

Survey Results and Reporting for the 2002 Medicare CAHPS[®] Disenrollment Reasons Survey

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**SURVEY RESULTS AND REPORTING FOR THE 2002 MEDICARE CAHPS®
DISENROLLMENT REASONS SURVEY**

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SECTION 1 INTRODUCTION

1.1 Overview of the Survey

This report describes the implementation and results of the 2002 Medicare CAHPS[®] Disenrollment Reasons Survey, hereafter referred to as the “Reasons Survey,” which was conducted by the University of Wisconsin-Madison (UW-M) and RTI International for the Centers for Medicare & Medicaid Services (CMS). The Reasons Survey is designed to collect information on *reasons* why people with Medicare choose to leave their Medicare managed care plan and thus to help explain disenrollment rates. The survey can help managed care organizations contracting with CMS understand and improve the experiences of their Medicare plan members.

The Reasons Survey provides information to three major constituents:

- CMS, to aid in fulfillment of its legislative mandate to present disenrollment rates to Medicare beneficiaries and to help CMS monitor the quality of the services for which it contracts
- Medicare managed care plans, for use in quality improvement initiatives
- Medicare beneficiaries, to help them make more informed health plan choices

Medicare beneficiaries can use the Medicare Personal Plan Finder—available on the CMS Medicare Web site, www.Medicare.gov—to make plan-to-plan comparisons on disenrollment rates and beneficiaries’ reasons for leaving a plan. This same information is available through Medicare’s toll-free help number (1-800-MEDICARE). The results from the 2002 Reasons Survey were posted on the Medicare Web site in the winter of 2004.

The 2002 Reasons Survey was conducted from July 2002 through July 2003 with a sample of Medicare beneficiaries who disenrolled from a Medicare Advantage (MA) organization during each quarter of 2002. The major tasks completed during the 2002 Reasons Survey are described in this report. These include the following:

- selecting a sample of Medicare beneficiaries who disenrolled from an MA organization in 2002 and surveying those beneficiaries to determine the reasons why those chose to leave their health plan
- processing and weighting survey data, and constructing data files needed for analysis
- analyzing data from each health plan to produce plan comparative information and submitting those results to CMS for posting on Medicare’s Personal Plan Finder Web site

- analyzing data from each health plan to produce plan comparative information for inclusion in individual health plan reports, and producing and distributing those reports to health plans
- compiling plan comparative data for inclusion in individual reports to Quality Improvement Organizations (QIOs), and producing and distributing those reports to QIOs
- conducting meetings with the technical expert panel (TEP) that advises this project

The project team was also responsible for analyzing data about various subgroups included in the survey. Our analysis methods and results are described in a separate report entitled *Analysis of the 2002 Medicare CAHPS Disenrollment Reasons Survey* (Mobley et al., 2004).

1.2 Background and Need for the Project

The Reasons Survey is one of *two* surveys that form the Medicare CAHPS Disenrollment Survey sponsored by CMS; the other is the Medicare CAHPS Disenrollment *Assessment* Survey (referred to as the “Assessment Survey”).¹ Both surveys are being implemented as a result of legislative actions requiring that (1) an annual CAHPS 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 the *Consumer Assessment of Health Plans Study (CAHPS) Medicare Disenrollee Field Test Analysis Report* (Guess et al., 2000) and in the *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey* report (Lynch et al., 2003b).

1.3 Overview of This Report

This report focuses on the implementation and results of the 2002 Medicare CAHPS Disenrollment Reasons Survey. Information about the Reasons Survey conducted in prior years can be found in other reports, a list of which is provided in Section 6 of this report. **Section 2** of this report provides information about the activities of the TEP, which advises CMS and the project team on selected survey, reporting, and analysis issues. **Section 3** presents an overview of the 2002 Reasons Survey data collection and provides detailed information about the survey results. **Section 4** describes data processing, and **Section 5** provides background on how these results were reported to consumers (via the Medicare Web site) and to health plans. **Appendix A** includes a list of TEP members during the 2002 Reasons Survey administration. **Appendix B** contains a copy of the 2002 Reasons Survey questionnaire. **Appendix C** provides a summary of the types of calls made to the project hotline and discusses key reasons sample members called. **Appendix D** presents a report analyzing the effectiveness of telephone numbers received from

¹ The UW-M and RTI project team conducted the annual implementations of the Assessment Survey in 2000, 2001, and 2002; however, the survey is currently being conducted for CMS by another contractor. Information about the 2002 Assessment Survey implementation is described in a separate report entitled *Survey Results and Reporting for the 2002 Medicare CAHPS Disenrollment Assessment Survey* (Lynch et al., 2004).

the Social Security Administration, health plans, and a commercial telephone matching service. *Appendix E* presents a list of the changes made to the 2003 Reasons Survey questionnaire, after evaluation of the 2002 Reasons Survey implementation. *Appendix F* provides the set of codes used for coding the most important and other reasons for leaving the health plan.

It should be noted that the terms “health plan,” “plan,” and “sample plan” are used throughout this report to refer to 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 individual contracts that CMS holds with Medicare managed care organizations rather than to specific benefits packages.

SECTION 2 TECHNICAL EXPERT PANEL

2.1 Overview and Purpose of the Technical Expert Panel

Prior to the 2000 implementation of the Medicare CAHPS Disenrollment Reasons Survey, 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
- one or more members from a Statistical Expert Panel that CMS had convened in the summer of 1999

In addition, CMS required that 4 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 plan comparative 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 their 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 each meeting. Each report was also distributed to TEP members. In addition to the above meetings, we 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 DATA COLLECTION

3.1 Overview

Although data were analyzed on an annual basis, the 2002 Reasons Survey was conducted quarterly to determine the *reasons* Medicare beneficiaries leave their Medicare managed care plans. A sample of Medicare beneficiaries who disenrolled during one quarter was selected at the end of the quarter, with data collection for that quarter taking place during the next quarter. *Exhibit 3-1* presents the sampling window and data collection schedule for the 2002 Reasons Survey.

**Exhibit 3-1
2002 Reasons Survey sampling window/data collection schedule**

Reasons quarter	Sampling window (during which beneficiaries disenrolled)	Data collection period
1	January–March 2002	July–November 2002
2	April–June 2002	August–December 2002
3	July–September 2002	December 2002–May 2003
4	October–December 2002	March–July 2003

The target population for the 2002 Reasons Survey consisted of Medicare beneficiaries who *voluntarily* left a Medicare managed care plan during calendar year 2002. The Reasons Survey was administered as a mail survey with telephone follow-up of nonrespondents. Data collection for the survey took place from July 2002 through July 2003.

3.2 Sample Design and Selection

The sampling frame for the 2002 Reasons Survey consisted of all Medicare beneficiaries who had voluntarily disenrolled from one of 170 Medicare Advantage (MA) organizations and continuing cost contracts in 2002. To be included in the sample, health plans were required to have contracts in effect on January 1, 2001; that is, they must have been in operation for at least one full year prior to the beginning of the survey year.

The overall sampling goal for the Reasons Survey was to select up to 388 sample members per plan across all four quarters. In the 2000 and 2001 surveys, we selected quarterly samples that approximated the disenrollment pattern in prior years, therefore the sample distribution was approximately 20 percent during Quarter 1, 20 percent during Quarter 2, 20 percent during Quarter 3, and 40 percent during Quarter 4. When selecting cases for the 2002 Reasons Survey, however, we initially changed the distribution of sampling across the quarters

to approximately 30 percent in Quarter 1, 22 percent in Quarter 2, 5 percent in Quarter 3, and 43 percent in Quarter 4. The reason for this shift was that CMS expected lock-in to be implemented; consequently, we were concerned that many more beneficiaries than usual were going to disenroll during the first quarter of the year. After Quarter 1, the government decided to postpone lock-in, so the disenrollment patterns that we had expected did not occur. Therefore, our final overall distribution in the 2002 survey was 22 percent in Quarter 1, 20 percent in Quarter 2, 23 percent in Quarter 3, and 35 percent in Quarter 4.

As we have traditionally done in every prior survey year, if the number of disenrollees in a plan in any given quarter was not sufficient to meet the targeted number, we attempted to make up those cases in subsequent quarters. For some plans in some quarters, we therefore took a census of disenrollees.

In Quarter 3, we began including disenrollees from a Private Fee for Service (PFFS) plan. Since this plan covered beneficiaries in multiple states, we worked with the other Medicare CAHPS teams to develop a sampling plan to reflect geographic strata. Seven states were chosen that had the largest numbers of enrollees: Louisiana, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, and Washington. Each of these states formed its own stratum. An eighth stratum was created that contained the remainder of the United States. Our intention was to sample 388 disenrollees from each stratum. However, since sampling did not begin until Quarter 3, it was not possible to meet this quota in 2002.

The sample for the 2002 Reasons Survey consisted of 53,241 Medicare beneficiaries who had disenrolled from an MA organization in 2001. The number of Medicare beneficiaries selected in each quarter in the 2002 Reasons Surveys is shown in *Exhibit 3-2*. The sample sizes for the 2000 and 2001 Reasons Surveys are shown for comparison purposes. Note that the 2002 sample followed the trend of decreasing sample sizes begun the previous year. This is due to the fact that there were fewer MA organizations under contract with CMS in 2002 than there were in 2001 (approximately 23 plans did not renew their contract with CMS in 2002; another 9 elected not to renew their contract with CMS in 2003, which affected the Quarter 4 sample in the 2002 survey).

Exhibit 3-2
Reasons Survey sample size by quarter

Quarter	Sample size		
	2002	2001	2000
1	11,716	13,595	19,958
2	10,501	12,454	18,829
3	12,118	15,017	23,219
4	18,906	23,364	25,459
Total	53,241	64,430	87,465

3.3 Survey Instrument

We collected data for the 2002 Reasons Survey via a mail survey with telephone follow-up of nonrespondents. The Reasons Survey was designed to collect information about the reasons why sample members left their former Medicare managed health care plan. The questionnaire used in the 2002 survey contained 77 questions, the same number included in the 2001 survey questionnaire. The 2002 survey included the following questions:

- four screening questions to verify that the respondents were voluntary disenrollees
- thirty-seven questions about reasons for leaving the health plan, including 33 preprinted reasons, 1 question about any other reasons for leaving, and 1 question that asked for *the most important reason* for leaving the plan
- six questions asking the respondent to rate the sample health plan, the care received from that plan, and the experience with that plan
- eight questions about the appeals process
- twenty-two questions about health status and demographic characteristics

The screening questions were designed to identify sample members who were considered “involuntary” disenrollees and to exclude them from the survey. Reasons for ineligibility to participate in the 2002 Reasons Survey included the following:

- The sample member never left the Medicare managed care health plan for any length of time during the year 2002.
- The sample member moved out of the area where the Medicare managed care health plan was available.
- The Medicare managed care health plan stopped serving Medicare beneficiaries in the sample member’s area.
- The sample member was enrolled in the plan without his or her knowledge (for example, by a salesperson or family member).
- The sample member was accidentally disenrolled from the plan (for example, due to a paperwork or clerical error).

In addition, deceased and institutionalized sample members were ineligible to be included in the Reasons Survey.

