

Survey Results and Reporting for the 2002 Medicare CAHPS Disenrollment Assessment Survey

CMS Contract No. 500-95-0061-TO#5
RTI Project No. 7659

Submitted to:

Amy Heller, Ph.D.
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices/Beneficiary Education and Analysis Group
7500 Security Boulevard
Mail Stop S1-13-05
Baltimore, Maryland 21244

Prepared by:
RTI International* and the
Center for Health Systems Research and Analysis, University of Wisconsin at Madison

October 29, 2004

This project was funded by the Centers for Medicare & Medicaid Services under contract number 500-95-0061-TO#5. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI International assumes responsibility for the accuracy and completeness of the information contained in this report.

*RTI International is a trade name of the Research Triangle Institute

TABLE OF CONTENTS

SECTION 1 INTRODUCTION	1
1.1 Overview of the Survey	1
1.2 Background and Need for the Project	2
1.3 Overview of this Report	2
SECTION 2 TECHNICAL EXPERT PANEL	3
2.1 Overview and Purpose	3
2.2 Composition	3
2.3 TEP Meetings	3
SECTION 3 ASSESSMENT SURVEY DATA COLLECTION	5
3.1 Overview	5
3.2 Sample Design and Selection:	5
3.3 Survey Instrument	6
3.4 Data Collection Activities	9
3.5 Data Collection Quality Control Procedures	11
3.6 Data Collection Results	11
3.7 Weighting and Nonresponse Analysis	14
SECTION 4 DATA PROCESSING	19
4.1 Overview	19
4.2 Data Receipt and Scanning	19
4.3 Coding Open-Ended Text Entries	19
4.4 Questionnaire Completeness Criteria	20
4.5 Data File Construction	20
SECTION 5 CONSUMER AND HEALTH PLAN REPORTING	23
5.1 Overview	23
5.2 Weighting for Consumer and Health Plan Reporting	23
5.3 Consumer Survey Reporting	23
5.4 Health Plan Reporting	23
SECTION 6 REFERENCES	25

LIST OF APPENDICES

APPENDIX A 2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY: TECHNICAL EXPERT PANEL MEMBERS	A-1
APPENDIX B 2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY: QUESTIONNAIRE	B-1
APPENDIX C 2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY: SUMMARY OF PROJECT HOTLINE EXPERIENCE:	C-1
APPENDIX D MOST IMPORTANT REASONS CODES	D-1
APPENDIX E CROSSWALKS USED TO DEVELOP THE COMBINED 2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY AND MEDICARE CAHPS MANAGED CARE ENROLLEE SURVEY DATA FILE	E-1

LIST OF EXHIBITS

Exhibit 3-1 Assessment survey sample sizes: 2002, 2001, and 2000	6
Exhibit 3-2 2002 Assessment survey mail survey data collection schedule.....	10
Exhibit 3-3 Number of cases selected and final response rate.....	12
Exhibit 3-4 Sample disposition of the assessment survey sample.....	13
Exhibit 3-5 Response at each survey stage, 2000 through 2002 assessment surveys.....	15
Exhibit 3-6 2002 Assessment survey response rates by demographic characteristics.....	17
Exhibit 3-7 Response rates for Medicare Private Fee-for-Service health plan disenrollees.....	18
Exhibit C-1 Calls to the project hotline by year	C-1
Exhibit C-2 2002 Assessment survey hotline usage	C-3

SECTION 1 INTRODUCTION

1.1 OVERVIEW OF THE SURVEY

This report discusses the background, implementation, and results of the 2002 Medicare CAHPS® Disenrollment Assessment Survey, hereafter referred to as the “Assessment Survey,” which was conducted by the University of Wisconsin-Madison (UW-M) and RTI International for the Centers for Medicare & Medicaid Services (CMS).¹ The Assessment Survey is fielded on an annual basis to collect data about sample members’ experiences with their former Medicare Advantage health plan, including their overall ratings of that plan. Because disenrollees’ assessments of their former health plan are needed to reduce potential bias in plan assessments provided by active members of Medicare Advantage plans, the 2002 Assessment Survey was conducted in close coordination with the research organization that conducts the Medicare CAHPS Managed Care Enrollee Survey for CMS (hereafter referred to as the “Enrollee Survey”).

The sample for the Assessment Survey is drawn at about the same time and in the same proportion for each health plan as that for the Enrollee Survey, to minimize design effects in the combined estimates. Both surveys require that beneficiaries must have had at least 6 months of continuous enrollment in the health plan to be eligible for sample selection. The samples for the two surveys are such that both enrollees and disenrollees were active members of the sample plan during the same period. In addition, the questions included in the Assessment Survey are virtually identical to those administered to sample members in the Enrollee Survey.

The 2002 Assessment Survey was conducted in the fall of 2002 with a sample of Medicare beneficiaries who disenrolled from their health plans in May through August 2002. The Assessment Survey project team combined the data collected in the 2002 Assessment Survey with the data collected in the 2002 Enrollee Survey and assigned sample weights to the combined data. The combined data were analyzed together, and comparative plan information, which reflected the perspectives of both those who remained in the plan and those who left the plan, was reported to Medicare beneficiaries and to the public via the www.Medicare.gov Web site in the fall of 2003. In addition to conducting the survey, the Assessment Survey project team worked in conjunction with the Medicare CAHPS Enrollee Survey team to revise the template used for reporting survey results to health plans and to provide information about the Assessment Survey that was included in that report. Survey results from the combined data were reported to Medicare Advantage organizations via an annual health plan report produced and distributed to health plans by the Enrollee Survey project team in September 2003.

¹ In 2000, 2001, and 2002, the Assessment Survey was conducted for CMS by project staff at UW-M and RTI. Starting in 2003, the annual Assessment Survey is being conducted by another survey research organization.

1.2 BACKGROUND AND NEED FOR THE PROJECT

The Assessment Survey is one of two surveys that form the Medicare CAHPS Disenrollment Survey sponsored by the CMS; the other is the Medicare CAHPS Disenrollment *Reasons* Survey (referred to as the “Reasons Survey”).² Both surveys are being implemented as a result of legislative actions requiring that (1) an annual satisfaction survey be conducted for all Medicare and Medicaid plans that have contracts with physicians or physician groups that are at high risk of referral to specialists and (2) CMS report 2 years’ worth of disenrollment rates to Medicare beneficiaries. More background information on the two Medicare CAHPS Disenrollment Surveys is provided in *Consumer Assessment of Health Plans Study (CAHPS) Medicare Disenrollee Field Test Analysis Report* (Guess et al., 2003) and *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey* (Lynch, 2003).

1.3 OVERVIEW OF THIS REPORT

This report describes the methods used for and results of the 2002 Medicare CAHPS Disenrollment Assessment Survey, including sample selection, data collection, and survey and analysis results. Information about the Assessment Survey conducted in prior years can be found in other reports, which are listed with the references in **Section 6** of this report. **Section 2** describes the Technical Expert Panel (TEP) activities, **Section 3** presents an overview of Assessment Survey data collection, **Section 4** describes data processing, and **Section 5** provides background on how these results were reported to consumers (via the www.Medicare.gov Web site) and to health plans. The appendices include a list of experts who served on the technical expert panel for the Medicare CAHPS Disenrollment Surveys (**Appendix A**), a copy of the 2002 Assessment Survey questionnaire (**Appendix B**), a summary of the types and reasons for calls made to the project’s telephone hotline (**Appendix C**), and definitions of codes used to code the most important reason that Assessment Survey sample members reported for leaving the health plan (**Appendix D**). Crosswalks of questions in the 2002 Assessment Survey and the 2002 Medicare CAHPS Enrollee Survey are shown in **Appendix E**.

It should be noted that the terms “health plan,” “plan,” and “sample plan” are used throughout this report to refer to the individual contracts that CMS holds with managed care organizations, both corporate and nonprofit. However, according to CMS regulations, a “plan” is a benefits package, and each contract can offer any number of different plan benefit packages. Readers of this report should keep in mind that these terms in this report refer to the individual contracts that CMS holds with Medicare managed care organizations rather than to a benefits package.

² The UW-M and RTI project team has conducted the annual implementations of the Reasons Survey since 2000. Information about the 2002 Reasons Survey implementation is described in a separate report, *Survey Results and Reporting for the 2002 Medicare CAHPS Disenrollment Reasons Survey*.

SECTION 2 TECHNICAL EXPERT PANEL

2.1 OVERVIEW AND PURPOSE

Prior to the 2000 implementation of the Medicare CAHPS Disenrollment Surveys, the project team established a 12-member technical expert panel (TEP) to provide advice on a number of issues concerning the survey, including case-mix adjustment of survey data, oversight of the entire survey process, formats for presenting survey results to the public and to health plans, and analysis.

2.2 COMPOSITION

The contract for this project specified the types of experts to be included on the TEP:

- two to three industry experts from managed care health plans;
- two to three Medicare consumer advocates with expertise in managed care;
- two or more academic researchers with expertise in disenrollment from managed care and/or the presentation of comparative plan information to purchasers, plans, and consumers; and
- one or more members from a Statistical Expert Panel that CMS had convened in the summer of 1999.

In addition, CMS required that four of the 12 TEP members be CMS employees—including the CMS Project Officer and other CMS employees with expertise in disenrollment and/or responsibility for either the analysis of comparative plan information for plan evaluation purposes or the presentation of comparative plan information to the public.

The composition of the 2002 TEP remained essentially the same as that of earlier survey years; however, one of the industry experts from managed care left the panel and was replaced by another industry expert from managed care. Similarly, the individuals from CMS who served on the TEP during 2002 changed slightly, with one leaving and another joining in her place. The names of the TEP members for the 2002 Disenrollment Surveys, and their organizational affiliations, are included in *Appendix A*.

2.3 TEP MEETINGS

We have conducted five meetings with TEP members from the inception of this project through early 2003, to obtain guidance and input on survey methods, plans for reporting, and subgroup analysis. In-person meetings were held at or near CMS' headquarters in Baltimore on the following dates:

- April 10, 2000.
- January 11, 2001.

- February 6, 2002.
- May 2, 2003.

After each in-person meeting, we prepared and submitted to CMS a report that summarized the major discussions at the meeting. Each report was also distributed to TEP members. In addition to the above meetings, we also conducted a telephone conference with TEP members in June 2001 and a “virtual meeting” with TEP members in August 2001, where we mailed informational materials to TEP members for review and asked them to provide input through either a telephone call or electronic mail.

SECTION 3 ASSESSMENT SURVEY DATA COLLECTION

3.1 OVERVIEW

This chapter describes the sampling strategy used in the 2002 Assessment Survey, as well as data collection methods and results. Because data collection methods used in 2002 were basically the same as those used in 2001, they are not repeated in this report. More detailed information on survey data collection methods can be found in *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey* (Lynch, 2003).

3.2 SAMPLE DESIGN AND SELECTION

The Medicare CAHPS Enrollee Survey was designed to allow CAHPS outcomes to be compared between plans and between Medicare managed care and Original Medicare plans. Each Medicare managed care plan comprised a reporting unit. In cases where a contract covered a wide geographic area, some plans (reporting units) were further defined by geographic location. Thus, a single plan with wide geographic coverage in a large state might have multiple reporting units. Within each reporting unit, a simple random sample was drawn of plan enrollees who had been enrolled in the plan for 6 months or longer. For the 2002 Enrollee Survey, approximately 600 Medicare beneficiaries were sampled from each of 175 reporting units. To be included in the samples for the 2002 Enrollee and Assessment Surveys, health plans had to have been in operation as of July 1, 2001.

The Assessment Survey of disenrollees was designed to mirror the Medicare CAHPS Enrollee Survey by sampling at the same rate from each reporting unit. This had the benefit of minimizing design effects when results from the two surveys were combined. RTI project statisticians working on the Assessment Survey analyzed the sampling specifications used by the Enrollee Survey project team and developed the sampling ratio and sample size for each health plan at the county level (i.e., reporting units). However, because some plans had only a small number of disenrollees and because the Assessment and Reasons Surveys are conducted at the same time, the Assessment Survey project team used a strategy that would ensure that sampling could support both surveys. On the Assessment Survey, the sample size was capped for an entire *health plan* at 600 disenrollees. So if the initial specifications meant exceeding that cap, the reporting unit was proportionally scaled down until the maximum limit was met. For the 2002 Assessment Survey, only a handful of plans needed to be scaled down.

Project statisticians constructed the sampling frame and selected the Assessment Survey sample using administrative data files housed at CMS' data center. Deceased and institutionalized sample members were removed from the sampling frame before the sample was selected. In addition, sample members who moved out of their sample plan's service area were also deleted from the Assessment Survey sampling frame. The 2002 Assessment Survey sample consisted of 20,759 Medicare beneficiaries who disenrolled from their plan in May through August 2002, representing a total of 175 managed care health plans. For comparison purposes, *Exhibit 3-1* includes the sample sizes for the Assessment Surveys conducted in 2002, 2001 and 2000. Note that the 2002 sample is similar in size to that of the 2001 survey. This is due to the

Exhibit 3-1
Assessment survey sample sizes: 2002, 2001, and 2000

Assessment survey year	Sample size
2002	20,759
2001	19,345
2000	31,041

fact that the number of plans remained relatively stable across both years. The sample size for the 2000 survey reflects the larger number of MCOs that were in operation in 2000 (approximately 65 MCOs did not renew their contracts with CMS in 2001).

