

ATTACHMENT 5: MA Only Survey

Medicare Disenrollee Survey

Version: MA Only (OMB Version)

Language: English

Last Updated: March 11, 2013

(This survey contains 61 effective items – numbered 1 through 56 -
- and is estimated to require 13.5 minutes to complete, assuming a
rate of 4.5 items per minute.)

DEPARTMENT OF HEALTH & HUMAN
SERVICES Centers for Medicare &
Medicaid Services
7500 Security
Boulevard, Mail Stop
S2-24-25 Baltimore,
Maryland 21244-1850



CMS PRIVACY OFFICE

<<name>>

<<address1>>

<<address2>>

<<city>>, <<state>> <<zip>>

Dear Medicare Beneficiary:

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program, and it is our responsibility to ensure that you get that high-quality care at a reasonable price. One of the ways we can fulfill that responsibility is to find out directly from you about the care you received from your **Medicare health plan**.

CMS is conducting a survey of people who have disenrolled from their Medicare health plan to learn more about the reasons **why people leave or switch health plans**. Your name was selected at random by CMS because according to our records, you recently left [PLAN_NAME] ([CONTRACT_ID]). We would greatly appreciate it if you would take the time, about 18 minutes, to fill out this questionnaire. As you answer the questions in the survey, please think about your experiences with [PLAN_NAME].

All information you provide will be held in confidence and is protected by the Privacy Act. This means that the information you provide will not be shared with anyone other than authorized persons at CMS and CSS, the survey research organization assisting us in this survey. **You do not have to participate in this survey. Your help is voluntary, and your decision to participate or not to participate will not affect your Medicare benefits in any way.** The information you provide will help us improve the quality of services you receive. This is your opportunity to help us serve you better.

If you have any questions about the survey please call the CSS direct toll-free number 1-855-400-3657 anytime from 9:00 a.m. to midnight Eastern time, Monday through Friday. Thank you for your help with this important survey.

Sincerely,

A handwritten signature in black ink that reads "Walter D. Stone". The signature is written in a cursive, flowing style.

Walter Stone

CMS Privacy Officer

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 **0938- 1113**. The time required to complete this information collection is estimated to average **18 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, Attn: PRA Reports Clearance Officer, Mail Stop C426-05, Baltimore, Maryland 21244-1850.

Survey Instructions

This survey asks about your former health plan. Answer each question thinking about yourself. Please take the time to complete this survey. Your answers are very important to us. Please return the survey with your answers in the enclosed postage-paid envelope to CSS.

- Answer all the questions by putting an “X” in the box to the left of your answer, like this:
 X Yes
- Be sure to read all the answer choices given before marking your answer.
- You are sometimes told not to answer some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: [**If No, Go to Question 3**]. See the examples below:

Example

1. Do you wear a hearing aid now?

Yes

X No **If No, Go to Question 3**

2. How long have you been wearing a hearing aid?

Less than one year

1 to 3 years

More than 3 years

I don't wear a hearing aid

3. In the last 6 months, did you have any headaches?

X Yes

No

YOUR FORMER HEALTH PLAN

We are sending you this survey because we believe you recently left or were dropped by a health plan, or switched health plans.

1. Our records show that you used to belong to [PLAN_NAME] ([CONTRACT_ID]), but no longer belong to that plan. Is that right?

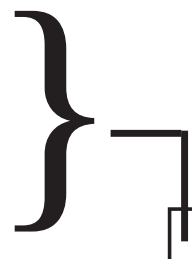
- Yes **If Yes, go to Question 2**
- I left a plan but it was not [PLAN_NAME] **Go to Question 2**
- No, I did not belong to [PLAN_NAME] **Stop and return the survey**
- No, I still belong to [PLAN_NAME] **Stop and return the survey**

If you answered No to Question 1, please stop and return the survey.

You DO NOT have to complete the survey.

2. Did you have to switch or leave [PLAN_NAME] for any of the following reasons?

- I moved outside of the area where the plan was available
- I was dropped by the plan
- The plan was cancelled or discontinued in my area
- The plan was changed by the organization that provides my insurance (such as an employer or a union)



PLEASE READ: If you checked any of the reasons above, please stop and return the survey. You DO NOT have to complete the survey.

