

**COMMENTS OF KAISER PERMANENTE ON
DISENROLLMENT REASONS SURVEY IN APRIL 23, 2010
COMMENT REQUEST
CMS - 10316/OMB#0938-NEW**

Kaiser Foundation Health Plan, Inc. and its subsidiary Kaiser Foundation Health Plans (collectively “Kaiser”) contract with CMS as Medicare Advantage Organizations (MAOs) and Medicare Cost contractors sponsoring Part D benefits. Kaiser is thus subject to requirements to collect and report performance data for Part D prescription drug plans such as the proposed survey as set forth in the Federal Register on April 23, 2010. Kaiser appreciates the opportunity to comment on CMS’s proposed information collection titled: Medicare Prescription Drug Plan (PDP) and Medicare Advantage Prescription Drug Plan (MA-PD) Disenrollment Reasons Survey.

CMS is proposing a survey whose purpose to obtain information about beneficiary reasons for disenrolling from their chosen Part D or MA-PD plan and as well as beneficiary expectations relative to provided benefits and services. Kaiser provides comments on the proposed Disenrollment Reasons Survey as set forth below.

Supporting Statement

According to Section B1 (“Respondent Universe and Sample”), “a total of 120,000 disenrollees from July 2010 through March 2011 will be sampled” There is no indication of whether this sample will be comprised of only voluntarily disenrolled beneficiaries or both voluntarily and involuntarily disenrolled beneficiaries. The initial sentence of both the prescription drug plan (PDP) and Medicare Advantage with Prescription Drug coverage plan (MA-PD) surveys, however, states that “We are sending you this survey because we believe you recently left, switched or *were dropped*” by a health plan or PDP. From this, it appears that CMS intends to survey both voluntary and involuntary disenrollees. The inclusion of involuntarily disenrolled beneficiaries does not appear to further the intended goals of the survey. Involuntarily disenrolled members did not exercise their own choice to leave their Part D plan. CMS says the survey is intended to question beneficiaries as to the *actual* reasons they *chose* to disenroll. Inclusion of involuntarily disenrolled members is inappropriate and could skew the data collected in this survey. For these reasons, Kaiser recommends that involuntarily disenrolled members, to the extent identifiable in the CMS data systems, be excluded from the survey universe and ultimate survey sample.

Kaiser also has concerns regarding the timing of the initial mailing of the survey packet to disenrolled beneficiaries. According to Section B2 (“Information Collection Procedures”), it is “important to survey disenrollees relatively soon after their disenrollment experience”, however, the timeframe in which the first survey packet will be sent out to disenrollees is not clear. It is merely explained that a beneficiary will be mailed a survey packet with a CMS cover letter; no time frame specified. Is it the intent of CMS to have the initial survey packets sent out within a short period of time (e.g. one or two weeks) after the beneficiary has disenrolled from the Part D plan or within a more

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open period of time (e.g. one to four weeks)? Although the timing of the subsequent contacts to the beneficiary is set forth in the information collection procedures, the timing of the initial contact is unspecified. The timing of surveying beneficiaries after disenrollment should be consistent among the surveyed beneficiaries from the various Part D plans across the country. As time passes from when a beneficiary disenrolled from his/her prior Part D plan, it is possible that his/her opinions regarding the prior plan may change. In order to minimize this possibility, or at least even the temporal bias that may occur over time to all plans, Kaiser requests that CMS establish a specific time frame in which the initial contact to the beneficiaries will be made and apply such time frame uniformly to all Part D sponsors when disenrolled beneficiaries will be surveyed.

Kaiser seeks clarification from CMS as to ultimate intent of the disenrollment reason survey. While the Supporting Statement expressly states that the survey is to take place over the nine-month period of July 2010 through March 2011, there are indications in the Supporting Statement that this survey may have more use in the future. For example, in the "Background" it is stated that the information obtained from this survey "can be used by CMS to improve the design and functioning of the Part D program" and "quality improvement and oversight." This sentiment is echoed in the "Justification" ("The data collected in this survey can be used to improve the operation of Medicare Advantage (MA) and Part D (PDP) plans...") and the "Publication/Tabulation Dates" ("The extent to which contract-level data disenrollment rates for the applicable reasons ... correlate with contract-level CAHPS beneficiary assessments has important implications ... and may influence CMS' future interest in reporting disenrollment information.") These uses of the information are longer-term uses that benefit from data aggregated over time. The data collected in a one-time survey only yields a single snapshot over the one survey period. In order to more effectively obtain data for improvement of the Part D program, improvement of the Part D sponsors collectively and oversight of the individual sponsors, it would seem that repeated use of the proposed survey would be indicated. While the survey is identified as a one-time survey, are there intentions of using it as a repeated survey? Kaiser seeks clarification as to the foreseeable uses of this survey in the future and if it will be a repeated survey conducted by CMS.

Medicare Disenrollee Survey: Medicare Advantage with Prescription Drug Coverage (OMB Version) (Attachment 4)

Question	Comment
3	<p>"Customer Service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from [PLAN NAME]'s customer service?"</p> <p>The definition of "customer service" in this question does not seem adequate and does not reflect what people think of when they refer</p>

