Part C and D Complaints Resolution Performance Measure

CMS-10308

OMB Supporting Statement – Part A

September 3, 2010

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A. Background

The Health Maintenance Organization Act of 1976, the Balanced Budget Act of 1997 (BBA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) introduced private insurers into the Medicare program. With the HMO Act of 1976, health maintenance organizations (HMOs) began to be offered as a Medicare option. The BBA established the Medicare + Choice program, which gave beneficiaries the option of enrolling in a variety of private plans including HMOs, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. Title I of the MMA established the new prescription drug benefit under Part D of Title XVIII of the Social Security Act (Act). Title II of the MMA modified Part C of the Act to rename the Medicare + Choice program as the Medicare Advantage (MA) program. These programs are administered by the Centers for Medicare & Medicaid Services (CMS).

Part C Sponsors provide medical coverage through at-risk arrangements with CMS. Part C Sponsors include: Local Coordinated Care Plans, which include HMOs, PPOs, and PSO plans; Private fee-for-service plans (PFFS); Special needs plans (SNPs); MSAs; and Regional PPOs. Under Sections 1876 and 1833(a)(1)(A) of the Social Security Act, an HMO or CMP can participate in the Medicare program by receiving "reasonable cost" reimbursement for furnishing covered services to enrolled beneficiaries. 1833 Cost Plans (or Heath Care Prepayment Plans) must either be union- or employer-sponsored and must not provide inpatient hospital services for its enrollees.

Part D Sponsors provide prescription drug benefit coverage through private at-risk prescription drug plans that offer drug-only coverage (Prescription Drug Plans), or through Medicare Advantage (MA) plans that offer integrated prescription drug and health care coverage (MA-PD plans). MA plans that offer this coverage can be risk-based or cost-based plans. A Prescription Drug Plan (PDP) serves one or more PDP regions.

The right of consumers to make informed health care treatment decisions is a tenet that has gained ascendancy in recent years. The August 8, 2006 Executive Order mandating that Federal agencies promote transparency of health care quality and pricing data was the most recent official acknowledgement of this right.[1] Due to this Executive Order, as of CY 2008, performance measurement ratings for Medicare Part C & Part D can be found online on Medicare Options Compare and the Medicare Prescription Drug Plan Finder (MPDPF), respectively. Both of these web sites provide rating information for beneficiary use. Plans are

[1] "Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," 73 Fed. Reg., 51089 (August 8, 2006). http://edocket.access.gpo.gov/2006/pdf/06-7220.pdf

assigned a performance-based star rating, which helps beneficiaries make informed choices among the many plan alternatives available to them under Medicare Parts C and D. Plans are assigned scores for each category on a scale of one to five stars, with one star indicating poor performance and five stars indicating excellent performance. Currently, Medicare Advantage Organizations are rated on how well they perform in five different domains,[2] which have a total of 33 different measures. Prescription Drug Plan sponsors are rated on how well they perform in four different domains,[3] which, combined, have 19 different measures. CMS intends to follow a procedure with the proposed performance measure similar to the one it currently uses for other measures.

To maximize the ability of beneficiaries to compare different plans, CMS seeks to expand these measures to provide more comprehensive and sensitive performance measures. The focus of the current project is to assess the satisfaction of beneficiaries with the process by which their complaints were resolved by the plans in which they were enrolled, and to evaluate the final outcome through an objective exploration of beneficiaries' complaint resolution experiences.

The agency does not have access to this information through regular administrative or reporting requirement mechanisms. The proposed data collection effort would assist CMS in obtaining this critical information. CMS has the option to use the results from this data collection effort for program monitoring (internal use) or for public reporting purposes via the Medicare Choice website or other alternative means. The survey will target a sample of complaints—filed by beneficiaries or their representatives—that have been closed in the Complaints Tracking Module (CTM) by a plan during the first quarter of CY 2011. The selected timeframe has been chosen in order to collect data for the months with the greatest number of complaints, which will therefore likely provide the most statistically valid sample (further detail regarding the proposed sampling plan is provided in Supporting Statement B). The proposed surveys will occur within 7 to 21 calendar days of the complaint closure and will collect beneficiaries' opinions on the complaint resolution process and their satisfaction with the final outcome, among other issues.

Several substantive issues are involved in this data collection request. First, CMS will follow several approaches to control for factors affecting satisfaction with the final outcome and the complaint resolution process. The key aspect is that several variables will be considered in the development of the preliminary measure so as not to rely on a single aspect of the beneficiary's experience. This includes the use of beneficiary, plan, and complaint characteristics recorded in other CMS datasets. Second, CMS will emphasize that the primary issue of interest is the "final

[2] The domains are: ratings of health plan responsiveness and care; managing chronic (long-lasting) conditions; health plan telephone customer service; staying healthy: screenings, tests, and vaccines; and health plan member complaint, appeals, and choosing to leave the health plan.

[3] The domains are: drug plan customer service; drug plan member complaints, members who choose to leave, and Medicare audit findings; member experience with drug plan; drug pricing and patient safety.

outcome or decision," to prevent confusion with a beneficiary's opinion of the decision. A focus on the "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. Third, CMS recognizes the potential for complaints that are outside the scope of the plan (restricted by CMS guidelines), particularly regarding some issues related to enrollment, complaints and will exclude such complaints from the sampling framework.

The premise of the proposed data collection is to conduct a full study of the entire population (contracts). CMS will review the results of the survey responses and the analysis and then decide whether to convert the information gathered through the survey to a set of performance measures to be used by Medicare beneficiaries for the next plan year. As mentioned before, it is also possible that CMS may choose to use the results for monitoring purposes only for any number of reasons.

There may be some potential and yet-undefined issues that would have to be addressed prior to using the information from the survey for public reporting purposes. Some potential issues are listed and described below:

a) Are beneficiaries responding distinctly to issues of complaint settlement and resolution? Can we produce performance measures that inform the difference between these two? To some extent, the pilot test will provide some insight here. However, we may need the larger scale data collection to provide more information on this issue.
b) Have the analytical methods used for composing the performance measures produce results that provide distinct outcomes across beneficiary satisfaction levels and across contracts?
c) A low response rate for certain contracts and/or low number of complaints during the data collection period (real-time data collection).
d) Positive response from industry to preliminary results regarding measurement of beneficiary satisfaction of complaint resolution.

