Part C and D Complaints Resolution Performance Measure

60-Day Comment Summary

Parts C and D Complaints Resolution Performance Measure OMB PRA Package								
#	**Organization**	**Document**	**Item**	**Description of Issue or Question**	**Suggested Revision**	**CMS ACTION**	**REASON FOR ACTION**	**Need to:**
1	Aetna Inc.	6401 OMB Supporting Statement A 100202	Q9	Question # 9, "Based on your recent experience with this plan, are you planning to stay with this plan when you have the opportunity to switch plans?" Statement A does not address the performance measure weight, if any.	*N/A*	Accept	Clarify text in the Supporting Statement A regarding each question, its purpose, and the indicator associated with it. In addition this question has been reworded to a more positive tone.	Add text to Supporting Statement
2	Aetna Inc.	6401 OMB Survey Instrument 100202	Q8	Question #8, "Why are you dissatisfied with the way your complaint was handled?" Check box #1, "It took too long for the plan to process my complaint" Concern how the retroactive enrollment/disenrollment process time guidelines will be taken into account, if applicable, when tabulating this response.	*N/A*	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis.	Add text to Supporting Statement
3	Aetna Inc.	6401 OMB Survey Instrument 100202	Q8	Question #8, "Why are you dissatisfied with the way your complaint was handled?" Check box #3, "Plan staff did not explain things in a way I could understand" Medicare is a complex product and in many situations the member may not fully understand their plan benefit or may not agree with the resolution and explanation. Therefore, members may not answer this question in the context that was intended.	*N/A*	Accept	Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan.	Edit survey instrument
4	Aetna Inc.	6401 OMB Survey Instrument 100202	Q7	Beneficiary Satisfaction with Complaint Handling Process: Question #7, "Now, please indicate how satisfied you are with the way your complaint was handled by the plan." Although the purpose is to distinguish itself from Question #3, if a member is dissatisfied with a correct resolution, there is a high probability that the member will be dissatisfied with the handling as well.	*N/A*	Accept	CMS has decided to add clarifying text to this question asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself and focus on different aspects of the complaint process and the overall handling of the complaint (New questions Q2 and Q6).	Edit Q7
5	Aetna Inc.	6401 OMB Advance Letter 100202	General	In situations where the member has an appointed representative, how will this person be contacted for this survey.	Please clarify how address information is being identified for situations where the member appointed an authorized representative as well as complaints filed by other parties, such as SHIP counselors, providers, facility attendants, etc. Will this type of complaint be omitted from the sample selection?	Accept	CMS considers an appointed representative to be a valid respondent. Further clarification will be added to the supporting statement regarding the participation of appointed representatives in the survey. This explanation will include how representatives will be contacted (through beneficiaries and/or CTM logs) and how representative data can be used in the survey data analysis.	Add text to supporting statement
6	Aetna Inc.	6401 OMB Survey Instrument 100202	Q5	Repeat Complaints: Question #5 "Did you have to make more than one attempt to resolve your complaint before the plan contacted you?" Statement indicates this question will be asked if member states they were contacted by the plan- it is critical that members are appropriately educated on the timeframes that have been established by CMS for plans to respond to CTM complaints at the time they are filing their compliant with 1-800 Medicare, otherwise the member may file their complaint multiple times.	*N/A*	Partial Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument

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7	Aetna Inc.	6401 OMB Survey Instrument 100202	Q9	Question # 9, "Based on your recent experience with this plan, are you planning to stay with this plan when you have the opportunity to switch plans?" This question has a negative connotation to it and the member could interpret it as a suggestion to change plans, when in all actuality their complaint resolution may have no bearing on a future decision to change their insurance carrier at the first opportunity.	*N/A*	Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan based on recent experience, which provides a more comprehensive insight on the beneficiaries perspective.	Edit Q9
8	Aetna Inc.	6401 OMB Supporting Statement A 100202	Background	Last paragraph indicates survey sampling will be based on CTM closed in first qtr 2011.	Recommend sampling period be a broader timeframe, keeping in mind that the first quarter of CY is a busier time period for MAO call volume and complaints due to annual benefit changes taking effect and members who did not read their plan materials may experience a problem and require education on their plan benefits/coverage.	Partial Accept	CMS is interested in the months with the largest number of complaints in order to achieve the most statistically valid sample. The sampling strategy will exclude complaints that are outside of the scope of the plan; particularly some complaints associated with enrollment issues.	No action needed
9	Aetna Inc.	6401 OMB Supporting Statement A 100202	General	Statement indicates final results will not be shared until 8/2011.	Please clarify if this is only being shared with CMS or will plans also receive a copy? Plans should be provided with dissatisfied response data as quickly as results are tabulated, prior to July 2011 in order to allow sufficient time for plans to develop and implement appropriate action plans/training to address the low performance areas identified prior to going into the next AEP, which should be the main goal of this survey data.	Partial Accept	CMS will follow a similar process for this measure as it does for other measures. It is undetermined what level of data will be shared with plans. This data collection is a preliminary effort to develop a satisfaction measure. CMS will review the feasibility to develop a performance measure in coming years.	No action needed
10	Aetna Inc.	6401 OMB Survey Instrument 100202	Q2	Veracity of Plan's Description of Resolution: Question #2 "What was the resolution?" The concern regarding this open forum question is that it will lead to the beneficiaries' perception and potential lack of understanding of their plan benefit because of the time period selected for review.	Criteria selected for "major action" and "should be known by the complainant" should be developed and shared with plans in advance of finalizing and implementing the survey.	Partial Accept	CMS will review beneficiary responses with HPMS CTM records for the veracity of the complaint resolution. Additional information on the use of this data will be included in the justification statement. CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis.	Add text to Supporting Statement
11	Aetna Inc.	6401 OMB Survey Instrument 100202	Q5	Repeat Complaints: Question #5 "Did you have to make more than one attempt to resolve your complaint before the plan contacted you?" Concern that this question could be interpreted and answered two different ways. Some beneficiaries may include calls made to plan prior to calling 800-Medicare and others may not have contacted the plan prior to filing a complaint with 800-Medicare.	Recommend asking "Did you contact the plan to attempt to resolve this complaint prior to contacting 800-Medicare?" This question is important in order to determine if the member gave the plan the opportunity to resolve their complaint prior to contacting 800-Medicare.	Partial Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument

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12	Aetna Inc.	6401 OMB Survey Instrument 100202	Q6	Beneficiary Satisfaction w/time until a resolution: Question #6 "How satisfied are you w/the amount of time it took to resolve your complaint?" This measure is only appropriate, if the timeframes that CMS has established for plans to resolve a complaint are clearly explained by the staff at 800 Medicare when the member is filing their initial complaint so that the appropriate expectations are established and 800-Medicare staff are appropriately capturing and documenting all of the member's complaint that requires resolution by the plan.	Recommend adding a question that asks the member if the timeframes the plan has for resolving complaints was explained to them when they filed their initial complaint.	Partial Accept	Question 6 has been removed from the survey. Some issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument.	Remove Q6 from survey instrument
13	Aetna Inc.	6401 OMB Survey Instrument 100202	Q6	Beneficiary Satisfaction w/time until a resolution: Question #6 "How satisfied are you w/the amount of time it took to resolve your complaint?" Agree w/CMS limiting sample selection to "Immediate Need" and "Urgent".	Please clarify if actual CTM specified resolution timeframes will be factored into the final survey results. For example, beneficiary unhappy with time it took to receive resolution, however, plan resolved in less than CMS required resolution timeframe. This response should not reflect negatively in plan performance rating.	Partial Accept	Question 6 has been removed from the survey. Some issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	Remove Q6 from survey instrument
14	Aetna Inc.	6401 OMB Survey Instrument 100202	Q1	Beneficiary Awareness of Resolution: Question #1 "According to our records, the complaint you filed was recently closed by the plan. Was the complaint resolved?" Concern regarding this question is the beneficiary may not consider the complaint resolved even though the resolution was correct based on their benefit structure and/or CMS regulations/guidelines.	*N/A*	Partial Accept	The supporting statement will clarify the difference between the selected terms. "Resolved" will be replaced with "settled" in this question to prevent beneficiary bias. An "I don't know" answer choice has been added for beneficiaries who feel they do not yet have a resolution or are unsure/do not remember. Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement Edit Q1
15	Aetna Inc.	6401 OMB Survey Instrument 100202	Q10	Beneficiary Consequences during Complaint Resolution Process: Question #10 "During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved?". General Comment Concern with the response available for member selection given that some will be based on member perception and lack of understanding of their plan benefit structure and/or applicable CMS guidelines.	*N/A*	Partial Accept	This question gathers data regarding the experiences beneficiaries may have during the complaint resolution process. The survey questions have also been revised to reflect more neutral wording.	Edit Q10
16	Aetna Inc.	6401 OMB Supporting Statement A 100202	General	Small Businesses	Please clarify that the definition of small businesses is referring to the exclusion of 800 series members.	Reject	This survey gathers data regarding the experiences beneficiaries may have during the complaint resolution process. We will clarify that contracts with only 800 series members will not be included.	Add text to Supporting Statement A

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17	Aetna Inc.	6401 OMB Survey Instrument 100202	Q10	Beneficiary Consequences during Complaint Resolution Process: Question #10 "During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved?". Check box #2 "I did not receive my medications" Please clarify how the Part D exceptions process timeframes will be taken into account, if applicable, when tabulating this response.	*N/A*	Partial Accept	Timeframes will not be taken into account. This question gathers data regarding the experiences beneficiaries may have during the complaint resolution process. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	No action needed
18	Aetna Inc.	6401 OMB Advance Letter 100202	General	Opening of letter repeatedly mentions Medicare program, however the complaint is really associated to the plan contracted with Medicare.	This should be more clearly explained to the member in the letter to avoid confusion.	Accept	To reduce confusion about the topic and source of the complaints, the advance letter will make explicit reference of the MAO or Part D sponsor.	Add text to Advance Letter
19	Aetna Inc.	6401 OMB Supporting Statement A 100202	Background	Last paragraph indicates proposed surveys will occur within 21 calendars days of the complaint closure and will collect beneficiaries' opinions on the complaint resolution process and their satisfaction with the resolutions. Specific to all Immediate/Urgent need cases, plan attempts to contact the complainant by telephone to provide resolution. If a minimum of 3 telephone contact attempts are unsuccessful, the plan mails a letter of resolution to the address on file. Concern is that the proposed survey could take place prior to receipt of a mailed resolution letter.	*N/A*	Accept	We understand the concern about allowing sufficient time for beneficiaries to be notified of the resolution. Due to the short timeframe for completion of the surveys, we can accommodate 7 days between complaint closure and initial contact with the beneficiary to allow time for beneficiaries to receive notification of their complaint resolution. This method will be used for the third quarter pilot test.	Add text to Supporting Statement Adjust sampling plan
20	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q3	"How satisfied are you with the resolution of your complaint?" – Survey Question #3 (Supporting Statement – Part A, pages 9-10). CMS states that "to relay the extent to which complainants are satisfied with the resolutions that plans have provided to their complaints" the survey will ask (Survey Question 3), "How satisfied are you with the resolution of your complaint?" +The four options to respond to this question include "very satisfied, satisfied, dissatisfied, and very dissatisfied," but do not permit a neutral response. We are concerned that the absence of a neutral option could increase the potential for a negative response. For example, the complaint may have been resolved according to CMS rules, and the beneficiary may understand that this was the case but be reluctant to indicate satisfaction with a resolution that was not the requested outcome.	Consistent with our comments above, we recommend that an appropriate nationally recognized quality measurement organization review the potential responses and recommend an approach that is likely to provide the most useful responses for performance measurement. This comment also applies to other questions with response choices that are similarly structured.	Partial Accept	This data collection is a preliminary effort to develop a satisfaction measure. CMS will review the feasibility to develop a performance measure in coming years. At this point a quality measurement organization is not needed. A neutral answer choice would be "neither satisfied nor dissatisfied." However, CMS decided against including a neutral answer choice in order to encourage beneficiaries to select an opinion one way or the other. Instead, CMS will provide an "I Don't Know/NA" answer choice for beneficiaries who do not believe they have received a final outcome or who do not remember the resolution of their complaint.	Edit survey instrument

