden private providers. The purpose of this study is to determine whether RACs can perform effectively with a low risk of burden and friction with healthcare providers.

The RAC demonstration is authorized by Section 306 of the Medicare Prescription Drug and Modernization Act of 2003 (MMA), which requires the Secretary of Health and Human Services to conduct a demonstration project for the Medicare population to evaluate the use of RACs under the Medicare Integrity Program. The RACs are private companies that contract with CMS to conduct analyses and investigations of claims that were not previously identified by the Medicare Affiliated Contractors (MACs[1]; formerly, Carriers and Fiscal Intermediaries). Three states having among the highest per capita Medicare expenditure amounts—California, Florida, and New York—have been selected for the demonstration project. RAC compensation is provided through contingency fees from recouped overpayments. To date, CMS has successfully awarded contracts to five RACs in three states including:

Non-Medicare Second Payer (non-MSP)

- PRG Schultz, International (CA)
- Connolly Consulting (NY)
- Health Data Insights (FL)

Medicare Second Payer (MSP)

- Public Consulting Group (FL)
- DCS (Diversified Collections Services, Inc.) (CA)

Beginning in January, 2006, the RACs began a post-payment claim review process designed to identify erroneous Medicare payments not previously identified by the MACs. In addition, they

[1] Including all Medicare Fee-for-Service (FFS) Contractors, including Fiscal Intermediaries (FIs), Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Regional Home Health Intermediaries (RHHIs).

began to recover overpayments made to providers under the Medicare program for services that had been paid under part A or B of title XVIII of the Social Security Act[2] (including Medicare Secondary Payer (MSP) non-beneficiary Group Health Plan based overpayments). Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the U.S. Government.

The concept of recovery audits originates in the Defense Department's demonstration programs of recovery audits in the mid-1990s. In fiscal year 1996, Congress authorized the Defense Logistics Agency (DLA) to perform a recovery audit to identify any duplicate payments, unauthorized charges, and other discrepancies that might have occurred in the payment process. Congress permitted DLA to contract with an auditing company and compensate this contractor by up to 25 percent of the total amount recovered as a result of the recovery audit. According to a June 2000 report issued by the General Accounting Office, the DLA recovery audit identified $30.4 million in potential overpayments on DLA purchases.

The RACs are a key component of Medicare reform proposals being considered by Congress and the Administration. This survey will allow CMS to better understand providers' experiences with this new initiative and demonstrate that RACs can effectively perform their mission with minimal adverse outcomes to providers. Results will be used to determine whether the use of RACs offers a cost-effective means of ensuring that providers receive the correct payments and that taxpayer funds are used for their intended purpose, without negatively impacting the provider community.

A.2. Purpose and Use of the Information

The purpose of the RAC Provider Satisfaction Survey is to gauge provider communications and satisfaction with the RACs. Measuring providers' reactions to and experiences with the RACs will enable CMS to better understand the potential impact of the RACs on providers nationwide and to improve and refine the process, both in the context of the current demonstration as well as future reform initiatives. The survey will cover all aspects of the providers' transaction with the RAC, including:

1) the initial contact and data collection techniques used by the RACs (e.g., soft vs. hard approach, clarity of the requests).

2) the information provided on the determination (including timelines of decisions, reasonableness of requests, clarity of the rationale used to make the decisions).

[2]Including hospital and other Part A claims, Part B claims, or Durable Medical Equipment Regional Carrier (DMERC) claims.

3) the quality of discussions/correspondence (e.g. regarding repayment options and/or appeals) .

4) overall provider communication (e.g., appropriateness of written and verbal communication, clarity of explanations, follow-through, professionalism and courtesy).

Results will be used to compare the RACs with the current Medicare Affiliated Contractors and to recommend improvements to the process, including data collection approach, professional methods, and clear communication techniques between the RAC and the Provider.

The draft instrument (see Appendix B) has been developed to provide an integrated, in-depth picture of the impact of the RACs on providers. Separate questions will be asked of those in the comparison group, (i.e., providers who have not had communication with a RAC) to determine how the RACs compare with the current Medicare contractors.

A.3. Use of Improved Information Technology

The data collection for the RAC Provider Satisfaction Survey will be performed using Computer Assisted Telephone Interviewing (CATI). This mode of data collection has been selected to provide acceptable levels of response at a reasonable cost. This mode had also proven to be effective in gathering high quality data from providers for other surveys.

