CMS Response to Public Comments Received for CMS-10316 (OMB Control Number 0938-1113)

The Centers for Medicare & Medicaid Services (CMS) received the following comments related to CMS-10316.

Comment:

CMS received a comment from a health insurer that supports the current Disenrollment Reasons Survey, that includes questions capturing reasons Medicare beneficiaries switch plans for better benefits with the new plan instead of low satisfaction with their old plan. Further, they disagree with CMS' statement that voluntary disenrollment is a broad indicator of beneficiary dissatisfaction with some aspects of plan services, asserting that among its disenrollees, most rated the plan a 7 or higher on a scale of 0-10 with most switching plans to attain richer benefits.

Response:

CMS appreciates the health insurer's support for the survey items that ask if a respondent switched to a new Medicare health or drug plan because of better benefits (i.e., lower premiums, lower copayments for doctor's visits and prescription drugs). CMS does find lower scores on CAHPS measures for overall plan satisfaction for those who disenroll than those who do not disenroll.

Comment:

CMS received a comment from a health insurer about combining data across multiple years for selected composite disenrollment reason measures. The health insurer doesn't find the two-year aggregation of data useful because contract-level benefits and strategies change yearly. They instead suggest CMS increase annual sample sizes to enable reporting using only the most recent single year of data.

Response:

Disenrollment composites are calculated annually, and most composites (all but two) can be measured using only the most recent year's data. Combining information from previous year and current year provides a more precise estimate of a contract's score for two composite measures. The increased precision is due to the increased sample size for a contract and the high correlation between the previous and current year's scores on these two composite measures. The high correlation suggests that scores on these measures are stable over time and thus can be combined without an appreciable loss of information.

While larger sample sizes may allow all composites to be estimated using only current year data for larger contracts with high disenrollment rates, present resources don't allow for such an increase. Current practices are valid and reliable.

Comment:

CMS received a comment from a health insurer that CMS should consider additional forms of outreach beyond telephone to increase the contract-level sample sizes of CMS disenrollment surveys.

Response:

CMS continues to explore ways to increase response rates, including alternative modes to complement the current mail survey. For example, CMS has investigated a web mode that relies on respondents' email addresses. However, CMS does not collect or maintain email addresses of Medicare beneficiaries that would be required to field a web survey. Getting email addresses from the MA and PDP plans would be problematic given that beneficiaries disenroll monthly throughout the year and it would be burdensome to request monthly lists of email addresses from 600+ MA and PDP plans from which beneficiaries disenrolled. Further, it would be challenging to get email addresses in a timely manner and not delay getting surveys out to disenrollees. Analyses conducted by CMS's survey vendor found that delays between time of disenrollment and survey delivery have a negative impact on response rates.

Comment:

CMS received a request from a health insurer to provide contracts with scores that are both unadjusted and adjusted for case mix. This contract expressed concern that the adjustment can alter scores and does not necessarily reflect the membership within a contract.

Response:

Case-mix adjusted scores are the official scores. Case-mix adjustment improves the validity of the measures and ensures that contract scores are not influenced by beneficiary-level factors beyond the contract's control that affect how respondents answer survey items. Case-mix adjustment accounts for the characteristics of those who respond, rather than the characteristics of all contract enrollees.

Unadjusted scores are not valid for comparisons between contracts because the characteristics of respondents vary across contracts. Unadjusted scores could be different due to differences in the beneficiaries in each contract or differences in contract performance.

CMS sends contracts unadjusted response frequencies in a CSV file with their annual reports. These are for informational purposes and not recommended for comparing quality differences across contracts. CMS appreciates this contract would find unadjusted scores useful. Case-mix adjustment coefficients are available upon request.

Comment:

CMS received a request from a health insurer to provide both contract-level survey results and at a cohort level, including carrier tenure and application channel.

Response:

The annual Disenrollment Survey report shared with plans includes national-level results stratified by beneficiaries who are dually-eligible for Medicare and Medicaid (duals) or who receive the Low Income Subsidy (LIS) versus the beneficiaries who are neither dual nor receive the LIS. CMS is continuing to investigate other ways to understand differences in disenrollment reasons.