It is important to note that CMS has addressed most technical issues with assessing the representativeness of the complaints in the sampling universe and the survey instrument has been vetted with several survey and Medicare experts including CMS staff involved on other CMS surveys (such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey). Thus, any issues that are reviewed during analysis are likely to be outside of these technical aspects. Points (a) and (c) above demonstrate the necessity of a larger scale data collection (6,500 beneficiaries) in order to ensure the high quality of the data and its viability for the development of a performance measure. CMS will review and analyze the responses to the survey and discuss the results with subject-matter experts at CMS and other institutions as well as selected Part C and D contracts to assess its usability and/or representativeness of beneficiary satisfaction with the complaint resolution process.

In addition to the vetting and technical reviews of the survey completed in advance, CMS will conduct a pilot test of 100 beneficiaries (in addition to the pre-test consisting of cognitive interviews conducted with 9 beneficiaries) to work out any technical and operational issues with the instrument or study logistics. Under very limited circumstances, CMS will consider minor adjustments to the instrument. The pilot test will simulate all tasks and activities of the full-scale study from mailing the advance letters and survey sample management to the statistical analysis of the survey responses and contract and beneficiary information.

It is important to note that all survey responses will be submitted to a rigorous analytical review using multinomial and regression analyses to produce measures that are controlled by contract characteristics (enrollment, type of contract, etc) and beneficiary characteristics. We will also compute correlation factors among different survey responses and other contract and beneficiary factors. The multinomial and regression analyses will support statements of the likelihood of a beneficiary being satisfied or not with a statistical level of certainty. Further information on the proposed analysis is included in Section B.16.a. Tabulations, *Analysis*.

As in the past, CMS strives to share information and communicate with plans on issues of performance measures. However, at this time, it is undetermined what level of data will be shared with plans regarding the results of the preliminary data collection effort and whether the data will be used to develop performance measures in this area. It should be noted that even after all technical issues have been addressed, CMS has vetted the results with the industry and there is consensus that the results of the study meet CMS objectives, CMS may still choose to not using the information for public reporting of performance measures and use the information for program monitoring.

B. Justification

1. Need and Legal Basis

This clearance package seeks approval to conduct a survey as part of the Part C and D Complaints Resolution Performance Measure project. This preliminary survey effort is sponsored by the Centers for Medicare & Medicaid Services (CMS) and is being implemented, under contract to CMS, by IMPAQ International, LLC. The purpose of the project is to develop and support implementation of a performance measure for the Medicare Advantage (Part C) and Prescription Drug (Part D) program that represents, from the beneficiary's perspective, the way in which plans handle complaints.

The proposed data collection is necessary because a survey is the only way to collect information about the resolution process from the beneficiary's perspective. Currently, there is no other data source that collects such information for Part C and Part D Medicare plans.

The proposed survey instrument is attached to this statement. An accompanying document, "Explanations for the Inclusion of Survey Questions," presents the rationale for the inclusion of each question in the survey.

2. Information Users

Data collected from the proposed surveys will be used by CMS to construct performance measures of the veracity and effectiveness of plan complaint resolution from the beneficiary's perspective. If CMS chooses to publish a performance metric using the results of the survey, it will do so in November 2011.

3. Use of Information Technology

Computer Assisted Telephone Interviewing (CATI) will be used by interviewers to conduct telephone surveys. Paper surveys will be sent through the mail to beneficiaries who cannot be reached by phone. The mail-in surveys will be identical to the telephone surveys and will not be analyzed separately. Telephone interviews are more cost-effective and impose less burden on respondents than do in-person interviews. The CATI system is installed on each interviewer's computer and assists the interviewer in conducting the survey by presenting each survey question and answer choices and automatically following skip patterns. Only the interviewer has contact with the system. CATI is more cost effective than paper and pencil interviewing for many reasons, including the fact that CATI programs accept only valid responses and can be programmed to check for logical consistency across answers. Interviewers are thus able to correct errors during the interview, eliminating the need to call back respondents to obtain missing data. Also, calls will be made through an auto-dialer, linked to the CATI system, virtually eliminating dialing error. The automated call scheduler will simplify the scheduling

and rescheduling of calls to respondents at their convenience and can assign cases to specific interviewers, for example, those who are fluent in Spanish.

The two modes of data collection (telephone and mail-in) include all the same questions and answers as the survey instrument is identical in both cases. The instrument was designed to be administered as easily by phone as by paper-and-pencil self-administration. The sole difference between the modes is that FAQs will be available to beneficiaries completing the telephone survey. However, this is not anticipated to affect the results of the data collection and the data will not be separated or treated differently in analysis. The FAQs will include general information that will also be found in the Advance Letter and the cover page of the survey instrument. For example, FAQs will cover questions beneficiaries may have about why they are being contacted, how their contact information was compiled, whether participation in the survey will affect their current benefits, and IMPAQ International's role in the data collection. As these types of questions will also be covered by the mailed materials, there is little reason to expect the mode of data collection to effect the uniformity of responses.

As detailed in Supporting Statement B (Section 3.a. Response Rates) telephone surveys are the primary mode of data collection. If any differences arise between the two modes, the effects will be minimized by the relatively small number of surveys completed by paper-and-pencil. Methods to distinguish any differences are described in the analysis overview in section B.16.a. Tabulations, *Analysis Plan*. The statistical analysis has taken into account the two modes of data collection and a control variable will be included in the multinomial analysis to assess the statistical effect of the results regarding beneficiary satisfaction.

4. Duplication of Efforts

This survey will be conducted to collect key information from CMS beneficiaries. No other survey data collection effort has been conducted or has been planned to collect similar information. The study also will use administrative data from the Complaints Tracking Module (CTM) and other CMS datasets, such as the Medicare Beneficiary Database (MBD, Common Tables). CTM data are not sufficient to conduct the study because they do not include the perspective of beneficiaries; hence, survey data are needed to supplement the CTM and other CMS data.

5. Small Businesses

The survey will only involve individual beneficiaries; therefore, it will not pose a burden to small businesses. Members of 800 series contracts will be excluded from the data collection effort for reasons described in Supporting Statement B (Section 1: Respondent Universe and Sampling).

6. Less Frequent Collection

The survey will be the primary source of data for the construction of the beneficiary-focused performance measures. The survey will collect information about the resolution process and the resolution from the beneficiary's perspective. Currently, there is no other data source that collects such information for Part C and Part D Medicare plans.

The beneficiaries affiliated with the sampled complaints for this project will only be surveyed once. Therefore, less frequent data collection is equivalent to not being able to collect any data and would result in an inability to construct the performance measures.