The use of CATI technology will improve the quality of the data by streamlining the interview, customizing the wording of questions, performing range and logical consistency checks, and by automating complex skip patterns. These capabilities will reduce respondent burden and improve data quality by reducing the chance of interviewer errors.

A.4 Efforts to Identify Duplication

This evaluation is the only one planned for the CMS RAC Demonstration program; as such, there is no similar survey on the impact of RACs on healthcare providers.

The survey questions themselves, however, will be modeled after those relevant questions tested for the pilot study of the Medicare Contractor Provider Satisfaction Survey (MCPSS), conducted from January to April, 2005. The MCPSS was designed to 1) provide feedback from providers to contractors so they may implement process improvement initiatives and 2) establish a uniform measure of provider satisfaction with contractor performance. The MCPSS pilot survey instrument included seven modules, each related to a specific business function performed by Medicare Contractors, including 1) provider communications, 2) provider inquiries, 3) provider enrollment, 4) provider reimbursement, 5) claims processing, 6) appeals, and 7) medical review[3].

[3] Several of these business functions are not applicable to RACs (such as provider enrollment and provider reimbursement).

A.5. Effect on Small Businesses

We expect over 50 percent of the sample to comprise hospitals and the remainder to comprise group practices and ambulatory care clinics. Thus, this data collection does not affect small entities.

A.6. Consequences of Less Frequent Data Collection

This is the first wave of a two-wave survey. This first wave has been constructed to collect basic information regarding project implementation issues and to capture early impressions of providers. These data are critical in assessing the impact of the Medicare RAC demonstration on the provider community. In addition, the demonstration has the potential to yield significant cost savings for the Medicare program. Many changes are occurring in the health care delivery system, including the rising costs of Medicare. Medicare spending currently comprises 12 percent of the federal budget and 17 percent of total national health spending. With the aging of the baby boom population and expected increases in overall health care costs, largely due to new and more expensive medical technologies, Medicare spending is projected to grow at significant rate. Changes in Medicare are necessary to limit both the growth in federal spending and rising health care costs. The use of RACs could result in a significant cost savings for the Medicare system by recovering overpayments made to providers in a quick, efficient and cost effective manner.

The survey will meet the requirements of the previously identified legislative mandates.

A.7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

No circumstances can be foreseen where a survey respondent would have to do more than respond to the survey itself. Responding to this data collection effort is completely optional. Providers will be given the opportunity to respond whenever it is convenient for them during the data collection period. Sample members will be informed that their participation or lack of participation in the survey will in no way affect their Medicare payments. This information collection fully complies with 5 CFR 1320.5(d)(2).

A.8. 5 CFR 1320.8: Public Comments and Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the Federal Register on January 24, 2003 (68 7R 3536, TAB I). No comments were received.

Additionally, in March, 2006, four discussion groups were conducted with both providers who

have and have not been contacted by a RAC to discuss their awareness, knowledge, perceptions and satisfaction with the RAC process. These discussions helped both to define the issues and refine the draft survey questions. Two groups were held in New York and two groups were held in Florida. The discussion groups also helped to determine the most knowledgeable respondent for the survey and to develop appropriate screening questions for the interview. Identifying who the interviewer should speak with is critical to increasing response rates, lowering costs and improving the quality of the data.

Individuals outside CMS who have been consulted about the availability of other data sources and the data that need to be collected include staff of the evaluation contractor, Econometrica, and their subcontractor, Insight Policy Research, Inc. Consultation included meetings, telephone calls, and e-mail communications.

A.9. Respondent Compensation

The survey will not offer payments or remuneration of any kind to sample members.

A.10. Assurance of Confidentiality

In accordance with the Privacy Act of 1974, each questionnaire will contain a statement informing respondents that the data are being collected under the authority of CMS, that cooperation is voluntary, that responses will be used to produce statistical summaries only, and that it will be impossible to identify individuals from their responses.

All potential survey respondents will receive an advance letter (see Appendix A) containing a reference to the Privacy Act. This letter will explain how respondents were chosen to participate in the study, and will inform them that their participation is voluntary, their responses will remain confidential, and their participation or lack of participation will have no effect on their Medicare payments. The letter will also provide an estimated completion time for the survey and a toll-free telephone number that respondents can call if they have questions about the survey. Individuals contacted on the telephone will be read the Privacy Act statement if they have not received or read the letter. In addition, interviewer training will stress the importance of maintaining confidentiality and the provisions of the Privacy Act.