3.3 SURVEY INSTRUMENT

The Assessment Survey Questionnaire was designed to collect information about sample members' experiences with their former Medicare managed care health plan, including their overall ratings of that plan. The survey questions that asked about experience with and rating of care and the plan were core CAHPS questions and matched those included in the Enrollee Survey. However, the wording of questions in the Assessment Survey was changed so that sample members were asked to report on their experiences with their former plan, *when they were members of that plan or during the last 6 months that they were in that plan*.

The 2002 Assessment Survey questionnaire contained 92 questions, one more than the 2001 survey. The questions in the 2002 survey included the following:

- 4 screening questions to verify that the respondents were voluntary disenrollees;
- 3 questions about reasons for leaving the plan, including the most important reason for leaving;
- 1 question about length of time in the plan;
- 9 questions about experience with a personal doctor or nurse while in the health plan;
- 5 questions about getting health care from a specialist;
- 2 questions about calling for medical help during the week;
- 46 questions about the sample member's experiences with getting health care and services in the last 6 months before leaving the health plan; and
- 22 questions about health status and demographic characteristics, including the SF-12 series of questions.

A copy of the questionnaire used in the mail survey component of the 2002 survey is included as *Appendix B*. The questionnaire used in telephone follow-up with nonrespondents from the mail survey was designed to mirror the mail survey instrument as closely as possible and was developed as a computer-assisted telephone interview (CATI) instrument. Both the mail and telephone survey instruments were customized so that they were plan-specific for each respondent—that is, the name of the sample plan was printed in nearly all the core CAHPS questions. The survey instruments were also translated into Spanish and were available upon request, as either a hard copy questionnaire or as a Spanish-language telephone interview.

Prior to conducting the 2002 survey, we examined patterns in the responses to the 2001 Assessment Survey questionnaire as part of our ongoing efforts to monitor and evaluate the data collection process and survey questionnaire. In particular, we examined the screening questions, which were designed to identify sample members who are considered “involuntary” disenrollees—some of whom were considered ineligible to participate in the 2002 Assessment Survey. Although the screening questions included in the 2001 Assessment Survey were much improved over those included in the 2000 Assessment Survey, our evaluation of the 2001 data showed that some respondents did not necessarily consistently (or correctly) interpret the screening questions, often resulting in their exiting prematurely from the questionnaire. Other respondents marked an answer to a screening question that indicated that they were involuntary disenrollees; however, this same reason was not marked as their most important reason for leaving the plan.

CMS and project staff decided to consider all beneficiaries in the 2002 Assessment Survey eligible for survey participation *except* those who reported that their most important reason for leaving the plan was because someone else had signed them up for the plan without their knowledge and those who said they never left the sample plan. Note that in previous survey years sample members who reported that they left the plan because they moved out of the plan’s service area and those who reported that they were accidentally disenrolled from the plan (because of a paperwork error) were considered ineligible for survey participation. CMS decided not to exclude sample members who left for those reasons from the survey effective with the 2002 survey.

If a sample member reported during a telephone call to the project’s telephone hotline or during telephone follow up that that they left the plan because they found out that someone else had enrolled them in that plan without their knowledge, the telephone interviewer used a set of written probes to ensure that this was the only reason the sample member left the plan. If it was, the respondent was deemed ineligible for survey participation; if it was not the only reason for leaving, the respondent was asked to continue the interview.

Similarly, to ensure that respondents who responded to the survey by mail did not prematurely exit the questionnaire at the screening questions, we removed the stop instructions that appeared in each of the following three screening questions from the mail survey version of the 2002 Assessment Survey Questionnaire:

- Q2: Did you leave [HEALTH PLAN NAME] because the plan left the area or you heard that the plan was going to stop serving people with Medicare in your area?

- Q3: Did you leave [HEALTH PLAN NAME] because you found out that someone had signed you up for the plan without your knowledge (for example, a relative, salesperson, or someone else)?
- Q4: Did you leave [HEALTH PLAN NAME] because of a paperwork or clerical error (for example, you were accidentally taken off the plan)?

As in previous years, sample members who reported that they never left the Medicare managed care health plan for any length of time during the year 2002 or who were deceased or institutionalized were also not considered eligible for the survey.

Following the completion of the 2001 Assessment Survey, the Assessment Survey project team worked in conjunction with CMS and the other two Medicare CAHPS project teams in the spring and summer of 2002 to revise the questionnaire based on some changes to core CAHPS questions that the Agency for Healthcare Research and Quality (AHRQ) recommended. The following is a list of changes that were made to the questionnaire prior to implementing the 2002 Assessment Survey based on the experience in the 2001 survey and the AHRQ recommended changes:

- The question that asked about leaving the plan because the employer no longer offered the plan was reworded to include the spouse's former employer.
- The answer choices in the question about how long the sample member had been going to his/her personal doctor or nurse were changed to less than 6 months, at least 6 months but less than 1 year, 1 to 2 years, more than 2 years but less than 5, and 5 or more years. This change was made because these answer choices are more distinctive and eliminate any seeming overlap between the units of time in the answer choices for this question that were included in the 2001 questionnaire.
- The two questions in the section in the 2001 survey entitled "Calling Doctor Offices" were combined with those in the section on "Your Health Care in the Last 6 Months Before You left the Plan"
- The wording of the question about making an appointment for regular or routine health care (Question 20 in the 2001 survey) was changed. This question in the 2002 questionnaire will read "In the 6 months before you left (PLAN), not counting the times you needed health care right away, did you make any appointments with a doctor or other health provider for health care?" This change was intended to eliminate any confusion on what to consider as regular or routine health care. The wording of the follow-up question to this question was also changed.
- In the question about having an illness or injury that needed care right away from a doctor's office, clinic, or emergency room, the wording was changed so that the question now reads "In the last 6 months, did you have an *illness, injury, or condition that needed care right away* from a clinic, emergency room, or doctor's office?" The wording of the follow-up question to this question was also changed.

- A new gate question was added to determine if the sample member or his/her doctor believed the sample member needed care, tests, or treatment.
- In the question about how much of a problem it was to get care that the sample member or doctor believed necessary, the wording was changed to "...how much of a problem, if any, was it to get the care, *tests, or treatments* you or a doctor believed necessary?"
- A new gate question was added to determine if the sample member needed approval from the health plan for any care, tests, or treatment in the 6 months before he/she left the plan.
- The question about waiting in a doctor's office or clinic for more than 15 minutes was changed to read "...how often did you see *the person you came to see within 15 minutes* of your appointment?" In addition, a definition of "wait time" was added to this question.
- The question about looking for information in written form was changed to read "In the last 6 months before you left (PLAN), did you look for any information about how Medicare works in written material or on the Internet?"
- The answer choices in the age question were expanded to identify sample members 44 or younger and those who were between 45 and 64.

Project staff also added an additional question to the 2002 Assessment Survey CATI instrument to ensure that telephone interviewers probed sample members who called the project's telephone hotline to report that they left the plan for a reason that made them an involuntary disenrollee. The purpose of this question was to confirm that the sample member did not have any other reasons for leaving the plan.

For the 2002 survey, CMS considered adding up to four new questions about new rules that govern how often and when Medicare beneficiaries who are enrolled in a Medicare managed care plan can disenroll from their plan. These questions related to the "lock-in" rules that were expected to come into effect in 2002. CMS provided project staff with four questions related to lock-in that would have been added to the 2002 Assessment Survey questionnaire. RTI conducted cognitive testing activities to support CMS' evaluation of these potential new questions. The methods and results of that testing are described in a separate report entitled *Summary of Cognitive Test Activities to Test Questions About Lock-in: Medicare CAHPS Disenrollment Survey*, which was submitted to CMS in April 2002 (Hall, 2002). The final versions of questions about lock-in were not included in the 2002 Assessment Survey questionnaire because lock-in was postponed until 2005.

3.4 DATA COLLECTION ACTIVITIES

We conducted data collection activities for the 2002 Assessment Survey from October 11, 2002 through February 10, 2003. During survey implementation, we used a multiwave survey process that involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail.

Exhibit 3-2 presents the sampling window and the mail survey data collection schedule for the 2002 Assessment Survey.

Exhibit 3-2
2002 Assessment survey mail survey data collection schedule

Task	Dates
Presurvey notification letters sent to 20,759 sample members	October 11, 2002
First questionnaire package mailed to 20,759 sample members	October 16, 2002
Thank you/reminder postcard mailed to 20,759 sample members	November 18, 2002
Second questionnaire mailed to 13,060 nonrespondents	December 10, 2002
Spanish-language questionnaire mailed to 96 sample members	December 10, 2002
Telephone follow-up data collection with 12,041 nonrespondents	January 6, 2003-February 10, 2003
Third questionnaire sent by overnight shipment to 1,404 nonrespondents for whom no phone numbers were available	January 21, 2003

We conducted telephone follow-up with mail survey nonrespondents from January 6, 2003 through February 10, 2003.

Sample members were given the option to call a toll-free project telephone hotline at any time during the data collection period if they had questions about the survey, wanted to refuse, or wanted to request a telephone interview. For the 2002 Assessment Survey, RTI developed and implemented a hotline component as part of the 2002 Assessment Survey CATI instrument. Thus, all calls to the hotline were tracked directly in the CATI system. Just prior to mailing the prenotification letter, experienced telephone interviewers were trained on the CATI hotline module so that they could conduct interviews with sample members who called RTI to request a telephone interview or otherwise answer questions from sample members. The interviewers answered these calls, coded out cases, conducted interviews, or scheduled callbacks as required. In addition, sample members had the option to speak with a Spanish-speaking hotline representative or request a telephone interview in Spanish with a bilingual telephone interviewer. A summary of our hotline experience is provided in *Appendix C*.

CMS does not have telephone numbers for Medicare beneficiaries. Therefore, it was necessary to use various tracing sources to obtain telephone numbers for sample members included in the 2002 Assessment Survey. We used a combination of three sources to obtain a current telephone number for mail survey nonrespondents, including

- each of the Medicare managed care health plans represented in the sample,
- the Social Security Administration (SSA), and
- a commercial telephone matching service.

When none of these sources yielded a working telephone number, we conducted limited intensive tracing activities using RTI's specialized in-house Tracing Operations Unit (TOPS).

3.5 DATA COLLECTION QUALITY CONTROL PROCEDURES

To ensure that data of the highest possible quality would be collected, RTI project data collection staff implemented quality control procedures during every phase of the mail and telephone survey data collection process. These were discussed in detail in the 2000 report and are listed briefly below.

- Prior to sending the prenotification letter, we sent sample member addresses to an outside address service firm to append four-digit zip codes to the existing zip code information.
- We printed a unique RTI identification number on every page of the questionnaire, ensuring that if pages became separated during the scanning procedure, all data associated with a particular respondent would remain with that respondent's ID.
- During each mailing, every 10th package was checked to verify that it contained the correct materials and that it was assembled correctly.
- Quality control checks on the work performed by data receipt staff were conducted by checking an "error log" in the project control system and by maintaining and checking a "problem bin" for ineligible surveys and surveys containing hand-written notes. Project data collection staff reviewed these cases on a regular basis and assigned the appropriate status code to each case.
- We thoroughly trained all telephone interviewers on telephone follow-up procedures with mail survey nonrespondents before telephone data collection began and required all interviewers to complete and pass a written "exit" exam after the training session ended. Telephone interviewers were not allowed to begin work on this project unless they had performed satisfactorily during the training and passed the exit exam.
- Telephone supervisors and data collection staff used RTI's computerized silent monitoring system to unobtrusively listen to and evaluate a sample of calls made by all telephone interviewers. These staff provided feedback to interviewers after their calls were monitored and, if necessary, reviewed relevant data collection procedures with them.

In addition to the measures described above, project staff held quality circle meetings with telephone interviewers throughout the telephone data collection period. The purpose of these meetings was to discuss the status of the project, identify questions that were problematic for respondents, and discuss reasons sample members gave for not participating in the survey and possible ways of overcoming those objections to participating in the survey.

3.6 DATA COLLECTION RESULTS

Data collection efforts on the 2002 Assessment Survey resulted in an overall response rate of 60.4 percent. The response rate for the Assessment Survey is calculated using the following formula:

$$\frac{\text{Numerator} = \text{the number of completed interviews}}{\text{Denominator} = \text{All sample members included in the sample minus those considered ineligible (i.e., institutionalized, deceased, or involuntary disenrolled)}}$$

The number of cases selected and the final response rate for the Assessment Survey is shown in *Exhibit 3-3*. The response rate in the 2002 survey increased slightly over that obtained in the 2001 Assessment Survey.

Exhibit 3-3
Number of cases selected and final response rate

Assessment survey year	Number selected	Number categorized as eligible	Completed interviews	Response rate
2002	20,759	19,000	11,485	60.4%
2001	19,345	16,110	9,630	59.8%
2000	31,041	27,272	12,208	54.8%

The final disposition of cases included in the 2002 Assessment Survey sample is shown in *Exhibit 3-4*, along with the disposition of cases included in the 2000 and 2001 surveys, for comparison. Especially notable is the continued reduction from 2000 through 2002 in the percentage of cases ineligible for the survey because they were involuntary disenrollees. Involuntary disenrollees for the 2002 Assessment Survey include sample members who reported that they

- left because they were enrolled without their knowledge,
- did not disenroll from the sample plan, or
- were not on Medicare.

