Implementation of the 2000 Medicare CAHPS® Disenrollment Survey

Final Report

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IMPLEMENTATION OF THE 2000 MEDICARE CAHPS® DISENROLLMENT SURVEY

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EXECUTIVE SUMMARY

This report summarizes the methodology and findings from the 2000 Medicare Consumer Assessment of Health Plans (CAHPS®) Disenrollment Reasons and Assessment Surveys, which the University of Wisconsin-Madison and RTI International conducted for the Centers for Medicare & Medicaid Services (CMS). Two separate surveys were conducted as part of this project: the Medicare CAHPS Disenrollment Reasons Survey and the Medicare CAHPS Disenrollment Assessment Survey. This report provides a general overview of the tasks that were conducted on each of these two surveys. More detailed information about many of the topics presented in this report is available in the individual project reports that are referenced throughout the report.

Throughout this report, the term “health plan” or “Medicare managed care plan” is used to refer to individual contracts that CMS holds with managed care organizations, both corporate and nonprofit. However, this terminology is different from that designated by CMS regulation, where a “plan” is defined as a benefit package, and each contract can offer any number of different plan benefit packages. For purposes of the Medicare CAHPS Disenrollment Survey, however, disenrollment represents a choice to leave a specific company and delivery structure rather than a specific benefit package.

The Medicare CAHPS Disenrollment Reasons and Assessment Surveys

The Medicare CAHPS Disenrollment Surveys were conducted with samples of Medicare beneficiaries who disenrolled from their Medicare managed care health plans in 2000. The purpose of the Medicare CAHPS Disenrollment Reasons Survey was to determine the reasons why Medicare beneficiaries choose to leave their health plans. Results from this survey were used to help explicate annual health plan disenrollment rates, which CMS is required to report to beneficiaries and to the public. The Medicare CAHPS Disenrollment Assessment Survey is conducted annually to collect data about Medicare beneficiaries’ experiences with and ratings of their health plans. Data from the Assessment Survey are combined and analyzed with data collected in the annual Medicare CAHPS Managed Care Enrollee Survey sponsored by CMS so that plan-comparative information reported to consumers and to the public reflects the experiences of both beneficiaries who stay in a plan and those who chose to leave the plan. Plan-comparative information resulting from the Reasons and Assessment Surveys is posted on CMS’ Medicare.gov Web site—it is intended to help Medicare beneficiaries make more informed decisions when choosing a health plan. Plan-comparative information from these surveys is also reported to health plans for them to use in their quality improvement efforts and to Medicare Quality Improvement Organizations (QIOs).

Section 1 of this report provides more information about the history and development of these surveys, and Section 2 describes the Technical Expert Panel that was convened to provide guidance to the entire project. Sections 3 and 4 provide information on the implementation of the surveys. An overview of each of the surveys is provided below.
The 2000 Reasons Survey—Although data were analyzed annually, the 2000 Reasons Survey was conducted quarterly to determine the reasons Medicare beneficiaries leave their Medicare managed care health plans.

Sampling and Data Collection. At the end of each quarter, a sample of Medicare beneficiaries who disenrolled during the prior 3 months was selected. Consequently, data collection for disenrollments during one quarter took place during the following quarter. The target population for the 2000 Reasons Survey consisted of Medicare beneficiaries who voluntarily left a Medicare health plan during calendar year 2000. The Reasons Survey was administered as a mail survey with telephone follow-up of nonrespondents. Data collection for the survey took place from June 2000 through July 2001.

The questionnaire used in the 2000 Reasons Survey was designed to collect information on the reasons sample members left their former Medicare managed health care plan. The questionnaire contained 78 questions, including screening questions to identify involuntary disenrollees, 33 specific reasons for leaving the health plan and an open-ended question to identify the one most important reason, ratings of the health plan and the care received while enrolled in that plan, questions about the appeals process, and questions to collect data about health status and demographic characteristics.

The project team selected random samples of beneficiaries who voluntarily disenrolled from each eligible Medicare+Choice (M+C) health plan (the reporting unit) during 2000. To be eligible for the survey, Medicare managed care health plans were required to have contracts in effect on January 1, 1999—that is, they must have been in operation for at least 1 full year prior to the beginning of the survey. A total of 87,465 Medicare beneficiaries were selected to participate in the 2000 Reasons Survey—the average sample size per quarter was approximately 21,800. For each quarterly implementation of the survey, a multiwave survey process was used that involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. Efforts to reach Spanish-speaking sample members included providing a postcard with the initial mailing for respondents to use to request a Spanish version of the questionnaire and a telephone number for an English- and Spanish-language toll-free hotline. Of the 87,465 sample members included in the 2000 Reasons Survey, 59,191 were deemed eligible for inclusion in the survey. Of that number, 37,336 eligible respondents returned a completed questionnaire for a response rate of 63.1 percent.

More detailed information on the questionnaire, sample selection, and data collection activities is provided in Section 3.1 of this report and in the report Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey (Lynch et al., 2003a).

Survey Analysis. In addition to conducting the survey, this project required that we analyze Reasons Survey data to obtain plan-comparative information for reporting to Medicare beneficiaries on the Medicare.gov Web site, as well as preparing and distributing reports to health plans that showed survey results from their former plan members. Since the Reasons Survey questionnaire contained over 30 different reasons that beneficiaries might have had for leaving a Medicare health plan, the project team condensed the survey results by grouping different types of reasons together for reporting to consumers and health plans. Therefore,
reasons for leaving reported during the survey were assigned to one of two main reasons groupings—Problems with Care or Service (reported to consumers under the heading “Members left because of Health Care or Services”) and Concerns about Costs and Benefits (reported to consumers as “Members left because of Costs and Benefits”). For consumer reporting, the two main reason groupings were further divided into five reason subgroups, and for health plan reporting, the two main groups were further subdivided into eight subgroupings. The groupings of reasons were developed based on consumer research, analysis of results from the survey, and CMS requirements.

Another analytic task was to develop recommendations regarding case-mix adjustment as a strategy for reporting the reasons beneficiaries disenrolled from plans. The report Final Report on Case Mix Adjustment on the 2000 Medicare CAHPS Disenrollment Reasons Survey was completed in October 2002 (Rudolph, Booske, and Robinson, 2002). The analysis conducted supports CMS’ current decision not to use case-mix adjustment when reporting disenrollment reasons to the public. This decision will be reevaluated over time after additional data are collected and further analyses are conducted.

The project team conducted subgroup analysis on 2000 Reasons Survey data to determine whether beneficiaries with different health status, health care utilization, health insurance, and sociodemographic characteristics chose to leave M+C plans for different reasons. By examining national level variation in reasons for leaving M+C plans by beneficiary subgroup characteristics, CMS will be better able to understand beneficiary experience with M+C plans. The subgroup analyses looked at two different ways to measure beneficiaries’ reasons for disenrollment: (1) all reasons each respondent gave for leaving (based on the preprinted list of over 30 specific possible reasons for leaving a plan) and (2) each respondent’s most important reason for leaving. The subgroup analyses used the same reasons groups that were developed and used for reporting results to health plans. We found significant differences in reasons for leaving among a number of different disenrollees subgroups. The methods and findings from the analysis of the 2000 Reasons Survey are described in a full analysis report, Medicare CAHPS® 2000 Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups, which was submitted to CMS in January 2003 (Harris-Kojetin et al., 2002).

An overview of the analytic methods and findings is provided in Section 3.2 of this report.