CMS takes precautionary measures to minimize the risk of unauthorized access to the records and to ensure that the data is kept confidential by the evaluation contractor and CMS staff. Only authorized project staff will have access to respondents' data and the telephone interviewers will each sign a statement of confidentiality. In addition, to protect the confidentiality of the respondent, each subject's name and work address will be kept separate from his/her individual survey data. A unique ID number will be assigned to each sample member at the time of sample selection. It will be impossible to link questionnaire data to a provider without access to the

'linking file'. This password protected file will contain each sample member's unique ID and basic sampling information. Only the project supervisor and programmer will have access to this file. All computer accounts will be password protected as well.

A.11. Questions of a Sensitive Nature

The survey questions address the respondent's knowledge of and satisfaction with the RACs. These questions are not considered sensitive.

A.12. Estimates of Respondent Burden

One survey instrument will be used for data collection (see Appendix B). The instrument includes two different question routes, which are determined according to whether or not the sample member has been contacted by a RAC. The sample members who have been contacted by a RAC will be asked specific questions about their experiences with the RAC whereas sample members who have not been contacted by a RAC will be asked about their experiences with their current Medicare Affiliated Contractors. The CATI instrument will ask only those questions that apply to the respondent, reducing respondent errors, unit and/or item nonresponse. This will also minimize response times since respondents will only be asked those questions that apply to them. In this way, we can ensure that we have an adequate number of responses to questions in order to make reliable comparisons between providers who have and have not been contacted by a RAC.

Preliminary research indicated that including the name of the RAC in the text of the questions helps respondents focus on the specific RAC that contacted them. For this reason, the survey will include the name of the specific RAC or Medicare Affiliated Contractor that would have contacted each respondent, as determined by their location and sample status.

The survey will be administered in two waves. The first wave will be conducted in mid-2006 so that results can be included in the interim report (due at the close of FY 2006). The second wave will be conducted in late 2008, when a larger number of providers have been contacted by a RAC. Structuring the survey in two waves will enable us to contact providers as close to their communication with the RAC as possible, improving the overall quality of the data. The second wave will utilize a more comprehensive survey instrument that will be submitted for OMB review under a second application process in FY2008.

The annual burden estimates for questionnaire completion are shown in Table A-1. The estimated response burden is based on actual questionnaire completion time on other surveys with the same or similar length, including the Medicare Contractor Provider Satisfaction Survey (MCPSS), as well as the discussion groups previously conducted on the development of the survey.

Table A.1. Estimated Response Burden

	No. of Respondents	No. of Responses per Respondent	Average Burden Hours per Response	Burden Total (Hours)
Respondents Contacted by RAC	900	1	.25 (15 min)	225
Respondents Not Contacted by RAC	300	1	.17 (10 min)	51
Total	1,200	-	-	276

A sample of 1,667 potential respondents will be selected to achieve this number of actual respondents. Assuming ten percent are ineligible to participate, and a targeted response rate of 80 percent, the estimated number of respondents is 1,200. Because respondents who have not been contacted by a RAC would skip a large part of the questionnaire, their time burden would be less.

A.13. Estimates of Annualized Cost to Respondents (Non-Hour Burden)

There are no fixed or variable non-hour costs for respondents participating in the survey. They are not asked to keep records. Respondents will be given a toll-free number by the contractor to call if they have questions about the study or about their rights as a study participant.

A.14. Estimates of Annualized Cost to the Federal Government

The total cost to the Government for collecting these data is estimated to be the portion of the Econometrica, Inc. contract that is devoted to the study data collection efforts. These activities include developing the questionnaire and programming the CATI instrument as well as the interviewer time to administer the survey. The total estimated cost is approximately $120,000 for FY 2006.

A.15. Program Changes in Burden

This is a new data collection. There is no expectation that burden will change during this one-time survey administration.

A.16. Time Schedule and Reporting Plan

The schedule for the information collection and dissemination of wave one data for the Provider Satisfaction Survey follows:

Activity	Expected Activity Period
Survey development	January-April, 2006
Receive OMB Approval	June, 2006
Select Sample and Prepare for Mail Out	April-May, 2006
Conduct Wave 1 Data Collection Activities	June-July, 2006
Code and Edit Data	June-July, 2006
Data Analysis	July, 2006
Prepare and Submit Draft Interim Report	August, 2006
Prepare and Submit Final Interim Report	September, 2006

Plans for the first wave of the survey include a data collection period in mid-2006, corresponding with preliminary tabulations available for the interim report. In order to meet the data analysis objectives, three types of data analysis will be done: 1) a descriptive analysis of the overall survey data; 2) a cross-state analysis comparing data from the three states; 3) a cross-comparison of the data from the six RACs themselves, and 4) an inferential analysis of the relationships between variables within the study (e.g., type and size of provider). These analyses will be carried out after the contractor provides initial weighted and unweighted frequencies for each of the variables in addition to estimates of variances. We also anticipate including a scoring framework that will calculate a score (e.g., composite score by business functions and aggregate overall score) for each RAC.

