OMB No.:	XXXX-XXXX
Expiration Date:	XX/XX/20XX
MPR Reference No.:	
MPR ID Number: _	
·	
Medicare Advantage	Contract Number

Evaluation of the Quality Bonus Payment Demonstration

Initial Call Form

Draft

June 1, 2012

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is XXXX-XXXX. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850.

Hello, my name is [INTERVIEWER'S FULL NAME]. I am calling from Mathematica Policy Research on behalf of the Centers for Medicare & Medicaid Services. May I please speak to [PERSON LISTED ON CONTACT SHEET] of [CONTRACTOR ORGANIZATION NAME]?

REASON FOR THE CALL

	We recently sent [you/PERSON] a letter described described evaluation of the Quality Bonus Payment a few questions about the plans operating unclike your help in identifying the person at your should be sent.	t Demonstration. I would like to ler this Medicare Advantage co	ask [you/him/ ntract. I would	/her] d also
Q1.	According to information provided by CMS, the plans. Is that correct?	is contract includes [NUMBER (OF PLANS] h	ealth
	Number of Plans under this contract will be fee	d in to this form from HPMS		
		YES(GO	ТО	Q3)
		NO 0		
Q2.	How many health plans operate under this MA	A contract?		
		_ Health Plans		
Q3.	INTERVIEWER: CHECK QUESTION Q	2. IS THERE MORE THAN ON	E PLAN?	
		YES 1		
		NO(GO 0	ТО	Q6)
Q4.	Do quality improvement activities differ in any	meaningful way across plans u	nder this cont	ract?
		YES 1		
		NO(GO 0	ТО	Q6)
Q5.	What are two or three main ways they differ?			

We would like to send you a questionnaire which asks you to describe the quality impro programs of this contract. The survey takes about 25 minutes to complete.		
responding con	onses to this survey will be kept confidential. Answers fr tract holders will be tabulated and provided to CMS in ag idual responses will not be linked to individual contracts	
To whom should th	ne questionnaire be sent?	
INTERVIEWER:	IF THE PERSON TO WHOM YOU ARE SPEAKING WANTS T QUESTIONNAIRE SENT TO HIM OR HER, VERIFY (AND COL ADDRESS AND OTHER CONTACT INFORMATION ON THE SHEET.	
	ASK WHETHER THE PERSON WOULD LIKE TO HAVE THE DOCUMENT SENT VIA EMAIL AND IF SO, GET THE PERSO ADDRESS.	
	IF THE QUESTIONNAIRE IS TO BE SENT TO ANOTHER PER RECORD THE NAME AND MAILING INFORMATION UNDER WHETHER THAT PERSON SHOULD ALSO RECEIVE THE QUESTIONNAIRE VIA EMAIL AND IF SO, MAKE SURE TO F THE EMAIL ADDRESS BELOW.	
NAME:		
TITLE:		
ORGANIZATION:		
ORGANIZATION:		
ORGANIZATION: ADDRESS 1:		
ADDRESS 2:		

Q8.	IF MORE THAN ONE QUESTIONNAIRE SHOULD BE SENT BECAUSE QUALITY IMPROVEMENT PROGRAMS DIFFER SUBSTANTIALLY ACROSS PLANS WITHIN THIS CONTRACT, RECORD THE ADDITIONAL RESPONDENT'S MAILING INFORMATION HERE. BRING THIS CASE TO THE ATTENTION OF YOUR SURVEY SUPERVISOR.
	NAME:
	TITLE:
	ORGANIZATION:
	ADDRESS 1:
	ADDRESS 2:
	CITY:
	STATE:
	ZIP CODE:
	TELEPHONE NUMBER:
	EMAIL ADDRESS:

Q8.