Reporting to Consumers and Health Plans. Reporting of 2000 Disenrollment Reasons Survey results to Medicare beneficiaries and the general public was done by posting the survey results on the Medicare.gov Web site in March 2002. The two main groups of the most important reason for leaving a plan were displayed on the Medicare Web site along with each plan’s 2000 disenrollment rate. Users of the Web site also have an option to see more detailed information on the reasons for leaving based on the five subgroups described above. That is, they can “drill down” to see the percentage of members who left the plan in each of the five subgroups. All of the reporting to Medicare beneficiaries takes place annually based on a full year of disenrollment reasons data. Results of the Reasons Survey were reported to health plans by preparing and distributing two separate reports during the course of the survey year. The first report, Medicare
CAHPS Disenrollment Reasons Survey Health Plan Interim Report, was based on survey results from the first two quarters of the 2000 Reasons Survey. This report contains information about the survey (methodology, national and plan-specific response rates for the first two quarters, etc.) and the frequency of responses to the questionnaire items. The second report, Medicare CAHPS Disenrollment Reasons Survey Annual Health Plan Report, was prepared and distributed to health plans in December 2001. It contained information about the background and history of the project and included the average disenrollment rate and the percentages of disenrollees reporting reasons for leaving in each of the two main reason groups and eight subgroups described above. Each annual report included data for the state (or region) and for each plan within the state (or region). Consumer and health plan reporting activities are described in more detail in Section 3.3 of this report and in Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey (Lynch et al., 2003a).

The 2000 Assessment Survey—CMS has conducted the Medicare CAHPS Managed Care Enrollee (hereafter referred to as the Enrollee Survey) on an annual basis since 1998. The results from each annual implementation of that survey are reported to consumers and to health plans. One criticism of the Enrollee Survey has been that survey results may possibly have a positive bias, since members who left the plan (disenrollees) were not included in that survey. The Medicare CAHPS Disenrollment Assessment Survey is being fielded annually to collect data from a sample of Medicare beneficiaries who leave their health plans to collect data on their experiences with their former plans, including their overall ratings of those plans. These data supplement the information collected from those who stay in their plan to provide a more comprehensive description of the experiences of all beneficiaries in a plan (i.e., including those who stay and those who choose to leave). The data collected in the Disenrollment Assessment Survey are combined and analyzed with the data collected from sample members who participate in the Medicare CAHPS Managed Care Enrollee Survey, and the results from the combined surveys are reported to consumers and to health plans.

Sampling and Data Collection. The target population for the 2000 Assessment Survey consisted of Medicare beneficiaries who voluntarily left their Medicare managed care health plan during May, June, or July 2000. The Assessment Survey sample consisted of 31,041 Medicare beneficiaries representing a total of 281 M+C health plans. CMS selected the sample using sampling specifications provided by RTI. The sampling strategy was designed to match the rate of selection used for selecting the Medicare CAHPS Managed Care Enrollee survey sample in order to minimize the effect of sample design on the combined survey results. To be included in the Assessment Survey sample, M+C organizations had to have been in operation as of January 1, 1999. Eligible respondents were Medicare beneficiaries who had voluntarily left their M+C organization between May and July 2000, after having been continuously enrolled in the plan for at least 6 months.

The questionnaire used in the 2000 Assessment Survey was designed to capture the health plan assessments of beneficiaries who disenrolled from a sample Medicare health plan. It contained questions about plan availability, the respondents’ personal doctor or nurse, specialist care, availability of care, care in the last 6 months, other health services, assessment of their former health plan, knowledge of the appeals process, and health status and demographic
The survey questions that asked about experience with and rating of care and the plan were core CAHPS questions and matched those included in the Medicare CAHPS Managed Care Enrollee Survey. However, the wording of questions in the Assessment Survey was changed so that sample members were asked to report on their experiences with the plan when they were members of the plan or during the last 6 months that they were in the plan.

Data collection for the 2000 Assessment Survey took place from October 2000 through February 2001. Data collection involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. Efforts to reach respondents in English and Spanish included providing a postcard with the initial mailing for respondents to use to request a Spanish version of the questionnaire and a telephone number for an English- and Spanish toll-free hotline. The outreach and the follow-up procedures used on the 2000 Assessment Survey were the same as those used on the Reasons Survey and the Medicare CAHPS Managed Care Enrollee Survey. Of the 31,041 sample members included in the Assessment Survey, 22,272 were deemed eligible for inclusion in the survey. Data collection resulted in completed interviews obtained from 12,208 eligible sample members and a response rate of 54.8 percent.

More detailed information about the 2000 Assessment Survey sampling and data collection activities is provided in Section 4.1 of this report.

Reporting to Consumers and Health Plans. The Assessment Survey project team combined the data collected in the 2000 Assessment Survey with that collected in the 2000 Medicare CAHPS Managed Care Enrollee Survey and assigned sample weights to the combined data. The combined data were analyzed together and the resulting plan-comparative information, reflecting for the first time the perspectives of both those who stayed in the plan as well as those who left the plan, was reported to Medicare beneficiaries via the Medicare.gov Web site in fall 2001. Survey results from the combined data were reported to M+C organizations via an annual health plan report in August 2001. More information about reporting results from the combined Medicare CAHPS Managed Care Enrollee and the Disenrollment Assessment Survey is provided in Section 4.2.

Subgroup Analysis. The analysis that was conducted on the 2000 Assessment Survey data consisted of examining disenrollees’ assessments of their health plans compared to those of beneficiaries still enrolled in the plan, with a focus on differences between selected subgroups. The main purpose of this descriptive analysis was to compare managed care enrollee and disenrollee CAHPS ratings and composite response distributions overall and for various subgroups. Disenrollee subgroup sample sizes at the plan level for the Assessment survey were too small to make plan-level comparisons between disenrollees and enrollees; therefore we conducted this comparison on a national level only. The results of this descriptive analysis were shared with the Disenrollment Survey technical expert panel and with CMS. A summary of the methods and findings is provided in Section 4.3.

More detailed information on the Assessment Survey is available in Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey (Lynch et al., 2003b).
SECTION 1
INTRODUCTION

1.1 Background

Several legislative actions led the Centers for Medicare & Medicaid Services (CMS) to undertake the implementation of the Medicare CAHPS Disenrollment Survey, including the Balanced Budget Act (BBA) of 1997. All Medicare and Medicaid plans that have contracts with physicians or physician groups that are at high risk of referral to specialists are required to conduct both an annual enrollment and an annual disenrollment survey and report the results to CMS. The enrollment survey requirement is satisfied for those Medicare plans that qualify for inclusion in the annual nationwide administration of the Medicare CAHPS Managed Care Enrollee Survey, which CMS has sponsored each year since 1998. The General Accounting Office (GAO) and other critics pointed out that the results of the satisfaction survey may be biased in favor of the plan, given that disenrollees, who may be among the most dissatisfied members, are excluded from the Enrollee Survey sample.

Previously, the 1997 BBA’s disenrollment survey requirement for Medicare plans had been satisfied by each individual plan conducting its own disenrollment survey. In 1997, CMS made a public pledge to Medicare plans that it would develop a Medicare health plan disenrollment survey as part of the CAHPS project sponsored by the Agency for Health Care Research and Quality (AHRQ) and then implement that survey nationwide, thereby relieving Medicare health plans that qualified for inclusion in the survey of the burden of conducting their own disenrollment surveys.

In 1998, CMS, AHRQ, and the three CAHPS grantees—Harvard University, RAND, and RTI International—began developing a survey of voluntary disenrollees as part of AHRQ’s CAHPS project to determine the reasons Medicare beneficiaries disenroll from their health plans and to assess their experiences with their former plans. The CAHPS grantees were also tasked with developing formats for reporting survey results that beneficiaries could understand and use to choose a health plan. The original scope of work for the development project was to design the sampling strategy, develop a single questionnaire to be used in the national implementation, and conduct a field test with a sample of Medicare beneficiaries who had disenrolled from one of four health plans through a mail survey with telephone follow-up of mail survey nonrespondents.