The telephone survey instrument was designed to mirror the mail survey instrument as closely as possible and was developed to be used as a computer-assisted telephone interview (CATI). Both the mail and telephone survey instruments were customized so that they were plan-specific for each sample member. 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.

At the end of each survey year, the project team analyzes the survey questions and responses and evaluates whether changes are needed for the following year. Some of the changes are made to keep the questionnaire consistent with changes being made on the other Medicare CAHPS surveys, while other changes are related to observation of how sample members are responding to the Reasons Survey itself. We therefore revised the Reasons Survey questionnaire after the 2001 Reasons Survey year as follows:

- We changed the order of the first two screening questions, to move the question about whether the respondent left because he or she moved out of the area where the plan was offered to the first question asked, allowing those who answered “yes” to end their participation without having to answer any additional questions.
- We removed the stop instructions from screening questions 2 through 4 to allow respondents to continue answering questions if any of these reasons was not their “only” reason for leaving the plan.
- We removed the word “only” from Questions 3 and 4, the screening questions asking whether respondents left because they found out that someone had signed them up without their knowledge or because of a paperwork or clerical error.
- We reworded Question 5 to include the spouse’s former employer.
- We moved the question that asked if the respondent left the plan because he or she could not pay the monthly premium (which appeared as Question 6 in the 2001 Reasons Survey questionnaire) to appear later in the questionnaire along with other questions about premiums.
- We made some minor wording changes in the preamble that appeared before the first question in the appeals section.
- We changed the wording in the question about rating overall health to match the wording of the same question included in the Medicare CAHPS Fee-for-Service Survey.
- We added the categories “44 or younger” and “45 to 64” as answer choices to the age question.

We removed the stop instruction from screening questions 2 through 4 to ensure that sample members did not prematurely exit the questionnaire if that was not their only reason for leaving. The decision was made to code respondents as ineligible only if they reported any of these reasons for ineligibility as either their “other” reason for leaving or their most important reason for leaving. When callers to the hotline or sample members who called as part of the telephone follow-up reported any of these reasons for ineligibility, they were asked probing questions to determine whether this was their “only reason” for leaving the plan. If it was the

only reason for leaving, they were deemed ineligible; if it was not, they were asked to continue the interview.

A copy of the questionnaire used in Quarters 1-4 is included in *Appendix B*.

3.4 Data Collection Activities

We conducted data collection and data processing activities for Quarters 1-4 of the 2002 Reasons Survey from July 12, 2002, through July 7, 2003. For each quarterly implementation of the survey, we used the same multiwave survey process, which involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. The schedules for the mail and telephone collection activities on the 2002 Reasons Survey are shown in *Exhibits 3-3* and *3-4*, respectively.

Exhibit 3-3
2002 Reasons Survey data collection schedule: mail survey

Activity	Mailing week			
	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Prenotification letter mailed	7/12/02	8/12/02	12/27/02	3/11/03
Toll-free project hotline open for in-bound requests for telephone interviews	7/12/02	8/12/02	12/27/02	3/11/03
First questionnaire package mailed	7/22/02	8/15/02	1/7/03	3/17/03
Thank you/reminder postcard mailed	8/9/02	9/2/02	1/24/03	4/11/03
Second questionnaire package mailed	8/21/02	9/12/02	2/18/03	4/28/03
Third questionnaire package mailed	10/7/02	10/29/02	4/8/03	6/2/03

Exhibit 3-4
Telephone follow-up data collection schedule for 2002 Reasons Survey, by quarter

Quarter	Telephone interviewers trained	Telephone follow-up
1	9/20/02–9/21/02	9/23/02–11/10/02
2	Same staff as Qtr. 1	10/14/02–12/1/02
3	3/26/03	3/28/03–5/6/03
4	5/29/03–5/30/03	5/31/03–7/6/03

Sample members were given the option of calling a toll-free project hotline at any time during the data collection period in each quarter if they had questions, wanted to refuse, or wanted to request a telephone interview. Telephone interviewers were trained just before the beginning of the mail survey so they could conduct interviews with sample members who called

to request a telephone interview. 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. Project data collection staff received telephone calls precipitated by receipt of the mailings from approximately 7.6 percent of the total sample for the 2002 Reasons Survey. A summary of the 2002 Reasons Survey hotline experience is provided in *Appendix C*.

For the 2002 survey, a health plan in Puerto Rico became eligible for inclusion in the sample. As a result of this addition of primarily Spanish-speaking disenrollees, we adapted our protocol by sending Spanish versions of all letters and mail survey materials (instead of English versions as is done with sample members who live in the continental United States). We included an English version of a post card in the initial questionnaire mailing which asked sample members to return the card to request an English version of the questionnaire.

Because CMS does not have access to telephone numbers for Medicare beneficiaries, it was necessary to conduct some preliminary tracing before beginning the telephone follow-up portion of the data collection. We used a combination of four sources to obtain a current telephone number for the sample members:

- requested telephone numbers from each of the Medicare managed care health plans represented in the sample (in Quarter 4, we did not request telephone numbers from health plans that were not renewing their MA contract with CMS in 2003)
- obtained telephone numbers from a commercial telephone number matching service
- requested telephone numbers from the Social Security Administration (SSA) through an arrangement between CMS and SSA
- conducted limited intensive tracing activities performed by RTI's specialized in-house Tracing Operations Unit (TOPS)

3.5 Quality Control Procedures

To ensure that data of the highest possible quality would be collected, RTI project staff implemented quality control procedures during every phase of the mail and telephone survey data collection process. The actions taken are briefly described 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 was assembled correctly.

- Quality control checks on the work performed by the 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 handwritten 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 other project 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 about their performance after the 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 data collection period. These meetings were held to discuss the status of telephone survey data collection, identify questionnaire items that were problematic for respondents, discuss reasons that some sample members initially gave for not wanting to participate in the survey, and identify possible ways to overcome those objections.

3.6 Data Collection Results

Data collection efforts on the 2002 Reasons Survey resulted in an overall response rate of 66.3 percent. This response rate was calculated using the following formula:

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

The response rate obtained in each quarter and overall for the 2002 Reasons Survey is shown in *Exhibit 3-5*. For comparison purposes, quarterly and overall response rates for the 2000 and 2001 Reasons Surveys are also included. As shown, the response rate in the 2002 Reasons Survey varied by quarter, ranging from 64.4 percent to 67.4 percent, which reflects a slight dip overall from the prior year. Project staff analyzed data collection procedures to try to account for this difference; however, since the data collection modes and procedures are the same in all quarters and all survey years, we do not have an explanation for this difference.

Exhibit 3-5
Sample distribution and response rate by quarter: 2002, 2001, and 2000 Reasons Surveys

Quarter		Number selected	Completed interviews	Response rate
2002	1	11,716	5,927	67.4%
	2	10,501	5,119	67.0%
	3	12,118	5,119	64.4%
	4	18,906	9,589	66.4%
	Subtotal	53,241	25,754	66.3%
2001	1	13,595	6,965	69.5%
	2	12,454	5,587	64.6%
	3	15,017	6,362	65.4%
	4	23,364	11,923	69.9%
	Subtotal	64,430	30,837	67.8%
2000	1	19,958	9,604	65.8%
	2	18,829	8,347	58.9%
	3	23,219	7,395	58.4%
	4	25,459	11,990	67.5%
	Subtotal	87,465	37,336	63.1%

The final disposition of sample cases in the 2002 Reasons Survey is shown in *Exhibit 3-6*, along with final distributions of cases in the 2001 and 2000 surveys for comparison. Approximately 27 percent of the 2002 sample was ineligible to participate in the survey—that is, the sample members had died or became institutionalized after the sample was selected, or they were considered involuntary disenrollees. Involuntary disenrollees include sample members who reported that

- the plan stopped serving the area,
- they moved out of the plan’s service area,
- they were enrolled in the plan without their knowledge,
- they were accidentally disenrolled from the plan due to a paperwork or clerical error,
- they did not disenroll from the sample plan, or
- they were not on Medicare.

The “Other Ineligible” category shown in *Exhibit 3-6* includes sample members who marked “yes” to two or more of the questions designed to identify involuntary disenrollees or who reported that they were never enrolled in the sample plan. Approximately 7.4 percent of the 2002 sample refused to participate in the survey. We were unable to contact 7.2 percent of mail survey nonrespondents after repeated attempts, and 0.3 percent promised to complete and return

**Exhibit 3-6
Final disposition of the 2002, 2001, and 2000 Reasons Survey samples**

Sample disposition	2002 Reasons Survey		2001 Reasons Survey		2000 Reasons Survey	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Completed interviews	25,754	48.4%	30,837	47.9%	37,336	42.7%
Mail survey	21,574	40.5%	25,625	39.8%	29,851	34.1%
Telephone interview	4,180	7.9%	5,212	8.1%	7,485	8.6%
Eligible nonrespondents	13,066	24.5%	14,612	22.7%	21,855	25.0%
Mentally/physically incapable	659	1.2%	777	1.2%	1,249	1.4%
Language barrier	391	0.7%	339	0.5%	273	0.3%
Refusal	3,955	7.4%	4,381	6.8%	6,129	7.0%
Unable to contact after repeated attempts	3,817	7.2%	3,189	4.9%	4,601	5.3%
Promised to return mail survey	143	0.3%	74	0.1%	213	0.2%
Unable to obtain phone number	4,101	7.7%	5,852	9.1%	9,390	10.7%
Ineligibles	14,421	27.1%	18,981	29.5%	28,274	32.3%
Deceased	1,385	2.6%	1,579	2.5%	2,038	2.3%
Institutionalized	1,811	3.4%	1,322	2.1%	1,160	1.3%
Did not leave sample plan	1,859	3.5%	1,898	2.9%	2,950	3.4%
Plan no longer offered	1,556	2.9%	6,116	9.5%	11,181	12.8%
Moved outside plan service area	6,668	12.5%	5,956	9.2%	5,923	6.8%
Paperwork error	422	0.8%	793	1.2%	N/A	N/A
Enrolled by other	158	0.3%	448	0.7%	N/A	N/A
Other ineligibles ^a	562	1.1%	869	1.3%	5,022	5.7%
Eligible sample members	38,820	72.9%	45,449	70.5%	59,191	67.7%
Original sample	53,241	100%	64,430	100%	87,465	100%

^a Includes respondents who reported not being on Medicare, who never enrolled in the sample plan, or who gave inconsistent answers to the screening questions.

the mail questionnaire when they were contacted by telephone but did not. Another 1.2 percent were physically or mentally incapable of participating in the interview, and 0.7 percent did not speak English or Spanish (language barriers). We were unable to obtain a telephone number for 7.7 percent of the mail survey nonrespondents.

The percentage of the sample that was deemed ineligible continued to decline from 2000 to 2002, although several categories of ineligibles showed an increase: deceased, institutionalized, and those who left because they moved outside of the plan's service area. As can be seen in Exhibit 3-6, the percentage of sample members reporting that they moved out of the plans' service area has increased during each survey year. The percentage of sample members who reported that they left because the plan was no longer offered to them declined dramatically from 2000 (12.8 percent) to 2002 (2.9 percent), reflecting that fewer plans chose not to renew their contract with CMS in 2002 and 2001 than in 2000. The percentage of individuals for whom we were unable to obtain a telephone number declined from 2001 (9.1 percent) to 2002 (7.7 percent), most likely due to the added source of telephone numbers from the SSA. However, the percentage of cases we were unable to contact after repeated attempts increased from 2001 (4.9 percent) to 2002 (7.2 percent), likely reflecting the fact that although we had more telephone numbers, many of them may not have been valid for the sample member.