Exhibit 3-4
Sample disposition of the assessment survey sample

Sample disposition	2002 Assessment survey		2001 Assessment survey		2000 Assessment survey	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Completed interviews	11,485	55.3%	9,630	49.8%	12,208	39.3%
Mail survey	9,319	44.9%	7,634	39.5%	9,423	30.4%
Telephone interview	2,166	10.4%	1,996	10.3%	2,785	8.9%
Eligible nonrespondents	7,515	36.2%	6,480	33.5%	10,064	32.4%
Mentally/physically incapable	356	1.7%	465	2.4%	229	0.7%
Language barrier	157	0.8%	184	1.0%	175	0.6%
Refusal	1,722	8.3%	964	5.0%	1,739	5.6%
Unable to contact after repeated attempts	2,858	13.8%	710	3.7%	937	3.0%
Promised to return mail survey	135	0.7%	16	0.1%	159	0.5%
Unable to obtain phone number	2,287	11.0%	4,141	21.4%	6,825	21.9%
Ineligibles	1,759	8.5%	3,235	16.7%	8,769	28.2%
Deceased	347	1.7%	446	2.3%	778	2.5%
Institutionalized	655	3.2%	384	2.0%	423	1.4%
Did not leave sample plan	573	2.8%	391	2.0%	744	2.4%
Plan no longer offered	n/a	n/a	1605	8.3%	3,238	10.4%
Moved outside plan service area	n/a	n/a	n/a	n/a	2,051	6.6%
Left due to paperwork or clerical error	n/a	n/a	203	1.0%	n/a	n/a
Enrolled in plan without knowledge	67	0.3%	99	0.5%	n/a	n/a
Other ineligibles	117	0.6%	100	0.5%	1,535	4.9%
Eligible sample members	19,000	91.5%	16,110	83.3%	22,272	71.8%
Original sample	20,759	100.0%	19,345	100.0%	31,041	100.0%
Final response rate		60.4%		59.8%		54.8%

n/a = not applicable

In examining the final disposition status across 2001 and 2002, the percentage of ineligible sample members in the 2001 survey was nearly two times higher than it was in the 2002 survey. However, part of this reduction was because sample members who left the plan because the plan was no longer offered or who left because they were accidentally disenrolled due to a paperwork error were treated as ineligible for survey participation in the 2001 survey, but not in the 2002 survey. The number of beneficiaries deemed ineligible for survey participation because of “other reasons” from 2001 to 2002 remained virtually unchanged. Interestingly, although the response rate for 2002 was higher than for 2001, the number of refusals in 2002 was higher than observed in 2001 (8.3% versus 5.0%).

Finally, it is worth noting that in both 2000 and 2001, we were unable to obtain a telephone number for over 21 percent of the sample using the outside telephone number vendor and requesting a number from the health plans directly. However, in 2002, as a result of an agreement between CMS and the SSA to have the SSA provide telephone numbers, the number of cases for which we could not obtain a telephone number dropped by half, to 11 percent. Although there were fewer cases for which we could not obtain a telephone number, the number of cases that we could not contact, despite repeated attempts, increased dramatically from 3.7 percent in 2001 to 13.8 percent in 2002, reflecting the fact that though we had more telephone numbers, many of them may not have been valid for the sample member.

Exhibit 3-5 shows the percent of cases that returned a completed questionnaire after each main event or stage of data collection (first, second, and third mailings and telephone follow-up). The percent of cases responding to the first mailing was higher in 2002 than in 2001 but in 2002, fewer responses were received to the second mailing than in 2001. The percentage responding to the telephone survey was about the same in both years. Of the 96 sample members to whom a Spanish-language questionnaire was sent in 2002, 39 (40.6 percent) returned a completed questionnaire to RTI, an increase from the previous year. The average telephone interview administration time for sample members included in the telephone follow-up data collection was 26 minutes.

3.7 WEIGHTING AND NONRESPONSE ANALYSIS

To be consistent with the treatment of the Enrollee survey, the weights for the 2002 Assessment survey are simple population-based weights that incorporate a trivial adjustment for nonresponse. This approach is called cell weighting (where the cells are the counties belonging to a plan’s service area). The weights are calculated by dividing the population total for each plan at the county-level by the number of respondents in the same county. To be consistent with the same time frame as the Enrollee survey, weights are then post-stratified to represent the number of disenrollees over a 10-month window. Because the Enrollee and Disenrollee Assessment surveys are mutually exclusive domains of M+C beneficiaries, these cell weights can be combined easily to analyze the domain as a whole.

After cleaning the data and preparing a data file, we conducted a nonresponse analysis on the 2002 Assessment Survey data. For this analysis, we classified sample members as respondents or nonrespondents; response propensities were then modeled using logistic regression in SUDAAN. The models used for nonresponse analysis of 2002 Assessment Survey data were similar to those used in the 2002 Reasons Survey. However, the models for the

Exhibit 3-5
Response at each survey stage, 2000 through 2002 assessment surveys

Response per survey stage	2002 Assessment survey		2001 Assessment survey		2000 Assessment survey	
	Number of sample members	Number of completed questionnaires Percent of total	Number of sample members	Number of completed questionnaires Percent of total	Number of sample members	Number of completed questionnaires Percent of total
First mailing	20,759	7,763 37.4%	19,345	5,071 26.2%	31,041	6,625 21.3%
Second mailing	13,060	1,336 6.4%	15,727	2,239 11.6%	19,748	2,147 6.9%
Spanish mail survey	96	39 0.2%	58	0* 0.0%	97	22 0.1%
Telephone follow-up	12,041	2,166 10.4%	9,698	1,996 10.3%	9,206	2,785 8.9%
Third (overnight) mailing	1,404	181 0.9%	2,985	324 1.7%	8,612	629 2.0%
Total number of respondents		11,485 55.3%		9,630 49.8%		12,208 39.3%
Final response rate		60.4%		59.8%		54.8%

* None of the 58 sample members to whom a Spanish-language questionnaire was sent in 2001 returned a completed questionnaire to RTI. This is likely due to the fact that the second questionnaire mailing and the Spanish-language questionnaire mailing were initiated simultaneously with the start of the telephone follow-up of nonrespondents and so these beneficiaries probably completed the interview by telephone.

Assessment Survey involved different sample members with different characteristics and used different coefficients for beta parameters, although they were in the same direction and magnitude as those used in the 2002 Reasons Survey.

We used demographic characteristics, Census region, address variables, dual eligibility status, and design variables and removed them from the original model in a backward-stepwise fashion. We included two-way interactions and kept variables with p-values of 0.20 or less. The final logistic regression model contained the independent variables—age, race, dual eligibility, the metropolitan and micropolitan indicators, a rural route indicator, and the design variable, which was the Enrollee Survey sampling unit.

The metropolitan and micropolitan indicators were developed by the United States Office of Management and Budget (OMB) in June 2003 and are new to the nonresponse analysis. The definitions are very complex and involve the sizes of core cities within an area, the percentage of urbanization within a county, and economic and social integration between adjacent communities. For simplicity, a metropolitan statistical area includes at least one urbanized area of 50,000+ inhabitants, and a micropolitan statistical area includes at least one urban cluster of 10,000+ inhabitants but less than 50,000. These variables were very significant in our analysis. Beneficiaries residing in metropolitan and micropolitan statistical areas were more likely than beneficiaries not living in those areas to respond to the survey.

The age, race, and dual eligibility variables have been consistently significant in the Reasons and Assessment Survey in both the 2000 and 2001 survey years. Those who were older, disabled (under age 65), and nonwhite were less likely to respond. Dually eligible beneficiaries were also less likely to respond. Addresses with a rural route were less likely to respond to the survey. Response rates by demographic characteristics and other information resulting from this analysis are shown in *Exhibit 3-6*. We also show response rates for Sterling Health Insurance, a private fee-for-service plan that was newly included in the Assessment Survey in 2002. These response rates are shown for comparison purposes in *Exhibit 3-7*.

Exhibit 3-6
2002 Assessment survey response rates by demographic characteristics

Subpopulation	Total sample		Respondent sample		Response rates among eligibles ³	Response rates among eligibles, 2001
Overall						
USA	20,759	100.0%	11,485	100.0%	60.5%	59.8%
Gender (EDB)						
Male	8,516	41.0%	4,776	41.6%	60.9%	60.9%
Female	12,243	59.0%	6,709	58.4%	60.1%	50.0%
Age group (EDB)						
<65	1,772	8.5%	988	8.6%	58.8%	52.7%
65-69	3,491	16.8%	2,149	18.7%	65.0%	65.6%
70-74	5,394	26.0%	3,261	28.4%	63.8%	64.0%
75-79	4,211	20.3%	2,430	21.2%	62.5%	60.6%
≥80	5,891	28.4%	2,657	23.1%	53.0%	51.8%
Race (EDB)						
White	16,385	78.9%	9,434	82.1%	63.0%	63.2%
Black	2,832	13.7%	1,407	12.3%	54.4%	48.7%
Other/Unknown	1,542	7.4%	644	5.6%	44.9%	45.3%
Dual eligible (EDB)						
Yes	3,673	17.7%	1,583	13.8%	49.3%	45.3%
No	17,086	82.3%	9,902	86.2%	62.7%	62.5%
Census region						
I. New England	883	4.2%	496	4.3%	62.2%	58.2%
II. Middle Atlantic	4,152	20.0%	2,279	19.8%	59.5%	61.4%
III. East North Central	2,317	11.2%	1,268	11.1%	60.3%	62.9%
IV. West North Central	1,168	5.6%	692	6.0%	66.6%	54.5%
V. South Atlantic	4,627	22.3%	2,244	19.6%	51.6%	55.1%
VI. East South Central	722	3.5%	452	3.9%	68.6%	66.8%
VII. West South Central	1,337	6.4%	805	7.0%	65.5%	61.9%
VIII. Mountain	1,407	6.8%	902	7.9%	69.1%	69.6%
IX. Pacific	4,146	20.0%	2,347	20.4%	63.6%	57.8%

³1,759 sample members were ineligible (8.5%).

Exhibit 3-7
Response rates for Medicare Private Fee-for-Service health plan disenrollees

Subpopulation	Total Sample		Respondent sample		Response rates among eligibles
Overall					
USA	556	100.0%	337	100.0%	68.6%
Stratum					
I. Texas	112	20.1%	71	21.0%	69.6%
II. Louisiana	107	19.2%	67	19.9%	67.7%
III. Washington	70	12.6%	37	11.0%	69.8%
IV. Oklahoma	72	13.0%	43	12.8%	68.3%
V. Tennessee	17	3.1%	10	3.0%	71.4%
VI. Ohio	58	10.4%	37	11.0%	67.3%
VII. Pennsylvania	33	5.9%	26	7.7%	83.9%
VIII. Remainder of USA	87	15.7%	46	13.6%	62.2%

SECTION 4 DATA PROCESSING

4.1 OVERVIEW

Data processing for the 2002 Assessment Survey involved receiving incoming mail from the mail survey and updating the project's computerized control system to reflect the status of that incoming mail, scanning the data from completed questionnaires, and assigning codes to open-ended text entries, including sample members' most important reason for leaving the plan. File construction activities included preparing a data file that combined data from the 2002 Enrollee Survey with the 2002 Assessment Survey data and preparing a separate data file containing only 2002 Assessment Survey data. Data processing and file construction activities are described below.

4.2 DATA RECEIPT AND SCANNING

Data Receipt staff entered a disposition/status code of "999" in the control system to all nonblank questionnaires as they were received at RTI. All questionnaires assigned a 999 status code were then scanned, and a computer algorithm determined the final event status code. As project staff received calls from sample members or their families that resulted in a final disposition of a case (such as a sample member being deceased or incapable of participating in the interview), they entered the appropriate final status code for the case into the receipt control system. Project staff updated the control system with new addresses as new address information was obtained (either from returned mail or reported by telephone calls from sample members).

Ineligible sample members were identified from their responses to the questionnaire, via a telephone interview, via a note submitted with a questionnaire, or via a call to the project hotline. In addition, project staff coded cases as ineligible based on a review of open-ended text entries for the "most important" reason.

4.3 CODING OPEN-ENDED TEXT ENTRIES

One question in the survey instrument allowed an open-ended response: a question asking the respondent for the one most important reason for leaving the Medicare health plan. A description of the development of the code list, training procedures in which coders participated, and quality control checks performed on the coded entries is provided in the final report prepared and submitted to CMS on the 2000 Assessment Survey.⁴

For the 2002 questionnaire, the question that asked for open-ended responses was coded by project staff according to a list of 67 codes developed by the analysis team. The list of codes used in the 2002 coding process was the same as that used in the 2001 coding process, with the exception of an additional most important reason for leaving code (465) indicating ineligibility:

⁴ The results of the 2000 Survey can be found in *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey*, June 23, 2003.

“I was enrolled without my knowledge (for example, by a friend, relative or salesperson) (Q3).” A complete list of all codes used in the 2002 Assessment Survey is included in *Appendix D*.

4.4 QUESTIONNAIRE COMPLETENESS CRITERIA

A questionnaire in the 2002 Assessment Survey was considered complete if the respondent marked an answer to at least one question other than the screening questions designed to identify involuntary disenrollees. However, even if a case met this completeness criteria, it was excluded from the data file (and treated as ineligible) if the respondent’s most important reason for leaving the plan was one that made him/her an involuntary disenrollee. These reasons included leaving the plan because they found out that they were signed up without their knowledge or never having left the plan.

4.5 DATA FILE CONSTRUCTION

Project staff members created two separate data files. The first file, which contained only data from the 2002 Assessment Survey, was created for subgroup analysis of that survey. The second file combined respondent data from the 2002 Assessment Survey with that collected in the 2002 Enrollee Survey. The combined Enrollee/Assessment Survey data file was prepared and used for analyzing data for comparative plan information that was eventually posted on the www.Medicare.gov Web site and for comparative plan information included in an annual report sent to health plans, which was intended to help health plans in their quality improvement efforts.