Early rounds of consumer testing of reporting disenrollment rates to Medicare beneficiaries conducted by the CAHPS grantees found that strict compliance with the mandate to present the last 2 years of disenrollment rates would not help people with Medicare choose a health plan because beneficiaries did not understand what the disenrollment rate meant. Disenrollment rates can represent dissatisfaction, but they can also reflect market competition on costs and benefits. A high disenrollment rate due to market competition does not necessarily reflect the quality of health care provided. Beneficiaries know this, and, in consumer testing of reports with disenrollment rates, beneficiaries consistently asked why people chose to leave their
Cognitive testing of initial versions of the Disenrollment Survey developed by the CAHPS grantees identified a number of issues for further investigation. The most important finding from cognitive testing was that Medicare beneficiaries who disenroll from their health plan within 3 months or so after having enrolled in the plan have little time to receive services and, therefore, cannot rate those services in the same way that longer-tenured enrollees can. Initial cognitive testing also revealed that rapid disenrollees, that is, beneficiaries who are in their plan for less than 6 months before disenrolling, may have different reasons for leaving the plan than those who stay in the plan for 6 months or longer before disenrolling (referred to as “nonrapid disenrollees”).

Consequently the CAHPS grantees developed and tested two versions of the questionnaire (Nonrapid and Rapid) in the Spring/Summer of 1999. The field test versions were designed to be as comparable as possible to the Medicare CAHPS Managed Care Enrollee Survey questionnaire. Where necessary, questions were modified slightly to be appropriate for the disenrollee population. The questionnaires also contained questions about the reasons beneficiaries chose to leave their managed care plans. These reasons related to six content areas: doctors and other health professionals, access to care, pharmacy benefit, costs and benefits, plan availability, and information and customer service.

In March-June 1999, RTI field-tested the disenrollee questionnaires developed by the CAHPS grantees in a separate mail and telephone survey of beneficiaries in two geographic areas—Los Angeles, California, and Miami, Florida. The purpose of the field test was to determine whether the survey instruments were workable and to explore how best to collect data from the disenrollee population, with an eye toward national implementation of the survey. Results of the field test showed that it was very burdensome for respondents when they were asked to explain the reasons why they had left a plan as well as provide feedback on their experiences with that plan. Furthermore, since CAHPS questionnaires are traditionally administered annually, it was also difficult for respondents to recall the reasons why they had left an M+C organization, since they may have left a plan over a year prior to survey administration. In addition, some respondents’ abilities to recall their experience with and reasons for leaving the sample plan were affected by the fact that they had had multiple disenrollments since leaving the sample plan.

As a result of field test findings, the CAHPS grantees recommended that CMS conduct two separate surveys; an annual Assessment Survey with a sample of Medicare beneficiaries to gather data about their experience with and rating of the plan, and a Reasons Survey to collect data about the reasons Medicare beneficiaries choose to leave their managed care plan. The CAHPS grantees recommended that the Reasons Survey be conducted quarterly. CMS adopted the CAHPS grantees’ recommendation to separate the Assessment portion of the Disenrollment Survey—the portion that emulates the Medicare CAHPS Managed Care Enrollee Survey administered to plan enrollees—from the Reasons portion, thus creating two separate surveys.
1.2 The National Implementation of the Medicare CAHPS Surveys

CMS administered both the Disenrollment Reasons Survey and Disenrollment Assessment Survey for the first time in 2000. Results from the 2000 administration of the Assessment version of the survey were incorporated with the Medicare CAHPS Managed Care Enrollee Survey and reported to Medicare beneficiaries, the public, and to health plans in August 2001. CMS administers the Disenrollment Reasons Survey quarterly, since an annual administration of the questionnaire was particularly difficult for some field test respondents who had to recall the reasons they had left a plan over a year prior to survey administration.

The 2000 Medicare CAHPS Disenrollment Reasons and Assessment Surveys were conducted for CMS by the University of Wisconsin-Madison and RTI International. In addition to collecting and processing the data for these two surveys, the project team was responsible for analyzing the data to produce plan-comparative information for each survey, as well as preparing and distributing a report to each health plan, and for conducting subgroup analysis on data from each survey. The team also established and maintains a 12-member technical expert panel that is responsible for advising the project team on survey methods, analysis, and reporting results to Medicare beneficiaries, health plans, and CMS.

This report provides a broad overview of most of the major tasks undertaken on this project during the implementation of the 2000 Reasons and Assessment Surveys, and summarizes some of the findings. More detailed information about these surveys and analysis results is provided in the following individual reports prepared and submitted to CMS:

- All major activities conducted on the 2000 Reasons Survey, including sample selection and weighting, data collection, data processing and file construction, development of Reasons Survey Groupings, and Reasons Survey consumer survey and health plan reporting activities are described in *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey* (Lynch et al., 2003a).

- Results from the subgroup analysis conducted on 2000 Reasons Survey data are described in *Medicare CAHPS 2000 Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups* (Harris-Kojetin et al., 2002).

- Results of analyses conducted to determine if Reasons Survey data should be case-mix-adjusted for reporting purposes are included in *Final Report on Case Mix Adjustment on the 2000 Medicare CAHPS Disenrollment Reasons Survey* (Rudolph, Booske, and Robinson, 2002).

- All major activities conducted on the 2000 Assessment Survey, including sample selection and weighting, data collection, data processing and file construction, and consumer survey and health plan reporting activities are described in *Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey* (Lynch et al., 2003b).
• Results of research conducted to present survey results to health plans are described in *Feedback from Plans on 2000 Annual Disenrollment Reasons Report* (Booske and Frees, 2002).
SECTION 2
TECHNICAL EXPERT PANEL

2.1 Overview and Purpose of the Technical Expert Panel

During the winter of 2000, the Medicare CAHPS Disenrollment Survey project team established a 12-member technical expert panel (TEP) to advise CMS and the project team on a number of issues concerning the survey, including but not limited to 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. It was originally intended that the project team meet with TEP up to four times each survey year. The number and types of meetings with the TEP were changed to reflect the revised survey design (conducting two different surveys—an Assessment and Reasons Survey) and the data collection periodicity of each of those surveys. The revised survey design and data collection periodicity reduced the frequency of TEP meetings.

2.2 Composition

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

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

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

One of the first tasks undertaken by project staff was to identify and prepared a list of up to four non-CMS experts in each of the five categories specified by CMS and to submit that list to CMS for consideration. The list provided to CMS included information about each candidate’s area of expertise and highlighted any information regarding work on Medicare managed care enrollment and disenrollment that would be especially relevant to this project. CMS reviewed the initial list of candidates and added two additional names for consideration. The project team then discussed the candidates with the CMS Project Officer and culled the list down to about two
candidates in each of the five categories, with one candidate prioritized as the first choice and the other as the second choice.

We recruited candidates for the TEP in February 2000 by sending a letter to each candidate, followed by a telephone call from a project staff member. The letter provided information about the background and need for the survey, the role of TEP members, and meeting attendance requirements. We followed up with the candidates by telephone approximately 1 week after the letters were mailed to answer any questions that the candidates might have about the project and/or their roles as TEP members, and to determine their willingness to serve as panel members. Recruiting efforts resulted in establishment of a panel that consisted of two consumer advocates, two industry experts on managed care; two academic researchers with expertise in plan enrollment and disenrollment; one expert in survey methods and small area estimation (from the Statistical TEP that CMS convened in July 1999), and one expert on reporting survey results to consumers. The names of the TEP members included on the panel for the 2000 Disenrollment Surveys and their organizations are included in Appendix A.

2.3 TEP Meetings

We conducted four meetings with TEP members from the inception of this project through early 2002 to obtain their guidance and input on survey methods, plans for reporting, and subgroup analysis. Prior to each meeting, we prepared a “TEP Review Package,” which contained an update of activities conducted on the project since the last meeting and changes to methods, questionnaires, and plans for analysis based on decisions made by CMS and/or the project team. The TEP Review Package materials were sent to CMS for review and comment at least 3 weeks prior to each TEP meeting or telephone conference call with TEP members. The TEP review package materials prepared for each meeting were sent to the TEP members at least 1 week prior to the date of each meeting and/or telephone conference.