Exhibit 3-7 shows the percentage 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) for the 2000, 2001, and 2002 Reasons Surveys.

3.7 Nonresponse Analysis and Weighting

We conducted a nonresponse analysis on the 2002 Reasons Survey data after the data were cleaned. For this analysis, we classified sample members as respondents or nonrespondents; response propensities were then modeled using logistic regression in SUDAAN. The predicted response propensities were used to adjust the initial design-based weights upward for respondents so that they represented both respondents and nonrespondents; weights for nonrespondents were set to zero. The general approach used to adjust weights for nonresponse is described by Folsom (1991) and Iannacchione, Milne, and Folsom (1991).

For purposes of nonresponse adjustments, sample members who provided information on eligibility status were treated as respondents. Subsequently, those who were ineligible (deceased, institutionalized, involuntary disenrollees) were also given a weight as if they had completed the survey. Since we do not know the eligibility status of nonrespondents, this approach allowed us to estimate the proportion of ineligible sample members among the nonrespondents based on the respondent sample. When the ineligibles are discarded with their weighted values, the sum of the remaining weights (only including eligible sample members that completed a survey) now represents the *estimated population of eligible disenrollees*.

We simultaneously added to the model demographics, Census region, address variables, dual eligibility status, and design variables and removed them in a backwards-stepwise fashion. We also included two-way interactions and explored transformations of the continuous variable

Exhibit 3-7
Response per survey stage: 2002, 2001, and 2000 Reasons Surveys

Response per survey stage	2002 Reasons Survey			2001 Reasons Survey			2000 Reasons Survey		
	No. sample members	No. completed questionnaires	Percent of total sample	No. sample members	No. completed questionnaires	Percent of total sample	No. sample members	No. completed questionnaires	Percent of total sample
First mailing	53,241	16,348	30.7%	64,430	19,007	29.5%	91,988	22,660	25.9%
Second mailing	30,860	4,946	9.3%	37,989	6,207	9.6%	48,250	6,324	7.2%
Spanish mail survey	123	41	0.1%	96	29	0.05%	229	66	0.1%
Telephone follow-up	22,188	4,180	7.9%	26,595	5,212	8.1%	37,279	7,485	8.6%
Third (overnight) mailing	1,533	239	0.4%	5,162	382	0.6%	8,507	801	0.9%
Total number of respondents		25,754	48.4%		30,837	47.9%		37,336	42.7%
Eligible sample members		38,820	72.9%		45,449	70.5%		59,191	67.7%
Final response rate^a			66.3%			67.8%			63.1%

^a The final response rate was calculated as the eligible respondents divided by eligible sample members. The response rate includes all beneficiaries who returned a completed questionnaire, including some questionnaires that were later deemed incomplete for analytic purposes.

(age), keeping variables with p-values of 0.20 or less. The final logistic regression model contained the independent variables—age, race, dual eligibility, rapid enrollment, Census region, a metropolitan statistical area indicator, and a rural route indicator. The design variables (health plan and quarter) were included and forced to stay in the model. The response propensity analysis showed that those who were older and nonwhite were less likely to respond to the survey. Sample members under age 65 were also less likely to respond. Beneficiaries who were *not* dually eligible were more likely to respond. The odds of obtaining a response were roughly the same across the Census regions, with the exception of the Pacific region (Alaska, California, Hawaii, Oregon, and Washington), which had a higher propensity. The odds of a response had a trend of improving from east to west. Addresses with a rural route had significantly lower odds of obtaining a completed survey. Response rates by demographic characteristics and other information resulting from this analysis are shown in *Exhibit 3-8*.

We developed separate response rate tables to show response rates from a Medicare PFFS plan included in the 2002 survey sample. These tables are shown in *Exhibits 3-9* and *3-10*. The PFFS plan's disenrollee population is slightly different than that of the average Medicare health plan. They have almost twice as many disenrollees who are under age 65 compared to other plans (19.1 percent vs. 10.7 percent). Also, they have almost half the proportion of minorities as other plans (10.0 percent vs. 18.1 percent). Note that these demographic statistics are only for the disenrollee population and are not reflective of the entire plan.

The response rate from the sample PFFS plan was also higher than that of the overall sample. The overall response rate from PFFS sample members was 73.3 percent (compared to 66.3 percent for the overall sample). The PFFS plan had response rates that were also higher in every single demographic category, such as gender, age, and race. Even in categories with historically low response rates, the PFFS plan had higher responses. For example, the response rate for PFFS disenrollees who were dually eligible for Medicare and Medicaid was 73.0 percent, compared to 56.1 percent for the overall sample.

We constructed two sets of weights for the Reasons Survey. The first weight, referred to as the disenrollment weight, represents all eligible disenrollees in each plan and was developed as discussed above. The second weight is simply scaled by a plan-level multiplicative constant so that the weights sum to the proportion that voluntary disenrollees represent of the total population of enrollees. These latter weights (referred to as Enrollment weights) were used for weighting results for public reporting that are based on all members in a plan rather than just disenrollees.

3.8 Evaluation and Areas of Improvement for the 2003 Survey

Throughout every survey implementation, the project team continuously evaluates major components of the data collection and sampling methods to identify any activities that can improve the survey implementation. Our evaluation of the 2002 survey implementation focused on four major areas: sample design; questionnaire testing and revisions; review of existing systems, including CATI and all supporting data processing systems; and evaluation of telephone number sources. The results of our evaluation are discussed in the paragraphs that follow.

Exhibit 3-8
2002 Reasons Survey response rates by demographic characteristics: overall sample

Subpopulation	Total sample		Respondent sample		Response rates among eligibles ^a
Overall					
USA	53,241	100.0%	25,754	100.0%	66.3%
Gender (EDB)					
Male	22,093	41.5%	10,989	42.7%	66.7%
Female	31,148	58.5%	14,765	57.3%	66.0%
Age group (EDB)					
<65	5,690	10.7%	2,860	11.1%	64.5%
65-69	12,798	24.0%	6,840	26.6%	70.0%
70-74	12,719	23.9%	6,717	26.0%	69.1%
75-79	9,809	18.4%	4,784	18.6%	67.2%
≥80	12,225	23.0%	4,553	17.7%	58.6%
Race (EDB)					
White	43,628	81.9%	21,550	83.7%	68.8%
Black	6,226	11.7%	2,849	11.0%	59.0%
Other/unknown	3,387	6.4%	1,355	5.3%	51.2%
Dual eligible (EDB)					
Yes	9,492	17.8%	3,810	14.8%	56.1%
No	43,749	82.2%	21,944	85.2%	68.5%
Census region					
I. New England	2,677	5.0%	1,318	5.1%	67.2%
II. Middle Atlantic	11,290	21.2%	5,640	21.9%	64.3%
III. East North Central	7,060	13.3%	3,469	13.5%	69.2%
IV. West North Central	3,972	7.5%	1,880	7.3%	69.0%
V. South Atlantic	7,639	14.4%	3,343	13.0%	60.2%
VI. East South Central	2,732	5.1%	1,543	6.0%	72.8%
VII. West South Central	3,751	7.1%	1,893	7.3%	69.1%
VIII. Mountain	5,561	10.4%	2,768	10.8%	70.3%
IX. Pacific	8,376	15.7%	3,837	14.9%	65.5%
Other	183	0.3%	63	0.2%	47.0%

^a 14,421 sample members were ineligible (27.0%).

Exhibit 3-9
2002 Reasons Survey response rates by demographic characteristics for the sample PFFS plan

Subpopulation	Total sample		Respondent sample		Response rates among eligibles
Overall					
USA	2,050	100.0%	1,170	100.0%	73.3%
Gender (EDB)					
Male	885	43.2%	485	41.4%	71.4%
Female	1,165	56.8%	685	58.6%	74.6%
Age group (EDB)					
<65	391	19.1%	250	21.4%	75.8%
65-69	451	22.0%	242	20.6%	71.8%
70-74	443	21.6%	270	23.1%	73.8%
75-79	390	19.0%	229	19.6%	77.4%
≥80	375	18.3%	179	15.3%	66.8%
Race (EDB)					
White	1,845	90.0%	1,058	90.4%	73.9%
Black	140	6.8%	84	7.2%	71.8%
Other/unknown	65	3.2%	28	2.4%	57.1%
Dual eligible (EDB)					
Yes	290	14.2%	173	14.8%	73.0%
No	1,760	85.8%	997	85.2%	73.3%
Census region					
I. New England	2	0.1%	1	0.1%	100.0%
II. Middle Atlantic	135	6.6%	81	6.9%	69.8%
III. East North Central	221	10.8%	121	10.3%	70.4%
IV. West North Central	30	1.4%	17	1.5%	85.0%
V. South Atlantic	61	3.0%	26	2.2%	63.4%
VI. East South Central	198	9.6%	126	10.8%	72.0%
VII. West South Central	1,046	51.0%	629	53.8%	74.6%
VIII. Mountain	155	7.6%	80	6.8%	77.7%
IX. Pacific	198	9.7%	87	7.4%	70.7%
Other	4	0.2%	2	0.2%	66.7%

Exhibit 3-10
2002 Reasons Survey response rates by strata, for the sample PFFS plan

Subpopulation	Total sample		Respondent sample		Response rates among eligibles
Overall					
USA	2,050	100.0%	1,170	100.0%	73.3%
Strata					
I. Texas	388	18.9%	230	19.7%	75.4%
II. Louisiana	388	18.9%	230	19.7%	73.5%
III. Washington	151	7.4%	66	5.6%	72.5%
IV. Oklahoma	232	11.4%	142	12.1%	73.2%
V. Tennessee	185	9.0%	119	10.1%	72.6%
VI. Ohio	191	9.3%	102	8.7%	68.9%
VII. Pennsylvania	127	6.2%	78	6.7%	70.9%
VIII. Remainder of USA	388	18.9%	203	17.4%	74.6%

Sampling Design—As part of our ongoing evaluation of the sample design, we conducted an evaluation of the 2001 sample design and recommended changes for 2002. The 2001 Reasons Survey was burdened by a large design effect (i.e., unequal weighting effect, or UWE) when conducting analyses that involve aggregating data across all health plans. Although the effective sample size was sufficient for examining overall reasons for disenrollment, we quickly became limited when we attempted to drill down to other subgroups, such as age, race, geographic region, or other various combinations. This was primarily due to a handful of outlying plans with large numbers of disenrollees. As a result of our evaluation, we considered several options for reducing or eliminating the UWE. The first option was to draw a sample from a plan that is proportional to the number of disenrollees that plan has. Another strategy was to draw a proportional sample but guarantee that the smallest plans have a sufficient number of cases to make a plan-level estimate. The final option considered and recommended to CMS was to use optimal allocation using nonlinear methods.

Optimal allocation allows us to increase the sample size in some of the larger plans that have the larger weights. As the sample size increases in those problematic plans, their corresponding weights then decrease. CMS concurred with this recommendation, which was implemented with the first quarter of the 2004 Reasons Survey. More detailed information is included in a report prepared for CMS entitled *Report on the Results of Evaluating the Sample Design and Unequal Weighting Effects on the 2001 Medicare CAHPS Disenrollment Reasons Survey* (Scheffler et al, 2003).