Recoding data—After the raw data were cleaned and all cases identified as ineligible for the survey had been removed, we created a master Assessment Survey data file. In the master data file, the responses for the remaining respondents were recoded so that all “don’t know” responses and refusal codes (i.e., a code indicating that the respondent refused to answer a specific question in cases completed by telephone) were coded as blank.

Adding other variables to the data file and flagging cases—The next step in the file creation process was to add variables from CMS administrative files to the Assessment Survey data file, including the sample member’s race, gender, and age; length of enrollment in the plan; dates of enrollment and disenrollment from the sample plan; dual eligibility indicator; plan name; and contract number. Other variables, indicating the data collection mode (i.e., mail survey questionnaire or telephone interview), language indicator (i.e., whether the interview was conducted in English or Spanish), and respondent indicator (i.e., whether self or proxy respondent), were added to the Assessment Survey data file. Simple population-based weights (cell weighted to the plan and county totals) were also added to the final Assessment Survey data file.

The next step involved adding flags to selected cases in the Assessment Survey data file. The flags added were to indicate which cases were to be excluded when analyzing data to generate comparative plan information and/or for subgroup analysis. In the Assessment Survey data file, flags were added to cases where the

- plan the sample member left did not renew its M+C contract with CMS in either 2003 or 2004,

- the sample member left the health plan because their employer no longer offered the plan, and
- the sample member was dually eligible for both Medicare and Medicaid.

In addition, cases where the sample member was included in both the 2002 Assessment and Medicare CAHPS Managed Care Enrollee survey were identified and flagged.

Mapping most important reasons for leaving the plan—For the 2002 Assessment Survey, we mapped the respondents’ most important reason for leaving the plans to one of two main reasons groupings: members who left because of health care or services, and members who left because of costs and benefits. The most important reason for leaving the plan was further mapped into one of eight reasons subgroupings for analysis: five subgroupings for health care or services, and three for costs and benefits. More detailed information about the rationale for and the development of the reasons groupings is included in the final report on the 2000 Reasons Survey report, which was submitted to CMS in June 2003.⁵

The combined enrollee and assessment survey data file—After we created the Assessment Survey data file, we created a file containing combined respondent data from the Assessment and Enrollee Surveys. This file was created to be used in analyzing data to produce comparative plan information. To create the combined file, we first developed a crosswalk of the questions that were included in the questionnaires used in each of these two surveys (*Appendix E*). The crosswalk showed the questions that were included in both questionnaires and those that were unique to each survey. Variable names were assigned to each question and to the other items that were included in the individual data files for the surveys. A copy of the crosswalk mapping the item numbers in each survey to the variable names, shown in the order of both the Enrollee Survey questionnaire and the Assessment Survey questionnaire, is also included in *Appendix E*. Once the variable names were assigned, we created the file containing respondent data from both surveys. The combined data were weighted to reflect the proportion of enrollees and disenrollees in each of the reporting units by which plan-comparative information would be reported to Medicare beneficiaries, health plans, and CMS. The weights were then added to the combined file.

⁵ The “reasons groupings” were created during the 2000 Reasons Survey for compiling comparative plan information based on reasons for disenrolling from a plan. More information on the development of the reasons groupings can be found in the *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey* (Lynch et al., 2003).

SECTION 5 CONSUMER AND HEALTH PLAN REPORTING

5.1 OVERVIEW

During the winter and spring of 2003, the Assessment Survey project team worked closely with CMS and the Enrollee Survey and Fee-for-Service (FFS) project teams to coordinate the analysis and distribution (via the www.Medicare.gov Web site) of comparative health plan data from all three surveys. The three teams met periodically to resolve issues, coordinate analysis objectives, and ensure the prompt and efficient delivery and receipt of data files between the organizations. In addition, the project teams for the Enrollee and Assessment Surveys worked together to develop a template for reporting to health plans the analysis results from the combined data of the two surveys. The analysis conducted for producing comparative plan information is described in the following sections. The descriptive analysis of the 2002 Assessment Survey is provided in a separate report.

5.2 WEIGHTING FOR CONSUMER AND HEALTH PLAN REPORTING

As indicated in the preceding chapter, project staff created a data file with combined data from the 2002 Enrollee and Assessment Surveys and then prepared simple population-based weights that reflected the proportion of enrollees and disenrollees included for each health plan. When both data sources are combined, the enrollee and disenrollee weights are proportionally correct and represent the plan's true composition of enrollees and disenrollees. The weight was calculated at the health plan's state and county level, which is consistent with how beneficiaries were sampled. The number of eligible beneficiaries at the county level was divided by the number of respondents in that county. So, not only do the weight sums represent the number of individuals within that plan, they are also adjusted to the county level. To generate reports in a quick, timely manner, these weights were *not* response-propensity adjusted for other factors such as age, race, or sex.

5.3 CONSUMER SURVEY REPORTING

The Enrollee Survey project team took the lead in analyzing the combined 2002 Assessment and Enrollee Survey data to generate comparative plan information that would eventually be reported to consumers. The Assessment Survey project team also used the CAHPS macro to generate the comparative plan information. The Assessment and Enrollee project teams compared the output from the CAHPS macro that each team generated, and the output produced by both teams was considered final when the output generated by each team matched. The output containing ratings and composite scores from the combined data was merged into an Excel template and submitted to CMS. The results of this analysis were posted on the www.Medicare.gov Web site in the fall of 2003.

5.4 HEALTH PLAN REPORTING

Each year, the Enrollee Survey project team prepares and distributes an annual report for each M+C organization that participated in that year's enrollee survey. During the spring of

2003, the Assessment Survey project team worked with the Enrollee Survey team to update and revise the template as appropriate to report the combined results from the 2002 Enrollee and Assessment surveys to the health plans. The Enrollee Survey team produced and distributed these reports in September 2003.

SECTION 6 REFERENCES

- Guess, L.L., Lynch, J.T., Keller, S.D., Wiesen, C.A., Bender, R.H., and Kenyon, A.E.: Consumer Assessment of Health Plans Study (CAHPS) Medicare Disenrollee Field Test Analysis Report. Submitted to the Agency for Healthcare Research and Quality and the Health Care Financing Administration, March 24, 2000.
- Hall, P., Lynch, J., Kenyon, A., Morton, J., Flanigan, T., and Langer, M.: Summary of Cognitive Test Activities to Test Questions About Lock-in: Medicare CAHPS Disenrollment Survey. Technical report submitted to Centers for Medicare & Medicaid Services, April 2002.
- Lynch, J., Kenyon, A., Scheffler, S., Booske, B., McCormack, L., Rudolph, B., and Bender, R.: Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey. Technical report submitted to Centers for Medicare & Medicaid Services, June 23, 2003.
- Lynch, J., Kenyon, A., Scheffler, S., Booske, B., McCormack, L., Rudolph, B., and Bender, R.: Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey. Technical report submitted to Centers for Medicare & Medicaid Services, 2003.

APPENDIX A

2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY:
TECHNICAL EXPERT PANEL MEMBERS

Technical Expert Panel Members

Sue Andersen, MA, JD, LLM

President, HealthNav
4832 Langdrum Lane
Chevy Chase, MD 20815
phone: 301-652-2753
fax: 301-652-3025
lsandersen49@hotmail.com

Kathleen Thiede Call, PhD

Assistant Professor
Health Services Research and Policy
University of Minnesota
420 Delaware Street S.E.
Minneapolis, MN 55455
phone: 612-624-3922
fax: 612-624-2196
callx001@tc.umn.edu

Geraldine Dallek, MPH

Consultant
Washington, D.C. 20008
phone: 202-588-8963
fax: 202-588-8964
gdallek@aol.com

Constantine Gatsonis, PhD

Professor of Medical Science
Brown University
Center for Statistical Sciences, Box G-H
Providence, RI 02912
phone: 401-863-9183
fax: 401-863-9182
gatsonis@stat.brown.edu

Trudy Lieberman

Health Policy Editor, Consumer Reports
Consumers Union
101 Truman Ave.
Yonkers, NY 10703-1057
phone: 914-378-2513
fax: 914-378-2904
liebtr@consumer.org

Phyllis Torda

Vice President
National Committee for Quality Assurance
2000 L Street, NW, Suite 500
Washington, DC 20036
phone: 202-955-3500
fax: 202-955-3599
torda@ncqa.org

Patricia Venus, PhD

Center for Health Care Policy and Evaluation
United Health Group
P.O. Box 1459 MN008-W109
Minneapolis, MN 55440-1459
phone: 612-936-7341
fax: 612-936-7270
patricia_j_venus@uhc.com

Mark Schlesinger, PhD

Associate Professor
Yale University School of Medicine
Room 304, Dept. of Epidemiology and Public Health
60 College St.
New Haven, CT 06520
Phone: 203-785-4619
Mjs4@email.med.yale.edu

Chris Haffer, PhD

Director, Medicare Health Outcomes Survey
Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850
phone: 410-786-8764
fax: 410-786-8532
shaffer@cms.hhs.gov

Gerald Riley, MSHP

Social Science Research Analyst
Office of Research, Development, and Information
Centers for Medicare & Medicaid Services
7500 Security Blvd., Central Bldg.
Baltimore, MD 21244-1850
phone: 410-786-6699
fax: 410-786-6511
griley@cms.hhs.gov

Merilyn Francis, RN, MPP

Director of Research and Quality
American Association of Health Plans
1129 20th Street, NW
Washington, DC 20005
Phone: (202) 778-3224
mfrancis@aaahp.org

Shawn Bishop, MPP

Health Insurance Specialist
Center for Health Plans and Providers
Health Care Financing Administration
7500 Security Blvd., Central Bldg.
Baltimore, MD 21244-1850
phone: 410-786-5160
fax: 410-786-0322
sbishop@hcfa.gov

APPENDIX B

2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY:
QUESTIONNAIRE



2002 Medicare Satisfaction Survey^{-DA}



CAHPS[®]
Consumer Assessment
of Health Plans

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 0938-0779. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have any 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, Maryland 21244-1850, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Instructions for Completing This Questionnaire

This questionnaire asks about you and your experiences in a Medicare health plan. Answer each question thinking about yourself. Please take the time to complete the questionnaire because your answers are very important to us.

- Please use a BLACK ink pen to mark your answers.
- Be sure to read all the answer choices before marking your answer.
- Answer all the questions by putting an “X” in the box to the left of your answer, like this:

Yes
 No → **Go to Question 3**

- You will sometimes be instructed to skip one or more questions, depending on how you answered an earlier question. When this happens, you will see an arrow with a note that tells you what question to answer next, as shown in the example above.

If the answer you marked is not followed by an arrow with a note telling you where to go next, then continue with the next question, as shown below.

EXAMPLE

1. **Do you wear a hearing aid now?**

Yes
 No → **Go to Question 3**

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

Less than 1 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?**

Yes
 No

**IMPORTANT:
PLEASE READ BEFORE
BEGINNING THE QUESTIONNAIRE**

Our records show that you were a member of [HEALTH PLAN NAME] and that you left that plan for some period of time during the last 6 months.

If this is correct, please complete this questionnaire.

If you did not leave [HEALTH PLAN NAME], or if you were never enrolled in that plan, please call us toll-free at 1-877-834-7063 and let us know.

REASONS YOU LEFT [HEALTH PLAN NAME]

The following questions ask about reasons you may have had for leaving [HEALTH PLAN NAME].

1. Did you leave because you moved outside the area where [HEALTH PLAN NAME] was available?

Yes

No

2. Did you leave [HEALTH PLAN NAME] because the plan left the area or you heard that the plan was going to stop serving people with Medicare in your area?

Yes

No

3. Did you leave [HEALTH PLAN NAME] because you found out that someone had signed you up for the plan without your knowledge (for example, a relative, salesperson, or someone else)?

Yes

No

4. Did you leave [HEALTH PLAN NAME] because of a paperwork or clerical error (for example, you were accidentally taken off the plan)?

Yes

No

5. Some people leave their Medicare health plan because their former employer no longer offers the plan.

Did you leave [HEALTH PLAN NAME] because your former employer or your spouse's former employer no longer offered [HEALTH PLAN NAME] to you?

- Yes
- No
- Neither I nor my spouse were enrolled in this health plan through a former employer.

6. A premium is the amount that you pay to receive health care coverage from a health plan. Some health plans charge a premium to people on Medicare who are enrolled in that health plan.

This additional premium that the health plan charges is separate from the premium that people on Medicare pay for Medicare Part B, which is usually deducted from their Social Security Check each month.

Some people leave their Medicare health plan because they cannot afford to pay the premium. Did you leave [HEALTH PLAN NAME] because you could not pay the monthly premium?

- Yes
- No

7. What was the one most important reason you left [HEALTH PLAN NAME]? *(Please print.)*

8. How many months or years in a row were you in [HEALTH PLAN NAME]?

- Less than 6 months
- At least 6 months but less than 1 year
- 1 to 2 years
- More than 2 years but less than 5 years
- 5 or more years

YOUR PERSONAL DOCTOR OR NURSE

The next questions ask about the health care you got while you were a member of [HEALTH PLAN NAME].

Do not include care you got when you stayed overnight in a hospital.

Do not include the times you went for dental care visits.

A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a physician assistant, or a nurse.

9. When you were a member of [HEALTH PLAN NAME], did you have one person you thought of as your personal doctor or nurse?

- Yes
- No → If no, go to Question 17 on Page 6

10. Is this person a general doctor, a specialist doctor, a physician assistant, or a nurse?

- General doctor (Family Practice or Internal Medicine)
- Specialist doctor
- Physician assistant
- Nurse
- I didn't have a personal doctor or nurse when I was a member of that plan.