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Question	Comment
	to “customer service.” Customer service departments provide more services and functions than simply handing out information. As such, the provided definition seems confusing. Kaiser suggests the revision of the definition of customer service in Q3 to provide the respondents with a more accurate description of customer service such as the following: “Customer service is a department within your former health plan responsible for answering questions about your membership, benefits, grievances and appeals.”
4	<p>“How often did the plan’s customer service give you the information or help you needed?”</p> <p>The definition of “customer service” as set forth in Q3 is problematic when combined with the wording of Q4. Substituting in the definition from Q3 gives you the following: “How often did information you get from the plan’s staff give you the information or help you needed?” Kaiser suggests that the definition in Q3 be revised as set explained above in Comment 3 to provide respondents with a more precise definition and as such, more logical language in Q4.</p>
6 & 8	<p>Response Option 5 in both questions starts as follows: “I did not try and get information about”</p> <p>Kaiser suggests that the language be revised as follows: “I did not try to get” This revision is a grammatical improvement and agrees with the text of the question. In the alternative, Kaiser suggests that this response option be deleted altogether. It is not needed because Q5 and Q7 instruct respondents to skip Q6 or Q7 if they did not try to get information about prescription medicines.</p>
9 & 10	<p>Response Option 5 in Q10 states that “I did not need written information in a language other than English.”</p> <p>Kaiser suggests that this response option be deleted altogether. It is not needed because Q9 instructs respondents to skip Q10 if they did not need written information from the plan in a language other than English.</p>
11 & 12	<p>Q11: “Did you ever try to get any kind of care, tests, or treatment through the plan?”</p> <p>Q12: “How often was it easy to get the care, tests, or treatment you thought you needed through the plan?”</p>

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Question	Comment
	<p>These two questions do not lead to consistent interpretation and results for respondents enrolled in different types of HMOs (Staff/Group versus Network/IPA).</p> <p>Members of staff/group model HMOs do not generally differentiate between the health plan and the care delivery systems. Kaiser's research has showed that members of staff/group model HMOs are more likely to think of these two questions as typical access questions (e.g. difficulty making appointments and wait times). Members of network/IPA model HMOs are more likely to interpret these questions as the health plan creating administrative barriers (e.g. forms to obtain and have doctors complete and fax to health plan, phone calls to be made by doctor to health plan) to members getting care from the respondents' doctors. The differences in interpretation of these questions based on the type of HMO the respondent is enrolled in may lead to inconsistent results. Kaiser suggests clarifying the language in Q12 to better direct the respondents to comment on their experience with the health plan itself and their perception of barriers presented by the plan in terms of their ability to get care and treatment. Kaiser suggests Q12 be revised as follows: "How often did the health plan make it difficult for you (e.g. forms to fill out, phone calls to be made by your doctor to the health plan, etc.) to get the care, tests, or treatment you thought you needed through the plan?"</p>
15 & 16	<p>Response Option 5 in Q16 states that "I did not use the plan to fill a prescription at a local pharmacy."</p> <p>Kaiser suggests that this response option be deleted altogether. It is not needed because Q15 instructs respondents to skip Q16 if they did not use the plan to fill a prescription at a local pharmacy.</p> <p>Moreover, there may be some confusion with the term "local" pharmacy. It is not clear what distinction is being made by classifying a pharmacy as "local". What are "non-local" pharmacies? Does "local" depend on how far away they are from the respondents' homes? It is suggested that the term "local pharmacy" be defined for the respondent to provide a clearer question to which he/she can respond.</p>
17 & 18	<p>Response Option 5 in Q18 states that "I did not use the plan to fill a prescription by mail."</p>

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	Kaiser suggests that this response option be deleted altogether. It is not needed because Q17 instructs respondents to skip Q18 if they did not use the plan to fill a prescription by mail.
19	<p>“Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate the plan?”</p> <p>The placement of Q19 seems problematic. It follows a string of questions about prescription drug benefits and services. The responses to this question will be heavily influenced and highly correlated to responses to the preceding prescription questions. But the respondent may also think of other aspects of the health plan. If CMS wants respondents’ overall impressions of the health plan this question should be placed at the front of the questionnaire, before Q3. If, however, the intent is to obtain respondents’ impressions of their former plans’ Part D benefits and services, then Kaiser suggests that the question be revised to instruct respondents to think about Part D benefits and services when answering the question.</p>
20	In the introductory paragraph before Q20, Kaiser suggests the addition of a statement explaining that respondents might have multiple reasons for switching and/or dropping their former plan and that CMS is interested in capturing all their reasons.
45	<p>At the end of the section entitled “Other Reasons for Leaving Your Former Health Plan”, the survey asks the respondent in Q53 “What was the <u>one most important reason</u> you left [PLAN NAME]?”</p> <p>Kaiser suggests that a similar question should be asked in the section entitled “Reasons You Left Your Former Health Plan” after Q45: “Which of the above is <u>the most important reason</u> you left [PLAN NAME]?”</p>
46	Before Q46, Kaiser suggests that an introductory paragraph similar to that located before Q20 be added. The introductory paragraph should contain a statement explaining that respondents might have multiple reasons for switching and/or dropping their former plan and that CMS is interested in capturing all their reasons.
54-58	GENERAL COMMENT FOR THIS SET OF QUESTIONS: If the respondent was 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 attributes of the health plan. Analysis of these questions should be stratified by respondents’ length of membership in the plan. For example, scores

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Question	Comment
	should only be reported for respondents who have been with the health plan two years or less.

For the foregoing reasons, Kaiser recommends that CMS revise the proposed Part D disenrollment survey to better reflect and probe the quality of the interactions between the Part D sponsors and their members. The survey, as currently proposed, contains some ambiguous or confusing survey questions that do not properly assess member dissatisfaction with their Part D plan. These ambiguous questions could result in distorted perceptions of Part D sponsors and their interactions with members rather than meaningful data with which CMS may assess the performance of Part D sponsors.

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If CMS personnel have questions about these Comments or seek further information, please contact Carl Serrato (Carl.A.Serrato@kp.org, (510) 271-6659) or Lorilyn Rosales-Menzel (Lorilyn.M.Rosales-Menzel@kp.org, (510) 271-6310). Thank you.