7. Special Circumstances

In all respects, the data will be collected in a manner consistent with Federal guidelines. The statistical survey will produce valid and reliable results that can be generalized to the universe of the study, and it will include only statistical data classifications that have been reviewed and approved by OMB. The survey will include a pledge of confidentiality that is supported by authority established in statute or regulation and by disclosure and data security policies that are consistent with the pledge. It will not unnecessarily impede sharing of data with other agencies for compatible confidential use.

8. Federal Register/Outside Consultation

a. Federal Register Notice and Comments

The first Federal Register Notice and OMB PRA Package [Document Identifier: CMS-10308] was published in the Federal Register on February 25, 2010 (Vol. 75, No. 37, page 8723). A copy of the publication is attached to this package. In response, ten organizations submitted 136 comments.

The tables below summarize the revisions made to the Advance Letter, Explanation for Inclusion of Survey Questions, Supporting Statements A and B, and the Survey Instrument.

Advance Letter

Two main issues that arose were the reading level and clarity of the letter. As such, CMS has revised the letter to read at the 8th grade level. A few clarity issues that the organizations mentioned pertained to the logistics of scheduling surveys with beneficiaries, explanation of the purpose of the survey, specific reference to the beneficiary's MAO or Part D sponsor (not Medicare), and an explanation of IMPAQ International's role. The table below summarizes these revisions to the letter.

Category	Section	Change/Reason	Effect to Reporting Burden
Response to Public Comments	Advance Letter	The reading level of the letter was lowered to 8th grade.	None
Response to Public Comments	Advance Letter	Language was added to the Advance Letter to describe the calling process and how beneficiaries should expect to be contacted.	None
Response to Public Comments	Advance Letter	Language was added to the Advance Letter to describe the intended use of collected data as opposed to: "Your answers will be kept strictly confidential and be used only for research purposes." The purpose of the data collection (to improve how complaints are handled and to inform the development of a plan rating system) was explained.	None
Response to Public Comments	Advance Letter	The advance letter has been revised to make explicit reference to the MAO or Part D sponsor as well as the role of IMPAQ International (contractor). This will reduce confusion about the topic and source of the complaints.	None

Explanations for Inclusion of Survey Questions

There was a concern that the proposed indicators did not correspond with the survey questions. CMS has revised the explanation of the proposed indicators, together with the descriptions of each survey question, to better explain their importance in developing performance measures.

Category	Section	Change/Reason	Effect to Reporting Burden
Response to Public Comments	Explanations for Inclusion of Survey Questions	This document describing the proposed indicators has been revised to better explain their importance, meanings, and how they will help develop the performance measures. Specifically: – Rationale for use of "resolution" vs. "final outcome" – Use of 4-point Likert scale vs. 5-point Likert scale (and addition of "I don't know/NA" answer choice) – Strengthening of rationale for inclusion of Veracity of Plan's Description indicator	None

Supporting Statements A and B

There was some concern about the purpose and calculation of indicators such as “Veracity of Complaints Resolution,” and “Beneficiary Awareness of Resolution.” Further information regarding these indicators has been added to the supporting statements. Some organizations were concerned with how the results of the survey will be utilized and if/when that information would be shared publicly. At this time, it is undetermined which data will be shared with the plans.

Some comments suggested that the survey instrument should undergo an evaluation by a quality measurement organization. Because this is a preliminary effort to assess the possibility of developing performance measures, this type of review is unnecessary at this time.

Some plans mentioned that overall satisfaction may be affected by dissatisfaction with the final outcome and resolution of the complaint. CMS has revised the language to ask beneficiaries about several aspects of their satisfaction besides the final outcome. Similarly, concerns about confusion between "resolution" and "final outcome" have been addressed by emphasizing in the survey that CMS is interested in the series of actions taken by the plan to resolve complaints (e.g., the final outcome), rather than emphasizing the resolution.

It was suggested that the proposed sampling plan would not allow plans sufficient time to inform the beneficiary of the resolution. CMS has chosen to allow a delay of 7 days after the complaint is closed before contacting the beneficiary. In addition, CMS has provided further clarity on the types of contracts and plans that would be subject to data collection; this entailed an explicit exclusion of 800 series contracts and the inclusion of small contracts and contracts with a small number of complaints.

Some plans expressed more general concerns regarding the survey. These included how beneficiary-appointed representatives would be contacted, the uniformity of the survey approach for both telephone and mail-in, the reliability of collected data, and analyses to control for factors outside of the plan's control. The table below summarizes the actions CMS has taken to address these and other concerns in Supporting Statements A and B.

Several comments objected to the possible inclusion of complaints that are outside the scope of plans. CMS has chosen to exclude complaints that are likely to be outside of the scope of plans, primarily some issues related to enrollment complaints.

Category	Section	Change/Reason	Effect to Reporting Burden
Response to Public Comments	Supporting Statement A	Clarification was added regarding how CMS intends to disseminate results of the survey. CMS will follow a process for this performance measure similar to the one it uses for other measures. At this time, it is undetermined what level of data will be shared with plans.	None
Response to Public Comments	Supporting Statement A	Information regarding the use and calculation of the "Veracity of Complaint Resolution" indicator has been added.	None
Response to Public Comments	Supporting Statement A	Information regarding the use and calculation of indicators for new survey questions has been added.	None

Category	Section	Change/Reason	Effect to Reporting Burden
Response to Public Comments	Supporting Statement A	The calculation of the "Beneficiary Awareness of Resolution" indicator has been clarified. The description has been revised so that it more clearly refers to the answer choices for this survey question and explains how the answers will influence the calculation of the indicator.	None
Response to Public Comments	Supporting Statement A	The Information Users section has been updated to reflect that CMS may opt not to use the results of the survey for performance measurement. This is a preliminary gathering of information to determine the possibility of developing a performance measure..	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	Information has been added regarding the participation of representatives in the survey. This explanation includes how representatives will be contacted (through beneficiaries and/or CTM logs) and how data from representatives can be used in the survey data analysis. A question has been added to identify individuals other than the beneficiary who participate in the survey.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	Language has been added to emphasize that this is a preliminary survey effort to assess the beneficiary's satisfaction with the complaint resolution.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	The pretest and pilot test methodologies have been clarified to emphasize efforts to achieve reliable data and remove complaints that are not within the plan's domain.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	Clarification has been added to indicate that the telephone and written survey instrument will have a uniform format.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	It has been clarified that members of 800 series contracts will be excluded from the data collection effort.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	Controlling the validity of complaints: Approaches to control for factors affecting satisfaction with the final outcome and the complaint resolution have been described. Also, language has been added to underscore that several factors will be considered in the development of the performance measure so as not to rely on a single aspect of the beneficiary's experience.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	The sampling strategy will exclude complaints that are outside the scope of the plan (restricted by CMS guidelines), particularly regarding issues related to enrollment complaints.	None