11. How many months or years have you been going to the personal doctor or nurse you had while you were in [HEALTH PLAN NAME]?

- Less than 6 months
- At least 6 months but less than 1 year
- 1 to 2 years
- More than 2 years but less than 5 years
- 5 or more years
- I didn't have a personal doctor or nurse when I was a member of that plan.

12. How would you rate the personal doctor or nurse you had in the 6 months before you left [HEALTH PLAN NAME]?

Using any number from 0 to 10 where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible, what number would you use to rate your personal doctor or nurse?

- 0 → Worst personal doctor or nurse possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 → Best personal doctor or nurse possible
- I didn't have a personal doctor or nurse while I was in [HEALTH PLAN NAME].

13. When you were a member of [HEALTH PLAN NAME], did your personal doctor or nurse know the important facts and decisions about your health care?

- Yes
- No
- I didn't have a personal doctor or nurse when I was a member of that plan.

14. When you were a member of [HEALTH PLAN NAME], did you have a physical or medical condition that seriously interfered with your ability to work or manage your day-to-day activities?

- Yes
- No → If no, go to Question 16 in the next column

15. When you were a member of [HEALTH PLAN NAME], did your personal doctor or nurse understand how any health problems you had affected your day-to-day life?

- Yes
- No
- I didn't have any health problems or I didn't have a personal doctor or nurse when I was a member of that plan.

16. Was the personal doctor or nurse you had while you were in [HEALTH PLAN NAME] the same one you had before you joined that plan?

- Yes
- No

17. How much of a problem, if any, was it to get a personal doctor or nurse you were happy with when you were a member of [HEALTH PLAN NAME]?

- A big problem
- A small problem
- Not a problem
- I didn't get a new personal doctor or nurse while I was in [HEALTH PLAN NAME].

GETTING HEALTH CARE FROM A SPECIALIST

When you answer the next questions do not include dental visits.

18. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.

In the 6 months before you left [HEALTH PLAN NAME], did you or a doctor think you needed to see a specialist?

- Yes
- No → If no, go to Question 20 in the next column

19. In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, was it to see a specialist that you needed to see?

- A big problem
- A small problem
- Not a problem
- I didn't need to see a specialist in the 6 months before I left [HEALTH PLAN NAME].

20. In the 6 months before you left [HEALTH PLAN NAME], how many times did you go to specialists for care for yourself?

- None → If none, go to Question 23 on page 7
- 1
- 2
- 3
- 4
- 5 to 9
- 10 or more

21. How would you rate the specialist you saw most often in the 6 months before you left [HEALTH PLAN NAME], including a personal doctor if he or she is a specialist?

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

0 → Worst specialist possible

1

2

3

4

5

6

7

8

9

10 → Best specialist possible

I didn't see a specialist in the 6 months before I left [HEALTH PLAN NAME].

22. Was the specialist you saw most often in the 6 months before you left [HEALTH PLAN NAME] the same doctor as the personal doctor you had when you were a member of that plan?

Yes

No

I didn't have a personal doctor or I didn't see a specialist in the 6 months before I left [HEALTH PLAN NAME].

**YOUR HEALTH CARE IN THE
LAST 6 MONTHS BEFORE YOU
LEFT THE PLAN**

23. In the 6 months before you left [HEALTH PLAN NAME], did you call a doctor's office or clinic during regular office hours to get help or advice for yourself?

Yes

No → If no, go to Question 25 on Page 8

24. In the 6 months before you left [HEALTH PLAN NAME], when you called during regular office hours, how often did you get the help or advice you needed?

- Never
- Sometimes
- Usually
- Always
- I didn't call for help or advice during regular office hours in the 6 months before I left [HEALTH PLAN NAME].

25. A health provider could be a general doctor, a specialist doctor, a physician assistant, a nurse, or anyone else you would see for health care.

In the 6 months before you left [HEALTH PLAN NAME], not counting the times you needed health care right away, did you make any appointments with a doctor or other health provider for health care?

- Yes
- No → If no, go to Question 27 in the next column

26. In the 6 months before you left [HEALTH PLAN NAME], how often did you get an appointment for health care as soon as you wanted?

- Never
- Sometimes
- Usually
- Always
- I didn't need an appointment for health care in the 6 months before I left [HEALTH PLAN NAME].

27. In the 6 months before you left [HEALTH PLAN NAME], did you have an illness, injury, or condition that needed care right away from a clinic, emergency room, or doctor's office?

- Yes
- No → If no, go to Question 29 on Page 9

28. In the 6 months before you left [HEALTH PLAN NAME], when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?

- Never
- Sometimes
- Usually
- Always
- I didn't need care right away for an illness, injury, or condition in the 6 months before I left [HEALTH PLAN NAME].

29. In the 6 months before you left [HEALTH PLAN NAME], how many times did you go to an emergency room to get care for yourself?

- None
- 1
- 2
- 3
- 4
- 5 to 9
- 10 or more

30. In the 6 months before you left [HEALTH PLAN NAME] (not counting times you went to an emergency room), how many times did you go to a doctor's office or clinic to get care for yourself?

- None → If none, go to Question 42 on Page 12
- 1
- 2
- 3
- 4
- 5 to 9
- 10 or more

31. In the 6 months before you left [HEALTH PLAN NAME], did you or a doctor believe you needed any care, tests or treatment?

- Yes
- No → If no, go to Question 33 on Page 10

32. In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?

- A big problem
- A small problem
- Not a problem
- I didn't need care, tests or treatment in the 6 months before I left [HEALTH PLAN NAME].

33. In the 6 months before you left [HEALTH PLAN NAME], did you need approval from your health plan for any care, tests or treatment?

- Yes
- No → If no, go to Question 35 in the next column

34. In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

- A big problem
- A small problem
- Not a problem
- I didn't need care, tests or treatment in the 6 months before I left [HEALTH PLAN NAME].

35. Wait time in a doctor's office or clinic includes the time you had to wait in the waiting room and the exam room.

In the 6 months before you left [HEALTH PLAN NAME], how often did you see the person you came to see within 15 minutes of your appointment?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

36. In the 6 months before you left [HEALTH PLAN NAME], how often did office staff at a doctor's office or clinic treat you with courtesy and respect?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

37. In the 6 months before you left [HEALTH PLAN NAME], how often were office staff at a doctor's office or clinic as helpful as you thought they should be?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

38. In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers listen carefully to you?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

39. In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers explain things in a way you could understand?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

40. In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers show respect for what you had to say?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

41. In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers spend enough time with you?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

42. How would you rate all the health care you got in the 6 months before you left [HEALTH PLAN NAME] from all doctors and other health providers?

Using any number from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible, what number would you use to rate all the health care you got in the 6 months before you left [HEALTH PLAN NAME]?

- 0 → Worst health care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 → Best health care possible
- I had no visits in the 6 months before I left [HEALTH PLAN NAME].

OTHER HEALTH SERVICES

The next questions ask about your experience with other types of health services that you may have had in the 6 months before you left [HEALTH PLAN NAME].

43. In the 6 months before you left [HEALTH PLAN NAME], did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?

Yes

No → If no, go to Question 45 in the next column

44. In the 6 months before you left the plan, how much of a problem, if any, was it to get the special medical equipment you needed through [HEALTH PLAN NAME]?

A big problem

A small problem

Not a problem

I didn't need to get any special medical equipment in the 6 months before I left [HEALTH PLAN NAME].

45. In the 6 months before you left [HEALTH PLAN NAME], did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy?

Yes

No → If no, go to Question 47 on Page 14

46. In the 6 months before you left the plan, how much of a problem, if any, was it to get the special therapy you needed through [HEALTH PLAN NAME]?

A big problem

A small problem

Not a problem

I didn't need any special therapy in the 6 months before I left [HEALTH PLAN NAME].

47. Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks.

In the 6 months before you left [HEALTH PLAN NAME], did you need someone to come into your home to give you home health care or assistance?

Yes

No → **If no, go to Question 49 in the next column**

48. In the 6 months before you left the plan, how much of a problem, if any, was it to get the home health care or assistance you needed through [HEALTH PLAN NAME]?

A big problem

A small problem

Not a problem

I didn't need home health care or assistance in the 6 months before I left [HEALTH PLAN NAME].

49. In the 6 months before you left the plan, how often did you get the prescription medicine you needed through [HEALTH PLAN NAME]?

Never

Sometimes

Usually

Always

I didn't need any prescription medicines in the 6 months before I left [HEALTH PLAN NAME].

50. In the 6 months before you left the plan, how much of a problem, if any, was it to get the prescription medicine you needed from [HEALTH PLAN NAME]?

A big problem

A small problem

Not a problem

I didn't need any prescription medicines in the 6 months before I left [HEALTH PLAN NAME].

51. At the time that you left [HEALTH PLAN NAME], did your plan cover some or all of the costs of your prescription medicines?

Yes

No

YOUR FORMER HEALTH PLAN

The next questions ask about your experience with [HEALTH PLAN NAME] in the 6 months before you left that plan.

52. In the 6 months before you left the plan, did you look for any information in written material or on the Internet about how [HEALTH PLAN NAME] works?

Yes

No → If no, go to Question 54 in the next column

53. In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, was it to find or understand this information?

A big problem

A small problem

Not a problem

I didn't look for information from [HEALTH PLAN NAME] in the 6 months before I left that plan.

54. In the 6 months before you left the plan, did you call [HEALTH PLAN NAME]'s customer service to get information or help?

Yes

No → If no, go to Question 57 on Page 16

55. In the 6 months before you left the plan, how much of a problem, if any, was it to get the help you needed when you called [HEALTH PLAN NAME]'s customer service?

- A big problem
- A small problem
- Not a problem
- I didn't call customer service at [HEALTH PLAN NAME] in the 6 months before I left that plan.

56. In the 6 months before you left the plan, how often were people at [HEALTH PLAN NAME]'s customer service as helpful as they should be?

- Never
- Sometimes
- Usually
- Always
- I didn't call customer service at [HEALTH PLAN NAME] in the 6 months before I left that plan.

57. In the 6 months before you left the plan, did you call or write [HEALTH PLAN NAME] with a complaint or problem?

- Yes
- No → If no, go to Question 60 on Page 17

58. How long did it take for [HEALTH PLAN NAME] to resolve your complaint?

- Same day
- 1 week
- 2 weeks
- 3 weeks
- 4 or more weeks
- I am still waiting for it to be settled.
- I didn't have any complaint or problem in the 6 months before I left [HEALTH PLAN NAME].

59. Was your complaint or problem settled to your satisfaction?

- Yes
- No
- I am still waiting for it to be settled.
- I didn't have any complaint or problem in the 6 months before I left [HEALTH PLAN NAME].

60. Paperwork means things like getting your ID card, having your records changed, processing forms or other paperwork related to getting care.

In the 6 months before you left the plan, did you have to fill out any paperwork for [HEALTH PLAN NAME]?

- Yes
- No → If no, go to Question 62 on Page 18

61. In the 6 months before you left the plan, how much of a problem, if any, did you have with paperwork for [HEALTH PLAN NAME]?

- A big problem
- A small problem
- Not a problem
- I didn't have any experience with paperwork for [HEALTH PLAN NAME] in the 6 months before I left the plan.

62. How would you rate all your experience with [HEALTH PLAN NAME]?

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 [HEALTH PLAN NAME]?

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

APPEALS AND COMPLAINTS

An appeal is a written complaint you can make to your health plan if they decide not to provide or pay for health care services or equipment, or to stop providing health care services or equipment.

63. Sometimes people cannot get their health plan to provide or pay for services that they think they need. Were you ever told by [HEALTH PLAN NAME] how to file a formal complaint if this happened to you?

- Yes
- No

64. Was there ever a time when you strongly believed that you needed and should have received health care or services that [HEALTH PLAN NAME] or your doctor decided not to give you?

- Yes
- No → If no, go to Instruction Box 1 on Page 19

65. The Medicare Program is trying to learn more about the health care or services that Medicare health plan members believed they needed but did not get.

May we contact you again about the health care or services that you did not receive if we need more information?

Yes

No

I was able to get the health care and services that I thought I needed when I was a member of this plan.

INSTRUCTION BOX 1

When answering Questions 66 through 70, please think about the time when you were a member of [HEALTH PLAN NAME].

66. If [HEALTH PLAN NAME] decided not to provide or pay for care that you believed you needed, did you know who to contact at [HEALTH PLAN NAME] to ask them to reconsider?

Yes

No

Don't Know

67. Did you ever ask [HEALTH PLAN NAME] to reconsider a decision to not provide or pay for a treatment?

Yes

No

68. If [HEALTH PLAN NAME] decided not to provide or pay for a particular treatment, could your doctor have contacted someone at the plan and asked them to reconsider?

Yes

No

Don't Know

69. If [HEALTH PLAN NAME] decided not to reconsider providing or paying for a particular treatment, would [HEALTH PLAN NAME] have automatically referred it to another organization for an independent review?

- Yes
- No
- Don't Know

70. If this independent organization turned down your request for reconsideration to [HEALTH PLAN NAME], did you have the right to ask for another review by a judge?

- Yes
- No
- Don't Know

ABOUT YOU

The next set of questions asks for your views about your health, about how you feel and how well you are able to do your usual activities.

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

- Excellent
- Very good
- Good
- Fair
- Poor

73. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

The next two questions are about activities you might do during a typical day.

74. Does your health now limit you in doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

75. Does your health now limit you in climbing several flights of stairs? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

The next two questions ask about your physical health and your daily activities in the past 4 weeks.

76. During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?

- Yes
- No

77. During the past 4 weeks, were you limited in the kind of work or other regular daily activities you did as a result of your physical health?