The first meeting with TEP members was held on April 10, 2000, at CMS’ headquarters in Baltimore, Maryland. The purpose of that meeting, which took place a few months before data collection began on either of the two surveys, was to provide information about the design of the two surveys, the proposed sampling strategy and survey methods, plans for reporting results to consumers and to the public, and to obtain TEP member guidance and advice on the proposed surveys. A second meeting with TEP members was held on January 11, 2001. The purpose of that meeting was to update TEP on data collection results to date on the two surveys and to describe plans for analysis and reporting results to Medicare beneficiaries.

We conducted a 2½-hour telephone conference with TEP members in June 2001 to describe the results from the 2000 Assessment Survey and to discuss plans for the 2001 Assessment Survey. In August 2001, we conducted what was referred to as a “virtual meeting,” that is, we prepared and mailed informational materials to TEP members for review, and asked them to provide input through either a telephone call or electronic mail messages to project staff. Preliminary results from subgroup analysis of the 2000 Reasons Survey data were presented to TEP members in an in-person TEP meeting that was held at CMS in Baltimore, Maryland, on February 2002. At that meeting, TEP members commented on the analysis conducted to date and provided suggestions for additional analyses of the 2000 Reasons Survey data. After each of
these meetings, we prepared and distributed a summary of deliberations and distributed it to TEP members and to CMS within 2 to 3 weeks after the meeting took place.
SECTION 3
THE 2000 MEDICARE CAHPS DISENROLLMENT REASONS SURVEY

3.1 Overview of Sample Design and Data Collection

Although data were analyzed on an annual basis, the 2000 Reasons Survey was conducted quarterly to determine the reasons Medicare beneficiaries leave their Medicare managed care health plans. A sample of Medicare beneficiaries who disenrolled from an M+C plan during one quarter was selected at the end of the quarter, with data collection for that quarter taking place during the next quarter. The target population for the 2000 Reasons Survey consisted of Medicare beneficiaries who voluntarily left a Medicare health plan during calendar year 2000. The Reasons Survey was administered as a mail survey with telephone follow-up for nonrespondents. Data collection for the survey took place from June 2000 through July 2001.

Implementation of the 2000 Reasons Survey involved the following major tasks.

- Sample selection and data collection.
- Development of reasons groups for reporting results to consumers and to the public.
- Analysis of data to determine if results should be case-mix-adjusted.
- Analysis of subgroups.
- Analysis to produce survey results reported to consumers.
- Analysis of survey results for preparing and distributing plan-specific reports to health plans.
- Research to elicit feedback on the presentation of survey results to health plans.

These major activities are described in the following sections.

Sample Design—The sampling frame for the 2000 Reasons Survey consisted of all Medicare beneficiaries who voluntarily disenrolled from one of 273 M+C organizations and continuing cost contracts. To be eligible for the survey, M+C health plans were required to have contracts in effect on January 1, 1999—that is, they must have been in operation for at least 1 full year prior to the beginning of the survey. The overall sampling goal for the survey was to select up to 388 sample members per plan across all four quarters. However, sampling was not uniform across the quarters, as it was based on the overall distribution of disenrollment during 1999. In 1999, disenrollment rates followed a pattern of 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 2000 Reasons Survey, if there were not a sufficient number of cases to select in any given quarter, we attempted to make up those cases in subsequent quarters. For
some plans, in some quarters, we therefore took a census of disenrollees. However, where sufficient numbers of disenrollees were present, a simple random sample was drawn from the plan. Assuming an approximate 63 percent response rate (respondents per M+C health plan), the sample was designed to be, on average, accurate within 7 percentage points (at a 95 percent confidence interval).

Since the sampling window for the 2000 Assessment Survey overlapped with Quarters 2 and 3 of the Reasons Survey, we developed two rules to help manage the selection of sample members from plans that did not have a sufficient number of disenrollees to select for both surveys:

- We reduced the desired sample size for the Assessment Survey by as much as one-half in plans with a projected small number of disenrollments for the year, meaning that priority was given to the selection of sample members for the Reasons Survey.

- We gave sample members in April a higher probability of selection into the Quarter 2 sample since there was no overlap between the Reasons Survey sample and the Assessment Survey sample during that month.

Deceased sample members were removed from the sampling frame before the sample was selected. In addition, sample members who moved out of their sample plan’s service area were also removed from the frame.

A total of 91,988 Medicare beneficiaries were originally selected for the 2000 Reasons Survey. Of those, 4,523 beneficiaries were later removed from the sample due to plan closures, mergers, or exemptions from the survey. Therefore the final sample consisted of 87,465 Medicare beneficiaries. Exhibit 3-1 shows the sampling window for each quarter, the number of beneficiaries selected each quarter, and the data collection period for each quarter.

### Exhibit 3-1
**Sampling Window, Sample Size, and Data Collection Period**

<table>
<thead>
<tr>
<th>Reasons Quarter</th>
<th>Sampling Window</th>
<th>Sample Size</th>
<th>Data Collection Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>January - March 2000</td>
<td>19,958</td>
<td>June - October 2000</td>
</tr>
<tr>
<td>2</td>
<td>April - June 2000</td>
<td>18,829</td>
<td>August - December 2000</td>
</tr>
<tr>
<td><strong>Total Selected</strong></td>
<td></td>
<td><strong>87,465</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Reasons Survey Instrument**—The 2000 Reasons Survey instrument contains 78 questions, including the following:

- 7 screening questions to verify that the respondents were truly voluntary disenrollees
- 35 questions about reasons for leaving the health plan, including 33 preprinted reasons, 1 question that asked if there were any other reasons for leaving the sample health plan, and 1 question asking for the *most important reason* for leaving the plan
- 2 questions asking the respondent to rate the sample health plan and the care received from that plan, plus a few other questions about the experience with the plan
- 8 questions about the appeals process (note that these were added starting at Quarter 2)
- 23 questions about health status and demographic characteristics.

It should be noted that the questionnaire used in Quarters 2, 3 and 4 of the 2000 Reasons Survey was slightly different from the questionnaire used in Quarter 1. One major difference between the questionnaires used is that nine new questions were added to the questionnaire used in Quarters 2-4. One of the new questions asked about leaving the health plan because of not being able to pay the monthly premium; the remaining eight questions were about the appeals and grievance process. The appeals and grievance questions were added as a result of the settlement in Grijalva v. Shalala. A copy of the questionnaire used in Quarters 2-4 is included in Appendix B.

The screening questions included in the questionnaire were designed to identify sample members who are considered “involuntary” disenrollees (i.e., they left the sample health plan because they moved out of the plan’s service area; the plan withdrew or reduced its service area; or the employer stopped offering the plan). We excluded these sample members from the survey sample as well as those who reported that they never disenrolled from the sample plan, were not enrolled in Medicare, and those who were deceased or institutionalized.

The telephone survey instrument that was used in the telephone follow-up with nonrespondents from the mail survey was designed to mirror the mail survey instrument as closely as possible. Both the mail and telephone survey instruments were customized so that they were plan-specific for each respondent. 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.

**Data Collection Methods and Results**—We conducted data collection and data processing activities for Quarters 1–4 of the 2000 Reasons Survey from June 30, 2000, to July 3, 2001. For each quarterly implementation of the survey, we used a multiwave data collection process that involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. These included mailing a prenotification letter, a
questionnaire package, and a thank you/reminder post card. A second questionnaire package was sent to all sample members who did not respond to the first questionnaire mailing (usually within 3 weeks of that mailing). We attempted to conduct a telephone interview with all mail survey nonrespondents. We sent a third questionnaire package by overnight express to all nonrespondents for whom we could not obtain a telephone number. Data collection and data processing activities conducted for the Reasons Survey are described in detail in Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey (Lynch et al., 2003a.)