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21	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q4	"Did the plan contact you about your complaint? This includes contact by telephone, mail, email, or other means." – Survey Question #4 (Supporting Statement – Part A, page 12). CMS states that this measure will assess the frequency with which plans contact complainants while handling the complaint to notify them of a resolution by asking (Survey Question 4), "Did the plan contact you about your complaint? This includes contact by telephone, mail, email, or other means." We understand that it is not uncommon for beneficiaries to forget or be unaware that they have received a plan contact. However, the survey instrument only allows beneficiaries to indicate "Yes" or "No" and does not include the options for "I don't know" or "I don't remember" as possible responses.	To address this concern, AHIP recommends that CMS revise the response options offered to beneficiaries.	Accept	Q4 has been removed from the survey instrument. Issues of plan communication with the beneficiary have been incorporated into Q2 of the new survey instrument. The new Q2 is a satisfaction question that encompasses several aspects of the complaint process such as courtesy of the plan representative and time until contact by the plan. In addition, in good faith CMS added other response options (Do Not Know, NA) for beneficiaries to choose when they do not have a clear response within the 4-likert scale.	Edit survey instrument
22	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q7	"Now, please indicate how satisfied you are with the way your complaint was handled by the plan." – Survey Question #7 and "Why are you dissatisfied with the way your complaint was handled?" – Survey Question #8 (Supporting Statement – Part A, page 11). CMS indicates that to learn "the extent to which plans treated the complainant courteously, provided the complainant with understandable explanations, and provided the complainant with enough information," the survey will ask (Survey Question 7), "Now, please indicate how satisfied you are with the way your complaint was handled by the plan." The survey question does not reference the three topics that CMS seeks to address with this question, and we believe it is unlikely that beneficiaries will consistently provide the information needed to address these three areas. In addition, it is not clear that beneficiaries will distinguish between satisfaction with the resolution and satisfaction with the handling of the complaint by the plan.	As an alternative approach, CMS could revise this question to specifically ask beneficiaries how satisfied they were with the plan's courtesy, clarity of explanation, and provision of sufficient information during the complaint resolution process.	Accept	Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating. Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan.	Edit survey instrument
23	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q8	"Now, please indicate how satisfied you are with the way your complaint was handled by the plan." – Survey Question #7 and "Why are you dissatisfied with the way your complaint was handled?" – Survey Question #8 (Supporting Statement – Part A, page 11). CMS also indicates that if the beneficiary indicates dissatisfaction with complaint handling, the surveyor will ask (Survey Question 8), "Why are you dissatisfied with the way your complaint was handled?" to "provide CMS and plans with a greater understanding of any low performance measure indicator values." The written survey instrument includes four specific choices and "other" for the beneficiary or surveyor to check to indicate the reasons for dissatisfaction. The reasons listed duplicate information gathered in Survey Question #6 regarding the amount of time it took to handle the complaint and the information that would be gathered in Survey Question #7, if CMS adopts AHIP's recommendation to reference the three areas of courtesy, clarity of explanation, and provision of sufficient information.	An alternative approach would be to eliminate Survey Question #7.	Partial Accept	Q8 has been removed. The new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as courtesy of the plan representative and time until contact by the plan. Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating.	Edit survey instrument

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24	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q10	"During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved?" – Survey Question #10 (Supporting Statement – Part A, pages 11-12). Additionally, beneficiaries who receive a paper survey rather than a survey administered by telephone will receive a list of potential problems from which to select. Their responses may be influenced by the checklist and potentially biased to select more problem areas. It is not clear how CMS will address this issue to differentiate and analyze the written and telephonic responses. Finally, CMS references a second question that will be used "to provide more knowledge about the scale of the negative incidents experienced by complainants." However, neither the Supporting Statement nor the survey materials include the question. We recommend CMS clarify whether there is a second question and if so, how it will be used.	We recommend that CMS use a uniform approach for the surveys administered in writing and by telephone and frame the question in a manner that avoid biasing the responses. This could be accomplished by removing the checklist.	Partial Accept	In review, CMS recognizes that there may be a misunderstanding regarding the dual survey formats and more clarifying text will be added to the supporting statement describing the uniformity of the telephone and written survey approaches. In regards to Q10, the checklist is the most appropriate method of gathering the specified data, therefore this question's structure will not be altered.	Add text to Supporting Statement Edit survey instrument
25	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Respondent Universe and Sampling (pages 3-5). Defining the Population: CMS states that the survey population "is made up of beneficiaries with closed urgent or immediate need complaints that were filed against their respective plans during the period covering the months of January and February of the year 2011." The Supporting Statement does not discuss how the survey will be administered in the case of beneficiaries who have an authorized representative who acts on their behalf or who may otherwise have physical or cognitive impairments that are a barrier to responding. The survey proposal also does not address the situation in which a party other than the beneficiary reported the complaint to 1-800-Medicare.	We recommend that CMS provide a description of the manner in which the survey design will address these issues.	Accept	CMS considers an appointed representative to be a valid respondent. Further clarification will be added to the supporting statement regarding the participation of appointed representatives in the survey. This explanation will include how representatives will be contacted (through beneficiaries and/or CTM logs) and how representative data can be used in the survey data analysis.	Add text to Supporting Statement
26	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q9	Parts C and D Complaint Closure Beneficiary Survey • Question 9 (page 2). The description of the performance measures that CMS intends to utilize, which appears on pages 8-12 of Supporting Statement – Part A, contains no discussion of Survey Question #9, which asks, "Based on your recent experience with this plan, are you planning to stay with this plan when you have the opportunity to switch plans?" It is unclear why CMS proposes to ask this question if it is not necessary for construction of any of the proposed performance measures. Furthermore, we are concerned that the wording of the question could potentially influence the response, because it could be understood to imply that the beneficiary should reconsider plan enrollment.	AHIP recommends that CMS either revise the question to ensure that it is neutral and explain its contribution to the performance measures or remove it from the survey.	Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan. Further clarification on how this question will be used in the development of the performance measure will be provided.	Add text to Supporting Statement Edit Q9
27	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Sampling First Quarter Complaints – It is our understanding that a significant proportion of calls received by 1-800 Medicare in the first quarter of each year are related to beneficiaries seeking information and education about the structure or operation of their new plans. To the extent that these complaints are categorized as immediate need/urgent through the process discussed above, their inclusion in the survey initiative is likely to make the results less useful to beneficiaries as an indicator of plan performance.	We recommend that such complaints be excluded from the sample or that CMS draw the sample across a broader time frame than the first quarter of the year to obtain a more representative cross-section of beneficiary complaints.	Partial Accept	CMS is interested in the months with the largest number of complaints in order to achieve the most statistically valid sample. The sampling strategy will exclude complaints that are outside of the scope of the plan; particularly complaints associated with enrollment issues.	No action needed

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28	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Categorization of Immediate Need/Urgent Complaint: CMS' decision to focus the survey on all immediate need/urgent complaints raises significant concerns about the use of the survey data for its intended purpose under the proposed Part C and D Complaint Resolution Performance Measurement initiative – as an indicator of plan performance. In contrast to the subset of complaints that involve access to medical services or prescription drugs, many of the complaints involve issues whose resolution is not within the sole, or in many cases principal control, of MA and Part D sponsors. Through the categorization process immediate need/urgent complaints may involve Social Security Administration (SSA) premium withhold, Part D excluded drugs, Part D eligibility date, or enrollment processes and policy. Expansion of MA and Part D plan sponsor performance measures to assess beneficiary satisfaction with the resolution of such complaints would not be reasonable or appropriate, because the measures would be more likely to reflect beneficiary understanding and satisfaction levels with CMS or SSA policy, rather than the plan sponsor's actions.	If CMS is considering evaluation of plan sponsor performance spanning a sampling of beneficiaries with closed complaints across the full spectrum of immediate need and urgent complaints received through 1-800-Medicare, we strongly recommend that the agency reconsider this approach and revise the initiative to ensure measures reflect actions within the control of MA and Part D plan sponsors.	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis. Other CMS data will be used to control for plan characteristics and beneficiary profiles. The supporting statement will clarify analyses that incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement
29	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	General	Survey content: As discussed in more detail below, we have serious concerns that features of the proposed survey could undermine its utility as an indicator of plan sponsor performance. For example, we believe that the content of the questions and the related telephone interview process have the potential to elicit beneficiary responses that are more informative about the beneficiary's ability to provide clear and responsive answers than about plan performance.	To address these concerns, we recommend that CMS submit the proposed survey instrument and process for evaluation by an appropriate nationally recognized quality measurement organization, such as NCQA in consultation with AHRQ, which develops and maintains the CAHPS suite of surveys. Following this critical step in the development process, we recommend that the final tool should be reviewed for endorsement by a national, multi-stakeholder consensus entity to ensure that the information provided to beneficiaries through this initiative is reliable for use in their decision-making.	Reject	This data collection is a preliminary effort to develop a satisfaction measure. CMS will review the feasibility to develop a performance measure in coming years. At this point a quality measurement organization is not needed.	No action needed