Questionnaire Testing and Revisions— As part of our ongoing effort to evaluate and improve the survey, we examined patterns in the responses to the 2002 Reasons Survey questionnaire in preparation for implementing the 2003 Reasons Survey. As part of these efforts, we conducted cognitive testing activities jointly with the Medicare CAHPS Managed Care Enrollee Survey project team to revise the series of appeals questions that appear in both the Reasons Survey and the Medicare CAHPS Managed Care Enrollee Survey. In addition, in preparation for adding the sample of disenrollees from Medicare PFFS plans to the Reasons Survey, the RTI project team conducted cognitive testing activities to evaluate whether the existing questions worked for PFFS disenrollees. Changes made to the 2003 Reasons Survey questionnaire as a result of our evaluation and cognitive testing activities are described in detail in *Appendix E*.

Review of Data Processing—Project staff regularly discussed the use of the hotline CATI with interviewers and telephone unit supervisors, to compare it with earlier methods of capturing hotline calls. All staff agreed that the use of a standardized hotline CATI, implemented for the first time in the 2002 Reasons Survey administration, was much easier for hotline operators and ensured a more consistent way of dealing with callers. The hotline CATI was therefore not modified for the 2003 survey administration.

We also evaluated the method of receipt and scanning and decided to continue assigning a “received” event to all questionnaires with at least one question answered and letting a computer algorithm determine the actual “event code” assigned to the case, based on the scanned data. This process removed the decision about whether a case was “complete” or not from the data receipt clerks, allowing them to log cases into the control system as received. These questionnaires could then be sent to the scanning area more quickly.

Based on our ongoing evaluation of the text responses to the “most important” and “other” reasons observed during the 2002 survey, project staff did not assign any new codes during the survey year. However, at the start of the 2003 survey year, we did add a new code, “Former plan reduced or changed benefits or coverage,” which we started using in the first quarter of the 2003 Reasons Survey.

Evaluation of Telephone Number Sources—Beginning with the 2002 Reasons Survey administration, RTI worked with CMS to obtain telephone numbers for sample members from SSA. Previously, we relied on telephone numbers from health plans, a commercial telephone number service provider, and in-house tracing efforts through RTI’s Tracing Operations Unit. To evaluate the effectiveness of the telephone numbers received from SSA, we conducted an assessment of the final disposition status of all cases in the 2002 Reasons Survey, by source of telephone number. *Appendix D* provides a detailed report analyzing the effectiveness of the telephone numbers received from SSA versus those received from health plans and the commercial telephone number matching service.

Overall, the evaluation demonstrated that SSA is a very productive resource for the Reasons Survey. Despite differences in the time at which we approach each of these resources for telephone numbers, cases with telephone numbers provided uniquely by SSA accounted for a greater percentage of completed telephone interviews (13.5 percent), ineligibles (3.1 percent), and final noninterviews (7.6 percent) than cases with telephone numbers uniquely provided by

either of the other two sources. The health plans accounted for more cases finalized by mail² (20.5 percent) than the other two sources. Perhaps the health plans return a larger proportion of cases overall, including more that are finalized by mail, because we ask them for phone numbers for the entire sample rather than just for mail survey nonrespondents.

² Some cases that were finalized by mail may have been prompted by telephone calls from our interviewing staff.

SECTION 4 DATA PROCESSING

4.1 Overview

Data processing for the 2002 Reasons Survey involved receiving incoming mail from the mail survey and updating the computerized control system to reflect the status of that incoming mail, scanning data from completed questionnaires, and assigning codes to open-ended text entries, including the most important reason and other reasons for leaving the plan. These processes are described in this chapter.

4.2 Data Receipt and Scanning

Data receipt staff updated a computerized control system as mail was received to indicate the status of incoming mail. They entered a disposition/status code of “999” in the computerized control system for all nonblank questionnaires. All questionnaires assigned the 999 code were then scanned, and a computer algorithm determined the final event status code. Project staff also updated cases in the control system as they received telephone 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). The control system was also updated 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 by their questionnaire responses, the telephone interview, notes submitted with a questionnaire, or calls 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” or “other” reason.

4.3 Coding Open-Ended Text Entries

The 2002 Reasons Survey contained several questions with an open-ended response choice, including questions that asked if there were any other reasons for leaving the plan not already addressed in the questionnaire and the most important reason for leaving the plan. Project staff assigned a numeric code to the other reasons for leaving (if any) and to the most important reason using a list of 67 codes developed by the analysis team during the 2000 Reasons Survey and expanded during the 2001 survey (based on reasons reported during the 2000 survey). We did not add any new codes during the 2002 Reasons Survey. A complete list of codes used in the 2002 survey is included in *Appendix F*. More detailed information about the development of the codes, training of coders, and quality control checks on coded data can be found in the *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons* (Lynch, et. al-2003b).

Any sample member whose most important or “other” reason for leaving the plan was a reason that made him/her an involuntary disenrollee was assigned an ineligible code. Project staff also coded any open-ended text entries recorded in the questions about the respondent. Any

cases assigned the code that represented any of the following reasons were deemed ineligible for the survey, and questionnaire data for these cases were removed from the data file:

- The sample member was institutionalized.
- The sample member was deceased.
- The plan stopped serving the area.
- The sample member was accidentally disenrolled (for example, by a paperwork or clerical error).
- The sample member was enrolled without his/her knowledge (for example, by a friend, relative, or salesperson).
- The sample member moved out of the plan's service area.
- The sample member did not disenroll from the sample plan.
- The sample member reported that he or she was not on Medicare or was never enrolled in the sample plan.

4.4 Questionnaire Completeness Criteria

Cases were retained in the 2002 Reasons Survey analysis file if the respondent answered “yes” to at least one of the preprinted reasons for leaving questions (Questions 5-38) *or* gave some other reason for leaving in Q40 *or* gave a most important reason for leaving in Q41. However, even if a case met these completeness criteria, it was excluded from the data file (and treated as ineligible) if the respondent's most important or “other” reason for leaving the plan made him/her an involuntary disenrollee.

4.5 Data File Construction

This section describes procedures used to construct files for subgroup analysis and health plan and consumer reporting.

Recoding Data—After the raw data file was cleaned and all ineligible cases had been removed, we created a master data file that consisted of all cases that had marked at least one reason for leaving the plan. 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.

Flagging Cases and Adding Other Variables to the Data File—We flagged cases on the master data file that were to be excluded from public reporting and health plan reporting according to specific criteria. The following cases were flagged so that they would not be included in consumer/public and health plan reporting:

- cases in nonrenewing plans (including plans that did not renew their MA contract in 2003 or 2004)
- cases in plans that were bought by a new owner
- cases indicating that their most important reason for leaving was because their employer no longer offered the plan or they left to join TRICARE for Life, the military health insurance program

In addition to flags indicating cases that would not be included in consumer and health plan reporting, we also added a flag to identify cases of plans that consolidated or merged with another plan, so that data from these plans would be reported under the surviving plan (rather than the subsumed plan).

In constructing the master data file, we added variables to the data file that would be needed in consumer and health plan reporting and subgroup analysis. These variables included two sets of weights: (1) design-based weights (disenrollment weights); and (2) weights that represent the proportion of disenrollees with respect to enrollees within a plan (enrollment weights), demographic variables from CMS' Enrollment Data Base (EDB) (such as gender, race, and age), and variables to indicate whether the interview was conducted in English or Spanish, whether it was completed by a proxy respondent, and the mode of completion (by mail or telephone survey).

4.6 Imputing Most Important Reason for Leaving

As noted in a preceding section, the responses to the question asking sample members for their most important reason for leaving their health plan were coded by project staff using 67 unique codes. Some of these codes corresponded to the 33 preprinted reasons in the survey, and others provided additional details not addressed in the questionnaire. These codes were assigned to reasons "groupings," comprising a series of related reasons for leaving. There are two main reasons groupings: "problems with care and services" and "concerns about costs." In addition, five subgroupings were used in consumer reporting and eight in health plan reporting. The analysis that led to these reasons groupings is described in a separate report submitted to CMS in July 2001 (Booske and Rudolph, 2001) and in the *Medicare CAHPS 2000 Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups* report, submitted to CMS in November 2002 (Harris-Kojetin et al., 2002).

If the most important reason for leaving the health plan was left blank (missing), the project team imputed a response wherever possible. The following rules were used to impute the most important reason:

- If the respondent marked "yes" to only one preprinted reason for leaving question, then that response was assigned as the most important reason response.
- If "yes" was marked for more than one preprinted reason question, then reasons groupings were examined for imputations. If the two preprinted reasons marked

“yes” were in the same main reasons groupings or subgroup, then the most important reason was imputed to be that subgroup.

- If “yes” was marked for two or more preprinted reasons, and each of these fell into different reasons groupings, then the most important reason was left missing.

In the 2002 Reasons Survey, 3,249 (12.8 percent) of the sample members who returned a completed questionnaire did not record a most important reason for leaving the plan in Question 41. Of those cases, the most important reason was imputed for 1,101 cases (2.1 percent of the total respondent sample).

4.7 Mapping Reasons to Reasons Grouping

One of the primary purposes of conducting the Reasons Survey is to report reasons to consumers, via the Medicare Web site and other media, to supplement information on the rates at which people voluntarily disenroll from health plans. Although the Reasons Survey collects data about 33 specific reasons for leaving and the one most important reason for leaving, CMS reports the most important reason and other reasons for leaving to beneficiaries, the public, and health plans by two major categories of “most important reasons” cited by people who leave Medicare plans. The CAHPS Disenrollee Development and Testing team tested these two main categories during the development of draft report templates for inclusion of disenrollment rates and reasons on Medicare’s Web site, as well as additional testing conducted as part of this project. The two categories were given the following labels:

- members left because of health care or services
- members left because of costs and benefits

CMS reports each plan’s disenrollment rate as a total rate (the percentage of enrollees choosing to leave a plan during the past year) and then broken out according to what percentage of enrollees left for reasons in each of these two main categories. More detailed information about testing on reporting disenrollment rates and reasons to Medicare beneficiaries is provided in reports submitted to the Agency for Healthcare Research and Quality (AHRQ) as part of the CAHPS Disenrollee Development and Testing Project (Harris-Kojetin, Jael, and Hampton, 1999; Harris-Kojetin, Jael, and Nemo, 1999; Harris-Kojetin et al., 1999). Some additional testing of reporting disenrollment rates and reasons was conducted as part of the national implementation. Results from testing conducted as part of this project were described in a report submitted to CMS in January 2000 (Harris-Kojetin, Miller, and Nemo, 2000).

In addition, CMS wanted to allow consumers and health plans interested in more information about either of these categories to be able to “drill down” to see more detailed subgroupings of reasons. As a result of a series of factor and variable cluster analyses, we developed eight reasons groupings based on the data from the 2000 Reasons Survey: five groupings that address problems with care or service and three groupings that address concerns about plan costs. These eight groupings were used for reporting to plans and for subgroup analysis. For the drill-down option available to consumers, three of the five care and service subgroupings (“problems getting care,” “problems getting particular needs met,” and “other problems with care or service”) were combined into one group, and two of the three cost

groupings (“premiums or copayments too high” and “copayments increased and/or another plan offered better coverage”) were combined into one group, for a total of five consumer subgroupings. *Exhibit 4-1* presents the assignment of Reasons Survey items and labels to the reasons groupings. More information about reasons groupings and the methodology used to derive them is provided in the 2000 Reasons Survey final analysis report, *Medicare CAHPS 2000 Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups* (Harris-Kojetin et al., 2002).