Category	Section	Change/Reason	Effect to Reporting Burden
Response to Public Comments	Supporting Statement A & Supporting Statement B	The difference between "resolution" and "final outcome" has been clarified. 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.	None
Response to Public Comments	Supporting Statement A & Supporting Statement B	Additional explanation has been added to the sampling plan (supporting statement B) and background (supporting statement A) regarding the selected data collection period. CMS is interested in the months with the largest number of complaints in order to achieve the most statistically valid sample..	None
Response to Public Comments	Supporting Statement B	Call center procedures have been further defined and clarified regarding how staff encourage participation without being forceful. The explanation of the CATI system has been refined to prevent misunderstandings of the purpose of the system.	None
Response to Public Comments	Supporting Statement B	The sampling framework has been modified to accommodate 7 days between complaint closure and initial contact with the beneficiary to allow time for beneficiaries to receive notification of their complaint resolution.	None
Response to Public Comments	Supporting Statement B	Explanation has been added regarding the decision to proceed with collecting data on small contracts and contracts with a small number of complaints.	None

Survey Instrument

Many organizations had general comments regarding the survey instrument. Some believed that the wording of the questions might yield negative responses and not allow for neutral responses. CMS has reworded the survey to be more specific on the key complaint resolution process and include answer choices of "I Don't Know/NA." The latter will provide an answer that allows beneficiaries a choice outside the 4-point likert scale to accommodate beneficiaries who feel that they do not yet have a resolution or are unsure/do not remember. Other concerns included language in the introduction that did not clarify why beneficiaries are being contacted, that did not fully explain the role of IMPAQ, and that lacked clarity regarding the complaint process (whether the beneficiary filed a complaint against their MAO/PDP sponsor/Medicare.).

Concerns also were expressed regarding specific questions on the survey instrument. Some plans commented that the use of the word "resolution" would not elicit the intended responses from beneficiaries; therefore, the word "resolved" has been replaced with "settled" in question 1 to prevent bias to respond negatively unless the final outcome was in favor of the beneficiary. Also, in question 2 and question 3, "resolution" has been replaced with "final outcome." Revising the wording will help beneficiaries to focus on the actions taken by the plan and not their opinion of the decision.

CMS has decided to remove questions 4, 5, 6, and 8 from the survey instrument. A new question 2 has been created to include beneficiary satisfaction with the level of communication given by the plan and other aspects of beneficiary satisfaction such as the courtesy of the plan representative and explanation of the final outcome.

With regard to questions 5 and 6, after the results of the pretest were reviewed, it became clear that beneficiary responses were not aligned with the intended purpose of the survey questions. Question 5 yielded responses about beneficiary burden rather than about the filing of duplicate complaints. Furthermore, respondents did not differentiate between their satisfaction with the amount of time it took to resolve their complaint and their satisfaction with how the complaint was handled by the plan; it appeared that these two satisfaction ideas were confounded in the beneficiary's mind.

Clarifying text has been added to question 7, to address concerns that beneficiary satisfaction would be dependent on whether or not the complaint was resolved. Language has been added to this question, asking the beneficiary to focus on the way the complaint was handled, regardless of whether or not he/she is satisfied with the final outcome. This overall satisfaction question is now Q6 in the revised survey.

It was suggested that questions 9 and 10 be rewritten because of their negative connotations. CMS has revised both of these questions to be more neutral. Question 9 is now question 8, and question 10 is now question 3 in the revised survey instrument.

CMS has added or reformulated some questions to the survey instrument without affecting the reporting burden. To set a baseline for the beneficiary's satisfaction with the plan, a question was added to obtain information on how satisfied beneficiaries are with their plan. This will be question 7 on the revised survey. Respondents are now asked to identify whether they are the beneficiary or a representative. This is question 9 on the revised survey. Last, an open-ended question was placed at the end of the survey. This allows respondents an opportunity to provide feedback about the complaints process and make suggestions for improvement. The table below summarizes the actions CMS has taken to address comments on the survey instrument. Again, there was no change in the reporting burden.

Category	Section	Change/Reason	Effect to Reporting Burden
Response to Public Comments	Survey Instrument - General	The survey questions have been revised to reflect more neutral wording.	None
Response to Public Comments	Survey Instrument - Introduction	Details have been added to the survey introduction explaining why beneficiaries are being contacted and specifying terms such as "Medicare," MAO, or Part D sponsor, and the role of the contractor in conducting the survey.	None
Response to Public	Survey Instrument -	"Resolved" has been replaced with "settled" in this question to prevent beneficiary bias. An "I don't know" answer choice has	None

Category	Section	Change/Reason	Effect to Reporting Burden
Comments	Q1	been added for beneficiaries who feel they do not yet have a resolution or are unsure/do not remember.	
Response to Public Comments	Survey Instrument - Q2	"Resolution" has been replaced with "final outcome or decision" in this question to prevent beneficiary bias and to guide the beneficiary towards the actions taken by the plan as opposed to the beneficiary's opinion of the decision. This question is now Q4 in the new survey instrument.	None
Response to Public Comments	Survey Instrument - Q3	"Resolution" has been replaced with "final outcome" in this question. 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. This question is now Q5 in the new survey instrument.	None
Response to Public Comments	Survey Instrument - Q4	Question 4 has been removed, and issues of plan communication with the beneficiary have been incorporated in Q2 of the new survey instrument.	Decrease
Response to Public Comments	Survey Instrument - Q5	Question 5 has been removed from the survey. (CMS has decided to drop questions about repeat complaints or multiple attempts to contact the plan)	Decrease
Response to Public Comments	Survey Instrument - Q6	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.	Decrease
Response to Public Comments	Survey Instrument - Q7	Clarifying text has been added to this question asking the beneficiary to disregard whether or not he/she is satisfied with the final outcome. The purpose of this question is to provide an overall satisfaction rating. This question is now Q6 in the new survey instrument.	None
Response to Public Comments	Survey Instrument - Q8	This question has been removed. The aspects of the complaint process that were included in this question have now been incorporated in Q2 of the new survey instrument. This revision will allow all respondents to rate their satisfaction with components of the process (as opposed to the skip pattern in the original instrument).	Decrease
Response to Public Comments	Survey Instrument - Q9	This question has been reworded to be more neutral and to ask about the likeliness of the beneficiary to stay with the plan. This question is now Q8 in the new survey instrument.	None
Response to Public Comments	Survey Instrument - Q10	The word "problems" has been removed from this question and the wording is more neutral (both in the question stem and in the answer choices). This question is now Q3 in the new survey instrument.	None
Response to Public Comments	Survey Instrument – New question	Add question to assess beneficiary satisfaction with aspects of the complaint handling process. Beneficiaries will rate their satisfaction with components of the handling process such as length of the complaint process and courtesy of the plan representative. In a simplified form, this satisfaction question addresses issues from the original Q6 and Q8. This question is now Q2 in the new survey instrument.	Increase
Response to Public Comments	Survey Instrument – New question	Add question to assess beneficiary satisfaction with the plan. This question sets a baseline for the beneficiary's overall satisfaction with the plan. This question is now Q7 in the new survey instrument.	Increase
Response to Public Comments	Survey Instrument – New question	Add question to identify survey respondent. This is a demographic question to differentiate between respondent and proxy.	Increase