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30	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q2	"What was the resolution?" – Survey Question #2 -- (Supporting Statement – Part A, page 10). CMS states that to "illustrate the accuracy of the plans' descriptions of their complaint resolutions in the CTM" the survey will ask (Survey Question 2), "What was the resolution?" CMS indicates that accuracy will be determined through comparison of the complainants' description of the resolution and any "major action steps" "that should be known by the complainant" with the plan's descriptions of the resolution. It is our understanding that plan sponsors commonly record the calls made by trained plan staff to notify members of the outcome of their complaints. We believe that the recording would be the most reliable source of verification of the content of the plan sponsor's description of their complaint resolutions. Further, we are concerned that subjective factors are likely to interfere with an effort to draw conclusions from any discrepancy between the beneficiary's response and the plan description of the resolution. The discrepancy is likely to provide insight into such areas as the accuracy of the member's memory since the time of resolution, the member's ability to articulate the resolution, the surveyor's understanding of the beneficiary's description, and the relevance of the "major action step" categories to what the member states and recalls as significant, rather than the accuracy of the plan sponsor's description.	While this information may have some utility, Question #2 is unlikely to elicit information that is useful to beneficiaries as they compare MA and Part D options. An alternative approach would be for CMS to revise this question to focus on the beneficiary's understanding of the plan's response to his or her complaint and modify the stated purpose of the question accordingly. If the list of "major action steps" is retained in conjunction with this question, we also recommend that CMS provide an opportunity for plan sponsor comment on the list to ensure that it corresponds to plan sponsor operations.	Partial Accept	CMS will review beneficiaries response with HPMS CTM records for the veracity of the complaint resolution. Additional information on the use of this data will be included in the supporting statement.	Add text to Supporting Statement
31	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Criteria for Inclusion of Beneficiaries/Complaints in the Survey Sample – As noted above, resolution of many complaints received through 1-800-Medicare is not within the control of MA and Part D plan sponsors, and resolution is in many cases the result of the application of CMS policy.	We recommend that CMS establish criteria that exclude from the survey sample beneficiaries whose complaints cannot be resolved solely by actions of the plan sponsor. Examples of such complaints include: o Complaints that must be resolved through a request for retroactive disenrollment through the CMS Regional Office; o Complaints that do not include clear documentation of the issue raised by the beneficiary and that the plan sponsor is unable to clarify because the beneficiary does not respond to requests for necessary information; o Complaints expressing dissatisfaction with the decision of the Independent Review Entity.	Accept	CTM categorization issues should have minimal impact on effective and timely complaint resolution. Complaint type will also be taken into consideration and excluded, if necessary. Sampling strategy will take into consideration complaints to be addressed by CMS as well as complaints that are challenging to identify as plan's responsibility. Further details will be included in the supporting statement.	Add text to Supporting Statement
32	America's Health Insurance Plans	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Timeframe: The Supporting Statement indicates that the purpose of the proposed expansion of Part C and D performance measurement is to add to the data available to beneficiaries on Medicare Options Compare and the Medicare Prescription Drug Plan Finder (MPDPF). The Supporting Statement – Part A explains that CMS plans to publish the new performance measures in November 2011. -- We note that CMS' past practice regarding the introduction of new performance measures has been to utilize at least the initial year of data collection and analysis to evaluate the validity and utility of the data for its intended purpose, effect any needed modifications, and determine how the information can be most effectively presented to the public. These steps are critical to ensuring that information is not misleading or confusing, and we urge CMS to follow this process for the proposed survey initiative. -- Further, there is insufficient information to understand how CMS envisions that the data may be incorporated into the existing performance indicators (i.e., the Star Rating System) or whether it would be utilized separately in some other manner.	Since CMS has stated the agency's intent to consider modifications to the Star Rating System in light of its role in the MA payment methodology beginning in 2012, it would be appropriate for CMS to consider addition of new performance data as part of a comprehensive approach to evaluating the agency's performance measures, and we recommend that these initiatives be coordinated.	Reject	Efforts are being made to coordinate changes to the Star Rating System with the bonus payments. The process will be made transparent to organizations and plans will be made aware of CMS's strategy and methodology.	No action needed

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33	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Respondent Universe and Sampling (pages 3-5). Contracts with Low Enrollment or Minimal Complaints: In the discussion of sampling, CMS notes that it plans to develop complaint resolution performance measures for "each contract" for a total of 541 contracts (based on CY2009 data) and states that all MA and Part D plans "will be surveyed regardless of their enrollment size." CMS further states that, "This distribution is expected to vary substantially from one contract to another, with some small contracts having a total number of closed complaints as low as one." For some contracts the total number of urgent and immediate need complaints and closed complaints is very small so that the survey data, even if all beneficiaries in the sample respond, is likely to produce results for the contract that would not be statistically valid. The potential for this circumstance to arise appears high, because the entire sample nationally will be 6,500 beneficiaries drawn from the approximately 541 contracts.	AHIP strongly recommends that CMS ensure that the project design addresses the issue of validity and reliability of results based upon small sample size at the contract level and that results are not publicly reported that are not statistically valid.	Reject	Statistically representative samples and enrollment size variables will be taken in consideration when developing measures. CMS is well aware of small sample size issues and has decided to proceed with collecting data for these contracts.	No action needed
34	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q5	"Did you have to make more than one attempt to resolve your complaint before the plan contacted you?" – Survey Question #5 (Supporting Statement – Part A, page 12). CMS states that this measure will "demonstrate any patterns of delay by plans when contacting complainants about their complaints" by asking (Survey Question 5), "Did you have to make more than one attempt to resolve your complaint before the plan contacted you?" We understand that beneficiaries often are unaware of the timeframes CMS has established for plans to resolve complaints and therefore beneficiaries may call multiple times within that timeframe regarding the same issue. The receipt of such multiple calls does not necessarily indicate that the plan sponsor is not compliant with CMS timeframes.	AHIP recommends that CMS factor into the analysis of responses to this question objective information about whether the plan complied with CMS requirements and timeframes for contacting the beneficiary and resolving the complaint.	Accept	CMS has decided to drop questions of repeat complaints/multiple attempts to contact the plan. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	Remove Q5 from survey instrument
35	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q6	"How satisfied are you with the amount of time it took to resolve your complaint?" – Survey Question #6 (Supporting Statement – Part A, pages 10-11). CMS states that to determine beneficiary satisfaction with the time between filing the complaint and the receipt of resolutions the survey will ask, (Survey Question 6) "How satisfied are you with the amount of time it took to resolve your complaint?" CMS has established timeframes that plans must meet when resolving urgent and immediate need complaints. However, as discussed above, the varied nature of the complaints in this category raises significant concerns that in many cases, evaluation of beneficiary satisfaction with the time required to resolve complaints is likely to be a measure of satisfaction with the timeliness of CMS action to effectuate resolution rather than with plan performance.	To address this issue, we recommend that CMS exclude from the survey sample beneficiaries whose complaints cannot be fully resolved through direct action by the plan sponsor. We also recommend that CMS exclude or otherwise make adjustments in the evaluation of survey results when transmittal of a complaint to a plan sponsor is delayed due to administrative factors inherent in the CMS complaint processing system or the plan sponsor's ability to take timely action is hindered by other factors outside of the plan sponsor's control. Without these changes, we believe that the information produced through responses to this question will not provide useful beneficiary information about plan performance.	Accept	Question 6 has been removed from the survey. Issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	Remove Q6 from survey instrument

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36	America's Health Insurance Plans	Explanations for Inclusion of Survey Questions	General	Indicators. This document contains a number of "performance measure indicators" which, in most cases roughly correspond to the "performance measures" discussed on pages 8-12 of Supporting Statement – Part A. However, it is not clear how the indicators will be used and whether the indicators are intended to be distinct from performance measures.	AHIP recommends that CMS revise this document to clarify the relationship or interaction between the "indicators" and the measures.	Accept	The indicators provide information on a particular area of interest and they will be further analyzed and revised to develop the performance measures.	Edit Explanations for Inclusion of Survey Questions Add text to Supporting Statement
37	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	General	Review and testing of the survey and interview protocol: Performance measures that utilize survey data typically undergo rigorous review and testing similar for example, to the process utilized by the Agency for Healthcare Research and Quality (AHRQ) to develop the Consumer Assessment of Health Plans Survey (CAHPS). These efforts are important to ensure that the survey questions and administration and the analysis of responses yield reliable data. However, it does not appear that CMS has utilized such an approach in the development of the survey.	*N/A*	Reject	This data collection is a preliminary effort to develop a satisfaction measure. CMS will review the feasibility to develop a performance measure in coming years. At this point a quality measurement organization is not needed. The instrument has been pre-tested and will be pilot tested prior to a full-scale implementation.	No action needed
38	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q3	"How satisfied are you with the resolution of your complaint?" – Survey Question #3 (Supporting Statement – Part A, pages 9-10). CMS states that "to relay the extent to which complainants are satisfied with the resolutions that plans have provided to their complaints" the survey will ask (Survey Question 3), "How satisfied are you with the resolution of your complaint?"	As noted above, AHIP recommends CMS focus the survey sample on complaints that the plan sponsor has the ability to resolve directly, so that the beneficiary's expression of satisfaction or dissatisfaction will be attributable to the plan sponsor's action and therefore, reflect plan performance.	Partial Accept	Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement
39	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q10	"During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved?" – Survey Question #10 (Supporting Statement – Part A, pages 11-12). CMS states that to "assess how well plans are able to resolve complaints before the beneficiary encounters a subsequent incident" the survey will ask (Survey Question 10), "During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved?" CMS states that this measure will "be constructed as a percentage of complainants who indicate that they have experienced any consequences due to their wait for a resolution." However, the question implies that the beneficiary experienced problems, and consequently, AHIP believes that responses could be skewed towards the occurrence of problems. Furthermore, the problem(s) a beneficiary may identify as having occurred during the time they were awaiting resolution of their complaint may be out of the plan's control and therefore would not be an indicator of how well the plan is able to resolve complaints. For example, if a beneficiary indicates he or she "did not receive my medications," this could be because the medications were not covered Part D drugs, or if the beneficiary "missed an opportunity to change plans," this may be because the beneficiary did not have an enrollment period available to change plans rather than an indicator of the plan's ability to resolve complaints. It is not clear how such information would be useful in evaluating plan performance.	An alternative approach would be for CMS to revise this question to ask whether the beneficiary experienced any problems that resulted directly from how the plan handled the complaint. Issues of this type illustrate the importance of submitting the survey for review by an appropriate nationally recognized quality measurement organization as recommended above.	Partial Accept	The survey questions have been revised to reflect more neutral wording. Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis.	Edit Q10

