**Evaluation of Care and Disease Management Under Medicare Advantage Survey**
**Response to 60-day FR Notice Comments**
**CMS-10255**

We were very pleased to receive the thorough and thoughtful comments through the public comment period. The team reviewed comments, mapped each comment to the research questions and goals set forth in the statement of work, and made decisions based on relevance to study goals and potential impact on survey length and subsequent respondent burden. Data and findings from the survey will be presented in an aggregate format in which individual health plans are not identified. The report containing the survey findings will be available following CMS review and approval for public release.

A number of comments appeared to request adding questions to the survey instrument. While some would indeed provide interesting information, the team felt they were either beyond the scope of the project or could be addressed through other portions of the study and thus not justify increasing respondent burden. Other suggestions requested information that was already being asked in the survey, and may not have been readily apparent to the reviewers.

For those comments that were felt to have scope-relevant importance and nominal impact on respondent burden, the project team made four changes to the survey instrument. These changes are detailed below.

1) For questions B9 and C10 about how plans proactively identify members who need care or disease management, the instructions over the answer categories have been changed from "MARK ONE" to "MARK THE MOST COMMON". There was a comment on providing the ability to check all that apply instead of only one because it is different for different methods and the commentor's organization used them all. In response to this comment we changed the instructions to collect only the most common frequency, as allowing respondents to check all that apply could potentially dilute the value of information captured by this question. This change should not increase respondent burden.

2) A new question B10a has been added after question B10:

**B10a. Do care managers serve only members covered under this (Medicare) contract, or do they also serve members covered under other (non-Medicare) contracts?**

1 ☐ Care managers serve only members with Medicare

2 ☐ Care managers also serve younger members covered under commercial contracts or other non-Medicare covered members

This question was added because it is important that care managers understand the needs of elderly people in general and not just those covered under the MA contract. There was

a comment to “Include a question at this point on whether the case managers are dedicated to Medicare or a geriatric population or do they also manage employed commercial populations.” This change and the one below should add about one minute to respondent burden. This estimate is based on the questionnaire having about 100 questions and 45 minutes of burden or about one half minute per question. We recommend that the burden estimate remain at 45 minutes given the large variance in the average with interviews ranging from 20 and 120 minutes and only nine cases used to compute the average.

3) A new question has been added which is similar to B10a above except it is about disease management staff.

After C11 question C11a was added:

**C11a. Do disease managers serve only members covered under this (Medicare) contract, or do they also serve members covered under other (non-Medicare) contracts?**

1 ☐ Disease managers serve only members with Medicare

2 ☐ Disease managers also serve younger members covered under commercial contracts or other non-Medicare covered members

The justification for this change is the same as for new question B10a above.