Category	Section	Change/Reason	Effect to Reporting Burden
		This question is now Q9 in the new survey instrument.	
Response to Public Comments	Survey Instrument - New question	Add question to elicit beneficiary feedback. Beneficiaries will be asked for feedback at the end of the survey, e.g., whether they have any comments or suggestions for improvement of the complaint resolution process. This question is now Q10 in the new survey instrument.	Increase

b. Consultation Outside of the Agency

The following individuals were consulted in designing the data collection plan and developing the questionnaire:

Name	Affiliation	Telephone Number
Oswaldo Urdapilleta	IMPAQ International	(202) 289 0004 x503
Alicia Schoua-Glusberg	IMPAQ International	(847) 864 5677
Jasmine Ainetchian	IMPAQ International	(202) 289 0004 x502
Camellia Bollino	IMPAQ International	(443) 718 4356
Julie Young	IMPAQ International	(443) 539 9766
Donald Nichols	IMPAQ International	(443) 539 0218
Peg Stessman	Strategic Health Solutions	(402) 452 3333
Kathy Goeser	Strategic Health Solutions	(402) 452 3333

No unresolved problems were identified by any of these individuals.

9. Payments/Gifts to Respondents

There will be no respondent payments for this survey.

10. Confidentiality

IMPAQ International will follow procedures for ensuring and maintaining confidentiality consistent with provisions of the Privacy Act of 1974. Respondents will receive information about confidentiality protection in an advance letter describing the survey (provided as an attachment to this package) and again at the outset of the interview as part of the interviewer's introductory comments. Respondents will be informed that all information they provide will be treated confidentially. Interviewers will be trained in confidentiality procedures and will be prepared to describe these procedures in full detail, if needed, or to answer any related questions from the respondents. For example, if asked about confidentiality, the interviewer will explain that the answers will be combined with those of others and presented in summary form only, that no identifiable information about participants will be made public, and that the answers will not affect past or future eligibility for any programs.

All data items that identify respondents will be kept only by the contractor, IMPAQ International, for use in assembling records data and conducting the interviews. Any data received by CMS will not contain personal identifiers, thus precluding individual identification.

In addition, the following safeguards will be employed to carry out confidentiality assurances:

- All employees at IMPAQ sign a confidentiality pledge that emphasizes the importance of confidentiality and sets forth the obligations of staff.
- Identifying information is maintained in a separate file from interview data. The files are linked only with a sample identification number.
- Access to link-files containing sample identification numbers connecting the research data and the respondents' identification is limited to a few individuals who have a need to know this information.
- Access to any hard-copy documents is strictly limited. Physical precautions include use of locked files and cabinets, shredders for discarded materials, and interview control procedures.

11. Sensitive Questions

The survey of CMS beneficiaries contains a minimal set of items that may be considered sensitive in nature. These questions are related to adverse medical episodes experienced by beneficiaries with complaints. These questions are needed to evaluate the frequency and degree to which beneficiaries suffer as a result of the amount of time spent by plans to determine a final outcome to complaints. As described in item A10, all respondents will be assured of confidentiality at the outset of the interview. All survey responses will be held in strict confidence and reported in aggregate, summary format, eliminating the possibility of individual identification. IMPAQ International will comply with the requirements of the Privacy Act of 1974, in collecting all information.

12. Burden Estimates (Hours & Wages)

The total annual hour burden for respondents for the proposed information collection is shown in Table 1 below. Total burden hours are based on 100 pilot test responses and 5,200 main survey responses (5,300 total responses).

Table 1: Annual Hour Burden for Respondents

Cite/reference	Total Survey Respondents	Frequency of Data Collection	Average Time per Respondent	Annual Hour Burden
Complaints Resolution: Pilot Test	100	Once	10 minutes	17
Complaints Resolution: Main Survey	5,200	Once	10 minutes	867
Total	5,300	Once	10 minutes	884

The total annualized cost to respondents of collecting this information is shown in Table 2 below.

Table 2: Annualized Cost to Respondents

Respondent Category	Number of Respondents	Total Number of Hours	Hourly Rate	Estimated Data Collection Cost to Respondents	Estimated Cost per Respondent
Not working	4,431*	739	$0.00	$0.00	$0.00
Working full-time	493*	82	$22.96**	$1,883	$3.82
Working part-time	376*	63	$13.06**	$823	$2.19
Total	5,300	884		$2,706	

** Based on U.S. Bureau of Labor Statistics figures for labor force participation of workers 65+*
*** Mean hourly earnings based on the National Compensation Survey, Dec. 2007-Jan. 2009*

13. Capital Costs

This is a new, one-time survey. There will be no capital or start-up costs incurred by respondents. There are no record keepers. There will be no costs to respondents for operations, maintenance, or purchase of services.

14. Cost to Federal Government

The cost to the Federal government of conducting the survey is $522,623, which is the total contractor cost of conducting the survey.

15. Changes to Burden

This is a new data collection effort.

16. Publication Tabulation Dates

a. Tabulations

All survey data will be combined with CMS administrative data, including the Medicare Beneficiary database, HPMS contract information, and the Complaints Tracking Module (CTM) records. Development of the preliminary performance measures will be derived from survey and administrative data. All measures are preliminary and will be run through exploratory, driver, and risk-adjusted analyses. The preliminary measures are listed below under each respective research domain:

- Beneficiary Satisfaction
    - Beneficiary satisfaction with the complaint handling process
    - Beneficiary satisfaction with the plan
- Resolution Effectiveness
    - Beneficiary awareness of resolution
    - Beneficiary satisfaction with final outcome
    - Veracity of plan's description of final outcome or decision
- Plan Effectiveness
    - Beneficiary experiences during complaint resolution process
    - Areas for improvement in the complaint handling process

The research domains are described below and followed by details of how the indicators are linked to the survey instrument questions and how they will be used in analysis.