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40	America's Health Insurance Plans	6401 OMB Advance Letter 100202	General	Plan Identification. The opening paragraph of the Advance Letter explains that CMS is conducting a survey about beneficiary satisfaction with the handling of a Medicare complaint, but does not clarify that the survey concerns a complaint about the beneficiary's Medicare health plan or Medicare prescription drug plan. This is likely to cause confusion for beneficiaries about the topic of the survey.	AHIP recommends that CMS revise the Advance Letter to explicitly reference the beneficiary's MA or Part D plan.	Accept	To reduce confusion about the topic and source of the complaints, the advance letter will make explicit reference of the MAO or Part D sponsor.	Add text to Advance Letter
41	America's Health Insurance Plans	6401 OMB Survey Instrument 100202	Q1	"According to our records, the complaint you filed was recently closed by the plan. Was your complaint resolved?" -- Survey Question #1 (Supporting Statement – Part A, page 9). CMS states that to "capture the percentage of a plan's complainants who agree that a resolution to their complaint has been implemented," the survey will ask, (Survey Question 1) "According to our records, the complaint you filed was recently closed by the plan. Was your complaint resolved?" AHIP is concerned that this question is unlikely to be specific enough to elicit a beneficiary response that is reliably linked to plan performance. For example, the question does not include any specific reference to the nature of the complaint and asking whether the complaint was "resolved" rather than for example, whether the beneficiary received or understood the plan's decision, may not be concrete enough for the beneficiary to provide an information response. AHIP also believes it is likely that beneficiaries could perceive a closed complaint as unresolved if the resolution was contrary to what the beneficiary requested, for example, denial of an enrollment or disenrollment request or denial of coverage of an excluded drug, consistent with CMS requirements. Furthermore, the cognitive status of the beneficiary who is surveyed could be an additional complicating factor in obtaining a answer that accurately reflects the responsiveness of the plan.	For these reasons, we recommend that this survey question be revised, and consistent with our recommendations above, be reviewed by an appropriate nationally recognized quality measurement organization to ensure the questions will solicit useful and valid information from the beneficiary. We have similar concerns about other questions that are framed in a similar manner, and if terminology/content (e.g., "resolved") is changed in Survey Question 1, we recommend that related changes be made to other questions, as appropriate.	Partial Accept	The supporting statement will clarify the difference between the selected terms. "Resolved" will be replaced with "settled" in this question to prevent beneficiary bias. An "I don't know" answer choice has been added for beneficiaries who feel they do not yet have a resolution or are unsure/do not remember. Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement Edit Q1
42	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Respondent Universe and Sampling (pages 3-5). Confidence Interval: CMS indicates that the goal of the survey is to generate an error margin of 10% for a minimum confidence level of 85% and that these parameters depend on the size of the sample, which would be 6,500 complaints. We are concerned that the specified confidence interval is inconsistent with general design practices for performance evaluation. It is our understanding that the commonly used margin of error for health plan performance evaluation is 5.7percent for a minimum confidence interval of 95 percent. For example, this is the margin of error and confidence interval used in CAHPS surveys where the minimum sampling size of 300 generates an error margin of 5.7 percent for the confidence interval of 95 percent (simple random sampling).	We recommend that CMS revaluate the error margin and confidence interval and make modifications as needed to ensure they are consistent with well-established parameters to performance measurement.	Reject	We cannot comply with this suggestion for several reasons: a) it is cost-prohibitive for the study, b) it would increase burden on beneficiary respondents, and c) some contracts may not have enough complaints to receive a measure and this may count negatively in the beneficiary's choice of a plan. CMS seeks to collect information on all contracts and this limits the number of complainants to be surveyed.	No action needed

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43	America's Health Insurance Plans	6401 OMB Supporting Statement B 100202	Methods to Maximize Response Rates and Data Reliability	Methods to Maximize Response Rates and Data Reliability (pages 8-9). To maximize response to the survey, the contractor will first send the Advance Letter, and then make up to 10 attempts over a three-week period to contact the beneficiary via telephone. If the beneficiary does not respond to the telephone survey by the three-week mark, the contractor will send the beneficiary a paper survey and will follow up with a mailed reminder to all non-respondents within one week after mailing the hard copy survey. If we are correct that the interview scheduling process could result in repeated messages for beneficiaries to call back the contractor, we are concerned that beneficiaries could react negatively to the number of attempts to contact them during a relatively short timeframe. Dissatisfaction with the survey process itself could impact how beneficiaries answer questions regarding plan activities, particularly if they inadvertently associate the surveying contractor with their plan.	AHIP recommends that CMS address this issue through the survey design either by modifying the strategy for contacting beneficiaries or in some other manner.	Partial Accept	We expect that the call center will adapt survey schedules to obtain prompt responses from beneficiaries. Contractor interviewers have a defined introductory statement separating the contractor from CMS and health plans and will follow best practices for refusal cases.	No action needed
44	America's Health Insurance Plans	6401 OMB Supporting Statement A 100202	Background	Timing of Surveys CMS indicates that the proposed surveys will occur within 21 calendar days of closure of complaints which could mean that some surveys will be administered soon after the start of this 21-day period. For example, if the survey is administered within two – three days following closure of a complaint, even though the plan may have resolved a complaint within the CMS required timeframes, the beneficiary may not know of the resolution. This could occur if the plan is unsuccessful in reaching the beneficiary by telephone and must send a letter in accordance with CMS CTM Standard Operating Procedures (SOP), released October 6, 2009.	AHIP recommends that when scheduling calls for the survey, CMS wait to administer the survey until at least 10 days after the complaint is closed to ensure that the beneficiary has been notified of its resolution.	Accept	We understand the concern about allowing sufficient time for beneficiaries to be notified of the resolution. Due to the short timeframe for completion of the surveys, we can accommodate 7 days between complaint closure and initial contact with the beneficiary to allow time for beneficiaries to receive notification of their complaint resolution. This method will be used for the third quarter pilot test.	Add text to Supporting Statement Adjust sampling plan
45	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	Q8	Q8 - Rewrite	Why are you dissatisfied with the way the plan handled your complaint? Mark all that apply [Same rationale for the change as above]	Partial Accept	Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan. Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating.	Edit survey instrument
46	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	Introduction	The sentence that reads, "you recently filed a complaint with your Medicare plan."	The more accurate sentence would be, "you recently filed a complaint with us about your Medicare plan." At the plans, we find that a lot of members are quite confused about the whole complaint process that they call in to CMS but then hear back from the plan. Perhaps a brief one-sentence explanation of that would be beneficial to the Medicare beneficiaries receiving this survey.	Accept	CMS finds that it is not in the best interest of the survey to use the suggested sentence. The survey introduction will be modeled on other similar beneficiary correspondance and survey instructions. More detail will be added to the survey introduction regarding why beneficiaries are being contacted and specifying terms such as "Medicare," the MAO or Part D sponsor, and the role of the contractor in conducting the survey.	Edit introduction of survey instrument

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47	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	Q7	Q7 - Rewrite	Now, please indicate how satisfied you are with the way the plan handled your complaint. [This makes it clear CMS is asking about the plan performance and not the complaint resolution. This is an example that despite the accuracy of the plan's response, the member will not be satisfied. Hopefully, this re-write makes the focus on the performance.]	Accept	CMS has decided to add clarifying text to this question asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself and focus on different aspects of the complaint process and the overall handling of the complaint (New questions Q2 and Q6).	Edit Q7
48	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	Q9	Q9 - Rewrite	Based on your recent experience with the plan, are you planning to stay with this plan when you have the opportunity to switch plans during an Enrollment Period? [We changed the first 'this plan' to 'the plan.' This question does read as though CMS is encouraging members to consider moving on to a different plan.]	Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan. The placement of this question in the survey (ordering) will also affect its interpretation.	Edit Q9
49	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	Q5	Q5. Did you have to make more than one attempt to resolve your complaint before the plan contacted you?	If yes, please mark the method you attempted: calling the plan's customer service, writing a letter, calling 1-800-Medicare	Partial Accept	CMS has decided to drop questions of repeat complaints/multiple attempts to contact the plan. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	Remove Q5 from survey instrument
50	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	General	Overall. When the members do not receive the answer that they want to hear from the plans, they will not be satisfied, nor will they believe that the complaint was resolved.	*N/A*	Partial Accept	The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement
51	BlueCross BlueShield of Tennessee	6401 OMB Survey Instrument 100202	General	For consideration.	Please consider asking a further question or including it on Q10 or Q8: Did the complaint involve Social Security (SSA) withhold?	Reject	This issue/question would only be relevant to a small portion of the respondents and would not improve the data gathered while it would increase the burden (number of questions) on the respondent.	No action needed
52	Coventry Health Care, Inc	6401 OMB Survey Instrument 100202	General	The Survey questions are set in a negative tone vs. being "Open ended Questions	*N/A*	Accept	The survey questions have been revised to reflect more neutral wording.	Edit survey instrument
53	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Repeat Complaints -- Calculation only conceders those that responded that the plan did contact them. So the assumption is there are only repeat complaints if the plan contacts a beneficiary?	To accurately measure repeat complaints the question should be presented to each survey respondent.	Partial Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument
54	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Beneficiary Satisfaction with Time until a Resolution -- Complainant responses may be very satisfied, satisfied, dissatisfied, very dissatisfied, or not yet settled. The values assessed for 2 through – 2 do not include not yet settled. How will a response of not yet settled be accessed? Will a response of not yet settled be included in the calculation of the mean value?	*N/A*	Accept	CMS has decided to drop questions related to amount of time it took to resolve a complaint. CMS will provide an "I Don't Know/NA" answer choice for beneficiaries who do not believe they have received a final outcome or who do not remember the resolution of their complaint.	Remove Q6 from survey instrument