- Yes
- No

The next two questions ask about problems with your work or other regular daily activities as a result of any emotional problems, such as feeling depressed or anxious.

78. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?

Yes

No

79. During the past 4 weeks, did you do work or other regular activities less carefully than usual as a result of any emotional problems, such as feeling depressed or anxious?

Yes

No

80. During the past 4 weeks, how much did pain interfere with your normal work, including both work outside the home and housework?

Not at all

A little bit

Moderately

Quite a bit

Extremely

The next three questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

81. How much of the time, during the past 4 weeks, have you felt calm and peaceful?

All of the time

Most of the time

A good bit of the time

Some of the time

A little of the time

None of the time

82. How much of the time, during the past 4 weeks, did you have a lot of energy?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

83. How much of the time, during the past 4 weeks, have you felt downhearted and blue?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

84. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

85. What is your age now?

- 44 or younger
- 45 to 64
- 65 to 69
- 70 to 74
- 75 to 79
- 80 or older

86. Are you male or female?

- Male
- Female

87. 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

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

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

89. 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

90. Did someone help you complete this questionnaire?

- Yes → **If yes, go to Question 91 on Page 25**
- No → **If no, go to Question 92 on Page 25**

**91. How did that person help you?
Please check all that apply.**

- Read the questions to me.
- Wrote down the answers I gave.
- Answered the questions for me.
- Translated the questions into my language.
- Helped me in some other way.
(Please print.)

92. We would like to be able to contact you in case we have any questions about any of your answers. Please write your daytime telephone number below.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

THANK YOU.

Please return your completed survey in the postage-paid envelope.

APPENDIX C

2002 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY:
SUMMARY OF PROJECT HOTLINE EXPERIENCE

Summary of Project Hotline Experience: 2002 Assessment Survey

The project's toll-free telephone hotline provides an important means of collecting information about sample members. The hotline number appears on all of the mailings that sample members receive. Sample members are encouraged to call if they have any questions about the survey or would like to find out how to complete the survey over the phone. *Exhibit C-1* shows the number of calls received to the hotline for each year of the Assessment Survey from 2000 to 2002. A total of 1,217 calls were made to the toll-free project telephone number during the 2002 Assessment Survey data collection period.

Exhibit C-1
Calls to the project hotline by year

Assessment survey year	Sample size	Number of callers	Percent of total sample
2002	20,759	1,217	5.9%
2001	19,345	1,935	10.0%
2000	31,041	2,584	8.3%

For the 2002 Assessment Survey year, we developed and implemented a hotline component as part of the same CATI instrument being used for telephone interviews. Programming the hotline script into the CATI allowed us to ensure consistency in how hotline staff responded to callers and handled calls. Experienced telephone interviewers, who had previously worked on the Medicare CAHPS Disenrollment Survey, were specially trained to handle hotline calls using the CATI. This 3-hour training included mock hotline calls and a discussion of how to handle calls as accurately, efficiently, and compassionately as possible.

When someone called the hotline, hotline staff indicated the reason for the call to the hotline according to the nine categories listed in the CATI. These nine categories were

- Question about the survey, Medicare or the health plan
- Question about the survey requiring project staff follow-up (e.g., the caller may have asked to speak to the Data Collection Manager)
- Request for a telephone interview
- Address change or update information
- Refusal
- Sample member incapable of participating
- Sample member deceased

- Sample member institutionalized
- Report a reason the sample member left the plan

Exhibit C-2 shows the reason for all hotline calls for the 2002 survey year. **The largest number of calls (28.1%) came from those respondents wanting to give a reason for leaving their Medicare plan and those calling with a question about the Survey, Medicare, or their health plan.** This number includes sample members who were calling to explain that they were still with the health plan and those who said they were never on the plan. These sample members were coded as ineligible. Sample members who indicated that they left the plan because they were enrolled without their knowledge were asked if this was their only reason for leaving. If additional reasons were identified, hotline staff was trained to set up an interview with the sample member or if necessary encourage the sample member to complete and return the mail questionnaire. Many sample members gave reasons for leaving that did not make them ineligible (for example, their doctor left the plan, they moved out of the plan's service area, the plan was no longer available to them). Hotline staff was trained to encourage these sample members to complete the interview either by mail or by phone. For sample members calling with a question about Medicare or their health plans, hotline staff was trained to direct questions to the National Medicare hotline. The telephone number for the Medicare hotline is programmed into the hotline CATI as a "help" screen so that it is easily accessible.

Respondents who called in to request a telephone interview comprised the third largest group of hotline callers (21.1%). Hotline staff was trained to set up appointments for these cases to be called at the sample member's convenience.

Approximately 12% of calls were to report that the sample member was incapable of participating in an interview, institutionalized, or deceased. The latter two categories were considered reasons for ineligibility. For the first, hotline staff was trained to ask whether a proxy was available to answer the questions for the incapable sample member. If no proxy was available, the case was finalized as sample member physically or mentally incapable.

Information gathered from talking with sample members continues to inform our understanding of the way the questionnaire items are working. The drop in call volume between the 2001 and 2002 survey years may indicate that the instrument itself has become easier to understand over the past implementations, as we have continued to make improvements. Many of these improvements have been a direct result of information collected through the hotline. The hotline is also an important tool for obtaining information about sample member ineligibility, thus providing a means of finalizing these kinds of cases.

Exhibit C-2
2002 Assessment survey hotline usage

Call-in hotline option	Responses	
	Frequency	Percent
Reason left plan or question about survey, Medicare, or health plan: no further action needed	342	28.1%
Telephone interview request	257	21.1%
Sample member institutionalized (nursing home, assisted living)	58	4.8%
Sample member incapable of participating in interview	50	4.1%
Sample member deceased	39	3.2%
Question about survey: project staff follow-up needed	40	3.3%
Sample member refused to participate	34	2.8%
Address change or update	28	2.3%
“Unresolved” cases	27	2.2%
Total number of calls to hotline	1,217	100.0%

APPENDIX D

MOST IMPORTANT REASONS CODES

2002 Assessment Survey
Coding of “Most Important Reason” for Disenrolling

Shading designates a new code added for the 2002 Assessment Survey.
Codes in bold indicated “rolled-up” codes.

Involuntary reason for disenrolling

465 I was enrolled without my knowledge (for example, by a friend, relative, or salesperson) (Q3)

Miscellaneous voluntary reason for disenrolling

- 51 Insecurity about future of plan or about my continued coverage
- 30 I was accidentally disenrolled (for example, by a paperwork or clerical error—not a reason for involuntary disenrollment) (Q4)
- 40 Employer stopped offering plan (not a reason for involuntary disenrollment) (Q5)
- 50 **Plan was no longer offered** (available) to me (not a reason for involuntary disenrollment) (Q2)
- 60 **I moved and now live outside the area** where the plan was available (not a reason for involuntary disenrollment) (Q1)

Doctors and other health care providers

- 70 **The plan did not include the doctors** or other health providers I wanted to see
- 71 Plan did not use hospital I wanted to go to
- 72 Did not like/trust/*get good care from*/want to see available plan doctors or other health providers
- 75 Dissatisfied with doctor’s office staff
- 80 **The doctor I wanted to see retired or left the plan**
- 81 Doctor I wanted to see was dropped by plan
- 90 **The plan doctor or other health provider I wanted to see was not accepting new patients**
- 100 **I could not see the plan doctor or other health provider I wanted to see on every visit**
- 110 **The plan doctors or other health providers did not explain things in a way I could understand**

- 111 I could not understand plan doctors or other health providers (e.g., language barrier)
- 120 **I had problems with the plan doctors or other health care providers**
- 130 **I had problems or delays getting the plan to approve referrals to specialists**
- 131 Plan doctor(s) would not refer you to the specialist you needed to see

Access to Care

- 140 **I had problems getting the care I needed when I needed it**
- 141 Took too long for appointments, care, services, approvals, or to be seen in doctor's office
- 150 **The plan refused to pay for emergency or other urgent health care**
- 160 **I could not get admitted to a hospital when I needed to**
- 161 Deductible or co-payment for hospital stay was too expensive
- 170 **I had to leave the hospital before I or my doctor thought I should**
- 180 **I could not get special medical equipment when I needed it**
- 190 **I could not get home health care when I needed it**
- 200 **I had no transportation or it was too far to the clinic or doctor's office where I had to go for regular or routine health care**
- 210 **I could not get an appointment for regular or routine health care as soon as I wanted**
- 220 **I had to wait too long past my appointment time to see the health care provider I went to see**
- 230 **I wanted to be sure I could get the health care I need while I am out of town or traveling away from home**

Information About the Plan

- 240 I thought I was given **incorrect or incomplete information** at the time I joined the plan
- 250 After I joined the plan, it **wasn't what I expected**
- 260 **Information from the plan about things like benefits, services, doctors, and rules, was hard to get or not very helpful**

Pharmacy Benefit

- 270 The **maximum dollar amount the plan allowed each year** (or quarter) for my prescription medicine **was not enough** to meet my needs
- 271 Cost of medications was or became too high

- 280 The plan required me to get a generic medicine when I wanted a brand name medicine
- 290 The plan would not pay for a medication that my doctor had prescribed
- 291 Plan eliminated or had no prescription coverage
- 299 Unspecified dissatisfaction with pharmacy benefits

Cost and Benefits

- 300 Another plan would cost me less
- 301 Former plan was or became too expensive/could not afford the monthly premium (Q6)
- 310 The plan would not pay for some of the care I needed
- 320 Another plan offered better benefits or coverage for some types of care or services
- 321 Another plan offered (better or cheaper) *dental* benefits or coverage
- 322 Another plan offered (better or cheaper) *home health care* benefits or coverage
- 323 Another plan offered (better or cheaper) *pharmacy* benefits or coverage
- 324 Another plan offered (better or cheaper) *vision* benefits or coverage
- 330 The plan started charging me a monthly premium or increased the monthly premium that I pay
- 340 The plan increased the co-payment that I paid for office visits to my doctor and for other services
- 350 The plan increased the co-payment that I paid for prescription medicines

Other Reasons

- 360 The plan's customer service staff were not helpful or I was dissatisfied with the way they handled my questions or complaint
- 361 Didn't like changes the plan made or that the plan could make changes it wanted to when it wanted to
- 362 Plan was not concerned about or for patients
- 363 Plan did not help with administrative matters or correct administrative errors
- 364 Felt wronged, poorly served, or unfairly treated (by whom not specified)
- 365 Don't like HMO's
- 366 Problems with billing from the plan
- 369 Unspecified dissatisfaction with plan

- 370** **My doctor or other health care provider or someone from the plan told me that I could get better care elsewhere**
- 371 Influenced by sales person/literature/presentation or by a friend or relative to change plans
- 380** **I or my spouse, another family member, or a friend had a bad (medical) experience with that plan**
- 390** **No longer needed coverage under the plan**
- 391 Never used the plan
- 392 Now on Medicaid
- 393 Have VA benefits
- 394 Have TRICARE/CHAMPUS military benefits
- 500** **Miscellaneous (unable to code as a reason for disenrolling)**
- 501** **Opinion/just wanted to leave/regret (no reason for disenrolling given), “none”**
- 600** **Left because heard about lock-in**
- 000** **Blank, -1, N/A, Don’t know, No → gets recoded to Missing**

APPENDIX E

**CROSSWALKS USED TO DEVELOP THE COMBINED 2002 MEDICARE
CAHPS DISENROLLMENT ASSESSMENT SURVEY AND MEDICARE
CAHPS MANAGED CARE ENROLLEE SURVEY DATA FILE**

Crosswalk of questions included in the 2002 Medicare CAHPS Disenrollment Assessment and
the Medicare CAHPS Managed Care Enrollee Surveys

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
Did you leave because you moved outside the area where [HEALTH PLAN NAME] was available? (Disenrollee)	Q1	NA	
Our records show that you are now covered by [HEALTH PLAN NAME]. Is that right? (MMC)	NA	Q1	
Did you leave [HEALTH PLAN NAME] because the plan left the area or you heard that the plan was going to stop serving people with Medicare in your area? (Disenrollee)	Q2	NA	
What is the name of your health plan(s)? (MMC)	NA	Q2	
Did you leave [HEALTH PLAN NAME] because you found out that someone had signed you up for the plan without your knowledge (for example, a relative, salesperson, or someone else)? (Disenrollee)	Q3	NA	
Did you leave [HEALTH PLAN NAME] because of paperwork or clerical error (for example, you were accidentally taken off the plan)? (Disenrollee)	Q4	NA	
Did you leave [HEALTH PLAN NAME] because your former employer or your spouse's former employer no longer offered [HEALTH PLAN NAME] to you? (Disenrollee)	Q5	NA	
Did you leave [HEALTH PLAN NAME] because you could not pay the monthly premium? (Disenrollee)	Q6	NA	
What was the one most important reason you left [HEALTH PLAN NAME]? (Disenrollee)	Q7	NA	
How many months or years in a row were you in [HEALTH PLAN NAME]? (Disenrollee)	Q8	Q3	
How many months or years in a row have you been in [HEALTH PLAN NAME]? (MMC)			
When you were a member of [HEALTH PLAN NAME], did you have one person you thought of as your personal doctor or nurse? (Disenrollee)	Q9	Q4	
Do you have one person you think of as your personal doctor or nurse? (MMC)			
Is this person a general doctor, a specialist doctor, a physician assistant, or a nurse?	Q10	Q5	
How many months or years have you been going to the personal doctor or nurse you had while you were in [HEALTH PLAN NAME]? (Disenrollee)	Q11	Q6	
How many months or years have you been going to your personal doctor or nurse? (MMC)			
How would you rate the personal doctor or nurse you had in the 6 months before you left [HEALTH PLAN NAME]? (Disenrollee)	Q12	Q7	
How would you rate your personal doctor or nurse now? (MMC)			
When you were a member of [HEALTH PLAN NAME], did your personal doctor or nurse know the important facts and decisions about your health care? (Disenrollee)	Q13	Q8	
Does your personal doctor or nurse know the important facts and decisions about your health care? (MMC)			