Data collection activities resulted in obtaining an overall response rate of 63.1 percent, with the response rate for individual quarters ranging from 58.4 percent to 67.5 percent. We calculated the response rate using the following formula:

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

Exhibit 3-2 shows the sample size, the number of completed interviews obtained, and the response rate for each quarter.

### Exhibit 3-2
Sample Distribution and Response Rate by Quarter

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number Selected</th>
<th>Completed Interviews</th>
<th>Response Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19,958</td>
<td>9,604</td>
<td>65.8</td>
</tr>
<tr>
<td>2</td>
<td>18,829</td>
<td>8,347</td>
<td>58.9</td>
</tr>
<tr>
<td>3</td>
<td>23,219</td>
<td>7,395</td>
<td>58.4</td>
</tr>
<tr>
<td>4</td>
<td>25,459</td>
<td>11,990</td>
<td>67.5</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>87,465</strong></td>
<td><strong>37,336</strong></td>
<td><strong>63.1</strong></td>
</tr>
</tbody>
</table>

Approximately 32 percent of the sample was ineligible to participate in the survey; that is, the sample members had died or become 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 did not disenroll from the sample plan; and they were not on Medicare. Other sample members designated as ineligible for the survey included those who marked “yes” to two or more of the questions designed to identify involuntary disenrollees. Approximately 7 percent of the sample refused to participate in the survey. We were unable to contact 5.3 percent of mail
survey nonrespondents after repeated attempts, and 0.2 percent promised to complete and return the mail questionnaire when they were contacted by telephone but did not. Another 1.4 percent were physically or mentally incapable of participating in the interview, and 0.3 percent did not speak English or Spanish (language barriers). We were unable to obtain a telephone number for 10.7 percent of the mail survey nonrespondents.

**Nonresponse Analysis and Sample Weighting**—We conducted nonresponse analysis on the 2000 Reasons Survey data after the data were cleaned. We classified sample members as respondents or nonrespondents; response propensities were then modeled using logistic regression in SUDAAN®. We simultaneously added demographics, census region, address variables, dual eligibility status, and design variables to the model and removed them in a backwards-stepwise fashion. We also included two-way interactions and explored transformations of the continuous variable (age), keeping variables with p-values of .20 or less. The final logistic regression model contained the independent variables—age, race, dual eligibility, and address type (post office box, rural route, and other addresses) and the design variables (health plan and quarter).

The response propensity analysis showed that those who were older and nonwhite were less likely to respond to the survey. Beneficiaries who were *not* dually eligible were more likely to respond than those who were dually eligible. Beneficiary addresses that contained a post office box or rural route were also less likely to respond to the survey. Response rates by demographic characteristics and other information resulting from the nonresponse analysis are shown in Exhibit 3-3.

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) or Iannacchione, Milne, and Folsom (1991).

For the purposes of nonresponse adjustments, persons who provided information on eligibility status were treated as respondents. Subsequently, those who were ineligible (deceased, institutionalized, involuntary disenrollees, etc.) were given a weight of zero. Since we do not know the eligibility status of nonrespondents, this approach allows the sample to estimate the proportion ineligible among the nonrespondents based on the respondent sample.

We constructed two sets of weights for the 2000 Reasons Survey. The first set of weights represents all eligible enrollees in each plan and was developed as discussed above. (These weights are referred to as Disenrollment weights.) The second set of weights 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) are based on all members in a plan rather than just disenrollees and were used for weighting results for public reporting.
### Exhibit 3-3
**Reasons Survey Response Rates by Demographic Characteristics**

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Total Sample</th>
<th>Respondent Sample</th>
<th>Response Rates Among Eligibles&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n) (%)</td>
<td>(n) (%)</td>
<td>(%)</td>
</tr>
<tr>
<td>Overall USA</td>
<td>87,465 100.0</td>
<td>37,336 100.0</td>
<td>63.1</td>
</tr>
<tr>
<td>Gender (EDB)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>36,662 41.9</td>
<td>15,943 42.7</td>
<td>64.3</td>
</tr>
<tr>
<td>Female</td>
<td>50,803 58.1</td>
<td>21,393 57.3</td>
<td>62.1</td>
</tr>
<tr>
<td>Age Group (EDB)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 65</td>
<td>9,116 10.4</td>
<td>4,025 10.8</td>
<td>59.0</td>
</tr>
<tr>
<td>65-69</td>
<td>23,167 26.5</td>
<td>10,752 28.8</td>
<td>67.6</td>
</tr>
<tr>
<td>70-74</td>
<td>20,881 23.9</td>
<td>9,469 25.4</td>
<td>67.0</td>
</tr>
<tr>
<td>75-79</td>
<td>16,281 18.6</td>
<td>6,899 18.5</td>
<td>63.3</td>
</tr>
<tr>
<td>≥ 80</td>
<td>18,020 20.6</td>
<td>6,191 16.6</td>
<td>54.1</td>
</tr>
<tr>
<td>Race (EDB)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>72,204 82.6</td>
<td>31,076 83.2</td>
<td>65.3</td>
</tr>
<tr>
<td>Black</td>
<td>9,955 11.4</td>
<td>4,325 11.6</td>
<td>56.8</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>5,306 6.0</td>
<td>1,935 5.2</td>
<td>48.6</td>
</tr>
<tr>
<td>Dual Eligible (EDB)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12,205 14.0</td>
<td>4,470 12.0</td>
<td>50.5</td>
</tr>
<tr>
<td>No</td>
<td>75,260 86.0</td>
<td>32,866 88.0</td>
<td>65.3</td>
</tr>
<tr>
<td>CMS Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Boston Regional Office</td>
<td>5,325 6.1</td>
<td>2,316 6.2</td>
<td>66.0</td>
</tr>
<tr>
<td>II. New York Regional Office</td>
<td>8,334 9.5</td>
<td>3,881 10.4</td>
<td>62.0</td>
</tr>
<tr>
<td>III. Philadelphia Regional Office</td>
<td>7,520 8.6</td>
<td>3,221 8.6</td>
<td>64.4</td>
</tr>
<tr>
<td>IV. Atlanta Regional Office</td>
<td>18,019 20.6</td>
<td>7,924 21.2</td>
<td>63.1</td>
</tr>
<tr>
<td>V. Chicago Regional Office</td>
<td>13,639 15.6</td>
<td>5,895 15.8</td>
<td>64.1</td>
</tr>
<tr>
<td>VI. Dallas Regional Office</td>
<td>10,499 12.0</td>
<td>3,936 10.5</td>
<td>59.2</td>
</tr>
<tr>
<td>VII. Kansas City Regional Office</td>
<td>3,038 3.5</td>
<td>1,423 3.8</td>
<td>67.4</td>
</tr>
<tr>
<td>VIII. Denver Regional Office</td>
<td>2,004 2.3</td>
<td>811 2.2</td>
<td>65.9</td>
</tr>
<tr>
<td>IX. San Francisco Regional Office</td>
<td>12,885 14.7</td>
<td>5,451 14.6</td>
<td>61.4</td>
</tr>
<tr>
<td>X. Seattle Regional Office</td>
<td>6,158 7.0</td>
<td>2,476 6.6</td>
<td>65.4</td>
</tr>
<tr>
<td>Other</td>
<td>44 &lt;1</td>
<td>2 &lt;1</td>
<td>6.1</td>
</tr>
</tbody>
</table>

<sup>1</sup> 28,274 sample members were ineligible.
3.2 Reasons Survey Analysis

Analysis activities on the 2000 Reasons Survey consisted of analysis of data for plan-comparative information that are provided to Medicare beneficiaries, health plans, and to the public; case-mix-adjustment analysis; and subgroup analysis. Summaries of these activities are provided in the following sections. Further details are available in Medicare CAHPS 2000 Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups (Harris-Kojetin et al., 2002).