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55	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Veracity of Plan's Description -- Calculation of measure is unclear uses same logic as Beneficiary Awareness of Resolution. Additionally, a dichotomous variable will be created for each included complaint and the dichotomous variable will be used as the performance measure.	Need definitions of 'major action' terminology/phrasing CMS looking for which will affect the dichotomous variable. If a respondent needs to match to the 'major action' plans need to know what these are to provide same/similar language to the complainant providing a consistency throughout the entire process.	Reject	CMS will consider working toward this in the future, but CMS is not standardizing responses to beneficiaries regarding complaint resolutions. CMS is looking for the interventions that plans made. Plans should continue following SOP guidelines.	No action needed
56	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Beneficiary Awareness of Resolution – calculation of measure is unclear. The denominator will be the count of sampled complaints where the complainant indicates he/she is or is not aware of a resolution." However, exclusion criteria for the denominator will be responses of "Don't know" or "Refused". How is don't know different from 'is not aware'? Unclear if respondent is not aware of resolution whether it will be counted in denominator or not.	*N/A*	Accept	In the explanation of the "Beneficiary Awareness of Resolution" indicator, the denominator will be the number of complainants who are "not aware of resolution." This language was intended to indicate that the beneficiary gave a "no" response to this question. The survey will include the following response options: "yes," "no," "I don't know," or no response. The text of supporting statement A will be further clarified with the calculation of the denominator.	Add text to Supporting Statement
57	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Beneficiary Satisfaction with Resolution -- what is the target threshold for plans or the value assessed to accumulate to the star rating?	*N/A*	Reject	Star rating information is not yet available.	No action needed
58	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Beneficiary Satisfaction with Complaint Handling Process -- Unclear what target thresholds for plans to achieve are not clearly defined.	*N/A*	Reject	Star rating information is not yet available.	No action needed
59	Coventry Health Care, Inc	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	That given limited sample size (6,500),question whether the survey would accurately portray CTM satisfaction for any given health plan	*N/A*	Partial Accept	Statistically representative samples and enrollment size variables will be taken in consideration when developing measures.	No action needed
60	Coventry Health Care, Inc	6401 OMB Supporting Statement B 100202	Methods to Maximize Response Rates and Data Reliability	Need to ensure that the response rates equals a statistical valid sample	*N/A*	Partial Accept	Statistically representative samples and enrollment size variables will be taken in consideration when developing measures.	No action needed
61	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Information Users	CMS may publish a performance metric using these data in November 2011. "May" is not a clear/defined affirmative statement. What would prevent CMS from publishing?	Recommend change 'may' to 'will' publish.	Reject	This data collection is a preliminary effort to develop a satisfaction measure. CMS will review the feasibility to develop a performance measure in coming years. The "may" refers to the fact that "CMS may opt not to use the results of the survey for performance measurement."	Add text to Supporting Statement A

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62	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	General	It stated that these interviews will not be done through a person but through a telephonic process. This is nota good tool to use for our Medicare population and most people might hang up in frustration	*N/A*	Reject	The CATI system is a computerized system that a live interviewer uses to record the responses from beneficiaries who take the telephone interview. The beneficiary will be speaking directly to the interviewer.	No action needed
63	Coventry Health Care, Inc	6401 OMB Supporting Statement A 100202	Publication Tabulation Dates	Beneficiary Satisfaction with Complaint Handling Process -- Interpretation of satisfaction very subjective and measure should be more concrete. For example, a member may not be satisfied because they still have out of pocket expenses therefore dissatisfied with the process/response/ resolution.	*N/A*	Partial Accept	The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. More information will be included regarding analysis plans and calculations of satisfaction.	Add text to Supporting Statement
64	Coventry Health Care, Inc	6401 OMB Supporting Statement B 100202	Methods to Maximize Response Rates and Data Reliability	The statistical Methods are very confusing to understand	*N/A*	Reject	There were limited options for a detailed narrative while still maintaining the technical level required for the sampling approach.	Add text to Supporting Statement Adjust sampling plan
65	Coventry Health Care, Inc	6401 OMB Survey Instrument 100202	Q10	Beneficiary Consequences During Complaint Resolution Process -- Very leading question assumes problems existed. Additionally, the question in the document states “Mark all that apply” where is the listing of all that apply. How does the measure calculate no problems?	Perhaps following other survey examples such as CAHPS and conduct a leading question of Did you experience any problems... yes no? Then if no obtain more detail.	Accept	This question gathers data regarding the experiences beneficiaries may have during the complaint resolution process. The survey questions have also been revised to reflect more neutral wording.	Edit Q10
66	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Survey Instrument 100202	General	Questions appear to assume that any resolution that is not in the member’s favor, or that grants the member’s request, is an unsatisfactory resolution. The complaint resolution may not be in the member’s favor, but determined by other factors, such as CMS guidelines	*N/A*	Partial Accept	CMS understands there is a possibility that beneficiaries will associate dissatisfaction with the resolution and the overall complaint experience. In order to address this concern, the supporting statement will clarify the difference between "resolution" and "final outcome." An emphasis on “final outcome or decision” rather than “resolution” puts the focus on the series of actions the plan took, regardless of whether the beneficiary believes his/her complaint was resolved. Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. Survey questions will be reworded to be more neutral. Beneficiaries will be asked to provide an opinion of the resolution regardless of whether they agree with it.	Add text to Supporting Statement Edit survey instrument
67	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Advance Letter 100202	General	Is the interviewer going to call twice? Once to arrange a time to conduct the interview and another to do the interview?	*N/A*	Accept	Add language to the Advance Letter to describe the calling process and how beneficiaries should expect to be contacted.	Add text to Advance Letter

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68	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Survey Instrument 100202	Q5	This question is confusing. Did the member make more than one attempt to contact the plan to resolve this complaint? Or is it a combination of contacting the plan and Medicare? Or, did the member need to contact Medicare multiple times?	*N/A*	Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument
69	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Survey Instrument 100202	Q6	Time to resolution may not be controlled by the plan. For example, requests for retroactive disenrollment date changes must be routed to the CMS contractor. The processing time is outside of the control of the plan.	*N/A*	Accept	Question 6 has been removed from the survey. Some issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument. However, approaches to control for issues outside the plan's control will be described in supporting statement.	Remove Q6 from survey instrument Add text to supporting statement
70	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Survey Instrument 100202	Q9	This may be confusing to dual-eligible beneficiaries, that have an on-going Special Election Period.	*N/A*	Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan.	Edit Q9
71	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Survey Instrument 100202	General	Questions do not consider that complaint resolution may be affected by factors that are outside of the control of the plan. For example, loss of Medicaid eligibility is not controlled by the plan.	*N/A*	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis.	Add text to Supporting Statement
72	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Advance Letter 100202	General	The advance letter reading level is too high and the role of IMPAQ International is not clear.	Recommend that the reading level of the language in the letter be lowered. Recommend to add the IMPAQ International is a contractor being used by Medicare to conduct the survey	Accept	It is reasonable to lower the reading level of the documents and add descriptive language to the Advance Letter to further identify the contractor.	Add text to Advance Letter
73	Gateway Health Plan (Medicare Assured - H5932)	6401 OMB Survey Instrument 100202	General	The beneficiaries are being contacted because they filed a complaint with 1-800-Medicare, but all questions are directed at the plan. No questions with regard to the service the beneficiary received by Medicare.	*N/A*	Reject	Survey questions are designed to measure plan performance rather than Medicare.	No action needed
74	Group Health Cooperative and its wholly owned subsidiary, H2810 Group Health Options, Inc.	6401 OMB Survey Instrument 100202	Q2	1-800 Medicare representatives do not appear to be adequately trained on the use and purpose of the CTM and all need training on how to use it correctly. Improper categorization of complaints leads to difficulties for the plans attempting to resolve the complaints.	Evaluating the CTM would need to include whether or not the complaint was correctly categorized by 1-800-Medicare and whether 1-800-Medicare delivered the complaint to the correct party.	Reject	CTM categorization issues should have minimal impact on effective and timely complaint resolution. Complaint type will also be taken into consideration and excluded, if necessary. Sampling strategy will take into consideration complaints to be addressed.	No action needed
75	Group Health Cooperative and its wholly owned subsidiary, H2810 Group Health Options, Inc.	General	General	The measure seems to be designed simply to lower plan star ratings. Some plans receive very few complaints. The complaints that these plans receive will all be subject to review whereas only a percentage of complaints for other plans will be reviewed.	*N/A*	Reject	Statistically representative samples and enrollment size variables will be taken in consideration when developing measures.	No action needed

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76	Group Health Cooperative and its wholly owned subsidiary, H2810 Group Health Options, Inc.	General	General	Plans are already measured by CMS on CAHPS surveys for beneficiary perception of complaint resolution, and this is published to the public on www.medicare.gov	Suggested not to use the proposed measure as a performance measure for plans. Please use CAHPS process for eliciting responses from beneficiaries.	Reject	The CAHPS surveys do not capture the beneficiary's satisfaction with the plan's handling of their complaint. This is a new and necessary measure.	No action needed
77	Group Health Cooperative and its wholly owned subsidiary, H2810 Group Health Options, Inc.	General	General	Gathering information on beneficiary satisfaction with the CTM process is not an accurate measurement of what plans must do to be in compliance with CMS regulations to correctly resolve CTM complaint, and the role that CMS plays in CTM resolutions.	An accurate assessment of whether the CTM process works from the beneficiary perspective would need to incorporate all the CMS rules plans must comply with, and what role CMS itself plays in the CTM complaint resolution decisions.	Partial Accept	The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis.	Add text to Supporting Statement
78	Group Health Cooperative and its wholly owned subsidiary, H2810 Group Health Options, Inc.	6401 OMB Survey Instrument 100202	General	Why does CMS focus on such negative response? There are no questions that positively measure helpfulness and courtesy of plans regardless of what the complaint is. This survey is designed to elicit the most negative response possible from beneficiaries.	*N/A*	Accept	The survey questions have been revised to reflect more neutral wording.	Add text to Supporting Statement Edit survey instrument
79	Independent Health (HP010)	6401 OMB Survey Instrument 100202	Q8	Question # 8 from the survey attempts to get to the core of why the person was dissatisfied but it is reasonable to expect that a person who did not have a problem resolved favorably will take the opportunity to "kill the messenger".	*N/A*	Accept	Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan. Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating.	Edit survey instrument
80	Independent Health (HP010)	6401 OMB Survey Instrument 100202	General	The current survey gives the member an opportunity to bash their plan without taking into account the terms and conditions of their contract or whether the response to the complaint was within the appropriate time frame.	The "new" survey should ask the member what it is that could have been done differently to avoid the complaint in the first place or to help resolve the problem quicker once it has been identified. It should also ask if the member has filed complaints about this plan previously.	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in justification statement. Other CMS data will be used to control for plan characteristics and beneficiary profiles. CMS will assess the validity of complaints against plans and screening complaints that are included in analysis. CMS will add an additional question to the survey asking beneficiaries for feedback such as, what it is that could have been done differently to avoid the complaint in the first place or how the complaints process can be better handled by their plan.	Add text to Supporting Statement A Edit survey instrument