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
When you were a member of [HEALTH PLAN NAME], did you have a physical or medical condition that seriously <u>interfered with your ability to work</u> or manage your day-to-day activities? (Disenrollee) Do you have a physical or medical condition that seriously <u>interferes with your ability to work</u> or manage your day-to-day activities? (MMC)	Q14	Q9	
When you were a member of [HEALTH PLAN NAME], did your personal doctor or nurse <u>understand how any problems you had affected your day-to-day life?</u> (Disenrollee) Does your personal doctor or nurse <u>understand how any health problems you have affect your day-to-day life?</u> (MMC)	Q15	Q10	
Was the personal doctor or nurse you had while you were in [HEALTH PLAN NAME] the same one you had before you joined that plan? (Disenrollee) Did you have the same personal doctor or nurse before you joined [HEALTH PLAN NAME]? (MMC)	Q16	Q11	
How much of a problem, if any, was it to get a personal doctor or nurse you were happy with when you were a member of [HEALTH PLAN NAME]? (Disenrollee) Since you joined Medicare, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with? (MMC)	Q17	Q12	Getting Needed Care
In the 6 months before you left [HEALTH PLAN NAME], did you or a doctor think you needed to see a specialist? (Disenrollee) In the last 6 months, did you or a doctor think you needed to see a specialist? (MMC)	Q18	Q13	
In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, was it to see a specialist that you needed to see? (Disenrollee) In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see? (MMC)	Q19	Q14	Getting Needed Care
In the 6 months before you left [HEALTH PLAN NAME], <u>how many times did you go to specialists</u> for care for yourself? (Disenrollee) In the last 6 months, <u>how many times did you go to specialists</u> for care for yourself? (MMC)	Q20	Q15	
How would you rate the specialist you saw most often in the 6 months before you left [HEALTH PLAN NAME], including a personal doctor if he or she is a specialist? (Disenrollee) How would you rate the specialist you saw most often in the last 6 months, including a personal doctor if he or she is a specialist? (MMC)	Q21	Q16	
Was the specialist you saw most often in the 6 months before you left [HEALTH PLAN NAME] the same doctor as the personal doctor you had when you were a member of that plan? (Disenrollee) In the last 6 months, was the specialist you saw most often the same doctor as your personal doctor? (MMC)	Q22	Q17	
In the 6 months before you left [HEALTH PLAN NAME], did you call a doctor's office or clinic <u>during regular office hours</u> to get help or advice for yourself? (Disenrollee) In the last 6 months, did you call a doctor's office or clinic <u>during regular office hours</u> to get help or advice for yourself? (MMC)	Q23	Q18	

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
<p>In the 6 months before you left [HEALTH PLAN NAME], when you called during regular office hours, how often did you <u>get</u> the help or advice you <u>needed</u>? (Disenrollee)</p> <p>In the last 6 months, when you called during regular office hours, how often did you <u>get</u> the help or advice you <u>needed</u>?(MMC)</p>	Q24	Q19	Getting Care Quickly
<p>In the 6 months before you left [HEALTH PLAN NAME], not counting the times you needed care right away, did you make any <u>appointments</u> with a doctor or other health provider for health care? (Disenrollee)</p> <p>In the last 6 months, not counting the times you needed health care right away, did you make any <u>appointments</u> with a doctor or other health provider for health care? (MMC)</p>	Q25	Q20	
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did you get an appointment for health care as soon as you wanted? (Disenrollee)</p> <p>In the last 6 months, how often did you get an appointment for health care as soon as you wanted? (MMC)</p>	Q26	Q21	Getting Care Quickly
<p>In the 6 months before you left [HEALTH PLAN NAME], did you have an illness, injury, or condition that <u>needed care right away</u> from clinic, emergency room, or doctor's office? (Disenrollee)</p> <p>In the last 6 months, did you have an illness, injury, or condition that <u>needed care right away</u> from a clinic, emergency room, or doctor's office? (MMC)</p>	Q27	Q22	
<p>In the 6 months before you left [HEALTH PLAN NAME], when you <u>needed care right away</u> for an illness, injury, or condition, how often did you get care as soon as you wanted? (Disenrollee)</p> <p>In the last 6 months, when you <u>needed care right away</u> for an illness, injury, or condition, how often did you get care as soon as you wanted? (MMC)</p>	Q28	Q23	Getting Care Quickly
<p>In the 6 months before you left [HEALTH PLAN NAME], how many times did you go to an <u>emergency room</u> to get care for yourself? (Disenrollee)</p> <p>In the last 6 months, how many times did you go to an emergency room to get care for yourself? (MMC)</p>	Q29	Q24	
<p>In the 6 months before you left [HEALTH PLAN NAME] (not counting times you went to an emergency room), how many times did you go to a <u>doctor's office or clinic</u> to get care for yourself? (Disenrollee)</p> <p>In the last 6 months (not counting times you went to an emergency room), how many times did you go to a <u>doctor's office or clinic</u> to get care for yourself? (MMC)</p>	Q30	Q25	
<p>In the 6 months before you left [HEALTH PLAN NAME], did you or a doctor believe you needed any care, tests or treatment? (Disenrollee)</p> <p>In the last 6 months, did you or a doctor believe you needed any care, tests, or treatment? (MMC)</p>	Q31	Q26	
<p>In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, was it to get the care, tests, or treatment you or a doctor believed necessary? (MMC)</p>	Q32	Q27	Getting Needed Care
<p>In the 6 months before you left [HEALTH PLAN NAME], did you need approval from your health plan for any care, tests or treatment? (Disenrollee)</p> <p>In the last 6 months, did you need approval from [HEALTH PLAN NAME] for any care, tests, or treatment? (MMC)</p>	Q33	Q28	

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
<p>In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, were delays in health care while you waited for approval from your health plan? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan? (MMC)</p>	Q34	Q29	Getting Needed Care
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did you see the person you came to see <u>within 15 minutes</u> of your appointment? (Disenrollee)</p> <p>In the last 6 months, how often did you see the person you came to see <u>within 15 minutes</u> of your appointment? (MMC)</p>	Q35	Q30	Getting Care Quickly
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did office staff at a doctor's office or clinic treat you with <u>courtesy and respect</u>? (Disenrollee)</p> <p>In the last 6 months, how often did office staff at a doctor's office or clinic treat you with <u>courtesy and respect</u>? (MMC)</p>	Q36	Q31	Courteous and Helpful Office Staff
<p>In the 6 months before you left [HEALTH PLAN NAME], how often were office staff at a doctor's office or clinic as <u>helpful</u> as you thought they should be? (Disenrollee)</p> <p>In the last 6 months, how often were office staff at a doctor's office or clinic as <u>helpful</u> as you thought they should be? (MMC)</p>	Q37	Q32	Courteous and Helpful Office Staff
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers <u>listen carefully to you</u>? (Disenrollee)</p> <p>In the last 6 months, how often did doctors or other health providers <u>listen carefully to you</u>? (MMC)</p>	Q38	Q33	Doctors who Communicate Well
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers <u>explain things</u> in a way you could understand? (Disenrollee)</p> <p>In the last 6 months, how often did doctors or other health providers <u>explain things</u> in a way you could understand? (MMC)</p>	Q39	Q34	Doctors who Communicate Well
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers show <u>respect for what you had to say</u>? (Disenrollee)</p> <p>In the last 6 months, how often did doctors or other health providers show <u>respect for what you had to say</u>? (MMC)</p>	Q40	Q35	Doctors who Communicate Well
<p>In the 6 months before you left [HEALTH PLAN NAME], how often did doctors or other health providers <u>spend enough time</u> with you? (Disenrollee)</p> <p>In the last 6 months, how often did doctors or other health providers <u>spend enough time</u> with you? (MMC)</p>	Q41	Q36	Doctors who Communicate Well
<p>How would you rate all the health care you got in the 6 months before you left [HEALTH PLAN NAME] from <u>all doctors and other health providers</u>? (Disenrollee)</p> <p>How would you rate all the health care you got in the last 6 months from all doctors and other health providers? (MMC)</p>	Q42	Q37	
<p>In the 6 months before you left [HEALTH PLAN NAME], did you have a health problem for which you <u>needed special medical equipment</u> such as a cane, a wheelchair, or oxygen equipment? (Disenrollee)</p> <p>In the last 6 months, did you have a health problem for which you <u>needed special medical equipment</u> such as a cane, a wheelchair, or oxygen equipment? (MMC)</p>	Q43	Q38	

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
<p>In the 6 months before you left the plan, how much of a problem, if any, was it to get <u>the special medical equipment</u> you needed through [HEALTH PLAN NAME]? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, was it to get <u>the special medical equipment</u> you needed through [HEALTH PLAN NAME]? (MMC)</p>	Q44	Q39	
<p>In the 6 months before you left [HEALTH PLAN NAME], did you have any health problems that <u>needed special therapy</u>, such as physical, occupational, or speech therapy? (Disenrollee)</p> <p>In the last 6 months, did you have any health problems that <u>needed special therapy</u>, such as physical, occupational, or speech therapy? (MMC)</p>	Q45	Q40	
<p>In the 6 months before you left the plan, how much of a problem, if any, was it to get the <u>special therapy</u> you needed through [HEALTH PLAN NAME]? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, was it to get the <u>special therapy</u> you needed through [HEALTH PLAN NAME]? (MMC)</p>	Q46	Q41	
<p>In the 6 months before you left [HEALTH PLAN NAME], <u>did you need someone to come into your home</u> to give you home health care or assistance? (Disenrollee)</p> <p>In the last 6 months, <u>did you need someone to come into your home</u> to give you home health care or assistance? (MMC)</p>	Q47	Q42	
<p>In the 6 months before you left the plan, how much of a problem, if any, was it to get the <u>home health care or assistance</u> you needed through [HEALTH PLAN NAME]? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, was it to get the <u>home health care or assistance</u> you needed through [HEALTH PLAN NAME]? (MMC)</p>	Q48	Q43	
<p>In the 6 months before you left the plan, how often did you get the prescription medicine you needed through [HEALTH PLAN NAME]? (Disenrollee)</p> <p>In the last 6 months, how often did you get the prescription medicine you needed? (MMC)</p>	Q49	Q44	
<p>In the 6 months before you left the plan, how much of a problem, if any, was it to get the prescription medicine you needed from [HEALTH PLAN NAME]? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, was it to get the prescription medicine you needed? (MMC)</p>	Q50	Q45	
<p>At the time that you left [HEALTH PLAN NAME], did your plan cover some or all of the costs of your prescription medicines? (Disenrollee)</p> <p>Does [HEALTH PLAN NAME] cover some or all of the cost of your prescription medicines? (MMC)</p>	Q51	Q46	
<p>In the 6 months before you left the plan, did you look for any <u>information in written material or on the Internet</u> about how [HEALTH PLAN NAME] works? (Disenrollee)</p> <p>In the last 6 months, did you look for any <u>information in written material or on the Internet</u> about how [HEALTH PLAN NAME] works? (MMC)</p>	Q52	Q47	
<p>In the 6 months before you left [HEALTH PLAN NAME], how much of a problem, if any, was it to find or understand this information? (Disenrollee)</p> <p>In the last 6 months, how much of a problem, if any, was it to find or understand this information? (MMC)</p>	Q53	Q48	Health Plan Customer Service

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
In the 6 months before you left the plan, did you call [HEALTH PLAN NAME]'s <u>customer service</u> to get information or help? (Disenrollee) In the last 6 months, did you call [HEALTH PLAN NAME]'s <u>customer service</u> to get information or help? (MMC)	Q54	Q49	
In the 6 months before you left the plan, how much of a problem, if any, was it to get the help you needed when you called [HEALTH PLAN NAME]'s customer service? (Disenrollee) In the last 6 months, how much of a problem, if any, was it to get the help you needed when you called [HEALTH PLAN NAME]'s customer service? (MMC)	Q55	Q50	Health Plan Customer Service
In the 6 months before you left the plan, how often were people at [HEALTH PLAN NAME]'s customer service as helpful as they should be? (Disenrollee) In the last 6 months, how often were people at [HEALTH PLAN NAME]'s customer service as helpful as they should be? (MMC)	Q56	Q51	
In the 6 months before you left the plan, did you call or write [HEALTH PLAN NAME] with a complaint or problem? (Disenrollee) In the last 6 months, have you called or written [HEALTH PLAN NAME] with a complaint or problem? (MMC)	Q57	Q52	
How long did it take for [HEALTH PLAN NAME] to <u>resolve</u> your complaint?	Q58	Q53	
Was your <u>complaint or problem</u> settled to your satisfaction?	Q59	Q54	
In the 6 months before you left the plan, did you have to fill out any paperwork for [HEALTH PLAN NAME]? (Disenrollee) In the last 6 months, did you have to fill out any paperwork for [HEALTH PLAN NAME]? (MMC)	Q60	Q55	
In the 6 months before you left the plan, how much of a problem, if any, did you have with paperwork for [HEALTH PLAN NAME]? (Disenrollee) In the last 6 months, how much of a problem, if any, did you have with paperwork for [HEALTH PLAN NAME]? (MMC)	Q61	Q56	Health Plan Customer Service
How would you rate all your experience with your [HEALTH PLAN NAME]?	Q62	Q57	
Sometimes people cannot get their health plan to provide or pay for services that they think they need. Were you ever told by [HEALTH PLAN NAME] how to file a formal complaint if this happened to you?	Q63	Q58	
Was there ever a time when you strongly believed that you needed and should have received health care or services that [HEALTH PLAN NAME] or your doctor decided not to give you?	Q64	Q59	
May we contact you again about the health care or services that you did not receive if we need more information?	Q65	Q60	
If [HEALTH PLAN NAME] decided not to provide or pay for care that you believed you needed, <u>did you know who to contact</u> at [HEALTH PLAN NAME] to ask them to reconsider? (Disenrollee) If [HEALTH PLAN NAME] decided not to provide or pay for care that you believed you needed, <u>do you know who to contact</u> at [HEALTH PLAN NAME] to ask them to reconsider? (MMC)	Q66	Q61	
Did you ever ask [HEALTH PLAN NAME] to reconsider a decision to not provide or pay for a treatment?	Q67	Q62	