Grouping of Reasons—The main purpose of the CAHPS Disenrollment Reasons survey was to determine the reasons why beneficiaries choose to leave their Medicare managed care plan. In order to gather this information, the survey asked beneficiaries to indicate all of their reasons for leaving the sampled plan. Beneficiaries were asked to indicate whether or not each of 33 preprinted reasons (referred to from now on as “all reasons”) was a reason they chose to leave their plan. Respondents could cite multiple reasons for leaving. They were then asked to indicate if there were any other reasons that they had for leaving their plan. If so, they were prompted to write in the reason(s) using an open-ended format. Then beneficiaries were asked to write in an answer to the following question: “What was the one most important reason you left sample plan?” The responses to the two open-ended questions were coded using a coding scheme that is similar to the preprinted list of “all reasons.” Details about the coding process and the codes that were used to code other reasons for leaving and the most important reason for leaving the plan are provided in Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey (Lynch et al., 2003a).

Analyzing and reporting data on each of the 33 individual reasons for all M+C organizations in a state or region would likely create an overload of information and be difficult to interpret since very few beneficiaries cited some reasons. Consequently, CMS decided to use groupings of reasons for comparative data displays in reports prepared for consumers and health plans and for other analysis of reasons. The remainder of this section describes the background and methods used to identify appropriate groupings of reasons.

As noted previously, one of the primary purposes of conducting the Reasons survey was to report reasons to consumers, via the Medicare Web site and other media, to supplement information on the rates at which people disenroll from plans. The disenrollment Web pages on Medicare.gov include information about two major categories of “most important reasons” cited by people who leave Medicare plans. These two main categories were tested by the CAHPS Grantees during the development of draft templates for inclusion of disenrollment rates and reasons in the Medicare & You handbook and were labeled as

- Members left because of care or services.
- Members left because of concerns about costs and benefits.

CMS reports each plan’s disenrollment rate as a total rate and then breaks it out according to these two main categories. For example, if the overall disenrollment rate for a plan
is 10 percent and 40 percent of enrollees cited problems with care or services and 60 percent cited concerns about costs, the numbers reported would be 10 percent, 4 percent, and 6 percent, respectively.

In addition, CMS wanted to allow consumers interested in more information about either of these categories to be able to “drill down” to see more detailed subgroupings. Consequently, when analyzing the full year of 2000 Reasons Survey data, we followed the consumer reporting framework; that is, we divided the reasons into two main consumer reporting categories or “reasons groupings” and then identified appropriate reasons subgroupings within these two categories. Having allocated the preprinted and most important reasons between the two main categories, we then proceeded to conduct a series of factor and variable cluster analyses to identify potential subgroupings within each category. We reviewed the results of these analyses for statistical and substantive content and selected a grouping plan that created eight reasons groupings for general analysis and reporting to plans: five reasons groupings that address problems with care or service and three groupings that address concerns about plan costs. We reviewed the items within each group and labeled the groupings as clearly and succinctly as possible. Such labeling always involves a tradeoff between being able to provide full representation of all the items while maintaining a reasonable length for the label. While these labels have not been explicitly tested with consumers, we drew upon expertise within the team from those involved in previous consumer testing of disenrollment information.

Exhibit 3-4 shows the assignment of reasons survey items and labels to the reasons groupings. Some of the groupings were subsequently combined and labels were changed slightly to fit within the consumer reporting framework on Medicare.gov.

Case-mix Adjustment—One of the analytic tasks was to develop recommendations regarding case-mix adjustment as a strategy for reporting the reasons beneficiaries disenrolled from plans. To our knowledge, case mix adjustment has not previously been applied to adjust reasons given by enrollees for voluntarily leaving managed care plans. However, other CAHPS measures reported to the public on the Medicare.gov Web site are case-mix-adjusted to facilitate comparisons between beneficiaries’ ratings and reports of care provided by M+C organizations and care provided under Original Medicare.

Case-mix adjustment is a tool that adjusts for differences in the populations served by various plans. It is used in reporting information about quality to accommodate the fact that some plans have beneficiary members that are more difficult or complex for plans to provide with care or services. Overrepresentation of various beneficiary characteristics, such as advanced age or perceived poor health status, may have a negative impact on a plan when compared to other plans. Thus, the general research question for this task was to determine whether case-mix adjustment of disenrollee reasons would provide information that would fairly treat all plans, thus providing better support for decision-making by beneficiaries and potentially helping plans target plan quality improvement or plan design actions.

Because each most important reason could only be assigned to one of two main groupings, the dependent variable was the probability that a beneficiary would cite a reason within the Problems with Care or Services grouping. Prior CAHPS and disenrollment research
### Exhibit 3-4
Assignment of Reasons for Leaving a Plan to Groupings of Reasons

<table>
<thead>
<tr>
<th>Reasons Grouping</th>
<th>Reasons for Leaving a Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems with Care or Service</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 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 |
helped us determine the independent variables or potential case-mix variables. The variables we included in our analysis were Age group, Perceived health status, Race, Education, Gender, Proxy\(^1\), and Ansproxy\(^2\); we also included CMS Region and cross-product terms between all other individual level variables and CMS Region. The cross-product terms (in this case) help us account for differences that occur in the reporting of the most important reasons given the plan’s geographic location. For example, if a particular region has a population that is more predominantly Asian than the population in the other regions, the coefficient from the cross-product would account for those differences.

The analysis file consisted of completed unweighted responses to the 2000 Medicare CAHPS Disenrollment Reasons Survey. Because we were interested in modeling the probability that a beneficiary would cite a reason within the Problems with Care or Services grouping as a function of the independent variables (Age group, Race, Gender, Perceived health status, Proxy, Ansproxy, Region, Region interactions, and Health plan), we selected the logit function as the statistical tool for the analysis. We used a series of nested models and the likelihood ratio test to compare models and select our final model.

The final case-mix model included Age groups, Race groups, Perceived health status, Education categories, Gender, CMS region, and cross-products with CMS region. This model was a significant improvement over one that adjusted only for Age and Health status. While the model was significant and its capacity for prediction was beyond that of pure chance, it was not particularly robust. Other variables that might be explored as potential case mix factors include marital status, income, and functional status of the individual, or other plan-level variables such as plan type, managed care penetration rates, and market share. However, these variables have not been tested and, although there is some limited evidence of their influence on other plan outcomes, there is no evidence relating them directly to reasons for disenrollment.

Preliminary results of this analysis were shared with the Disenrollment Survey Technical Expert Panel. TEP members had some initial concerns about the potential for “washing away the differences” between plans with case-mix adjustment, when the goal was to present differences in plans. In addition, they expressed concern about the use of perceived health status as exogenous to the plan. They thought health status might reflect plan efforts, rather than serving as a characteristic of the individual, in the models. At least one TEP member felt that it would be more important to consider case-mix adjustment of disenrollment rates, with or without adjustment of reasons. The Disenrollment team will investigate this option as part of its case-mix analysis tasks for the coming year.

Although the results of the modeling were not very robust, there was some evidence that case-mix adjustment would lead to some changes in the relative standings of plans with respect to beneficiaries’ reasons for leaving if reasons were reported as a percentage of disenrollees. However, since reasons for disenrollment are currently reported as a percentage of enrollees (with a far larger denominator), the potential case-mix effect is significantly diminished.

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1 The Proxy variable indicates whether the respondent assisted the beneficiary in completing the survey.

2 The Ansproxy variable indicates that the respondent answered the question in place of the beneficiary.
Consequently, only a very few plans would experience a change in relative standing as a result of case-mix adjustment using the final model. This finding supports CMS’ current decision not to use case-mix adjustment when reporting disenrollment reasons to the public. This decision will be reevaluated over time after additional data are collected and further analyses are conducted.

**Subgroup Analysis**—The project team conducted subgroup analysis on 2000 Reasons Survey data to determine whether beneficiaries with different health status, health care utilization, health insurance, and sociodemographic characteristics chose to leave M+C plans for different reasons. By examining national level variation in reasons for leaving M+C plans by beneficiary subgroup characteristics, CMS will be better able to understand beneficiary experience with M+C plans.