- None of the above **If you did not choose any of the reasons in Question 2 please continue to Question 3**

**GETTING INFORMATION OR HELP
FROM YOUR FORMER
HEALTH PLAN**

These questions ask about your experience with your former health plan. As you answer the rest of the questions in this survey, please think only of your former plan.

3. Customer service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from [PLAN_NAME]'s customer service?

- Yes
 No If No, go to Question 5

4. How often did the plan's customer service give you the information or help you needed?

- Never
 Sometimes
 Usually
 Always
 I did not try to get information or help from the plan's customer service

5. Did you ever need written information from the plan in a language other than English?

- Yes
 No If No, go to Question 7

6. How often did the plan give you written information in a language other than English?

- Never
 Sometimes
 Usually
 Always
 I did not need written information in a language other than English

**GETTING HEALTH CARE YOU NEEDED
FROM YOUR FORMER HEALTH PLAN**

7. Did you ever try to get any kind of care, tests, or treatment through the plan?

- Yes
 No If No, go to Question 9

8. How often was it easy to get the care, tests, or treatment you thought you needed through the plan?

- Never
 Sometimes
 Usually
 Always

9. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate the plan?

- 0 Worst health plan possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best health plan possible

REASONS YOU LEFT YOUR FORMER HEALTH PLAN

People leave, drop, or switch health plans for different reasons. These questions are about reasons you may have had for switching, leaving, or dropping [PLAN_NAME].

10. Did you leave the plan because you found out that someone had signed you up for the plan without your permission?

- Yes
- No

11. Did you leave the plan because you were accidentally taken off the plan (or because of some other paperwork or clerical error)?

- Yes
- No

12. Some Medicare beneficiaries have to pay their health plan a monthly fee out of their own pocket for coverage for health care.

Did you leave the plan because the monthly fee for health care coverage went up?

- Yes
- No

13. Did you leave the plan because you stopped paying the monthly fee for coverage for health care?

- Yes
- No If No, go to Question 15

14. Why did you stop paying the plan's monthly fee?

- I stopped paying the monthly fee because I could not afford it
- I stopped paying the monthly fee because I was unhappy with the plan
- I stopped paying the monthly fee for some other reason

15. Did you leave the plan because the dollar amount you had to pay each time you visited a doctor went up?

- Yes
- No

16. Did you leave the plan because you found a health plan that costs less?

- Yes
- No

17. Did you leave the plan because a change in your personal finances meant you could no longer afford the plan?

- Yes
- No

18. Did you leave the plan because you were frustrated by the plan's approval process for care, tests, or treatment?

- Yes
- No

19. Did you leave the plan because you had problems getting the care, tests, or treatment you needed?

- Yes
- No

20. Claims are sent to a health plan for payment. You may send in the claims yourself or doctors, hospitals, or others may do this for you.

Did you leave the plan because you had problems getting the plan to pay a claim?

- Yes
- No

21. Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan?

- Yes
- No

22. Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan?

- Yes
- No

23. Did you leave the plan because it was hard to get information from the plan -- like which health care services were covered or how much a specific test or treatment would cost?

- Yes
- No

24. Did you leave the plan because you were unhappy with how the plan handled a question or complaint?

- Yes
- No

25. Did you leave the plan because you could not get the information or help you needed from the plan?

- Yes
- No

26. Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

- Yes
- No

27. Every year Medicare evaluates all Medicare health plans and gives each plan a quality rating. The ratings are referred to as the Medicare Star or Plan Ratings. The ratings provide Medicare beneficiaries information on the quality of services a plan provides.

Did you leave the plan because it got a low Medicare Star Rating?

- Yes
- No

28. Did you leave the plan because you found another plan with a higher Medicare Star Rating?

- Yes
- No

29. In the past year, did you think about the Medicare Star or Plan Ratings when making a decision about enrolling in a health plan?