Research Domains:

Beneficiary Satisfaction

In any industry, it is necessary to study the satisfaction of the consumer. There are many ways to define this term. To truly understand satisfaction, the researcher must evaluate consumers' emotions, which fluctuate within individuals and vary in range across individuals.[4] Measuring the consumer's emotions cannot be accomplished externally; therefore, optimal surveys ask consumers to rate their own emotions. Satisfaction is then the favorability of their subjective assessment of the organization, company, or group.[5] In the present context, the rating is a

[4] H. K. Hunt (1977), "CS/D-Overview and Future Research Direction," in *Conceptualization and Measurement of Customer Satisfaction and Dissatisfaction*, ed. H. K. Hunt, L. Hu, and P. M. Bentler.
5 R. A. Westbrook (1980), "A Rating Scale for Measuring Product\Service Satisfaction," *Journal of Marketing.* 44: 68-72.

representation of the beneficiary's sense of fulfillment with the customer service experience.[6] Have all his/her needs been met? Have all expectations been met?

It is important to note that a plan may comply with all CMS requirements, yet still receive a poor rating in this measure. Without regard to the plan's level of compliance with CMS requirements, beneficiaries reflect on their subjective evaluation of the plan's ability to resolve the complaint and adequately address their issues.

The following indicators from the beneficiary survey correspond to the beneficiary satisfaction domain:

- Beneficiary satisfaction with the complaint handling process
- Beneficiary satisfaction with the plan

For these satisfaction questions and others, CMS is using a 4-point Likert scale rather than a 5-point Likert scale (with a neutral option) to encourage beneficiaries to provide an opinion on each question. The use of a 4-point scale will improve the survey results. However, an N/A answer choice is available to beneficiaries who find the questions not be applicable such as beneficiaries who believe their complaint has not been resolved.

Resolution Effectiveness

Resolution effectiveness relates to both effectiveness and veracity. Questions of resolution effectiveness assess whether a complaint was resolved satisfactorily from the beneficiary's perspective. This is a subjective, but clear-cut, *outcome* measure of the complaint resolution process. However, resolution effectiveness also addresses resolution veracity, by comparing the beneficiary's knowledge of the complaint resolution with the plan's stated resolution, which can be found in the CTM. While the plan may have appropriately resolved the complaint and addressed all of the beneficiary's concerns, the beneficiary may not have been informed of the plan's decision. Veracity refers to the matching of beneficiary and plan information about the resolution. Moreover, the resolution effectiveness research question separates the plan's ability to properly *address* and *resolve* complaints from its ability to *handle* complaints well and to the beneficiary's satisfaction.

The following indicators from the beneficiary survey correspond to the resolution effectiveness domain:

- Beneficiary awareness of resolution
- Beneficiary satisfaction with final outcome

[6] R. L. Oliver (1997), *Satisfaction: A Behavioral Perspective on the Consumer* (New York: McGraw-Hill).

- Veracity of plan's description of final outcome or decision

Plan Effectiveness

Plan effectiveness refers to the complaint resolution *process*, as evaluated by the beneficiary. Questions about plan effectiveness will demonstrate how the beneficiary believes the complaint was handled by the plan. Regardless of whether the plan resolved the complaint to the beneficiary's satisfaction (what the outcome was), the perceived difficulty of the process may affect the beneficiary's subjective evaluation of the plan's performance. Subjects included in this domain are communication, timeliness, and consequences for the beneficiary.

The following indicators from the beneficiary survey correspond to the plan effectiveness domain:

- Beneficiary experiences during complaint resolution process
- Areas for improvement in the complaint handling process

"Beneficiary Experiences during the Complaint Resolution Process" is calculated from the percentage of beneficiaries who experienced any potential problems while waiting for a complaint to be resolved. "Contact by Plan" is the percentage of complaints where the beneficiary was contacted by the plan. "Repeat Complaints" highlights the percentage of beneficiaries who contacted the plan more than once before their complaint was resolved.

Indicators:

In principle, the exploratory analysis – described in greater detail in the following section – will include tabulations of survey item responses and beneficiary and plan characteristics. A driver analysis could determine statistically which areas most impact overall customer satisfaction, and it may be possible to estimate the direction and magnitude in which the drivers impact overall satisfaction. We could determine which specific attributes have the most impact on overall customer satisfaction and, therefore, would warrant primary attention and resources for CMS. For measure development, we will conduct analyses to construct risk-adjusted measures, using beneficiary characteristics, plan characteristics, and complaint characteristics.

These analyses will minimize measurement bias associated with confounding factors affecting the satisfaction measures. For example, beneficiaries with certain characteristics may have higher or lower levels of satisfaction than the average beneficiary. Overall, preliminary performance measures may be risk-adjusted to account for beneficiary and plan characteristics.

In all analyses, we will include information regarding whether the respondent is the beneficiary or a representative, since we assume that there may be differences between the satisfaction levels of these two groups.

Beneficiary satisfaction with the complaint handling process. Several measures will be developed to assess how satisfied complainants are with different aspects of the complaint resolution process. The main aspects include the following: length of the complaint process; courtesy of the plan representative; time your plan took to contact you; amount of time spent handling your complaint; awareness of the complaints process; and explanation of the final outcome. Beneficiary satisfaction on these issues will be measured through the following survey questions:

> *Q2. Thinking about the aspects of the complaints process, regardless of whether you agree or disagree with the final outcome, please indicate how satisfied you are with each of the following: [specific items follow]*
>
> *Q6. Whether you agree or disagree with the final outcome, how would you rate your overall satisfaction with the way your complaint was handled by the plan?*

The responses to each item in Question 2 and to Question 6 will together produce a preliminary measure of the complaint resolution process. The items in Question 2 will highlight the extent to which plans treated the complainant courteously, provided the complainant with understandable explanations of the final outcome, and provided the complainant with enough information about how the complaint was resolved. Question 6 will measure how satisfied beneficiaries are with the overall process undertaken by plans to resolve their complaint.

In responding to these questions (and each item within Question 2), the complainant must answer "very satisfied," "satisfied," "dissatisfied," "very dissatisfied," or "I don't know/NA." These responses will be translated into numerical values, where complainants who are very satisfied will have the greatest value (2), and those who are very dissatisfied will have the smallest value (-2). Each preliminary measure will be calculated as the mean value of the numerically translated responses about the complainants' satisfaction. Therefore, larger values will indicate better plan performance in handling complaints to complainants' satisfaction. It is important to note that the survey emphasizes the final outcome rather than the settlement (or resolution).