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
If [HEALTH PLAN NAME] decided not to provide or pay for a particular treatment, could <u>your doctor</u> have contacted someone at the plan and asked them to reconsider? (Disenrollee) If [HEALTH PLAN NAME] decided not to provide or pay for a particular treatment, can <u>your doctor</u> contact someone at the plan and ask them to reconsider? (MMC)	Q68	Q63	
If [HEALTH PLAN NAME] decided not to reconsider providing or paying for a particular treatment, would [HEALTH PLAN NAME] have automatically referred it to another organization for an independent review? (Disenrollee) If [HEALTH PLAN NAME] decided not to reconsider providing or paying for a particular treatment, would [HEALTH PLAN NAME] automatically refer it to another organization for an independent review? (MMC)	Q69	Q64	
If this independent organization turned down your request for reconsideration to [HEALTH PLAN NAME], did you have to right to ask for another review by a judge? (Disenrollee) If this independent organization turns down your request for reconsideration to [HEALTH PLAN NAME], do you have the right to ask for another review by a judge? (MMC)	Q70	Q65	
In general, how would you rate your overall <u>mental</u> health now?	Q71	Q72	
In general, how would you rate <u>your overall health</u> now?: (Disenrollee) In general, how would you rate <u>your overall health</u> now? (MMC)	Q72	Q66	
Compared to one year ago, how would you rate your health in general now?	Q73	Q67	
In the <u>last 12 months</u> , have you been a patient in a <u>hospital</u> overnight or longer? (MMC)	NA	Q68	
Do you now have any physical or medical conditions that have lasted for <u>at least 3 months</u> ? (MMC)	NA	Q69	
In the <u>last 12 months</u> , have you <u>seen a doctor</u> or other health provider <u>more than twice</u> for any of these conditions? (MMC)	NA	Q70	
Have you been taking <u>prescription medicine for at least 3 months</u> for any of these conditions? (MMC)	NA	Q71	
In the last 12 months, have you had a mammogram (a test to detect breast cancer in women)? (MMC)	NA	Q73	
In the last 12 months, have you had a pap smear (a test to detect cervical cancer in women)? (MMC)	NA	Q74	
In the last 12 months, have you had a prostate screening or PSA test (a test to detect prostate cancer in men)? (MMC)	NA	Q75	
Because of any impairment or health problem, do you <u>need the help</u> of other persons <u>with your personal care needs</u> , such as eating, dressing, or getting around the house? (MMC)	NA	Q76	
Because of any impairment or health problem, do you <u>need help with your routine needs</u> , such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? (MMC)	NA	Q77	
In the past 4 weeks, how often have you walked and/or exercised for more than 20 minutes at a time? (MMC)	NA	Q78	
Do you have a physical or medical condition that seriously <u>interferes with your independence</u> , participation in the community, or quality of life? (MMC)	NA	Q79	

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
Does <u>your health now limit you</u> in doing <u>moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling or playing golf? If so, how much? (Disenrollee)	Q74	NA	
Does <u>your health now limit you</u> in climbing <u>several</u> flights of stairs? If so, how much? (Disenrollee)	Q75	NA	
During the <u>past 4 weeks</u> , have you <u>accomplished less</u> than you would like as a result of your physical health? (Disenrollee)	Q76	NA	
During the <u>past 4 weeks</u> , were you limited in the <u>kind</u> of work or other regular daily activities you did as a result of your physical health? (Disenrollee)	Q77	NA	
During the <u>past 4 weeks</u> , have you <u>accomplished less</u> than you would like as a result of any emotional problems, such as feeling depressed or anxious? (Disenrollee)	Q78	NA	
During the <u>past 4 weeks</u> , did you do work or other regular daily activities <u>less carefully</u> than usual as a result of any emotional problems, such as feeling depressed or anxious? (Disenrollee)	Q79	NA	
During the <u>past 4 weeks</u> , how much did <u>pain</u> interfere with your normal work, including both work outside the home and housework? (Disenrollee)	Q80	NA	
How much of the time during the <u>past 4 weeks</u> have you felt calm and peaceful? (Disenrollee)	Q81	NA	
How much of the time during the <u>past 4 weeks</u> did you have a lot of energy? (Disenrollee)	Q82	NA	
How much of the time during the <u>past 4 weeks</u> have you felt downhearted and blue? (Disenrollee)	Q83	NA	
During the <u>past 4 weeks</u> , how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)? (Disenrollee)	Q84	NA	
What is your age now?	Q85	Q87	
Are you male or female?	Q86	Q88	
What is the highest grade or level of school that you have <u>completed</u> ?	Q87	Q89	
Are you of Hispanic or Latino origin or descent?	Q88	Q90	
What is your race?	Q89	Q91	
Did someone help you complete this questionnaire? (Disenrollee) Did someone help you complete this survey? (MMC)	Q90	Q92	
How did that person help you?	Q91	Q93	
We would like to be able to contact you in case we have any questions about any of your answers. Please write your daytime telephone number below. (Disenrollee)	Q92	NA	
Did you get a flu shot last year, at any time from September to December 2001? (MMC)	NA	Q80	
Did you get that flu shot either through [HEALTH PLAN NAME] or from your personal doctor? (MMC)	NA	Q81	

Question (Assessment Survey items are listed first for items common to both surveys' forms)	Assessment item no.	Enrollee item no.	CAHPS composites
Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine. (MMC)	NA	Q82	
Have you ever <u>smoked</u> at least 100 cigarettes in your entire life? (MMC)	NA	Q83	
Do you now smoke every day, some days, or not at all? (MMC)	NA	Q84	
How long has it been since you <u>quit smoking</u> cigarettes? (MMC)	NA	Q85	
In the last 6 months, on how many visits were you <u>advised to quit</u> smoking by a doctor or other health provider in your plan? (MMC)	NA	Q86	

Crosswalk of variable names with question numbers in the
2002 Medicare CAHPS Managed Care Enrollee and
2002 Medicare CAHPS Disenrollment Assessment Survey Questionnaires

Variable name (both files)	Question numbers in Enrollee Survey order		Question numbers in Assessment Survey order	
	Enrollee	Assessment	Assessment	Enrollee
R0201	Q1	--	Q1	--
REMOVED	--	Q1	--	Q1
R0202_O	Q2	--	Q2	--
RPLANSTO	--	Q2	--	Q2
RSIGNKNO	--	Q3	Q3	--
RPAPERER	--	Q4	Q4	--
REMPNOTO	--	Q5_1	Q5_1	--
REMPNORS	--	Q5_2	Q5_2	--
RNOTENRL	--	Q5_3	Q5_3	--
RNOPAYPR	--	Q6	Q6	--
RAMOSTIM	--	Q7_SKI	Q7_SKI	--
RMOSTIMP		Q7_CODE	Q7_CODE	
R0203	Q3	Q8	Q8	Q3
R0204	Q4	Q9	Q9	Q4
R0205	Q5	Q10	Q10	Q5
R0206	Q6	Q11	Q11	Q6
R0207	Q7	Q12	Q12	Q7
R0208	Q8	Q13	Q13	Q8
R0209	Q9	Q14	Q14	Q9
R0210	Q10	Q15	Q15	Q10
R0211	Q11	Q16	Q16	Q11
R0212	Q12	Q17	Q17	Q12
R0213	Q13	Q18	Q18	Q13
R0214	Q14	Q19	Q19	Q14
R0215	Q15	Q20	Q20	Q15
R0216	Q16	Q21	Q21	Q16
R0217	Q17	Q22	Q22	Q17
R0218	Q18	Q23	Q23	Q18
R0219	Q19	Q24	Q24	Q19
R0220	Q20	Q25	Q25	Q20
R0221	Q21	Q26	Q26	Q21
R0222	Q22	Q27	Q27	Q22
R0223	Q23	Q28	Q28	Q23
R0224	Q24	Q29	Q29	Q24
R0225	Q25	Q30	Q30	Q25
R0226	Q26	Q31	Q31	Q26
R0227	Q27	Q32	Q32	Q27
R0228	Q28	Q33	Q33	Q28
R0229	Q29	Q34	Q34	Q29
R0230	Q30	Q35	Q35	Q30
R0231	Q31	Q36	Q36	Q31

Variable name (both files)	Question numbers in Enrollee Survey order		Question numbers in Assessment Survey order	
	Enrollee	Assessment	Assessment	Enrollee
R0232	Q32	Q37	Q37	Q32
R0233	Q33	Q38	Q38	Q33
R0234	Q34	Q39	Q39	Q34
R0235	Q35	Q40	Q40	Q35
R0236	Q36	Q41	Q41	Q36
R0237	Q37	Q42	Q42	Q37
R0238	Q38	Q43	Q43	Q38
R0239	Q39	Q44	Q44	Q39
R0240	Q40	Q45	Q45	Q40
R0241	Q41	Q46	Q46	Q41
R0242	Q42	Q47	Q47	Q42
R0243	Q43	Q48	Q48	Q43
R0244	Q44	Q49	Q49	Q44
R0245	Q45	Q50	Q50	Q45
R0246	Q46	Q51	Q51	Q46
R0247	Q47	Q52	Q52	Q47
R0248	Q48	Q53	Q53	Q48
R0249	Q49	Q54	Q54	Q49
R0250	Q50	Q55	Q55	Q50
R0251	Q51	Q56	Q56	Q51
R0252	Q52	Q57	Q57	Q52
R0253	Q53	Q58	Q58	Q53
R0254	Q54	Q59	Q59	Q54
R0255	Q55	Q60	Q60	Q55
R0256	Q56	Q61	Q61	Q56
R0257	Q57	Q62	Q62	Q57
R0258	Q58	Q63	Q63	Q58
R0259	Q59	Q64	Q64	Q59
R0260	Q60	Q65	Q65	Q60
R0261	Q61	Q66	Q66	Q61
R0262	Q62	Q67	Q67	Q62
R0263	Q63	Q68	Q68	Q63
R0264	Q64	Q69	Q69	Q64
R0265	Q65	Q70	Q70	Q65
R0266	Q66	Q72	Q71	Q72
R0267	Q67	Q73	Q72	Q66
R0268	Q68	--	Q73	Q67
R0269	Q69	--	--	Q68
R0270	Q70	--	--	Q69
R0271	Q71	--	--	Q70
R0272	Q72	Q71	--	Q71
R0273	Q73	--	Q74	--
RMODACTV	--	Q74	--	Q73
R0274	Q74	--	Q75	--
RCLMBSTA	--	Q75	--	Q74

Variable name (both files)	Question numbers in Enrollee Survey order		Question numbers in Assessment Survey order	
	Enrollee	Assessment	Assessment	Enrollee
R0275	Q75	--	Q76	--
RHLACCLE	--	Q76	--	Q75
R0276	Q76	--	Q77	--
RKINDSWR	--	Q77	--	Q76
R0277	Q77	--	Q78	--
RMHACCLE	--	Q78	--	Q77
R0278	Q78	--	Q79	--
RMHCARLE	--	Q79	--	Q78
R0279	Q79	--	Q80	--
RPAINWRK	--	Q80	--	Q79
R0280	Q80	--	Q81	--
RFELTCAL	--	Q81	--	Q80
R0281	Q81	--	Q82	--
RHAVENER	--	Q82	--	Q81
R0282	Q82	--	Q83	--
RFELTBLU	--	Q83	--	Q82
R0283	Q83	--	Q84	--
RHLSOCAC	--	Q84	--	Q83
R0284	Q84	--		Q86
R0285	Q85	--	--	Q84
R0286	Q86		Q85	Q87
R0287	Q87	Q85	--	Q85
R0288	Q88	Q86	Q86	Q88
R0289	Q89	Q87	Q87	Q89
R0290	Q90	Q88	Q88	Q90
R0291A	Q91_1	Q89_1	Q89_1	Q91_1
R0291B	Q91_2	Q89_2	Q89_2	Q91_2
R0291C	Q91_3	Q89_3	Q89_3	Q91_3
R0291D	Q91_4	Q89_4	Q89_4	Q91_4
R0291E	Q91_5	Q89_5	Q89_5	Q91_5
R0292	Q92	Q90	Q90	Q92
R0293A	Q93_1	Q91_1	Q91_1	Q93_1
R0293B	Q93_2	Q91_2	Q91_2	Q93_2
R0293C	Q93_3	Q91_3	Q91_3	Q93_3
R0293D	Q93_4	Q91_4	Q91_4	Q93_4
R0293E	Q93_5	Q91_5	Q91_5	Q93_5
R0293_O	Q93_O	Q91_SKFI	Q91_SKFI	Q93_O
RTELENR	--	Q92	Q92	--