

Kaiser Foundation Health Plan, Inc. (“Kaiser”) appreciates the opportunity to comment on CMS’s proposed revision of a currently approved information collection titled: Consumer Assessment of Health Care Providers and Systems (CAHPS), published in the Federal Register on April 19, 2010.

CMS seeks approval to continue to annually conduct the Medicare CAHPS surveys in order to satisfy the requirement under Section 1860D-4 of the Medicare Prescription Drug Improvement and Modernization Act (MMA). As part of this requested approval, CMS proposes to require MA organizations, Part D sponsors, and Section 1876 Cost Contractors to be financially responsible for the costs of the data collection required by the annual CAHPS surveys beginning in 2011. Moreover, CMS proposes additions, deletions and modifications to the CAHPS surveys to be used in 2011. Kaiser provides comments to the proposed CAHPS survey as set forth below.

### ***General Comments related to CAHPS Data***

#### **Individual-Level Data Files**

Historically CMS released CAHPS data to the surveyed Medicare Advantage plans in an aggregate format wherein a summary of the collected data was provided to the plan in a pdf-formatted report, and an Excel file containing frequencies of survey responses. While plans such as Kaiser value the provision of such summaries, there is greater value to the health plans if individual-level or member-level data files, that have personally identifying member information removed, are provided instead. By having the data provided to the plans on a member-level, plans such as Kaiser are able to use the data for further analyses and quality assessment of its health plan operations. Kaiser does stress, however, that the provision of such individual-level data would be on a non-personally identifiable basis. The goal of the obtaining such raw data is to allow the plan to conduct more refined analyses of the CAHPS results, such as drivers analyses of Health Plan Rating, relationships between individual CAHPS measures, and geographic variation within and between Kaiser plans. As such, Kaiser strongly urges CMS to release the collected CAHPS data to surveyed plans in individual-level data files.

#### **Geographic Indicators within a Contract**

Closely linked to the above-stated data request, Kaiser strongly urges CMS to provide CAHPS data from membership within a particular Medicare contract number to include a geographic indicator. For example, Kaiser’s contract H0524 covers the majority of the geographic area of California. Although the service area of Kaiser’s H0524 contract covers much of the state, the administrative functions and providers for this contract are organized separately and distinctly in northern and southern California. As such, Kaiser seeks to obtain CAHPS data on its membership within this particular contract to include a generic individual-level indicator to classify the respondent member as part of the northern or southern California region. The provision of such a geographic indicator within the CAHPS individual-level data file would afford Kaiser and health plans with

various regions within a particular contract, to more accurately analyze the data and conduct region-specific performance assessments.

If CMS decides not to release individual-level data files, we request that CMS provide Kaiser with separate reports and summary level data files for our Northern and Southern California Regions under H0524.

### Relevance of Trending

The value of the Medicare CAHPS data is not only limited to the particular contract year being surveyed, but the trending of the data collected over time. Frequent changing of the survey questions and substantial changes to the survey itself, however, may lead to issues with respect to trending the data collected from the survey. Significant changes to the survey, as proposed in the Federal Register, could result in the lack of relevance in the trending of data collected from the CAHPS survey. An example of this risk is seen in the change from CAHPS 3.0 to CAHPS 4.0 that occurred in 2007. The substantial changes that occurred between CAHPS 3.0 and 4.0 resulted in a lack of relevance in terms of data trending, as the question wording, response categories used, question placement and respondents' answers were not comparable across most of the items in the two versions of the questionnaire. For this reason, Kaiser raises this issue as a concern for CMS to consider in its final assessment of the revised CAHPS survey for 2011, and when considering future changes to the questionnaire.