Results from the analysis of these data will be presented in reports and briefings for senior CMS management involved in the demonstration project both annually and at the completion of the project.

A.17. Waiver of Exemption for Display of Expiration Date

The OMB clearance expiration date will be displayed on the questionnaire. No waiver is needed.

A.18. 5 CFR 1320.9: Exemptions to Certification for Paperwork Reduction Act Submissions

This information fully complies with the guidelines in 5 CFR 1320.9. There are no exemptions to this certification.

B. Collection of Information Employing Statistical Methods

B.1. Respondent Universe and Sampling Methods

The sampling plan for the RAC Provider Satisfaction Survey will be probability based so that study findings can be used to make statistically defensible inferences about the entire population of Medicare providers. Steps involved in the sample design are briefly described below.

B.1.1 Target Population. The target population for this survey includes all Medicare providers in the states of New York, Florida, and California who have had communication with a Non-MSP RAC or a Medicare Affiliated Contractor[4] in the past year. The three RACs include PRG Schultz, International (CA), Connolly Consulting (NY), and Health Data Insights (FL). Providers include hospitals, skilled nursing facilities, rural health clinics, dialysis centers, physicians, licensed practitioners, ambulance service providers, home health agencies, and Durable Medical Equipment (DME) Suppliers.

B.1.2 Survey Eligibility. This study will include only those providers under the Medicare program who provide services for which payment had been made under part A or B of title XVIII of the Social Security Act. Medicare Secondary Payer (MSP) non-beneficiary Group Health Plans are excluded from the study.

B.1.3 Sampling Frame. The sampling frame for this survey will include a list of all health care providers working in the states of New York, Florida and California (including both providers who have been contacted and providers who have not been contacted by the RAC in the past year). The frame will include contact information for each provider and will indicate the date of contact, if applicable, by a RAC and/or MAC. The files will be obtained both from CMS's RAC data warehouse and from internal files maintained by the Medicare Affiliated Contractors.

B.1.4 Statistical Methodology for Stratification and Sample Selection. The sample design for this study will be a stratified, systematic random sample of Medicare providers (e.g., a random start and a sampling interval equal to the universe stratum size divided by the desired stratum sample size). In this way, each provider on the sampling frame will be given a known, nonzero probability of selection so that weighted inferences can be made about the entire population of Medicare providers.

Four strata will be created consisting of 1) providers in FL contacted by Health Data Insights (the RAC in Florida), 2) providers in CA contacted by PRG Schultz (the RAC in California) and 3) providers in NY contacted by Connolly Consulting (the RAC in New York), and 4) providers in

[4] Providers that have not been contacted by a RAC typically have been contacted by a Medicare Affiliated Contractor such as a carrier, FI, or DMERC.

FL, NY and CA who have not been contacted by a RAC, but have been contacted by a Medicare Affiliated Contractor in the past year. Within each stratum, three substrata will be created based on the type of provider (e.g., hospitals, private/group practices, and/or equipment/regional suppliers). Sample allocations to sub-stratum will be accomplished using Chromy's probability minimum replacement selection methodology (Chromy, 1979). The substrata will be sorted by size of provider and zip code to ensure a representative sample within these groups.

Assuming an 80 percent response rate and a 90 percent eligibility rate, we plan to select approximately 1,667 providers to participate in this survey. Approximately seventy five percent (n=1,250 providers) will have been contacted by a RAC and twenty five percent (n=417 providers) will not have been contacted by a RAC in the past year.

B.1.5 Response Rates. Our goal is to achieve an overall response rate of 80 percent. Our response rate estimates are based on recent experience with other surveys involving providers including the Medicare Contractor Provider Satisfaction Survey. The surveys that we considered when determining a likely response rate for this survey included those using the same data collection methodology (telephone survey with follow-up of non-respondents) as well as similar subject matter and respondent burden (questionnaire length).