The nationally representative data set for conducting the subgroup analysis of the 2000 Reasons Survey consisted of 30,053 Medicare beneficiary respondents who voluntarily disenrolled from approximately 273 M+C organizations during 2000. The data were weighted to account for differences in response rate by age, race, sex, census region, geographic indicators, dual eligibility, plan, and quarter variables.

In the subgroup analysis, we looked at the two different ways to measure beneficiaries’ reasons for disenrollment: (1) **all reasons** each survey respondent gave for leaving (from the preprinted list of reasons) and (2) each survey respondent’s **most important reason** for leaving (from the open-ended question). As previously noted, each specific reason was assigned to one of eight groupings. These categories or “reason groupings,” are (1) problems with information from the plan, (2) problems getting doctors you want, (3) problems getting care, (4) problems getting particular needs met, (5) other problems with care or service, (6) premiums or copayments too high, (7) copayments increased and/or another plan offered better coverage, and (8) problems getting or paying for prescription medicines. Consequently, each of the eight dichotomous outcome (reason grouping) variables for this subgroup analysis signifies whether or not a respondent cited at least one reason (or a most important reason) for leaving assigned to that grouping.

The 12 beneficiary subgroup variables fall into four main categories: health status, health insurance characteristics, other characteristics, and sociodemographic variables. The disenrollee **health status variables** include beneficiaries’ reports of their health status, health status compared to a year ago, combined health status and 1-year health status change, and number of outpatient visits. The **health insurance variables** include dual eligibility status and non-elderly disabled status (using age as a proxy). **Other disenrollee variables** include choice of coverage after disenrollment, hospitalization after disenrollment to fee-for-service (FFS), frequency of disenrollment in 2000, length of time in plan before disenrollment, and quarter in which the disenrollee left the plan. Disenrollee **sociodemographic variables** include race and ethnicity, education, and sex. We examined the bivariate relationships between each subgroup variable and outcome variable using the chi-squared statistic.

The subgroup analysis identified an array of notable findings. Detailed information about these findings is provided in the final analysis report *Medicare CAHPS 2000 Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups* (Harris-Kojetin et al.,...
2002). A few key consistent patterns that stand out from the many subgroup differences found are summarized below:

- Vulnerable Medicare populations (poorer health status, more doctor visits, dually eligible, and/or with a disability) cite more problems and are more likely than others to cite a host of access-related problems as reasons for leaving their M+C plans.

- Disenrollees who cite cost as a (contributory) driver for leaving (premiums or copayments too high) are more likely than those who cite information or access reasons to go to another managed care plan, to have a disability, to have been in the plan from which they disenrolled longer, to be a non-Hispanic person of a race other than Black or White, and to disenroll at either the beginning or end of the calendar year.

- Beneficiaries who leave a plan within a few months of enrolling are more likely to cite problems with plan information and with access to care, possibly suggesting a lack of understanding of how to navigate the managed care system.

*Exhibit 3-5* shows statistically significant differences of at least 10 percentage points between the subgroups listed compared to other disenrollees in citing a problem as a reason (or most important reason) for leaving. A checkmark (√) in any given cell indicates that a particular subgroup is more likely to cite reasons in that grouping. Subgroup differences occur most frequently for problems with plan information, problems getting care, problems getting particular needs met, and premiums or copayments being too high. Subgroups that were more likely to cite a most important reason in a particular grouping are indicated with a diamond (◊). The differences that appear among vulnerable subgroups in all reasons cited by voluntary disenrollees are less apparent when looking only at most important reasons for leaving a plan. Subgroup differences for most important reasons occurred primarily for problems getting particular doctors and premiums or copayments being too high.

Disenrollees with a greater number of outpatient visits and disabled disenrollees under age 65 cite the most different types of problems, followed by disenrollees whose health has worsened in the past year, disenrollees in fair to poor health, and disenrollees hospitalized within 90 days of disenrolling to FFS. A number of particularly vulnerable Medicare populations (those reporting poorer health status, those needing more care, those who are dually eligible for Medicare and Medicaid, and those who are younger and enrolled in Medicare due to disability) are more likely than others to cite a host of access-related problems as reasons for leaving their health plans. These reasons include getting plan information, getting care, getting particular needs met, and getting or paying for prescription medicines. These populations may be leaving M+C plans because they have special needs for care and/or information about how to get care that are not being met within their plans. An alternative interpretation of these findings is that these populations have more experiences trying to access care than those in better health and are thus more likely to experience problems in general. The disenrollees from these vulnerable groups experienced multiple problems and were less likely to cite any particular reason grouping as their most important reason for leaving. In contrast, less vulnerable beneficiaries, such as those who
## Exhibit 3-5
### Summary of Subgroup Differences in All Reasons Cited (√) and in Most Important Reason Cited (◊)

<table>
<thead>
<tr>
<th>Subgroups More Likely than Others to Cite Problem</th>
<th>Problems Cited as a Reason for Leaving M+C Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan Information</td>
</tr>
<tr>
<td><strong>Health status characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Fair to poor health</td>
<td>✓</td>
</tr>
<tr>
<td>Health worsened in past year</td>
<td>✓</td>
</tr>
<tr>
<td>Fair to poor health that has worsened</td>
<td>✓</td>
</tr>
<tr>
<td>Fair to poor health that is same or better</td>
<td></td>
</tr>
<tr>
<td>Excellent to good health that has worsened</td>
<td></td>
</tr>
<tr>
<td>No outpatient visit in past 6 months</td>
<td>✓</td>
</tr>
<tr>
<td>Only one outpatient visit in past 6 months</td>
<td></td>
</tr>
<tr>
<td>More outpatient visits in past 6 months</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Health insurance characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Dual eligibility</td>
<td>✓</td>
</tr>
<tr>
<td>Nondual eligibility</td>
<td></td>
</tr>
<tr>
<td>Disabled and less than age 65</td>
<td>✓</td>
</tr>
<tr>
<td>Age 80 or over</td>
<td></td>
</tr>
<tr>
<td><strong>Other disenrollee characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Disenrolled to managed care</td>
<td></td>
</tr>
<tr>
<td>Disenrolled to FFS</td>
<td>✓</td>
</tr>
<tr>
<td>Hospitalized less than 90 days after disenrolling to FFS</td>
<td>✓</td>
</tr>
<tr>
<td>In plan fewer months</td>
<td>✓◊</td>
</tr>
<tr>
<td>In plan more months</td>
<td></td>
</tr>
<tr>
<td>Disenrolled in 1st or 4th quarter</td>
<td></td>
</tr>
<tr>
<td>Disenrolled in 2nd quarter</td>
<td></td>
</tr>
<tr>
<td>Disenrolled in 3rd quarter</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Sociodemographic characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic other race</td>
<td></td>
</tr>
<tr>
<td>At least 4-year college degree</td>
<td></td>
</tr>
</tbody>
</table>
are White, more educated, or not eligible for Medicaid, are more likely to cite problems getting particular doctors as their most important reason for leaving.

Those disenrollees whose most important reason for leaving is cost-related (specifically, they leave because premiums or copayments are too high) are more likely to choose another managed care plan (possibly because they are seeking a lower cost option and cannot find it in FFS), have been in the plan awhile before leaving (and likely left the plan primarily for cost rather than quality reasons), and chose to leave either at the beginning of the calendar year or at the end (possibly after looking at the latest annual cost information on competing plans in the area).

Beneficiaries who leave M+C plans within a few months of enrolling—a subgroup more likely than those who stay longer to cite problems with plan information and with getting care as a reason for leaving—may not understand how the plan works before joining. In addition to the vulnerable subgroups already mentioned, Black and Hispanic disenrollees are more likely than others to cite problems with plan information as a reason for leaving. Those who cite problems with plan information are more likely to disenroll to FFS, perhaps due to a lack of understanding about how managed care works.