Once the most important reasons were imputed, the assigned code for the most important reason and other reasons for leaving the plan were rolled up into main categories that corresponded to the level of detail collected on the 33 preprinted reasons in the survey. At this point, most important reasons and preprinted reasons groupings were created based on the same assignments of the reasons groupings. The most important reason for leaving was mapped to one of the two main reasons groupings and to the five and eight subgroupings. All reasons that the respondent had marked in the preprinted reasons for leaving were also mapped to the main groupings and subgroupings. It should be noted that a beneficiary could have only one most important reasons grouping but could have multiple preprinted (or “All”) reasons groupings. Additionally, although “other reasons” were used to impute the most important reason if it was missing, they were not used in creating the reasons groupings for the annual health plan reports.

Exhibit 4-1
Assignment of reasons for leaving a plan to groupings of reasons

Reasons grouping	Reasons for leaving a plan
Problems with Care or Service	
Problems with information from the plan	Given incorrect or incomplete information at the time you joined the plan After joining the plan, it wasn't what you expected Information from the plan was hard to get or not very helpful Plan's customer service staff were not helpful Insecurity about future of plan or about continued coverage
Problems getting particular doctors	Plan did not include doctors or other providers you wanted to see Doctor or other provider you wanted to see retired or left the plan Doctor or other provider you wanted to see was not accepting new patients Could not see the doctor or other provider you wanted to see on every visit
Problems getting care	Could not get appointment for regular or routine health care as soon as wanted Had to wait too long in waiting room to see the health care provider you went to see Health care providers did not explain things in a way you could understand Had problems with the plan doctors or other health care providers Had problems or delays getting the plan to approve referrals to specialists Had problems getting the care you needed when you needed it
Problems getting particular needs met	Plan refused to pay for emergency or other urgent care Could not get admitted to a hospital when you needed to Had to leave the hospital before you or your doctor thought you should Could not get special medical equipment when you needed it Could not get home health care when you needed it Plan would not pay for some of the care you needed
Other problems with care or service	It was too far to where you had to go for regular or routine health care Wanted to be sure you could get the health care you need while you are out of town Health provider or someone from the plan said you could get better care elsewhere You or another family member or friend had a bad experience with that plan
Concerns about Costs and Benefits	
Premiums or copayments too high	Could not pay the monthly premium Another plan would cost you less Plan started charging a monthly premium or increased your monthly premium
Copayments increased and/or another plan offered better coverage	Another plan offered better benefits or coverage for some types of care or services Plan increased the copayment for office visits to your doctor and for other services Plan increased the copayment that you paid for prescription medicines No longer needed coverage under the plan
Problems getting or paying for prescription medicines	Maximum dollar amount the plan allowed for your prescription medicine was too low Plan required you to get a generic medicine when you wanted a brand name medicine Plan would not pay for a medication that your doctor had prescribed

SECTION 5

CONSUMER, HEALTH PLAN, AND QUALITY IMPROVEMENT ORGANIZATION REPORTING

5.1 Overview

The Reasons Survey project team compiled and submitted to CMS comparative plan information that CMS later posted on the Medicare Web site. In addition, we compiled and reported—via interim and annual Medicare CAHPS Disenrollment Reasons Survey Health Plan Reports—the results of the survey to the health plans for quality improvement efforts. We also aggregated health plan reports by state to create reports for Quality Improvement Organizations (QIOs). Annual voluntary disenrollment rates and information about the reasons that Medicare beneficiaries leave their former plans from the 2002 Reasons Survey were posted on the Medicare Web site in the winter of 2004. The results of the 2002 Reasons Survey were prepared and reported to each health plan that participated in the 2002 survey. First, an interim report was sent to the plans in February 2003 based on the first two quarters of data; then an annual health plan report was sent to sample plans in December 2003. Results of the 2002 Reasons Survey were distributed to QIOs in February 2004. This section describes the information that was reported to consumers, health plans, and QIOs.

5.2 Disenrollment Rates

One of the first steps in preparing for reporting 2002 Reasons Survey results to consumers and health plans was to calculate raw and adjusted disenrollment rates. CMS calculated an annual voluntary disenrollment rate for each health plan based on data in its administrative systems. This rate excludes disenrollment due to death, loss of eligibility, managed care organization (MCO) administrative actions (the effect of contract terminations and contract service area reductions), and beneficiary changes of residence out of a service area. In 2002, in addition to the adjustments made by CMS, we adjusted the disenrollment rates based on information gathered from sample members in the 2002 Reasons Survey who reported that

- they left the plan because their employer no longer sponsored the plan,
- they left their plan to join TRICARE for Life, or
- they left the plan because they moved.

5.3 Interim Report to the Health Plans

We prepared and distributed to each health plan a 2002 Medicare CAHPS Disenrollment Reasons Survey Interim Health Plan Report in February 2003. The data file used in creating this report included data from all eligible cases in Quarters 1 and 2 of the 2002 Reasons Survey that reported at least one reason for leaving the plan (i.e., answered “yes” to one of the preprinted reasons and/or indicated an “other” or “most important” reason for leaving). The interim report, which was prepared specifically for each plan, contained a section describing the background and purpose of the survey and sections on the Reasons Survey design and methods. For each

individual health plan interim report, we included information about the number of disenrollees sampled for that plan and the response rate for the first two quarters of the 2002 Reasons Survey. In addition, for each plan, we calculated and included in that plan's interim report the five most frequently cited reasons for leaving that plan, as well as the five most frequently cited "most important" reasons for leaving the plan. Each health plan report also contained a frequency of responses to each question (unweighted percentages of the survey responses). The report included a copy of the 2002 Reasons Survey questionnaire.

5.4 Annual Report to Health Plans

In December 2003, we prepared and distributed an annual 2002 Medicare CAHPS Disenrollment Reasons Survey Health Plan Report to most of the health plans that were included in the 2002 Reasons Survey. At CMS' request, the report was designed to mirror the format of the Medicare CAHPS Managed Care Enrollee Annual Health Plan Report—specifically, the intent was that the annual Reasons Survey Health Plan Report should have the same "look and feel" as the Medicare CAHPS Managed Care Enrollee Health Plan Report. Full health plan reports, which included comparative information for all plans within a given state, were provided to all plans with at least 30 respondents in the 2002 Reasons Survey. An Abridged Health Plan Report was prepared and sent to all plans with 10 to 29 respondents. The abridged report did not contain comparative information on other health plans. Plans with fewer than 10 respondents received only a letter.

Data Calculated for Health Plan Reporting—The data file used in creating the 2002 Annual Health Plan Report included all cases in Quarters 1 to 4 of the 2002 Reasons Survey that reported *at least one reason* for leaving the plan (i.e., answered "yes" to one of the preprinted reasons and/or indicated an "other" or "most important" reason for leaving). Cases that were excluded from health plan reporting included responses from sample members who reported that they left their plan because their employer no longer offered the plan or because they left to join TRICARE. Responses from sample members who disenrolled from plans that did not renew their MA contract with CMS for 2003 or 2004 and plans under new ownership were also excluded. Data from respondents who disenrolled from contracts that consolidated with other contracts held by the same organization were combined and analyzed with respondent data from the surviving contract; the results from these plans were included in the health plan report prepared for the surviving contract.

The 2002 Reasons Survey Annual Health Plan Report contained information about the sample design and survey methods, data collection results (overall and for the specific plan), raw and adjusted disenrollment rates, and tables showing the percentage of beneficiaries who left the plan in each of the two main reasons groupings: "problems with care and services" and "concerns about costs." To make the survey results more useful to the plans in their quality improvement efforts, the two main reasons groupings were divided into eight reasons subgroupings: five for "problems with care and services" and three for "concerns about costs."

The annual health plan report included the state, CMS regional, and national averages for all plans in a state. State averages were reported only for states with at least three Medicare health plans. For states with fewer than three plans, averages for all plans in the CMS region in which the plan was located were reported. If a plan had a service area in more than one state, the

data from that plan were included in the state averages of every state in which the plan operated. In addition, the reasons rates for plans that operated in more than one state were shown in the reports prepared for each state in which it operated. However, only one annual health plan report was prepared for a plan that had a service area in multiple states, and it was based on the state in which the plan had the most survey respondents.

All survey results displayed in the tables included in the annual health plan report were based on weighted data. CMS decided that survey results reported to consumers and to the public that are posted on the Medicare Web site will be based on *enrollment weights* rather than *disenrollment weights*. This means that Reasons Survey results posted on the Medicare Web site show the percentage of people *enrolled* in the plan during 2002 who left the plan, whereas the results provided in the annual health plan reports were calculated based on disenrollment weights. Therefore, the reasons rates shown in the annual health plan report indicate the percentages of disenrollees who left the plan. Two sets of results/data included in the annual health plan report were based on *unweighted* rather than weighted data. These include the top five most frequently cited “most important” reasons and the top five most frequently cited preprinted reasons for leaving. The response frequencies included in each plan’s report for individual survey items were also unweighted.

Percentages for each “most important” reasons grouping and preprinted reasons grouping were produced using SAS by plan and state/region. For the plan comparison information included in each report, the data analysts compared the scores for a particular health plan with the weighted mean for the other plans in the state or CMS region and tested for statistical significance. A two-sample t-test with a p-value of .05 was performed using SUDAAN. Plans with results that were significantly higher or lower (at a level of $p < .05$) than the mean for other plans in the state or region were denoted with an up or down arrow.

5.5 Reporting Survey Results to Consumers and the Public

The results of the 2002 Reasons Survey, along with annual disenrollment rates, were posted on the Medicare Web site in the winter of 2004. All rates and reasons reported to consumers and the public are based on enrollment weights; that is, the results displayed on the Web site show the percentage of people who were *enrolled* in the plan who chose to leave for the specific reason, rather than showing the percentage of people who disenrolled for a selected reason. We calculated an enrollment weight for each plan for consumer reporting. This weight is simply scaled by a plan-level multiplicative constant so that the weights sum to the proportion that voluntary disenrollees represent of the total population of enrollees.

The information posted on the Web site includes the percentage of enrollees who chose to leave the plan in each of the two main reasons groupings: “Members Left Because of Health Care or Services” and “Members Left Because of Costs and Benefits.” Consumers can also drill down from each of these two main groupings to see the percentage of enrollees who left the plan because of one of three subgroupings of reasons related to problems with care and services and to two subgroupings of related to costs and benefits.” *Exhibits 5-1* and *5-2* show how these data are displayed on the Medicare Web site.

