BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4780

TO: Office of Management and Budget, Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

From: Jane Galvin, Managing Director, Regulatory Affairs

Date: October 17, 2011

Re: Form Number CMS-R-246: Comments on "Medicare Advantage, Medicare Part D and Medicare Fee for Service Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

The following are comments on the PRA as issued in the Federal Register on September 16, 2011 regarding the CAPHS survey.

1. **Medicare Satisfaction Survey, MA and MAPD Survey pages 24 and 43 respective, question 50**

The question presently reads: "Thinking about the complaint process, regardless of whether you agree or disagree with the final outcome, how satisfied are you with how your health plan handled your complaint?" The beneficiary is then provided with the following options: "Very dissatisfied, Somewhat dissatisfied, Neither dissatisfied nor satisfied, Somewhat satisfied and Very Satisfied."

This language fails to provide the beneficiary with an explanation of how these categories are ranked, provides a negative rather than a positive outcome in the initial options available to the beneficiary, and may appear misleading to the beneficiary. Health plans suggest that the question be rephrased along the follow lines: "Were you satisfied with the outcome of your complaint process?" or "Did you agree with the final resolution of your complaint process?" Beneficiaries should be given the option of answering "yes" or "no".

In addition, we recommend the following question be added to the survey: "Could the plan have done something differently while working with you on your complaint?" Beneficiaries could be given the following options for a response: "Responded more timely", "Contacted you directly", or "Explained their answer more thoroughly".

Our modifications would simplify the questions for the beneficiary and obviate the need for them to distinguish between the various levels of dissatisfaction versus satisfaction that the CMS proposed question contains. At the same time our modifications would allow beneficiaries to provide plans with meaningful feedback on how they can implement changes to improve their complaint resolution process.

2. **Medicare Satisfaction Survey, 2012 Prescription Drug Plan Survey, question 14, page 59**

The question presently reads: "Thinking about the complaint process, regardless of whether you agree or disagree with the final outcome, how satisfied are you with how your plan handled your complaint?" Beneficiaries are provided with the following options for responding: "Very dissatisfied", "Somewhat dissatisfied", "Neither dissatisfied nor satisfied", "Somewhat Satisfied", and "Very Satisfied".

This language fails to provide the beneficiary with an explanation of how these categories are ranked, provides a negative rather than a positive outcome in the initial options available to the beneficiary, and may appear misleading to the beneficiary. Health plans suggest that the question be rephrased along the following lines: "Were you satisfied with the outcome of your complaint process?" or "Did you agree with the final resolution of your complaint process?" Beneficiaries should be given the option of answering "yes" or "no".

In addition, we recommend the following question be added to the survey "Could the plan have done something differently while working with you on your complaint?" Beneficiaries could be given the following options for a response: "Responded more timely", "Contacted you directly", "Explained their answer more thoroughly".

Our modifications would simplify the questions for the beneficiary and obviate the need for them to distinguish between the various levels of dissatisfaction versus satisfaction that the CMS proposed question contains. At the same time our modifications would allow beneficiaries to provide plans with meaningful feedback on how they can implement changes to improve their complaint resolution process.

3. **Medicare Satisfaction Survey, 2012 Prescription Drug Plan Survey question 15, page 59**

The question presently reads: "How long did it take for your plan to settle your complaint?" Beneficiaries are provided with the following options for responding: "Same day", "1 week", "2 weeks", "3 weeks", "4 or more weeks", and "I am still waiting for it to be settled".

This language combines several aspects of the complaint process and may be misleading to the beneficiary. Health plans suggest that the question be broken into several questions along the following lines:

a) "Was your complaint answered in writing?" Beneficiaries should be given the option of answering "Yes" or "No".
b) "How long did it take for you to get an answer your written complaint?" Response options could include: "One to Two Weeks", "Three Weeks to One Month", "Six Months", or "I am still waiting for a response".
c) "Was your complaint answered over the phone?" Beneficiaries should be given the option of answering "Yes" or "No".
d) "How long did it take for the complaint to be settled over the phone?" Response options could include: "Immediately", "One to Two Weeks", "Three Weeks to One Month", "Six Months", and "I am still waiting for a response".

These revisions would allow for the distinction between how complaints were handled over the phone versus a written response and specifically spell out the timeliness of the response.

4. **Medicare Satisfaction Survey, 2012 Prescription Drug Plan Survey question 16, page 60**

The question presently reads: "Was your complaint or problem settled to your satisfaction?" Beneficiaries are provided with the following options for responding: “Yes”, “No”, and “I am still waiting for it to be settled."

This language fails to take into account those situations where the plan is working diligently with the beneficiary to resolve the complaint or those situations where the beneficiary may not be pleased with the results but received the correct response from the plan. In addition while CMS specifies timeframes within which certain types of complaints must be addressed by the plan this information is not always shared with the beneficiary. This lack of information may in turn create false expectations for the timeframe within which the plan must respond to a complaint resulting in the beneficiary negatively scoring a plan's response to their complaint.

Health plans suggest the question be rephrased along the following lines: "Where does your complaint stand now?” Beneficiaries could be given the following response options: “Resolved”, “Working on it”, and “No response received".

Our modifications take into account the nature of the complaint as it stands now which directly impacts whether it was resolved to the beneficiary's satisfaction. The survey would be more transparent and of better statistical use to CMS and the plans if the beneficiaries were asked if the complaint was resolved, in process, or never followed up on.

Thank you for the opportunity to provide comment. Questions on these comments may be directed to Jane.Galvin@bcbsa.com or by phone at 202 626 8651.