July 25, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted Electronically: www.reginfo.gov/public/do/PRAMain

Re: Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Dear Administrator Brooks-LaSure:

UnitedHealthcare (UHC) is pleased to respond to the Center for Medicare & Medicaid Services Request for Information for Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, published in the Federal Register on June 25, 2024 (89 FR 53107). UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UHC is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

UHC supports the removal of the wait time question from the survey ("Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?"). This question is no longer used in the composite score calculation for the Getting Appointments and Care Quickly star measure starting with the 2024 survey, therefore is no longer needed and can be removed to reduce survey length burden.

UHC also strongly requests that CMS provide health plans with the respondent-level CAHPS survey data as soon as possible following the survey period. Sharing CAHPS respondent-level survey questionnaire responses will allow for a more detailed validation of results during plan preview and help plans better understand how to improve member experience. We propose that respondent-level data from the survey conducted in 2024 would be shared with health plans at the beginning of the first plan preview in August 2024 or sooner, which would allow health plans time to improve member experience ahead of the following survey.

In the CY 2021 final rule, CMS expressed concerns about the "confidentiality and validity" of sharing survey responses with plans[1]. However, neither is at risk should the data be shared. For the Health Outcomes Survey (HOS), CMS already provides respondent-level data which has allowed us to gain a better understanding of our members' barriers to improving health outcomes, indicating there is no barrier to sharing responses with plans. There is also no issue with validity as plans do not know in advance who will be in the survey sample and do not have an opportunity to improve member experience merely for those in the sample. Rather, once plans receive the respondent-level data they will be able to conduct improvement focused research to better identify root causes that may be impacting a member's experience. Members ultimately decide what plans they are enrolled in and there would be absolutely no incentive for plans to do anything beyond use the information and insights to better identify root cause issues that may be impacting members to focus improvement efforts.

The survey already has a question asking if the "Medicare Program" can follow-up with respondents. Nearly half of respondents select 'Yes'. This indicates a strong beneficiary interest for their responses to potentially drive experience improvements. In fact, members who selected 'Yes' may be expecting follow-up from their plans only to be disappointed when plans do not.

Finally, it is not sufficient to rely on survey vendors in lieu of providing the respondent-level data to plans. While vendors are able to conduct analyses with the respondent-level data, they are limited in their capabilities and expertise. Vendors are not able to append additional health plan member data without CMS approval of each data field, which is a long and cumbersome process. Additionally, vendors do not have the health plan expertise that is needed to review and analyze the data across multiple member experience touchpoints including call interactions, engagement with doctors, and filling prescription medications.

We appreciate CMS's consideration of our comments. Please feel free to contact me if you have any questions.

Sincerely,

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[1] Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program
https://www.federalregister.gov/d/2020-11342/p-472