Exhibit 5-1
Example of how data were displayed on Medicare Web site:
disenrollment rates in <<State>>

**Percentage of Plan Members Who Left Their
Medicare Managed Care Plan in the Year 2002 and the General Reasons Why**

	Most Important Reasons Why Members Chose to Leave		
	Members Left Because of Health Care or Services	Members Left Because of Costs and Benefits	Total Percentage of Members Who Chose to Leave
Average for all Medicare managed care plans in <<state>>	%	%	%
«id» «PlanName»	%	%	%
«id» «PlanName»...	%	%	%

Exhibit 5-2
Example of how data were displayed on Medicare Web site:
specific reasons plan members left their plan in <<State>>

**Percentage of Members Who Chose to Leave Their
Medicare Managed Care Plan in 2002 and the Specific Reasons Why**

	Members Left Because of Health Care or Services			Members Left Because of Costs and Benefits		Total Percentage of Members Who Chose to Leave
	Getting Doctors You Want	Getting Information from the Plan	Getting Care	Premiums, Copayments, or Coverage	Getting or Paying for Prescription Medicines	
Average for all Medicare managed care plans in <<state>>	%	%	%	%	%	%
«id» «PlanName»	%	%	%	%	%	%
«id» «PlanName»...	%	%	%	%	%	%

CMS suppressed disenrollment rates and information about reasons for disenrollment for all plans with a cumulative annual enrollment of less than 1,000 as well as information about reasons for disenrollment for plans with fewer than 100 respondents. Due to questions received from two health plans regarding their reported 2002 disenrollment rates, CMS made a decision to suppress the disenrollment rates and reasons for these two health plans as well. Reasons Survey data posted on the Web site show reasons for leaving in two main reasons groupings: members who left because of health care or services and members who left because of costs and benefits. Each of these two main groupings can be drilled down to the five consumer subgroupings: three

subgroupings for health care or services and two subgroupings for costs and benefits. Survey results reported to consumers were based only on the most important reason for leaving the plan.

There are two major differences between the data reported directly to plans in their annual report and the data reported to the public. First, the consumer reports are based only on the most important reason for leaving the plan, while the results included in the health plan reports are based on the most important reason *and* preprinted reasons (also referred to as “all reasons”) for leaving. Second, the results included in the annual health plan report are based on disenrollment weights rather than enrollment weights.

Data Calculated for Consumer Reporting—For each health plan in a state, we calculated an average adjusted disenrollment rate based on all plans in the state, as well as state averages for the two main reasons groupings and the five subgroupings. For consumer and public reporting, survey results for a plan were shown on the Medicare Web site in more than one state *if* that plan had a service area in more than one state. The average state disenrollment rate was calculated using all disenrollees and enrollees over the course of the year for those plans. The state means were calculated as weighted means, or averages, using the responses from all plans within the state. These averages represented the overall average percentage from all plans within the state. After computing the percentage for each most important reasons group by plan and state, the percentage was multiplied by the state-level adjusted disenrollment rate.

To ensure that the sum of the reasons percentages for the two categories and the more detailed five subgroupings always summed to the percentage of disenrollment rates, a two-step method was implemented. If the percentage equaled the adjusted voluntary disenrollment rates, then it was rounded to zero decimal places. If the percentage did not equal the adjusted voluntary disenrollment rates, it was displayed with three decimal places and then manually rounded to ensure that the percentages reported for each subgrouping summed to the appropriate percentage for the two major categories and, in turn, that the percentages for the two major categories summed to the overall disenrollment rate reported for each plan.

Public Report Preview—Prior to posting the results from the 2002 Reasons Survey on the Medicare Web site in the winter of 2004, we prepared and sent a “public report” preview to each Medicare health plan in December 2003. This report contained the same information that CMS posted on the Medicare Web site in February. The purpose of sending this report to health plans was to give them an opportunity to preview and comment on the information about their plan before it was posted on the Medicare Web site.

5.6 Quality Improvement Organization (QIO) Reports

In February 2004, we prepared and distributed an annual 2002 Medicare CAHPS Disenrollment Reasons Survey Quality Improvement Organization Annual Report to 32 QIOs whose states included health plans that participated in the 2002 Reasons Survey. The tables included in the 2002 QIO annual report displayed data for all health plans operating in that QIO’s state and were thus similar to the tables included in the 2002 annual report to health plans. The rules governing how the data were presented to the QIOs are summarized briefly below:

- Disenrollment rates were suppressed for health plans with a cumulative annual enrollment of less than 1,000 (this was the same rule used for the annual health plan reports).
- For the tables showing “All Reasons Cited by Disenrollees: Summary Level” and “Most Important Reasons Cited by Disenrollees: Summary Level,” we showed the data for all plans with greater than nine respondents. This differs from the health plan report, where the data were suppressed if the plan had fewer than 30 respondents.
- The data for plans with fewer than 30 respondents were not displayed for the other comparative tables in the report (this was the same rule used for the annual health plan reports).
- The Detailed Frequencies section in the QIO report contained *all plans* assigned to that state, with their frequencies and percentages computed as one group. These same plans were used to generate the State Frequency column on the table comparing the state frequencies to the national frequencies.
- The table showing the response rates by state and CMS region displayed the response rates for all plans assigned to the state. When computing the response rate by CMS region, we counted each plan only once if it was assigned to multiple states within the region.

QIO reports were only prepared for QIOs that had at least two health plans in their state who participated in the 2002 Reasons Survey. Any QIO that represented a state that had only one health plan in the 2002 Reasons Survey did *not* receive a QIO report but received instead a copy of the report or letter that was sent to that plan during the 2002 Annual Health Plan Report mailing.

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APPENDIX A

**2002 MEDICARE CAHPS DISENROLLMENT REASONS SURVEY:
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APPENDIX B

**2002 MEDICARE CAHPS DISENROLLMENT REASONS SURVEY
QUESTIONNAIRE**

2003 Medicare



Satisfaction Survey^{-DR}



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 about the reasons why you left [HEALTH PLAN NAME].

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].

Just as it is important for us to learn why you left [HEALTH PLAN NAME], it is also important for us to know what reasons did not affect your decision to leave that plan.

Therefore, please mark an answer for every question below unless the instruction beside the answer that you mark tells you to stop and return the questionnaire, or to skip one or more questions.

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

- Yes **STOP.** Do not answer the rest of these questions. Please put your questionnaire in the postage-paid envelope and mail it back to us. Thank you.
- 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 plan through a former employer.

DOCTORS AND OTHER HEALTH CARE PROVIDERS

A doctor or other health care provider can be a general doctor, a specialist doctor, a physician assistant, or a nurse.

6. Did you leave [HEALTH PLAN NAME] because the plan did not include the doctors or other health care providers you wanted to see?

Yes

No

7. Did you leave [HEALTH PLAN NAME] because the doctor you wanted to see retired or left the plan?

Yes

No

8. Did you leave [HEALTH PLAN NAME] because the plan doctor or other health care provider you wanted to see was not accepting new patients?

Yes

No

9. Did you leave [HEALTH PLAN NAME] because you could not see the plan doctor or other health care provider you wanted to see on every visit?

Yes

No

10. Did you leave [HEALTH PLAN NAME] because the plan doctors or other health care providers did not explain things in a way you could understand?

Yes

No

11. Did you leave [HEALTH PLAN NAME] because you had problems with the plan doctors or other health care providers?

Yes

No

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

Did you leave [HEALTH PLAN NAME] because you had problems or delays getting the plan to approve referrals to specialists?

Yes

No

ACCESS TO CARE

13. Did you leave [HEALTH PLAN NAME] because you had problems getting the care you needed when you needed it?

Yes

No

14. Did you leave [HEALTH PLAN NAME] because the plan refused to pay for emergency or other urgent care?

Yes

No

15. Did you leave [HEALTH PLAN NAME] because you could not get admitted to a hospital when you needed to?

Yes

No

16. Did you leave [HEALTH PLAN NAME] because you had to leave the hospital before you or your doctor thought you should?

Yes

No

17. Did you leave [HEALTH PLAN NAME] because you could not get special medical equipment when you needed it?

Yes

No

18. Did you leave [HEALTH PLAN NAME] because you could not get home health care when you needed it?

Yes

No

19. Did you leave [HEALTH PLAN NAME] because you had no transportation or it was too far to the clinic or doctor's office where you had to go for regular or routine health care?

Yes

No

20. Did you leave [HEALTH PLAN NAME] because you could not get an appointment for health care as soon as you wanted?

Yes

No

21. Did you leave [HEALTH PLAN NAME] because you had to wait too long past your appointment time to see the health care provider you went to see?

Yes

No

22. Did you leave [HEALTH PLAN NAME] because you wanted to be sure you could get the health care you need while you are out of town or traveling away from home?

Yes

No

INFORMATION ABOUT THE PLAN

23. Did you leave [HEALTH PLAN NAME] because you thought you were given incorrect or incomplete information at the time you joined the plan?

Yes

No

24. Did you leave [HEALTH PLAN NAME] because after you joined the plan, it wasn't what you expected?

Yes

No

25. Did you leave [HEALTH PLAN NAME] because information from the plan about things like benefits, services, doctors, and rules was hard to get or not very helpful?

Yes

No

PHARMACY BENEFIT

26. Did you leave [HEALTH PLAN NAME] because the maximum dollar amount the plan allowed each year (or quarter) for your prescription medicine was not enough to meet your needs?

Yes

No

The plan that I left did not cover my prescription medicines.

27. Did you leave [HEALTH PLAN NAME] because the plan required you to get a generic medicine when you wanted a brand name medicine?

Yes

No

The plan that I left did not cover my prescription medicines.

28. Did you leave [HEALTH PLAN NAME] because the plan would not pay for a medication that your doctor had prescribed?

- Yes
- No
- The plan that I left did not cover my prescription medicines.

COST AND BENEFITS

29. Did you leave [HEALTH PLAN NAME] because another plan would cost you less?

- Yes
- No

30. Did you leave [HEALTH PLAN NAME] because the plan would not pay for some of the care you needed?

- Yes
- No

31. Did you leave [HEALTH PLAN NAME] because another plan offered better benefits or coverage for some types of care or services?

- Yes
- No

32. 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.

Did you leave the plan because [HEALTH PLAN NAME] started charging you a monthly premium, or increased the monthly premium that you pay?

- Yes
- No
- The plan I left did not start charging a premium, nor did it increase my premium.

33. Some people have to 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

The next two questions ask about co-pays or co-payments, which are the amounts that you pay for certain medical services such as office visits to your doctor, prescription medicines, and other services.

34. Did you leave because [HEALTH PLAN NAME] increased the co-payment that you paid for office visits to your doctor and for other services?

When answering this question, do not include co-payments that you may have paid for prescription medicines.

Yes

No

The plan I left did not increase my co-payment for office visits.

35. Did you leave because [HEALTH PLAN NAME] increased the co-payment that you paid for prescription medicines?

Yes

No

The plan I left did not increase my co-payment for prescription medicines.

OTHER REASONS

36. Did you leave [HEALTH PLAN NAME] because the plan's customer service staff were not helpful or you were dissatisfied with the way they handled your questions or complaints?

Yes

No

37. Did you leave [HEALTH PLAN NAME] because your doctor or other health care provider or someone from the plan told you that you could get better care elsewhere?

Yes

No

38. Did you leave [HEALTH PLAN NAME] because you or your spouse, another family member, or a friend had a bad experience with that plan?