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81	Independent Health (HP010)	6401 OMB Survey Instrument 100202	Q7	(From question #7 on the survey) Now, please indicate how satisfied you are with the way your complaint was handled by the plan. A complaint that is not resolved in the members favor has a very limited chance of being reviewed favorably in the manner in which it was handled. A complaint that was resolved in the members favor, has a better chance of getting rated favorably even if the manner in which the problem was handled was not in accordance with all of the guidance.	*N/A*	Partial Accept	CMS understands there is a possibility that beneficiaries will associate dissatisfaction with the resolution and the overall complaint experience. In order to address this concern, the supporting statement will clarify the difference between "resolution" and "final outcome." An emphasis on “final outcome or decision” rather than “resolution” puts the focus on the series of actions the plan took, regardless of whether the beneficiary believes his/her complaint was resolved. Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. Survey questions will be reworded to be more neutral. Beneficiaries will be asked to provide an opinion of the resolution regardless of whether they agree with it.	Add text to Supporting Statement Edit survey instrument
82	Independent Health (HP010)	6401 OMB Advance Letter 100202	General	The letter states that "answers will be kept strictly confidential and be used only for research purposes."	The letter should clarify and put emphasis on plan monitoring. To simply state "research purposes" is misleading/not clear on how the results will be used.	Accept	Add language to the Advance Letter to describe the intended use of collected data. The purpose of the data collection (to improve how complaints are handled and to inform the development of a plan rating system) will be explained better.	Add text to Advance Letter
83	Independent Health (HP010)	6401 OMB Survey Instrument 100202	Q6	(From question #6 on the survey) How satisfied are you with the amount of time it took to resolve your complaint? This doesn't measure the plans responsiveness. The plan could have resolved the issue within 24 hours but if the member perceived that this was too long, we fail. (i.e.: if the member spends more time in pain because of the response time) This question does a better job of measuring whether the regulation that defines the response time is tracking with the member expectation of reaching a resolution to their problem.	*N/A*	Accept	Question 6 has been removed from the survey. Some issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument.	Remove Q6 from survey instrument
84	Independent Health (HP010)	6401 OMB Survey Instrument 100202	General	When compiling a score from these surveys, CMS should take into account whether the plan complied with the regulation.	If it did, the results should be reported separately from those that failed to comply with the regulation. Plans should not be penalized when they adhere to and execute based on government regulations.	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis.	Add text to Supporting Statement

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85	Independent Health (HP010)	6401 OMB Survey Instrument 100202	Q10	(From question # 10 from the survey) During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved? Then 11 options are given. Option 4: "It caused me stress and anxiety" should be removed and the member should be able to have that as a write-in on the "Other - please specify" option. A complaint, regardless of whether it was justified or not, handled properly or not; or handled timely or not is going to cause stress and anxiety. Having this arbitrary option diminishes the value of the other serious issues that the remaining options define, such as loss of coverage or missing an opportunity to undergo a necessary procedure.	*N/A*	Accept	Experiencing stress and anxiety is important and necessary to capture the severity of their experience. However, CMS will classify it as "extreme" stress and anxiety.	Edit Q10
86	Independent Health (HP010)	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	This section states that urgent and immediate need complaints will be used.	CMS would be able to increase the sample size and accuracy of the study if this was also opened to 30 day cases.	Reject	Immediate and urgent complaints are the primary concern of CMS.	No action needed
87	Independent Health (HP010)	6401 OMB Supporting Statement B 100202	Methods to Maximize Response Rates and Data Reliability	This section states that "interviewers especially skilled at encouraging cooperation will be available to persuade reluctant respondents to participate and will be assigned to attempt conversions with respondents who initially refuse (except for hostile refusals)." This sounds like interviewers will be badgering and attempting to talk potential respondents into participating until they become hostile. This seems like the wrong approach. Also, if interviewers persuade respondents to participate, these interviewers could potentially go too far by trying to persuade specific responses (particularly if a respondent sounds indecisive).	Respondents should be allowed to refuse initially, and their refusal response should be accepted and respected.	Reject	It is standard procedure in call center surveys. The call center staff have been trained to encourage participation without being forceful.	No action needed
88	Independent Health (HP010)	6401 OMB Survey Instrument 100202	Q5	(From question #5 on the survey) Did you have to make more than one attempt to resolve your complaint before the plan contacted you?	If the answer is "Yes", then the member should say "how many times".	Partial Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument
89	Independent Health (HP010)	6401 OMB Survey Instrument 100202	General	Will CMS take into consideration instances in which members make negative commentary even if the plan is expeditious and concise in its response, particularly in cases in which the plan is not at fault for the member's situation?	*N/A*	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will consider assessing the validity of complaints against plans and screening complaints that are included in analysis.	Add text to Supporting Statement

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90	Independent Health (HP010)	6401 OMB Survey Instrument 100202	Q3	(From question #3 on the survey) How satisfied are you with the resolution of your complaint? This is asking the member if the complaint was resolved to their satisfaction, not necessarily to the letter (or spirit) of the contract. It does nothing toward measuring whether the complaint was justified, resolved in accordance with the contract or handled within a time frame that meets the regulation. It actually measures how well the member likes the complaint resolution process that CMS has defined	*N/A*	Partial Accept	To ensure beneficiaries respond to the question as intended, the word "resolution" will be replaced with "final outcome" in Q3. An "NA" answer choice is available for beneficiaries who do not believe they have received a final outcome or who do not remember the resolution of their complaint. The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. More information will be included regarding analysis plans and calculations of satisfaction.	Add text to Supporting Statement
91	Independent Health (HP010)	6401 OMB Supporting Statement B 100202	Procedures for the Collection of Information	A minimum confidence level of 85% is not high enough.	The confidence level should be at least 90%, preferably 95%.	Reject	We cannot comply with this suggestion for several reasons: a) it is cost-prohibitive for the study, b) it would increase burden on beneficiary respondents, and c) some contracts may not have enough complaints to receive a measure and this may count negatively in the beneficiary's choice of a plan.	No action needed
92	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q7	Current language: "Now, please indicate how satisfied you are with the way your complaint was handled by the plan." This question is problematic in a similar manner as question 2. The question, as currently written, provides no context for the beneficiary as to the rules and constraints the Part C sponsor has as a regulated entity by CMS. As most beneficiaries do not fully understand the rules and processes Medicare Advantage plans must use to resolve issues, especially those related to enrollment/disenrollment which compromise 70% of Kaiser CTM cases, the concern is that this question may lead to responses that relate directly to actions/timing of the health plan that are not under the control of the Part C sponsor.	*N/A*	Partial Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will assess the validity of complaints against plans and screen complaints that are included in analysis. Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating.	Add text to Supporting Statement
93	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	General	Kaiser has strong concerns about the proposed project. While Kaiser supports and believes in beneficiary satisfaction with their Medicare Advantage and Prescription Drug plans, Kaiser feels that this survey is not an appropriate measure of the Part C sponsor's performance or its members' satisfaction with the Part C sponsor.	Kaiser urges CMS to reconsider and strengthen this project, as more fully discussed below.	Accept	CMS will clarify that the proposed project is intended to explore the possibility for a future performance measure. Based on public comments, CMS has made significant improvements to the survey and study design and intends to continue strengthening the project. After thorough testing and analysis of all collected data, CMS will decide if it will be possible to formulate a performance measure.	Edit survey instrument

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94	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q1	Current language: "According to our records, the complaint you filed was recently closed by the plan. Was the complaint resolved?"	We suggest alternative language for increased beneficiary understanding: "The complaint you filed with Medicare on xx/xx/xx was closed on xx/xx/xx by your Medicare health plan. Did the health plan explain how your complaint was handled and what the outcome was?"	Partial Accept	CMS recognizes the merit in providing the date of the complaint, however this suggestion will be included in the survey introduction as opposed to Q1.	Edit introduction of survey instrument
95	Kaiser Foundation Health Plan, Inc.	6401 OMB Advance Letter 100202	General	The Advance Letter indicates that the survey will be asking Medicare beneficiaries about "how well the [Medicare] program" responds to concerns and how "satisfied" the beneficiary is with the outcome of their complaint. This characterization of the survey, however, is not a truly accurate representation of the survey. Rather, it is a survey of the beneficiary's satisfaction with their Medicare plan's CTM resolution process, which may or may not be under the complete control of the Part C sponsor.	Kaiser urges CMS to screen the CTM complaints to determine if issues that are outside of the control of the Part C sponsor (i.e. enrollment/disenrollment issues) are at the core of the complaint and remove them from the survey pool.	Accept	CMS is well aware of other factors affecting complaint outcomes and issues outside the control of the plan. Approaches to control for these issues need do be described in more detail in the supporting statement. CMS will consider the validity of complaints against plans and screen complaints that are included in analysis. However, CMS disagrees that the survey is improperly characterized in the Advance Letter.	Add text to Supporting Statement
96	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q2	Current language: "What was the resolution?"	We suggest alternative language that is more specific in terms of obtaining a defined, and useful response: "Whether or not you agreed with the outcome, did you understand the outcome of your complaint?"	Partial Accept	While CMS does not accept the suggested revision, we recognize the importance of clarifying the difference between "resolution" and "outcome." To this end, the survey instrument and supporting statement will be edited to reflect the updated language.	Add text to Supporting Statement Edit Survey instrument
97	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	General	The survey, as currently structured, does not provide an unbiased and quality framework to properly assess member satisfaction with Part C sponsors. Rather, it is likely to result in distorted perceptions of health plans and their complaint resolution processes with members rather than meaningful data with which to assess Part C sponsors.	*N/A*	Partial Accept	CMS would like to clarify that this survey gathers data regarding the experiences beneficiaries may have during the complaint resolution process. CMS does recognize the importance of clarifying the difference between "resolution" and "outcome." To this end, the survey instrument and supporting statement will be edited to reflect the updated language. In the development of the performance measure, several factors will be considered as to not rely on one single item such as beneficiary's response of experiences of stress and anxiety.	Add text to Supporting Statement Edit survey instrument
98	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q1	Current language: "According to our records, the complaint you filed was recently closed by the plan. Was the complaint resolved?"	In addition, it is suggested that if, according to the response of the beneficiary, the complaint resolution was not the desired outcome, CMS should consider it "unresolved" and end the survey with the beneficiary.	Reject	An emphasis on "final outcome or decision" rather than "resolution" puts the focus on the series of actions the plan took, regardless of whether the beneficiary believes his/her complaint was resolved. Beneficiaries who feel their complaints have not been resolved may still contribute their opinions regarding how the complaints were handled.	No action needed