Final satisfaction with the process by which the complaint was handled (Q2) will be tabulated against satisfaction with each of the main aspects of the process (Q6). The responses to Question 6 will be used to isolate complaints where the beneficiary is satisfied with the final outcome, but has concerns about various aspects of the process.

As with the other measures, this measure will be tabulated against beneficiary and plan characteristics, and we will run risk-adjustment models. No single item will define satisfaction for each aspect of the complaint resolution process. In particular, different complaint categories may affect each aspect of the process in different ways.

Beneficiary satisfaction with the plan. An indicator of overall satisfaction with the plan will be included in the analysis. This indicator will be used to analyze the satisfaction measures listed above as well as allow for further analysis of critical satisfaction issues that may have significant repercussions in a beneficiary's selection of a plan. The information for overall beneficiary satisfaction will be derived from the following survey questions:

Q7. Based on your recent experience, how satisfied are you with [Plan name]?

Q8. How likely are you to stay with this plan?

Both questions address issues of the beneficiary's satisfaction with the plan including health care and the complaint resolution process. Question 8 will indicate to what extent a beneficiary's experience with the complaint resolution process affects his/her opinion of the plan. Being able to tabulate both questions will be insightful since we will learn about the overall satisfaction with the plan. On the one hand, if the complaint resolution process was so unsatisfactory that the beneficiary is willing to switch plans, it will provide context for plans with low "Resolution Handling" indicators. On the other hand, analysis of these responses may show that even beneficiaries with unsatisfactory complaint resolution experiences are not unhappy enough to actually switch plans.

Beneficiary Awareness of Resolution. This measure will capture the percentage of a plan's complainants who either are aware or agree that a settlement to their complaint has been implemented or reached. Since the complaints in our sample have been closed in the CTM, the expectation is that a complaint has been settled and that the beneficiary is aware of this resolution.

From the survey, the response to the following question will be used to calculate this measure:

Q1. According to our records, the complaint you filed about [Complaint Category] was recently closed by the plan. Was the complaint settled?

Complainants may answer say "yes," "no," or "I don't know." To calculate this measure, the numerator will be a count of the number of sampled complaints in which the complainant answered "yes." The denominator will be the total count of sampled complaints in which the complainant indicates either "yes" or "no" regarding the resolution of his/her complaint. Therefore, the exclusion criteria for the denominator will be a response of "I Don't Know" or those who did not answer that question.

Depending on the outcomes of the exploratory analysis and tests of the correlation between satisfaction with the final outcome and the awareness of a resolution, CMS likely will treat this measure as a monitoring measure. Using the data as a monitoring measure makes sense also

because of the potential that some beneficiaries would respond affirmatively ("yes, the complaint was settled") only if the complaint had been resolved in their favor.

Beneficiary satisfaction with final outcome. This measure will relay the extent to which complainants are satisfied with the final outcomes or decisions that plans have provided regarding their complaints. The assessment of satisfaction with the final outcome will be collected through the following question:

Q5. How satisfied are you with the final outcome of your complaint?

Responses to this question will be limited to four options ("very satisfied," "satisfied," "dissatisfied," and "very dissatisfied"). These will be translated into numerical values, where complainants who are very satisfied will have the greatest value (2), and those who are very dissatisfied will have the smallest value (-2).

The raw measure will be calculated as the mean value of the numerically translated responses about the complainants' satisfaction. Therefore, larger values will indicate better plan performance in resolving complaints to complainants' satisfaction. As with the other measures, this measure will be tabulated against beneficiary and plan characteristics, and we will run risk-adjustment models. In this way, no single item will define satisfaction with the final outcome.

Veracity of plan's description of final outcome. This measure will assist in the review of the accuracy of plans' descriptions of their complaint resolution (outcome, decisions, etc) in the CTM. Accuracy will be determined through comparison with the complainants' descriptions of the final outcome regardless of whether the beneficiary sees it as a resolution. This information will be gathered in the survey through the following question:

Q4. What was the final outcome or decision regarding your complaint?

In the comparison of the plan (CTM records) and beneficiary responses to Q4, we will check to ensure that any major action steps described by the plan—and which should be known by the complainant—also occur in the complainant's description of the final outcome. The accuracy of this measure depends upon the criteria for "major action" and "should be known by the complainant." Considerable time will be spent developing the criteria for what qualifies as a major action in a resolution and what percentage of the steps in a plan's description must also be found in the complainant's description. The criterion "should be known" will ensure that a plan does not receive a lower score for internal activities.

A dichotomous variable will be created for each included complaint. This variable will equal 1 for those complaints in which there is a match between the plan's resolution description in the CTM and the complainant's description. The value for this measure will be a function of the mean of the dichotomous variable and other variables used to control for categories of

complaints. Overall, the measure will represent the percentage of resolved sample complaints for which the veracity of the plan's resolution is supported by the complainant's description. As mentioned above, this measure also will be risk-adjusted with a full set of variables relevant to the question at hand. Larger values will indicate that a plan is more reliable in describing its resolution.

Beneficiary experiences during complaint resolution process. The performance measure will assess whether beneficiaries encounter incidents while waiting for their complaints to be resolved. One measure will be created to account for several of the critical beneficiary experiences during the complaint process. Subject Matter Experts emphasized the issues included in the survey as those most likely to have an impact on the beneficiary while their complaint is being settled. These issues include: delay in receiving care or medications; health complications; loss of health insurance coverage; and financial hardship. The information about beneficiary experiences will be derived from the following survey question:

> *Q3. During the complaint process, did you experience any of the following? [specific items follow]*

The responses to this question will be used to provide more knowledge about the scale of beneficiaries' experiences. As with the other measures, this measure will be tabulated against beneficiary and plan characteristics, and we will run risk-adjustment models. The implication is that no single item associated with the risks, difficulties, and problems of a particular complaint will define the measure.

With this indicator and others, the pilot test (100 surveys) may indicate the need to implement a rating scale for the answer choices to Question 3. The purpose of doing so would be to gather information on the severity of the beneficiary experiences. If this change was made, it would be in order to increase the utility of this question and its indicator, the nature of the instrument and the original intent of the question, survey and data collection would not be altered.