### ***CAHPS Data and the Star Ratings***

According to the changes set forth under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, Medicare Advantage plans will be subject to a pay for performance quality bonus system starting in 2012. The source of the quality bonus is a plan's Star Rating calculated and published by CMS annually. A significant component of the CMS Star Rating is the plan's scores on the Medicare CAHPS survey. In order for all plans to be better able to assess their performance on individual measures assessed in the CAHPS survey, Kaiser urges CMS to publicly release, in a convenient electronic file format, the individual, case-mix adjusted scores for each CAHPS survey measure for each and every plan completing the Medicare CAHPS. In addition, Kaiser urges CMS to publish the case-mix adjusted score values associated with the national percentile thresholds used in the formula to assign the number of stars to the CAHPS measures. The intent of this request is twofold: First, the provision of the case-mix adjusted scores for each of the individual measures for all plans affords the plans the opportunity to assess their performance relative to external benchmarks, and to better understand the specific areas where they are performing well and where they need to improve. Second, the provision of these scores affords the plans the ability to discern how much they may need to improve to be competitive with its competition and the industry nationally. This ability to compare itself to other plans will afford plans the opportunity to make better, more informed assessments of their performance and develop priorities for quality improvement.

### ***Proposed Question Changes***

Kaiser recommends that in the first year of administering the revised CAHPS survey CMS not publicly distribute scores from the new questions; although each plan should be provided their scores from the new measures, as well as relevant national and regional comparisons, such as means and percentile thresholds. Not publicly releasing scores from the new measures in the first year has two distinct benefits: First, it allows CMS an opportunity to evaluate the validity, reliability, usefulness, and psychographic properties of the new measures. Second, it allows plans the opportunity to address service improvement priorities based on their members' responses, before the results are made public. Not publicly releasing first year measures is also consistent with the National Committee for Quality Assurance's standard operating policies.

### ***MA Only Survey***

<b>Question</b>	<b>CMS Proposed Action</b>	<b>Kaiser Comment</b>
30 – How satisfied are you with the help you received to coordinate your care in the last 6 months?	Addition	Kaiser has some concerns about how consistently respondents will interpret “coordinate care.” In addition, the responses will likely vary for those members with complicated conditions. To be comparable, the scores should be case-mix adjusted for the presence (or number) of chronic conditions, as well as health status.
41 – Did an insurance agent or broker ever call you without your asking them to, to tell you about insurance for health care or prescription medicines?	Addition	GENERAL COMMENT FOR THIS SET OF QUESTIONS: If the respondent is a long-term member of the plan (e.g., joined the health plan five or more years ago), then the information collected from this member will not reflect current behaviors. Analysis of these questions should be stratified by respondents' length of membership in the plan. For example, scores should only be reported for respondents who have been with the health plan two years or less. The intent of the questions about insurance agents or brokers is not
42 – Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for health care or prescription medicines?	Addition	
43 – Did an insurance agent or broker ever switch you to a different health care plan without your permission?	Addition	

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		<p>clear. Does CMS intend to attribute the behaviors of insurance agents and brokers to the health plan? These questions should only be used to assess generally Medicare beneficiaries' experiences with brokers and agents. First, agents and brokers operate independently from health plans as they are contractors of the health plan. Second, the questions do not link the agent or broker to any specific health plan. The agent or broker may have represented a plan other than the one chosen by the respondent. Third, based on our research experience, consumers often cannot tell the difference between an insurance company's employed sales representative and an independent insurance agent or broker. Fourth, for plans such as Kaiser that do not engage contracted, independent agents and brokers, questions probing respondent's experiences with agents and brokers (which are not used by the plan) will be confusing and likely result in invalid responses.</p>

***MA-PD Survey – Proposed Additions***

Question	CMS Proposed Action	Kaiser Comment
30 – How satisfied are you with the help you received to coordinate your care in the last 6 months?	Addition	Kaiser has some concerns about how consistently respondents will interpret “coordinate care.” In addition, the responses will likely vary for those members with