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99	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q5	Current language: "Did you have to make more than one attempt to resolve your complaint before the plan contacted you?" This information is already captured by CMS.	The CTM module in HPMS has a repeat complainant function; as such, it is suggested that this question be eliminated.	Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument
100	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q9	Current language: "Based on your recent experience with this plan, are you planning to stay with this plan when you have an opportunity to switch plans?" In the context of a beneficiary that has disenrolled with the Part C sponsor at the time of survey, this question is not applicable. In the context of current members, however, this question is of great concern as it suggests to members that they should consider switching plans. Moreover, this question leads to the possibility that beneficiaries will respond to factors outside the context of the complaint resolution itself (e.g. change of provider, monthly premium, relocation, etc.).	It is suggested that this question be omitted from the survey as it does not provide feedback that is limited to the beneficiary's experience with the complaint resolution process.	Partial Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan. CMS is not suggesting that beneficiaries switch plans, but merely asking whether beneficiaries are likely to do so.	Edit Q9
101	Kaiser Foundation Health Plan, Inc.	6401 OMB Supporting Statement A 100202	Background	Beyond the sampling set proposed for this survey, Kaiser has concerns related to the timing of the survey itself. CMS proposes to conduct the survey using January and February 2011 CMT complaints. During this time period it is very likely that the complaints received by CMS and logged into CTM will be heavily biased in terms of the substance of the complaints as relating to plan/benefit changes which may be disproportionate to other types of complaints received throughout the plan year and may only be reflective of temporary issues caused by new CMS requirements.	*N/A*	Partial Accept	CMS is interested in the months with the largest number of complaints in order to achieve the most statistically valid sample. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	No action needed
102	Kaiser Foundation Health Plan, Inc.	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	"All Medicare Advantage and Prescription Drug plans will be surveyed, regardless of their enrollment size" There is no mention, however, of the possibility that Part C sponsors with low volumes of complaints in CTM that are in the surveyed category may be misrepresented in the survey. This possibility that the variation in distribution of complaint types will likely vary significantly between Part C sponsors with large enrollments (and likely larger numbers of complaints) and Part C sponsors with smaller enrollments (and likely fewer numbers of complaints) is of concern to Kaiser as it may lead to misrepresentations of Part C sponsors irrespective of the actual sponsors' overall efforts at complaint resolution.	Kaiser suggests CMS implement a minimum threshold of CTM complaints during the survey time period in order for a Part C sponsor to be included in the survey.	Reject	CMS is well aware of small sample size issues and has decided to proceed with collecting data for these contracts.	No action needed
103	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Introduction	The introduction indicates that beneficiary "recently filed a complaint with their Medicare plan", but actually the beneficiary filed a complaint with CMS through the CTM system.	We suggest revision of language to following: "According to our records, you recently filed a complaint through 1-800-Medicare."	Partial Accept	CMS disagrees with the inclusion of 1-800-Medicare in the survey. Not all complaints are captured through 1-800-Medicare and this may be confusing for some beneficiaries. However, the survey introduction will be reworded to improve beneficiary understanding.	Edit introduction of survey instrument

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104	Kaiser Foundation Health Plan, Inc.	6401 OMB Supporting Statement A 100202	Information Users	Kaiser has concerns as to the ultimate use of the information collected by the survey. It is unclear based on the documents describing this survey if or when Part C sponsors would receive a detailed report of the results of the survey.	Kaiser recommends that CMS provide detailed survey results to Part C sponsors so that they can implement process improvements as necessary. Moreover, the release of this report to Part C sponsors would further CMS' goal of transparency within the Medicare program.	Partial Accept	CMS will follow a similar process for this measure as it does for other measures. It is undetermined what level of data will be shared with plans. This data collection is a preliminary effort to develop a satisfaction measure. CMS will review the feasibility to develop a performance measure in coming years.	No action needed
105	Kaiser Foundation Health Plan, Inc.	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Kaiser is concerned that CTM cases may not be appropriately categorized and the beneficiary issue is not fully and accurately reflected in the notes that the Part C sponsor receives. If there is less than accurate information transmitted to the Part C sponsor, it is to the Part C sponsor's disadvantage in terms of resolution of the issue in a manner optimal to the beneficiary as well as the Part C sponsor.	*N/A*	Reject	CTM categorization issues should have minimal impact on effective and timely complaint resolution.	No action needed
106	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q6	Current language: "How satisfied are you with the amount of time it took to resolve your complaint?"	Suggested language: "Health Plans have xx days to resolve complaints like the one you filed. Your complaint was resolved in xx days. How satisfied are you with that time frame?" The rephrasing of the question to include the context in which Part C sponsors must operate helps to provide the beneficiary with a reasonable expectation of what is an "acceptable" response time.	Partial Accept	Question 6 has been removed from the survey. Some issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument.	Remove Q6 from survey instrument
107	Kaiser Foundation Health Plan, Inc.	6401 OMB Supporting Statement B 100202	Respondent Universe and Sampling	Kaiser questions the value of the beneficiary's response to the closure of his/her CTM complaint given that the beneficiary likely will not have a full understanding of the rules Medicare Advantage plans must follow to resolve system discrepancies. While Kaiser is sympathetic to the beneficiary's frustration and will do what it can to assist the beneficiary, the ultimate resolution of the issue is beyond Kaiser's immediate control. However the survey of the beneficiary based on this circumstance will not take into account this context for the Part C sponsor.	*N/A*	Partial Accept	The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement
108	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q3	Current language: "How satisfied are you with the resolution of your complaint?" As mentioned above, without a clear understanding of Medicare rules, the beneficiary may not be satisfied with the outcome, and the Part C sponsor may be unable to take any different action.	We suggest language that would indicate that there may be specific CMS rules that the Part C sponsor had to follow in terms of resolution of the complaint: "Was it explained to you how the plan reached its resolution of your complaint? With that information, were you satisfied with the explanation?"	Partial Accept	To ensure beneficiaries respond to the question as intended, the word "resolution" will be replaced with "final outcome" in Q3. An "NA" answer choice is available for beneficiaries who do not believe they have received a final outcome or who do not remember the resolution of their complaint. The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. More information will be included regarding analysis.	Add text to Supporting Statement Edit Q3

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109	Kaiser Foundation Health Plan, Inc.	6401 OMB Survey Instrument 100202	Q10	Current language: "During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved?" As written, this is a leading question.	It is suggested that the question be revised as follows: "During the complaint process did you experience any problems while you were waiting for your complaint to be resolved?" If yes, then the surveyor can ask further details. If the answer is no, the list of items will not be provided.	Accept	This question gathers data regarding the experiences beneficiaries may have during the complaint resolution process. The survey questions have also been revised to reflect more neutral wording.	Edit Q10
110	Medco Health Solutions	6401 OMB Survey Instrument 100202	Introduction	With regards to the introductory statement, "According to our records, you recently filed a complaint with your Medicare plan."	We recommend being more specific here, as in the introductory letter, and including reference to 1-800-Medicare.	Partial Accept	CMS disagrees with the inclusion of 1-800-Medicare in the survey. Not all complaints are captured through 1-800-Medicare and this may be confusing for some beneficiaries. However, the survey introduction will be reworded to improve beneficiary understanding.	Edit introduction of survey instrument
111	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q4	Q4. Did the plan contact you about your complaint? This includes contact by telephone, mail, email, or other means.	• We suggest adding "don't know" and "don't remember" to the list since it may be a common response to this question. ☐ Yes ☐ No ☐ Don't Know/Don't remember	Accept	Question 4 has been removed and issues of plan communication with the beneficiary have been incorporated in Q2 of the new survey instrument. "I don't know/NA" answer choices will also be offered to the respondents.	Edit survey instrument
112	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q8	Q8. Why are you dissatisfied with the way your complaint was handled?	• Suggest adding additional options to the list: ☐ Plan staff did not provide me with any alternatives ☐ I was not happy with the outcome	Partial Accept	Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan.	Edit survey instrument
113	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q7	Q7. Now, please indicate how satisfied you are with the way your complaint was handled by the plan. Same concern with a 4 point scale.	*N/A*	Partial Accept	A neutral answer choice would be "neither satisfied nor dissatisfied." However, CMS decided against including a neutral answer choice in order to encourage beneficiaries to select an opinion one way or the other. Instead, CMS will provide an "I Don't Know/NA" answer choice for beneficiaries who do not believe they have received a final outcome or who do not remember the resolution of their complaint.	Edit survey instrument
114	Medco Health Solutions	6401 OMB Survey Instrument 100202	General	The approach that will be used for training may result in upset/irritated responders which could negatively impact results.	A softer tone should be considered to persuade responders to complete the telephone surveys.	Partial Accept	CMS understands the concern with protecting beneficiaries, but surveyors will be complying with call center protocols. This approach will be clarified in the supporting statement. Text in the advance letter and survey introduction will also be revised.	Edit introduction of survey instrument Add text to supporting statement Edit Advance Letter

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115	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q10	Q10. During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved? We find this question to be negatively worded.	We suggest a revision: Q: During the complaint process, did you experience any problems during the resolution of your complaint? – Yes/No – If yes, please mark all that apply. For Phone surveys: • Since the list is lengthy, we recommend creating a predefined list for the surveyor to select from with an option for "other/free form text". • If the direction is to read the list then we suggest rotating the list for each survey to ensure that results aren't skewed toward those on the top of the list. For Mail surveys: • Several of the options do not apply to PDP plans. Our suggestion is to suppress for the survey. If this can't be done then our suggestion is to add "(if applicable)" or "(applies tot MAPD Plans only)" to the option: – Option 6 is specific to MAPD – Option 7 should be "Out of Network" for PDP plans (Out of Plan indicates MAPD) – Option 9 is specific to MAPD – Option 10 is specific to MAPD	Partial Accept	CMS did not agree with the suggested revisions, however this question will be revised to incorporate a more neutral tone. This question gathers data regarding the experiences beneficiaries may have during the complaint resolution process.	Edit survey instrument
116	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q3	Q3. How satisfied are you with the resolution of your complaint? We are concerned about the use of a 4 point scale for the survey. It is common for people to be dissatisfied with the handling of the complaint because they won't be able to differentiate between the complaint itself and the complaint handling. The likelihood of anyone responding "satisfied" on a complaint survey is low. A 5 point scale would allow for the option to respond "neutral."	We suggest tightening the question to ensure the respondent is rating the overall experience and not one specific area. For example, "Taking all aspects of the complaint resolution process into consideration, how satisfied are you with the process?"	Partial Accept	To ensure beneficiaries respond to the question as intended, the word "resolution" will be replaced with "final outcome" in Q3. An "NA" answer choice is available for beneficiaries who do not believe they have received a final outcome or who do not remember the resolution of their complaint. The supporting statement will clarify the difference between "resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines. In the development of the performance measure, several factors will be considered as to not rely on one single item such as beneficiary's response of experiences of stress and anxiety.	Add text to Supporting Statement
117	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q6	Q6. How satisfied are you with the amount of time it took to resolve your complaint? Same concern with a 4 point scale.	*N/A*	Partial Accept	Question 6 has been removed from the survey. Some issues related to the amount of time it took to resolve a complaint have been incorporated in Q2 of the new survey instrument.	Remove Q6 from survey instrument