Areas for improvement in the complaint handling process. This information will not be used in the development of a performance measure. However, information from this open-ended question will allow us to make further recommendations concerning CTM guidelines and identify which complaint categories are most likely to be flagged by beneficiaries or cause strong dissatisfaction by beneficiaries. The open-ended responses will come from the following question:

> *Q10. Do you have any suggestions or comments about how your plan could handle complaints better?*

Analysis:

Several statistical analyses will be implemented to untangle the reasons behind a beneficiary's assessment of a plan sponsor's resolution, or a beneficiary's satisfaction with a plan sponsor's complaint resolution process. This information is important for two reasons: (1) to define a set of monitoring and/or performance measures that can be used to validate the plan's resolution of beneficiary complaints closed by plans, from the perspective of the beneficiaries themselves; and (2) to provide critical elements that should be monitored or included in CMS Standard Operating Procedures, CMS guidance on handling of complaints, documentation standards, and other CMS documents on the subject.

For the analysis of survey responses, several administrative datasets will be used. For example, the Common Medicare Enrollment tables from the Medicare Enrollment Database (EDB) will be used to identify (1) beneficiary enrollment at the contract level, (2) beneficiary state and county codes, (3) election periods used for enrollment, (4) Part A and Part B entitlement, and (5) Part D eligibility. The Medicare Beneficiary Database (MBD) will be used to identify contract characteristics and contract service areas, while HPMS will be used to identify contract status and other contract characteristics.

In the analysis of the survey and complementary administrative data, we will look at descriptive statistics, testing, and the development of measures based on beneficiary survey responses. The information provided by beneficiaries will be very valuable in establishing a correlation with a plan's own assessment of its complaints resolution process.

Our analysis will be both quantitative and qualitative. First, we will use the quantifiable items from the survey to define and calculate measures of beneficiary satisfaction and exploratory analysis of patterns and correlations between beneficiary satisfaction and beneficiary and/or Part C/D sponsor characteristics. We will use information from HPMS CTM and other CMS data sets to explore who the beneficiary respondents are and to develop models for assessing patterns for certain populations (Low-Income-Status beneficiaries) or type of contracts (MA, MA-PD, PDP). Our reason for the exploratory analysis is that certain responses to beneficiary satisfaction have confounding factors that should be controlled in developing MAO and PDP sponsor ratings. For example, it could be the case that certain populations have a higher likelihood of being dissatisfied with Parts C and D sponsors; if a contract has a large proportion of this population, the plan sponsor will have lower ratings than it should have if we were to control for the share of the "prone to be dissatisfied" population. Similar arguments can be made regarding the type of plans.

In the initial analysis, we will prepare descriptions of the survey respondents (gender, age, marital status, health status, Low-Income Subsidy Status) and the plan sponsors (Contract and organization type, enrollment size, complaint type, complaint categories and proportion of subpopulation enrollees) in the study sample. In addition to these exploratory tables, we will test

nonresponse rates for those beneficiaries who did not respond to our survey to explore whether they are different from the survey respondents.

In a similar fashion, we will present univariate descriptive statistics for the MAO and Part D sponsors. It is important to emphasize that the survey responses are valid at the contract level. There is no need to adjust the survey results. However, further exploration of the results by contract characteristics would contribute to CMS understanding of the complaint resolution process. For example, are contracts with a large proportion of LIS beneficiaries more likely to have higher rates of disatisfaction, or are PFFS more likely to have more satisfied beneficiaries given the nature of the organization type? In addition, we will compare the data collected at the contract level to the overall universe of complaints.

Following the description of the beneficiaries and the contracts in the study sample, we will proceed to present bivariate descriptive statistics. In an early phase of the analysis, we will assess patterns across populations or Parts C/D sponsor characteristics to the beneficiary satisfaction measures. This information will provide insight on population/contract correlations to beneficiary satisfaction and some of the underlying factors influencing beneficiary satisfaction. We will also conduct cross tabulations of beneficiary satisfaction to consequences or problems associated with the complaint. Such tabulations will provide insights on how certain problems/consequences affect beneficiaries' perspective on satisfaction. Another table could be developed for satisfaction with the time it took to get a resolution.

After the draft measures have been calculated, we will conduct additional analyses to further refine the measure specifications based on the following criteria:

- What are the underlying distributions of performance data, such as the mean, median, standard deviation, and percentile scores?
- How much dispersion is there across plans? Is the dispersion random or does it appears to systematically affect certain types of plans?
- Are there too many contracts that are subject to the data suppression rules or that have a missing data issue?

We will also conduct a qualitative review of beneficiaries' responses, which will focus on the open-ended questions. Examples of such measures might be the following:

- Whether the complaint resolution recorded in the CTM data conforms to the beneficiary's response regarding the final outcome
- Whether the resolution provided by the plan conforms to the beneficiary's original request; What aspects of the plan's handling of the complaint were unsatisfactory to the beneficiary

We will review a sample of beneficiaries' responses in order to identify the key themes of their perceived/articulated responses. Once these themes have been identified, the results of these initial reviews will then be captured in keywords (with similar typologies identified as well), which will be used in the next search of the qualitative data. If frequent occurrences of those keywords or similar typologies are found, these issues/recommendations will be summarized as key findings in the Beneficiary Experience Reports. For keywords with less frequency, our summary results will highlight those for which some practical policy adjustments can be offered. Through this qualitative review of beneficiary responses, we can report on aspects of the beneficiary experience that may not have been captured elsewhere in the survey.

Last, we will conduct multivariate analysis that could be developed using data from the survey and other CMS data sources. Logistic and multinomial analysis for several questions of beneficiary satisfaction would provide information on the factors that influence beneficiary responses on a particular aspect of beneficiary satisfaction. These results would further CMS' knowledge about what is driving beneficiary satisfaction. Overall, these models allow predicting rates of beneficiary satisfaction given certain beneficiary and plan characteristics. On the basis of these results, we will risk-adjust beneficiary responses across contracts.

b. Publication Plans

The final report on the Part C and Part D Complaint Resolution Measures will be submitted to CMS in draft form in July 2011 and in final form in August 2011. The report will describe the data collection and analysis process and make recommendations for future improvements. The report also will contain summary statistics of the sampled surveys and the performance measures. The measure statistics will be stratified by various plan and complaint characteristics.

c. Time Schedule

The project began in September 2009 and will end in September 2011. The instruments were prepared between October 2009 and December 2009. The data collection will start in January 2011. The sample intake period will end either in March 2011 or when we have reached our sample goal, whichever is earlier. The analysis of the survey data and the construction of the monitoring and/or performance measures will be complete in August 2011. If CMS chooses to, CMS could publish the performance measures in November 2011.

17. Expiration Date

The expiration date will be displayed on the advance letter and on the hard copy version of the questionnaire.

18. Certification Statement

There are no exceptions taken to item 19 of OMB Form 83-1.