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		complicated conditions. To be comparable the scores should be case-mix adjusted for the presence (or number) of chronic conditions, as well as health status.
41 – Did an insurance agent or broker ever call you without your asking them to, to tell you about insurance for health care or prescription medicines?	Addition	GENERAL COMMENT FOR THIS SET OF QUESTIONS: If the respondent is a long-term member of the plan (e.g., joined the health plan five or more years ago), then the information collected from this member will not reflect current behaviors. Analysis of these questions should be stratified by respondents' length of membership in the plan. For example, scores should only be reported for respondents who have been with the health plan two years or less.  The intent of the questions about insurance agents or brokers is not clear. Does CMS intend to attribute the behaviors of insurance agents and brokers to the health plan? These questions should only be used to assess generally Medicare beneficiaries' experiences with brokers and agents. First, agents and brokers operate independently from health plans as they are contractors of the health plan. Second, the questions do not link the agent or broker to any specific health plan. The agent or broker may have represented a plan other than the one chosen by the respondent. Third, based on our research experience, consumers often cannot tell the difference between an insurance company's employed sales representative and an
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		independent insurance agent or broker. Fourth, for plans such as Kaiser that do not engage contracted, independent agents and brokers, questions probing respondent's experiences with agents and brokers (which are not used by the plan) will be confusing and likely result in invalid responses.
44 – Was there ever a time when you believed you needed care or services that [plan name] decided not to give you?	Addition	Kaiser sees this question as problematic for multiple reasons. The recall period “ever a time” is radically different from the typical six month recall period used in the questionnaire. The open-ended recall period will likely result in much more measurement error (faulty recall) than the six month recall period. Second, many respondents may have had the same insurance carrier prior to becoming Medicare eligible, and prior to joining the carrier's Medicare plan. There is likely to be some confusion for respondents on whether they should report experiences only while they have been enrolled in the carrier's Medicare plan, or at any time that they have been covered by the carrier.
46 – When you spoke to [plan name] about the decision not to provide care or services . . .	Addition	The term “resolve” is likely to be interpreted by respondents to mean, “they got what they wanted,” or that they are satisfied with actual decision made regarding their complaint or appeal. The actual decision about the complaint or appeal may not be in the control of a health plan (e.g., patient may think that they are entitled to a non-covered

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		Medicare benefit). Therefore, this question confuses two concepts: (1) did the health plan follow the correct procedures, in a timely manner, to address the member's complaints and appeals, and (2) is the member satisfied with the decision made regarding the complaint or appeal.
48 – How long did it take for [plan name] to resolve your complaint?	Addition	Suggest changing “to resolve your complaint” to “to settle your complaint.” See reasons outlined in comments to question 46 above.

***Medicare Stand Alone Prescription Drug Plan Survey***

Question	CMS Proposed Action	Kaiser Comment
7 - Did an insurance agent or broker ever switch you to a different Medicare Prescription Drug Plan without your permission?	<b>Addition</b>	The intent of this question about insurance agents or brokers is not clear. Does CMS intend to attribute the behaviors of insurance agents and brokers to the health plan? This question should only be used to assess generally Medicare beneficiaries' experiences with brokers and agents. First, agents and brokers operate independently from health plans as they are contractors of health plans. Second, the questions do not link the agent or broker to any specific health plan. The agent or broker may have represented a plan other than the one chosen by the respondent. Third, based on our research experience, consumers often cannot tell the difference between an insurance company's employed sales representative and an

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		independent insurance agent or broker. Fourth, for plans such as Kaiser that do not engage contracted, independent agents and brokers, questions probing respondent's experiences with agents and brokers (which are not used by the plan) will be confusing and likely result in invalid responses.

For the foregoing reasons, Kaiser recommends that CMS further revise the proposed CAHPS survey to better reflect and probe the quality of the interactions between the health plan and their members. The survey, as currently proposed, contains some ambiguous or confusing survey questions that do not properly assess member satisfaction with their health plan. Rather, it is likely that these ambiguous questions will result in distorted perceptions of health plans and their interactions with members rather than meaningful data with which to assess Part C and D sponsors. Moreover, Kaiser recommends the release of CAHPS survey data, as outlined above, to health plans in order to provide them with the analytical tools to better assess their own operations and performance as well compare their performance against competing health plans.

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Thank you for your consideration of Kaiser Permanente's views. Please do not hesitate to contact me at [Lorilyn.M.Rosales-Menzel@kp.org](mailto:Lorilyn.M.Rosales-Menzel@kp.org) or (510) 271-6310 with any questions.