- Yes
- No

OTHER REASONS FOR LEAVING YOUR FORMER HEALTH PLAN

30. Did you leave the plan because a family member or friend told you that another health plan was a better plan?

- Yes
- No

31. Did you leave the plan because you saw a commercial or advertisement for a health plan you thought you would like better?

32. Did you leave the plan because you found another plan that better met your prescription needs?

- Yes
- No

33. Did you leave the plan because another plan offered better benefits or coverage for some types of care, treatment, or services (for example, dental or vision care)?

- Yes
- No

34. What was the one most important reason you left [PLAN_NAME]? (Check one.)

- Yes No

- Financial or cost reasons
- Problems getting the care, tests, or treatment you needed through the plan
- Problems with plan not covering doctors or hospitals you wanted to see
- Switched to another plan that offers better benefits or coverage
- Another reason. Please specify:

**YOUR EXPERIENCE WITH INSURANCE
AGENTS, BROKERS, OR PLAN
REPRESENTATIVES**

35. Different kinds of people sell health insurance. Insurance may be sold by independent insurance agents or brokers who don't work for the health plan OR by plan representatives who work directly for the plan.

Did an insurance agent, broker, or plan representative ever call you without your asking them to, to tell you about insurance for health care or prescription medicines?

- Yes
 No

36. Did an insurance agent, broker, or plan representative ever visit your home without your asking them to, to tell you about insurance for health care or prescription medicines?

- Yes
 No

37. Did you decide to leave [PLAN_NAME] because of information you got from an insurance agent, broker, or plan representative?

- Yes
 No

38. Did an insurance agent, broker, or plan representative give you any information that was not correct?

- Yes
 No If No, go to Question 40

39. What kind of information was not correct? Please check all that apply.

- What the plan covered
 What the plan would cost you
 Which doctors belong to the plan
 Which pharmacies are covered by the plan
 Which hospitals are covered by the plan
 Some other information (please print)

ABOUT YOU

40. In general, how would you rate your overall health?

- Excellent
 Very good
 Good
 Fair
 Poor

41. In general, how would you rate your overall mental health?

- Excellent
 Very good
 Good
 Fair
 Poor

42. In the last 12 months, how many different prescription medicines did you fill? (Don't count the same prescriptions twice.)

- None
- 1 to 2 medicines
- 3 to 5 medicines
- 6 or more medicines

43. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

- Yes
- No If No, go to Question 45

44. Is this a condition or problem that has lasted for at least 3 months?

- Yes
- No

45. Do you now need or take medicine prescribed by a doctor?

- Yes
- No If No, go to Question 47

46. Is this to treat a condition that has lasted for at least 3 months?

- Yes
- No

47. Has a doctor ever told you that you had any of the following conditions?

- | | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|
| a. A heart attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Angina or coronary heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hypertension or high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cancer, other than skin cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Emphysema, asthma or COPD (chronic obstructive pulmonary disease)? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any kind of diabetes or high blood sugar? | <input type="checkbox"/> | <input type="checkbox"/> |

48. What is your age?

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 to 79
- 80 to 84
- 85 or older

49. Are you male or female?

- Male
- Female

50. What is the highest grade or level of school that you have completed?

- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
- More than 4-year college degree

51. Are you of Hispanic or Latino origin or descent?

- Yes, Hispanic or Latino
- No, not Hispanic or Latino

52. What is your race? Please mark one or more.

- White
- Black or African-American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native

53. What language do you mainly speak at home?

- Chinese
- English
- Russian
- Spanish
- Vietnamese
- Some other language (please print)

54. Did someone help you complete this survey?

- Yes
- No If No, Go to Question 56

55. How did that person help you? Please mark one or more.

- Read the questions to me
 - Entered the answers I gave
 - Answered the questions for me
 - Translated the questions into my language
 - Helped in some other way (please print)
-

56. The Medicare Program is trying to learn more about the health care or services provided to people with Medicare. May we contact you again about the health care services that you received?

- Yes
- No

THANK YOU FOR COMPLETING THIS SURVEY
Please return your completed survey in the postage paid envelope to:

**MEDICARE SATISFACTION
SURVEY PO BOX 1920
MANCHESTER CT 06045-9939**

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