Yes

No

39. Besides the reasons already asked about in Questions 2-38, are there any other reasons you left [HEALTH PLAN NAME]?

Yes

No **If no, go to Question 41 below**

40. On the lines below, please describe your other reasons for leaving [HEALTH PLAN NAME]. *(Please print.)*

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

YOUR EXPERIENCE WITH [HEALTH PLAN NAME]

The next set of questions is about your experience with [HEALTH PLAN NAME].

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

Yes

No

43. For about how many months were you a member of [HEALTH PLAN NAME] before you left?

1 month or less

2 months

3 months

4 months

5 months

6 months or more

Some of the following questions ask about the last 6 months you were in [HEALTH PLAN NAME]. If you were in this plan for less than 6 months, answer the questions thinking about the number of months that you were a member of that plan.

44. 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

1

2

3

4

5 to 9

10 or more

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.

45. Did you get a new personal doctor or nurse when you were a member of [HEALTH PLAN NAME]?

Yes

No

46. Think about all the health care you got from all doctors and other health providers in the 6 months before you left [HEALTH PLAN NAME].

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 your health care?

0 Worst health care possible

1

2

3

4

5

6

7

8

9

10 Best health care possible

47. Think about 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.

48. 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

49. 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 the next page**

50. 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 51 through 55, please think about the time when you were a member of [HEALTH PLAN NAME].

51. 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

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

- Yes
- No

53. 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

54. 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

55. 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.

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

- Excellent
- Very good
- Good
- Fair
- Poor

57. 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

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

59. 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

60. 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.

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

- Yes
- No

62. During the past 4 weeks, were you limited in the kind of work or other 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.

63. 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

64. 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

65. 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.

66. 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

67. 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

68. 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

69. 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

70. What is your age now?

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

71. Are you male or female?

- Male
- Female

72. 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

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

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

74. 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

75. Did someone help you complete this questionnaire?

Yes **If yes, go to Question 76 below**

No **If no, go to Question 77 in the next column**

76. 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 in some other way
(Please print.)

77. 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 mail your completed questionnaire in the postage-paid envelope.

APPENDIX C

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

Summary of Project Hotline Experience 2002 Medicare CAHPS Disenrollment Reasons Survey

The project's toll-free telephone hotline provides an important means of collecting information about sample members. The hotline telephone number was included on all of the mailings that sample members received. Sample members were encouraged to call if they had any questions about the survey or wanted to find out how to complete the survey by telephone. *Table C-1* shows the number of calls received to the hotline for each quarter of the 2000, 2001, and 2002 Reasons Surveys.

Table C-1
Calls to the project hotline by quarter

Quarter	Number of callers		
	2002 Reasons Survey	2001 Reasons Survey	2000 Reasons Survey
Quarter 1	861	1,586	1,900
Quarter 2	717	1,200	1,500
Quarter 3	922	1,422	1,360
Quarter 4	1,530	2,889	2,560
Total calls	4,030	7,097	7,320
Total sample size	53,241	64,430	87,465
Percentage using hotline	7.6%	11.0%	8.4%

In the first quarter of the 2002 Reasons Survey year, we developed and implemented a hotline component as part of the same computer-assisted telephone interview (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 4-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:

1. question about the survey, Medicare, or the health plan
2. question about the survey requiring project staff follow-up (e.g., the caller may have asked to speak to the data collection manager)

3. request for a telephone interview
4. address change or update information
5. refusal
6. sample member incapable of participating
7. sample member deceased
8. sample member institutionalized
9. reporting a reason the sample member left the plan

Table C-2 shows the reason for all hotline calls by quarter and for the entire 2002 survey year. **The largest number of calls (46.0 percent) came from those respondents wanting to give a reason for leaving their Medicare plan.** This number includes sample members who were calling to explain that they moved out of the plan's service area, those who 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 the plan stopped serving Medicare beneficiaries in their area, they were signed up for the plan without their knowledge, or they were accidentally disenrolled due to a paperwork or clerical error were asked if this was their only reason for leaving. If additional reasons were identified, hotline staff were trained to set up an interview with the sample member. Many sample members gave reasons for leaving that did not make them ineligible (for example, their doctor left the plan). Hotline staff were trained to encourage the sample member to complete the interview, either by mail or by phone.

Approximately 22 percent of callers wanted to ask a question about the survey, Medicare, or their health plan that did not require follow-up action by project staff. Hotline telephone interviewers (TIs) were trained to direct questions about Medicare and health plans 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 composed the third largest group of hotline callers (13.2 percent). Hotline TIs were also trained to set up appointments for these cases to be called at the sample member's convenience.

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.

**Table C-2
2002 Reasons Survey hotline usage**

Call-in hotline option	Responses by quarter									
	Qtr. 1		Qtr. 2		Qtr. 3		Qtr. 4		Total (Qtrs. 1-4)	
	n	%	n	%	n	%	n	%	n	%
Question about survey, Medicare, or health plan: <i>No Further Action Needed</i>	210	24.4	167	23.3	174	18.9	339	22.2	890	22.1
Question about survey: <i>Project Staff Follow-Up Needed</i>	14	1.6	15	2.1	29	3.1	23	1.5	81	2.0
Telephone interview request	107	12.4	110	15.3	134	14.5	179	11.7	530	13.2
Address change or update	4	0.5	3	0.4	6	0.7	5	0.3	18	0.4
Refusal by sample member	51	5.9	32	4.5	33	3.6	75	4.9	191	4.7
Sample member incapable of participating in interview	25	2.9	20	2.8	23	2.5	12	0.8	80	2.0
Deceased	45	5.2	19	2.6	28	3.0	39	2.5	131	3.3
Institutionalized	27	3.1	33	4.6	60	6.5	39	2.5	159	3.9
Reason left plan	363	42.2	310	43.2	414	44.9	765	50.0	1852	46.0
“Unresolved cases”	15	1.7	8	1.1	21	2.3	54	3.5	98	2.4
Total number of calls to hotline by quarter	861	100.0	717	100.0	922	100.0	1530	100.0	4030	100.0

APPENDIX D

TELEPHONE NUMBER SOURCE ANALYSIS

Implementation of the 2002 CAHPS Medicare Disenrollment Reasons Survey

Introduction

This report evaluates the effectiveness of the Social Security Administration (SSA) as a telephone number source during the 2002 implementation of the Medicare CAHPS Disenrollment Reasons Survey. Because CMS does not have access to telephone numbers for Medicare beneficiaries, it is necessary to conduct some preliminary tracing prior to beginning the telephone follow-up portion of the data collection. In 2002, we used a combination of three sources to obtain a current telephone number for the sample members:

1. The Medicare managed care health plans represented in the sample. We did not approach the health plans for phone numbers in Quarter 4 if the health plan was not renewing its Medicare Advantage (MA) contract with CMS.
2. A commercial telephone number matching service.
3. The Social Security Administration.

At the beginning of each quarterly data collection, we sent the entire sample to the health plans, along with a dummy sample (to protect confidentiality). The health plans returned the files with telephone numbers appended. Before we began the telephone follow-up for each quarter, we sent a file of pending cases to both the commercial telephone number matching service and SSA; the files were returned with telephone numbers appended. Cases were loaded into the computer-assisted telephone interview (CATI) with SSA numbers listed on the first roster line, followed by the telephone numbers from the health plans and/or the commercial telephone number matching service.

As part of our ongoing efforts to evaluate the effectiveness of the telephone numbers received from SSA, we examined the various case outcomes by this source and made comparisons with the two other sources that were used.

Analysis

Table D-1 shows the final disposition of cases for which SSA provided a telephone number. Approximately 9 percent of cases with telephone numbers provided by SSA resulted in a completed interview. Almost 17 percent of these telephone numbers were provided solely by SSA—that is, the health plans and/or the commercial telephone number matching service did not also provide numbers for these cases. Of cases with telephone numbers provided by SSA, 5.2 percent ended up with a final status of ineligible. The majority (57.2 percent) of cases with telephone numbers provided by SSA fell into the category of “Confirmed Sample Member: Not able to reach after repeated attempts.” For these cases, we established some type of contact with the sample member but were unable to obtain a completed interview within the time limitations of the data collection schedule (for example, the sample member asked to be called back at a

Table D-1
Effectiveness of telephone numbers received from the Social Security Administration:
2002 Medicare CAHPS Disenrollment Reasons Survey

Case Disposition	Telephone Number Found by SSA Only		Telephone Number Found by SSA and Health Plans		Telephone Number Found by SSA and Commercial Service		Same Telephone Number Found by SSA, Health Plans, and Commercial Service		Different Telephone Number Found by SSA, Health Plans, and Commercial Service		SSA Total	
	Frequency	Row Percent	Frequency	Row Percent	Frequency	Row Percent	Frequency	Row Percent	Frequency	Row Percent	Frequency	Percent of All Numbers Returned from SSA
Completes (Telephone Interviews)	563	16.9%	831	24.9%	504	15.1%	763	22.9%	673	20.2%	3,334	9.2%
Disconnected Numbers	1,045	32.4%	608	18.8%	215	6.7%	194	6.0%	1,166	36.1%	3,228	8.9%
Ineligibles (Deceased, Institutionalized, Involuntary Disenrollee)	449	23.7%	365	19.2%	160	8.4%	162	8.5%	761	40.1%	1,897	5.2%
Final Non-Interviews (Refused, Language Barrier, Physically/Mentally Incapable)	379	18.1%	414	19.8%	325	15.6%	466	22.3%	506	24.2%	2,090	5.8%
Confirmed Sample Member Not able to reach after repeated attempts	4,014	19.4%	8,198	39.6%	988	4.8%	1,933	9.3%	5,563	26.9%	20,696	57.2%
Sample Member Not Confirmed Not able to reach after repeated attempts	268	19.7%	270	19.9%	168	12.4%	283	20.9%	368	27.1%	1,357	3.7%
Finalized by Mail	1,078	30.0%	542	15.1%	520	14.5%	444	12.4%	1,006	28.0%	3,590	9.9%
Total	7,796		11,228		2,880		4,245		10,043		36,192	

later time, promised to complete the mail survey but never did, or was unavailable for the duration of the study).

Table D-2 shows the final disposition of cases with telephone numbers provided by each source, as a percentage of the total for 2002. Cases with telephone numbers provided by SSA accounted for more completed telephone interviews (79.8 percent), ineligibles (13.2 percent), and final non-interviews (41.8 percent) than cases with telephone numbers provided by the commercial telephone number matching service or the health plans.³ However, the health plans accounted for more cases finalized by mail⁴ (20.5 percent) than the other two sources. Perhaps since we ask the health plans for phone numbers for the entire sample rather than just mail survey non-respondents, they return a larger proportion of cases overall, including more that are finalized by mail.

Table D-3 shows the final disposition of cases with telephone numbers uniquely provided by SSA, the commercial telephone number matching service, and the health plans, again as a percentage of the total number for 2002. Consistent with the previous table, telephone numbers provided solely by SSA resulted in more (13.5 percent) of the total number of completed interviews, ineligibles (3.1 percent), and final non-interviews (7.6 percent) than telephone numbers provided uniquely by the other two sources. Telephone numbers provided solely by the health plans resulted in more cases finalized by mail (10.2 percent), possibly for the reason noted above.

Conclusion

An analysis of the effectiveness of telephone numbers provided by the Social Security Administration demonstrates that SSA is a very productive resource for the Medicare CAHPS Disenrollment Reasons Survey. However, in our attempts to locate and interview as many sample members as possible, we will continue to use and analyze additional sources (i.e., the health plans and the commercial telephone number matching service).