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#	**Organization**	**Document**	**Item**	**Description of Issue or Question**	**Suggested Revision**	**CMS ACTION**	**REASON FOR ACTION**	**Need to:**
118	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q9	Q9. Based on your recent experience with this plan, are you planning to stay with this plan when you have the opportunity to switch plans? • We find this question may lead the person to respond negatively	We recommend rewording it. For example: Q: How likely are you to stay with <Plan Name> in the future?" • Additionally, being able to differentiate responses by new vs. existing members would be beneficial. We suggest adding two demographic questions at the end of the survey to assist with results analysis: Q: Are you new to Medicare? Q: (If not new to Medicare) Are you new to the <Plan Name>	Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan. CMS is not suggesting that beneficiaries switch plans, but merely asking whether beneficiaries are likely to do so.	Edit Q9
119	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q2	Q2. What was the resolution? The open-ended responses to this survey question will be used in the "Resolution Veracity" indicator. The survey responses will be compared to the resolution summary provided by the plan in the CTM. Thereby, the indicator will indicate what percentage of a plan's CTM resolution descriptions agree with the experience described by the beneficiary.	• We suggest using pre-defined areas for this question, with the option for "other" to capture free form text. This would allow specific areas of focus with sufficient sample to draw a conclusion. For phone surveys, – recommend the surveyor fits the response into pre-defined areas with an option for free-form versus reading each area. (see below). For mail surveys, – recommend providing a list of pre-defined areas with an option for free form responses. • Based on an analysis of previous complaint types, we would like to suggest "pre-defined areas" as follows: – Enrollment correction – Disenrollment submitted – Prescription issued – Temporary supply provided – Coverage Determination offered – Explanation provided – Other (with free form text box)	Partial Accept	CMS will review beneficiaries response with HPMS CTM records for the veracity of the complaint resolution. Additional information on the use of this data will be included in the supporting statement.	Add text to Supporting Statement

Parts C and D Complaints Resolution Performance Measure OMB PRA Package								
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120	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q5	Q5. Did you have to make more than one attempt to resolve your complaint before the plan contacted you?	We suggest expanding on this question so it can be determined 1) who was contacted first (Medicare or the Plan), 2) And the number of contacts made prior to speaking with the Plan. It would be beneficial to know if the member attempted to resolve with the Plan before calling 1-800-Medicare, or if the issue went straight to CMS. For example: Q: Prior to filing your complaint with CMS, how many times did you attempt to resolve your issue directly with <Plan Name>? – 0 – 1 – 2 – 3 or more – Don't know/Don't remember Q: After filing your complaint with CMS, how many additional times did you attempt to resolve your issue? – 0 – 1 – 2 – 3 or more – Don't know/Don't remember	Partial Accept	CMS has decided to drop questions of repeat complaints or multiple attempts to contact the plan.	Remove Q5 from survey instrument
121	Medco Health Solutions	6401 OMB Survey Instrument 100202	Q1	Q1. According to our records, the complaint you filed was recently closed by the plan. Was the complaint resolved? • This question is critical to distinguish responder perception of complaint completion since satisfaction can greatly differ based on this.	Therefore we suggest a more specific line of questioning so the results can be differentiated between responders who believe the complaint is resolved vs. responders who feel it's not resolved. For example: Q: According to our records the complaint that you filed with CMS was recently closed by <Plan Name>. Is this your understanding? Q: If yes - Was your complaint fully resolved? ☐ Yes - go to Q2 Q: If No - Please explain why. ☐ Skip to Q4. ☐ For responders that don't think it's complete the questions should end after Q5 or differ then the questions for "yes". Q: Don't know	Partial Accept	The supporting statement will clarify the difference between the selected terms. "Resolved" will be replaced with "settled" in this question to prevent beneficiary bias. An "I don't know" answer choice has been added for beneficiaries who feel they do not yet have a resolution or are unsure/do not remember."resolution" and "final outcome." The survey will also be revised to distinguish responders who believe the complaint is resolved vs. responders who feel it is not resolved.	Add text to Supporting Statement Edit Q1
122	Medco Health Solutions	General	General	Has a satisfaction goal been established? And will a goal be set differently for mail vs. phone results?	*N/A*	Reject	The survey instrument is consistent for both implementation approaches. Furthermore, it is expected that most surveys will be answered by phone and a small proportion of surveys will be answered via mail.	No action needed
123	Medco Health Solutions	6401 OMB Survey Instrument 100202	General	For consideration.	Recommend including the plan name & type within the survey so it is clear to the responder what plan the survey is for, and not for Medicare in general.	Accept	To reduce confusion about the topic and source of the complaints, the advance letter will make explicit reference of the MAO or Part D sponsor.	Add text to Advance Letter

Part C and D Complaints Resolution Performance Measure

60-Day Comment Summary

Parts C and D Complaints Resolution Performance Measure OMB PRA Package								
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124	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q8	Why are you dissatisfied with the way your complaint was handled?	We suggest the following modification to the question being asked: "Please indicate how satisfied you are with the following support you received from the plan Length of time to process my complaint (Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied) Treated with courtesy and respect (Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied) Staff explained things in a way that was easy to understand (Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied) Staff provided enough information (Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied) Other comments (specify)"	Accept	Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan. Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating.	Edit survey instrument
125	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q8	Why are you dissatisfied with the way your complaint was handled?	We recommend that this question should be skipped if the member indicates that they are satisfied with how the complaint was handled. (Response to Q7)	Partial Accept	Q8 has been removed and the new Q2 is a satisfaction question that encompasses more aspects of the complaint process such as coutesy of the plan representative and time until contact by the plan. Clarifying text will be added to Q7 asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself. The purpose of this question will be to provide an overall satisfaction rating.	Edit survey instrument
126	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q7	Now, please indicate how satisfied you are with the way your complaint was handled by the plan.	We suggest the following modification to the question being asked: "Please indicate how satisfied you are overall with the way your complaint was handled by the plan. (Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied)"	Accept	CMS has decided to add clarifying text to this question asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome itself and focus on different aspects of the complaint process and the overall handling of the complaint (New questions Q2 and Q6).	Edit Q7
127	SilverScript Insurance Company and RxAmerica	6401 OMB Supporting Statement A 100202	General	Also, plans with a higher number of mentally challenged members would likely get lower marks, simply because of the demographics of their populations.	*N/A*	Accept	Beneficiary characteristics will be taken into consideration in the analysis of survey data. Further details regarding analyses will be included in supporting statement A.	Add text to Supporting Statement
128	SilverScript Insurance Company and RxAmerica	General	General	How will CMS determine who to survey? We have complaints filed by outside agencies, pharmacies, appointed representatives and congressional offices. The member may not always be involved in the resolution, but the complaint is resolved and handled appropriately.	*N/A*	Accept	CMS considers an appointed representative to be a valid respondent. Further clarification will be added to the supporting statement regarding the participation of appointed representatives in the survey. This explanation will include how representatives will be contacted (through beneficiaries and/or CTM logs) and how representative data can be used in the survey data analysis.	Add text to Supporting Statement

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129	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q5	Did you have to make more than one attempt to resolve your complaint before the plan contacted you? Is there any analysis planned to identify situations where enrollees make repeat requests hoping to obtain a different outcome?	*N/A*	Partial Accept	CMS has decided to drop questions of repeat complaints/multiple attempts to contact the plan. CMS will focus on complaints as the unit of analysis. No analysis will be conducted for the small number of repeated complaints.	Remove Q5 from survey instrument
130	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q9	Based on your recent experience with this plan, are you planning to stay with this plan when you have the opportunity to switch plans?	We recommend that this question should not be asked. Members should be encouraged to evaluate all aspects of the plan's performance, and not encouraged to focus on a single event when determining which plan best fits his/her needs.	Accept	CMS has decided to reword this question to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan.	Edit Q9
131	SilverScript Insurance Company and RxAmerica	6401 OMB Supporting Statement A 100202	Background	The time frame for the survey of members in immediately after the January 1st plan year start. This is a time of year when members are just becoming familiar with the elements of their new plan, and yet in many cases, because of transition policies, may not be experiencing the full impact of others.	CMS should consider selecting a different time period.	Reject	CMS is interested in the months with the largest number of complaints in order to achieve the most statistically valid sample.	No action needed
132	SilverScript Insurance Company and RxAmerica	General	General	Will CMS provide specifics on how plans will be evaluated?	*N/A*	Reject	CMS will follow a similar process for this measure as it does for other measures. Technical specifications will be provided.	No action needed
133	SilverScript Insurance Company and RxAmerica	6401 OMB Supporting Statement A 100202	General	Is there any implication of the "Do Not Call List." How will CMS gather data on members residing in LTC or other situations where access to a phone is not readily available?	*N/A*	Accept	Phone numbers are included in CMS datasets including the CTM records.	No action needed
134	SilverScript Insurance Company and RxAmerica	6401 OMB Supporting Statement A 100202	General	There have been cases that were our members have complained that they never received promised reimbursement, yet we are able to show canceled checks where they did.	A plan should be able to provide supportive data showing that they took the actions required.	Partial Accept	The purpose of the survey is to ascertain the satisfaction of the beneficiaries, not the appropriateness of the plan's actions. CMS will incorporate several data into the development of the preliminary measures including complaint categories, CMS guidelines, beneficiary and plan characteristics.	No action needed
135	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q1	According to our records, the complaint you filed was recently closed by the plan. Was the complaint resolved?	Please clarify what the definition of "resolved" means. We ask because resolution of an issue may not result in the enrollee being satisfied in the event the enrollee doesn't understand the requirements of the program that the Part D plan must comply with. As such, the enrollee might not conclude that the issue was resolved even after the Part D plan has done all it can to resolve it.	Partial Accept	The supporting statement will clarify the difference between the selected terms. "Resolved" will be replaced with "settled" in this question to prevent beneficiary bias. An "I don't know" answer choice has been added for beneficiaries who feel they do not yet have a resolution or are unsure/do not remember."resolution" and "final outcome." Analyses will incorporate information about resolutions in which plans are constrained by CMS guidelines.	Add text to Supporting Statement

Part C and D Complaints Resolution Performance Measure

60-Day Comment Summary

Parts C and D Complaints Resolution Performance Measure OMB PRA Package								
#	**Organization**	**Document**	**Item**	**Description of Issue or Question**	**Suggested Revision**	**CMS ACTION**	**REASON FOR ACTION**	**Need to:**
136	SilverScript Insurance Company and RxAmerica	6401 OMB Survey Instrument 100202	Q10	During the complaint process, what problems did you experience while you were waiting for your complaint to be resolved? There are concerns that Q10 is ambiguous as far as evaluating the plan's handling of requests. Even if the plan resolved the request in a very timely fashion, perhaps providing satisfaction to the member, that member may experience problems (e.g. stress and anxiety, out-of-pocket expenses, etc.) due to the event that raised the grievance, not necessarily a result in the delay of the resolution of that grievance. How will the person filling out the survey interpret this question?	*N/A*	Partial Accept	This question gathers data regarding the experiences beneficiaries may have during the complaint resolution process. The survey questions have also been revised to reflect more neutral wording. In the development of the performance measure several factors will be considered as to not rely on one single item such as beneficiary's response of experiences of stress and anxiety.	Edit Q10