B.1.6 Reliability of Estimates. With an overall respondent sample of 1,200, we propose a sample size of 300 respondents for each of the four strata including the three RACs/states and the comparison group overall. With this sample size, ten percentage differences in percentage estimates between the states will be detected with 80 percent power. In addition, 95-percent confidence intervals (CIs) are expected to be less than ± 5.7 percent for percentages generated for each group. For example, assuming that the respondent sample size is 300 for Florida and the percentage of providers who were satisfied with their communication is 50 percent, then using a 95 percent confidence interval, in 95 out of 100 samples like the one selected the results should be no more than 5.7 percentage points above or below this figure.

In addition to making survey comparisons between the three RACs/states, comparisons will also be made between providers who have had communication with the RAC and those who have not to determine whether provider experiences with the RAC differ, on average, from provider experiences with the MAC. We plan to allocate the sample to achieve 900 cases (precision at most 3.3 percent) who have been contacted by a RAC and 300 who have not (precision at most 5.7 percent). This would allow us to detect differences between the two groups of 4.9 percent or more (called minimal detectable differences).

Another important research objective is to be able to make estimates for different types of providers, such as hospitals and group practices. Although the sample sizes will not be sufficient to make estimates about these provider types within states, the data will be pooled across strata in order to analyze differences between these classes of providers.

Assuming an expected response rate of 80 percent and an ineligible rate of 10 percent, we would

need to select approximately 1,667 sample cases to reach this goal. Follow up CATI methods will be used to ensure that the response rate goal is achieved.

B.1.6 Estimation Procedures. Following data collection, sample weights will be prepared based on the initial probability of selection and adjusted to 1) compensate for nonresponse, and 2) remove multiple selection opportunities. The end product will be final analysis weights suitable for use in analysis. This weighting scheme inflates the respondents' data to represent the entire universe of providers in the three demonstration states.

Although data management and simple summaries will be conducted using SAS v6.12, we will use SUDAAN v7.11 for standard errors and tests of significance. SUDAAN provides the correct computations for the standard errors by accounting for the design of the sample. Various multivariate and descriptive statistical techniques will be used to analyze the data, including crosstabulations and frequency distributions, t-tests, chi-square tests, and regression analyses including logit, multinomial logit and least squares methods. Direct variance estimates that reflect the sample design will be computed for each analysis variable, and will be used in all analytic comparisons of final results.

B.2. Procedures for the Collection of Information

The proposed survey is designed as a telephone survey using Computer Assisted Telephone Interviewing (CATI) with non-response telephone follow-up. The use of CATI is advantageous for several reasons; 1) it simplifies questionnaires by offering pre-programmed logic options that dictate how the interviewer proceeds through the questionnaire (e.g., the survey can skip irrelevant questions, perform calculations, and modify questions based on the answers to earlier questions); 2) it can check the logical consistency of answers; and 3) it can present questions or response choices in a random order (to limit the potential bias of ordering effects, or the first presented item having an impact on the outcome of following items). In addition, CATI data collection offers several advantages that can shorten the data collection period. For example, call attempts can be scheduled to maximize the chances of reaching the intended respondent, and interviewers can often obtain immediate locating information when the contact information on file is incorrect. CATI often yields better quality data than mail surveys, thanks to pre-programmed skips and data fills, which reduce respondent error and burden, and the presence of an interviewer, who can help reduce item level nonresponse, and, when refusal conversion specialists are used, unit level nonresponse.

We believe that, overall, CATI would yield a higher response rate for this study than other modes of data collection, with an anticipated response rate of over 80 percent for the final results. In addition, CATI will improve the quality of the data by ensuring that the most knowledgeable respondent is interviewed for the survey.

The data collection methodology will include the following:

- The CATI instrument will be developed, tested and programmed to assign interim and final status codes to track refusal, ineligible, and unlocatable cases;

- A survey management system will be programmed to track completed cases, partially completed cases, call history, and locating history;

- A training program will be developed and interviewers will be thoroughly trained on all aspects of the study.