³ For some cases, telephone numbers were provided by more than one source (SSA, the commercial telephone number matching service, and/or the health plans), creating an overlap between the three groups. In addition, the three sources may have provided the same telephone number.

⁴ Some cases that were finalized by mail may have been prompted by telephone calls from our interviewing staff.

Table D-2
Comparison of the effectiveness of telephone numbers received from SSA, the commercial telephone number matching service, and health plans:
2002 Medicare CAHPS Disenrollment Reasons Survey

Case Disposition	SSA Total		Commercial Service Total		Health Plans Total		Total for 2002
	Frequency	Row Percent	Frequency	Row Percent	Frequency	Row Percent	
Completes (Telephone Interviews)	3,334	79.8%	2,426	58.0%	1,985	47.5%	4,180
Ineligibles (Deceased, Institutionalized, Involuntary Disenrollee)	1,897	13.2%	1,290	8.9%	1,279	8.9%	14,421
Final Non-Interviews (Refused, Language Barrier, Physically/Mentally Incapable)	2,090	41.8%	1,618	32.3%	1,315	26.3%	5,005
Finalized by Mail	3,590	16.6%	3,177	14.7%	4,427	20.5%	21,574

Table D-3
Comparison of the effectiveness of telephone numbers uniquely provided by SSA, the commercial telephone number matching service, and health plans:
2002 Medicare CAHPS Disenrollment Reasons Survey

Case Disposition	SSA Total		Commercial Service Total		Health Plans Total		Total for 2002
	Frequency	Row Percent	Frequency	Row Percent	Frequency	Row Percent	
Completes (Telephone Interviews)	563	13.5%	178	4.3%	241	5.8%	4,180
Ineligibles (Deceased, Institutionalized, Involuntary Disenrollee)	449	3.1%	70	0.5%	219	1.5%	14,421
Final Non-Interviews (Refused, Language Barrier, Physically/Mentally Incapable)	379	7.6%	133	2.7%	155	3.1%	5,005
Finalized by Mail	1,078	5.0%	428	2.0%	2,198	10.2%	21,574

APPENDIX E

CHANGES MADE TO THE 2002 REASONS SURVEY

Changes Made to the Reasons Survey Questionnaire

After every survey implementation, the project team reviews the questionnaire to evaluate whether changes are warranted for the subsequent annual implementation. Sometimes the changes are prompted by changes being made to similar questions on the two other major CAHPS surveys that CMS conducts. Other reasons for making a change are related to how sample members are interpreting the existing questions or, in the case of the changes made to the 2003 Reasons Survey, to accommodate a sample of disenrollees from a different type of health plan (i.e., Private Fee for Service (PFFS) plans).

There were four sets of changes made at the end of the 2002 Reasons Survey administration, as illustrated below. The first set of changes was made to the 2003 questionnaire, effective with the Quarter 1 administration. The second, third, and fourth sets of changes were all made effective with the Quarter 2 administration. The second set of changes was made as a result of cognitive testing activities conducted by the CAHPS Disenrollment project team to accommodate the inclusion of PFFS disenrollees in the sample. The third set of changes was the result of cognitive testing activities conducted jointly by the CAHPS Enrollee and CAHPS Disenrollment teams to support revisions to the series of “appeals” questions. The final set of changes was made to accommodate a new question and a change to an existing question, as the result of discussions with CMS.

Changes made effective with the Quarter 1 administration:

- Added “s” to “complaint” in Question 36: Did you leave PLAN because the plan’s customer service staff were not helpful or you were dissatisfied with the way they handled your questions or complaints?”
- Switched the order of several questions in the “About You” section, moving the question about mental health (Q56) to appear after the question about rating your health in general compared to one year ago (Q58).

Changes made to the Quarter 2 through 4 questionnaires, to accommodate the PFFS plans:

- We created two versions of the questionnaire to support the addition of the PFFS plans into our Reasons sample. Version A is the primary questionnaire, used with all non-PFFS plans. Questions 6, 7, and 12 of the Version A instrument were edited slightly to apply to the PFFS population, with the resulting questionnaire called “Version B.” The text of these questions as they appear in Version A and Version B are shown below:
 - **Version A Q6:** “Did you leave [HEALTH PLAN NAME] because the plan did not include the doctors or other health care providers you wanted to see?”
 - **Version B Q6:** “Did you leave [HEALTH PLAN NAME] because the doctors or other health care providers you wanted to see did not accept [HEALTH PLAN] insurance?”

- **Version A Q7:** “Did you leave [HEALTH PLAN NAME] because the doctor you wanted to see retired or left the plan?”
- **Version B Q7:** “Did you leave [HEALTH PLAN NAME] because the doctor you wanted to see retired?”
- **Version A Q12:** “Did you leave [HEALTH PLAN NAME] because you had problems or delays getting the plan to approve referrals to specialists?”
- **Version B Q12:** “Did you leave [HEALTH PLAN NAME] because you had problems or delays in seeing specialists?”

Changes made to the Quarter 2 through 4 questionnaires, to revise the appeals series of questions:

The Appeals and Complaints section was re-worked after a series of cognitive testing activities, conducted by both the CAHPS Disenrollment and CAHPS Enrollee teams. The questions appear in the 2003 Reasons Survey as follows:

You have the right to file an appeal if a doctor or if [HEALTH PLAN NAME] made a formal decision not to provide or pay for health care services, or to stop providing health care services.

Q49. When you were a member of [HEALTH PLAN NAME], was there ever a time when you strongly believed that you needed and should have received health care or services that your doctor decided not to give you?

- Yes
- No
- Don't know

Q50. Before today, did you know that you can ask [HEALTH PLAN NAME] to reconsider your doctor's decision not to provide health care or services?

- Yes
- No

Q51. When you were a member of [HEALTH PLAN NAME], did your doctor's office provide you with any information about what to do if a doctor did not give you a service that you believed you needed?

- Yes
- No
- Don't know

Q52. When you were a member of [HEALTH PLAN NAME], was there ever a time when you strongly believed you needed care or services that [HEALTH PLAN NAME] decided not to give to you?

Yes
No → If no, go to Question 56

Q53. Did you ever speak to someone at [HEALTH PLAN NAME], either in person or over the telephone, to ask them to reconsider a decision not to provide or pay for health care or services?

Yes
No → If no, go to Question 56
Don't know → If no, go to Question 56

Q54. When you called or spoke to [HEALTH PLAN NAME] in person about your complaint, did they...

Please mark one or more.

Tell you that your complaint could be filed as an appeal
Send you forms that you need to complete to change your complaint into an appeal or offer to send you forms that you need for an appeal
Suggest how to resolve your complaint
Listen to your complaint but did not help resolve it
Discourage you from taking action about your complaint

Q55. While you were a member of [HEALTH PLAN NAME], did your doctor ever ask someone at [HEALTH PLAN NAME] to reconsider the plan's decision not to provide or pay for health care or services?

Yes
No
Don't know

Q56. Before today, did you know that you can file an official appeal in writing to your plan?

Yes
No → If no, go to Question 58

Q57. Did you ever submit an official appeal in writing to [HEALTH PLAN NAME] asking them to reconsider a decision not to provide or pay for health care or services?

Yes
No
Don't know

Q58. The Medicare program is trying to learn more about the health care or services that Medicare health plans provide to beneficiaries.

May we contact you again about the health care services provided by [HEALTH PLAN NAME]?

Yes

No

Changes made to the Quarter 2 through 4 questionnaires, to add or revise existing questions:

- A new question (Q42) was added to both Versions A and B about prescription drug card coverage. The question is as follows:

“People who have a prescription medicine drug discount card get a discount on some prescription medicines when they show the card at a participating pharmacy. A prescription drug discount card is not insurance. When you were a member of [HEALTH PLAN], did you have a prescription medicine drug discount card that allowed you to buy prescription medicines at a discount?”

Yes

No

- Two age category responses were added to Question 73: “80 to 84” and “85 or older.”

APPENDIX F

**MOST IMPORTANT AND OTHER REASONS FOR LEAVING
CODE LIST**

2002 Medicare CAHPS Disenrollment Reasons Survey: Coding of “Most Important Reason” and “Other Reason” for Disenrolling

Listing and Explanation of “Most Important Reason” (Q.41) and “Other Reason” (Q40) codes:

Considered Involuntary Reasons for Disenrolling (these cases are all coded in the control system as ineligible)

- 420 Deceased
- 430 Institutionalized (nursing home, assisted living, retirement home, long-term care facility)
- 440 Still with plan, never left it
- 450 Plan was no longer offered (available) to me (Q2)**
- 460 I moved and now live outside the area where the plan was available (Q1)**
- 465 I was enrolled without my knowledge (for example, by a friend, relative, or salesperson) (Q3)**
- 475 I was accidentally disenrolled (for example, by a paperwork or clerical error) (Q4)**

Miscellaneous Voluntary Reason

- 40 Employer stopped offering plan (Q5)**
- 51 Insecurity about future of plan or about my continued coverage

Doctors and Other Health Care Providers

- 70 The plan did not include the doctors or other health providers I wanted to see (Q6)**
- 71 Plan did not use hospital you 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 (Q7)**
- 81 Doctor you wanted to see was dropped by plan
- 90 The plan doctor or other health provider I wanted to see was not accepting new patients (Q8)**
- 100 I could not see the plan doctor or other health provider I wanted to see on every visit (Q9)**
- 110 The plan doctors or other health providers did not explain things in a way I could understand (Q10)**
- 111 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 (Q11)**
130 **I had problems or delays getting the plan to approve referrals to specialists (Q12)**
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 (Q13)**
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 (Q14)**
160 **I could not get admitted to a hospital when I needed to (Q15)**
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 (Q16)**
180 **I could not get special medical equipment when I needed it (Q17)**
190 **I could not get home health care when I needed it (Q18)**
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 (Q19)**
210 **I could not get an appointment for regular or routine health care as soon as I wanted (Q20)**
220 **I had to wait too long past my appointment time to see the health care provider I went to see (Q21)**
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 (Q22)**

Information About the Plan

- 240 **I thought I was given incorrect or incomplete information at the time I joined the plan (Q23)**
250 **After I joined the plan, it wasn't what I expected (Q24)**
260 **Information from the plan about things like benefits, services, doctors, and rules was hard to get or not very helpful (Q25)**

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 (Q26)**
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 (Q27)**
290 **The plan would not pay for a medication that my doctor had prescribed (Q28)**
291 Plan eliminated or had no prescription coverage

299 Unspecified dissatisfaction with pharmacy benefits

Cost and Benefits

- 300 Another plan would **cost me less** (Q29)
- 301 Former plan was or became too expensive/Could not afford the monthly premium (Q33)
- 310 The plan **would not pay** for some of the care I needed (Q30)
- 320 Another plan **offered better benefits or coverage** for some types of care or services (Q31)
- 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 (Q32)
- 340 The plan increased the co-payment that I paid for **office visits** to my doctor and for other services (Q34)
- 350 The plan increased the co-payment that I paid for **prescription medicines** (Q35)

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** (Q36)
- 361 Didn't like changes plan made or that 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** (Q37)
- 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** (Q38)
- 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