- Prior to the start of data collection, a comprehensive review of phone numbers and potential phone number look-ups will determine the quality of the contact information;

- An initial pre-notification letter will be sent to all sample members via first class mail informing sampled individuals of the survey, its voluntary nature, the legislative authority under which the survey is conducted, and the Privacy Act provisions;

- Telephone interviewers will begin calling sample members two weeks after the advance letter mailing;

- Screening questions will be used to located the most knowledgeable respondent for the survey (for example: preliminary research informed us to initially ask for the RAC liaison or Health Information Management director);

- During data collection, trained locators will conduct intensive tracing to obtain updated phone numbers for non-respondents whom interviewers have been unable to reach,

- Tracing efforts using commercial locating databases and directory assistance will be done to obtain either new addresses or updated phone numbers to locate non-respondents, resulting in an update of any new information obtained from searches;

- Response rates will be monitored and analyzed by completed cases by time of day and days of the week to optimize calling times; and

- Refusal conversion calls will be made by specialists trained in refusal conversion.

The survey is cross-sectional. No future contacts are planned after a completed questionnaire is returned and/or the interview is completed by phone.

B.3. Methods to Maximize Response Rates and the Issue of Non-Response

The methods described above have been proven in methodological research to yield response rates of 80 percent when the survey is of reasonable length and sample members consider the topic salient. The following strategies will be used to help achieve this response rate:

- Personalized pre-notification letters;
- Endorsements from key organizations such as the American Hospital Association, etc.
- Strategically scheduled follow-up attempts;
- Survey sponsorship by a recognized agency;
- A brief introduction that underscores the saliency of the survey topic for sample members;
- Interviewer training that addresses potential obstacles in reaching or communicating with providers and offers strategies for overcoming these obstacles;
- A toll-free number for respondents with questions. Survey staff at Econometrica will receive and respond to these calls.
- Locating efforts using commercial locating databases and directory assistance in an effort to obtain updated phone numbers for unreachable sample members.

The most important of these factors is the number of contacts, including the pre-notification letter and telephone follow-up calls. The pre-notification letter will be mailed from CMS prior to contacting the sample members to complete the interview. The letter will be printed on CMS letterhead and will briefly explain the purpose of the study and the reasons why sample members should volunteer their time. The letter will also include the estimated completion time of the survey, and assurances of confidentiality. Stating the sponsorship of the survey helps to engage sample members by providing immediate assurance that the survey is legitimate and not an attempt to sell them something. The likelihood of acceptance is greatly increased when sample members are told early why the survey is being conducted and why their responses are important.

Prior to data collection, efforts will be made to identify the most appropriate respondent. The selected respondent should be the person most knowledgeable about the provider's experience with a RAC. The most knowledgeable person could be a physician, office manager or a staff member in the Billings Department. A set of screener questions will be added to the beginning of the questionnaire to identify which person is the most appropriate respondent.

B.4. Tests of Procedures

Four discussion groups were conducted with potential respondents in New York and Florida, during which the questions were tested and additional issues identified. Many of the changes in instructions, and question wording were made as a result of the focus groups. The telephone data collection procedures themselves have been well-tested on providers.

B.5. Consultants

Technical

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APPENDIX A

Sample Version of Advance Letter

Date

RECIPIENT NAME
ADDRESS

Dear [NAME],

I am contacting you to request your participation in a brief survey to address the impact of Medicare Recovery Audit Contractors (RACs) on health care providers in your state. As part of a new demonstration project, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program, has recently hired [name RAC] in your state to identify and rectify erroneous payments made by Medicare to health care providers.

As a Medicare provider, you deserve to get the highest quality of service from our contractors. CMS makes it our responsibility is to ensure that Medicare payments to providers are made accurately and fairly. One of the ways we can fulfill that responsibility is to find out directly from you about your experiences with our contractors.

You, along with 1,200 other providers, have been selected because of your recent experience with a RAC or a Medicare Affiliated Contractor. Within the next week or so, you will receive a telephone call from a representative at Insight Policy Research asking you to participate in a brief survey. The survey will last about 10-15 minutes. Results from the survey will be used by the CMS to inform future program and policy decisions and to make recommendations to the U.S. Congress.

Please be assured that all information you provide will be kept completely confidential and is protected by the Privacy Act. Your name will never be linked to your answers. **You do not have to participate in this survey. Your help is voluntary, and your decision to participate or not to participate will have no effect on your Medicare payments.** If you have any questions about the survey or would like more information, please call Wayne Slaughter toll-free at 1-800-xxx-xxxx Monday through Friday between 9:00 am and 5:00 pm Eastern Time.

We hope that you will take the opportunity to answer the questions and help us to serve you better. The accuracy of the results depends on getting answers from you and other providers selected for this survey. Thank you in advance for your cooperation.

Sincerely,

Project Officer
Centers for Medicare and Medicaid Services

APPENDIX B

Provider Satisfaction Survey