Medicare’s commitment to providing choices to all of its beneficiaries, including vulnerable subpopulations, means ensuring that these groups get appropriate information from M+C plans and access to care from M+C plans to meet their needs. The Medicare CAHPS Disenrollment Reasons Survey effort is one important tool for monitoring plan performance in these areas.

Some important insights into the makeup of all reasons and most important reasons were uncovered in an analysis of the two groupings of these reasons. These two approaches to obtaining disenrollment reasons are clearly producing somewhat different results, yet also display some commonality. While many insights came from this analysis regarding associations among reason groupings, perhaps the most important findings are which reason groups appear to be more primary or more secondary in nature from this analysis. We found the following:

- Reason groupings “Problems getting doctors you want,” and “Premiums or copayments too high” are more likely to be primary than secondary reasons for leaving a plan.

- Reason groupings “Copayments increased and/or another plan offered better coverage,” “Problems getting particular needs met,” and “Other problems with care or service” appear to be secondary reasons for disenrollment.

**Future Analysis**—The subgroup analysis undertaken provided results from the first national level survey of Medicare beneficiaries’ reasons for leaving M+C plans. The subgroup analysis from this new survey focused only on bivariate analyses of disenrollees’ reasons for leaving M+C plans during 2000. Reports from subsequent rounds of the Disenrollment Reasons
Survey will include additional analyses. Some examples of additional analyses that could be conducted to address specific issues include the following:

- Future rounds of the survey will enable us to study trends in the reasons that various subgroups give for choosing to leave M+C plans.

- We used a conservative approach in reporting bivariate results; we only reported statistically significant differences of at least 10 percentage points. By looking only at these differences, important differences of low-frequency events may be inappropriately ignored. It may be worthwhile in these instances to consider looking at smaller percentage differences.

- Where sample size permits, these subgroup analyses can be conducted at lower geographic levels, such as region, state, or market.

- Multivariate analyses would increase our understanding of outcomes for specific populations while holding other factors constant. For example, a model, perhaps hierarchical, could be developed that enables us to look at the independent impacts of beneficiary characteristics, plan, market, and region on reasons for leaving.

- Where specific subgroup differences are present for particular groupings of reasons for leaving, it may be helpful to investigate whether these differences occur for specific reasons or across all reasons within a given grouping.

- Additional subgroups could be examined, including M+C plan nonprofit versus for-profit status and M+C plan tenure.

- Persons disenrolling to FFS after a brief period of enrollment were more likely to report problems with plan information. We speculate that many of these enrollees may not have understood how managed care works. Future analyses could examine how many of these enrollees had enrolled in Medicare managed care before the period of enrollment and disenrollment under study. One would expect that most of them had no previous experience with Medicare managed care.

- The subgroup results indicate that disenrollees who have more outpatient visits and whose health is worse are among those who tend to have more problems with their plan. However, these results do not tell us what health conditions these beneficiaries have, what procedures they had done, or what costs they incurred. Linking the reasons data to claims data would enable CMS to learn whether there are any beneficiary condition, utilization, or cost patterns among disenrollees.

- Future analyses could also examine population-based rates of disenrollment for various reasons. That is, it would be interesting to combine rates of disenrollment with the percentage of disenrollees reporting various reasons for disenrollment. That
way, one could determine what percentage of the population enrolled at a point in time disenrolled over the next year because of problems getting care. This type of information would be interesting both overall and by plan.

- More research needs to be conducted to identify, understand, and address the specific problems that beneficiaries face that cause them to leave their plans. For example, further work is needed to determine whether and how language barriers play a role for Hispanic voluntary disenrollees who cite problems with plan information as a reason for leaving.

- Finally, in view of the interesting findings from analyzing relationships between all reasons and most important reason groupings, it would be of interest to pursue this type of analysis in more detail by examining individual item level (for all reasons) by individual code-level (for most important reason) relationships.

### 3.3 Reporting Survey Results to Consumers and Health Plans

As part of this project, the project team compiled and submitted plan–comparative information to CMS for posting on the www.Medicare.gov Web site. In addition, we compiled and reported the results of the survey to the health plans for quality improvement efforts via interim and annual Medicare CAHPS Disenrollment Reasons Survey Health Plan Reports. Annual voluntary disenrollment rates and information about the reasons that Medicare beneficiaries leave their former plans were posted on the Medicare Web site in March 2002. For health plans, we first prepared and sent to each health plan an interim report in the spring of 2001. The interim report was based on the first two quarters of data from the 2000 Reasons Survey. We prepared and sent an annual health plan report to sample plans in December 2001. In addition to preparing data for consumer reporting and for preparing and distributing survey results to health plans, we also performed research into the best presentation of survey results to health plans. Information about consumer and health plan reporting is provided in the following sections.

**Interim Report to the Health Plans**—We prepared and distributed to each health plan a 2000 Medicare CAHPS Disenrollment Reasons Survey Interim Health Plan Report in the spring of 2001. The data file used in creating this report included data from all eligible cases in Quarters 1 and 2 of the 2000 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 2000 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 questionnaire used in Quarters 2–4 of
the 2000 survey, along with a document describing the differences between the questionnaires used in Quarter 1 and Quarters 2, 3, and 4.

**Annual Report to Health Plans**—We prepared and distributed a CAHPS Medicare Disenrollment Reasons Survey Annual Health Plan report for most of the health plans that were included in the 2000 Reasons Survey. 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 2000 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.

The data file used in creating the 2000 Annual Health Plan report included all cases in Quarters 1-4 of the 2000 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 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. Responses from sample members who disenrolled from plans that did not renew their M+C contract with CMS for 2001 and plans under new ownership were excluded as well. Data from respondents who disenrolled from health plans that consolidated with another health plan were combined and analyzed with respondent data from the surviving plan; the results from these plans were included in the health plan report prepared for the surviving plan.

The 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. CMS calculated an annual health plan disenrollment for each health plan each year. RTI project statisticians calculated an “adjusted” disenrollment rate based on the number of sample members in the 2000 survey who reported that they left the plan because their employer no longer offered the plan. Both the raw disenrollment rate and unadjusted disenrollment rates were calculated using the number of enrollments and disenrollments in 2000 for each health plan, as provided by CMS. The raw disenrollment rate was computed by dividing the total number of annual enrollees into the total number of annual disenrollments. To create an adjusted disenrollment rate, the raw disenrollment rate was adjusted downward based on the proportion of respondents who reported that they left the plan because their employer no longer offered the plan.

To make the survey results more useful to the plans in their quality improvement efforts, the two main reasons groupings were further divided into eight reasons sub-groupings: five for Problems with Care and Services, and three for Concerns about Costs.

In addition to data for the sample plan, each annual health plan report included the applicable averages for that state or region as well as summary data for all plans in that 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, survey results for that plan were shown in all states in which the plan had a service area. If a plan served multiple
states, the survey results from all disenrollees from that plan were included in the state average for each state in which the plan served Medicare beneficiaries. However, only one annual health plan report was prepared for a plan that had a service area in multiple states—that report 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 primarily based on weighted data. The weights used were based on disenrollment—that is, the percentages shown in the tables in the report were the percentage of beneficiaries who disenrolled from the plan, not the percentage of beneficiaries who were enrolled in the plan in 2000. 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 statistically significant differences. A 2-sample t-test with a p-value of .05 was performed using SUDAAN®. Contracts with results that were significantly higher or lower than the state or region mean at a level of p<.05 were denoted with an up or down arrow.

**Reporting Survey Results to Consumers and to the Public**—Reasons Survey results along with annual disenrollment rates were posted on the Medicare Web site in early March 2002. 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. Reasons Survey data posted on the Web 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 for Costs and Benefits. Survey results reported to consumers were based only on the most important reason for leaving the plan.

Results posted on the Web were different from those included in the annual report to health plans because they were compiled based on enrollment weights—that is, the results showed the percentage of people who were enrolled in the plan, rather than the percentage of those who disenrolled from the plan. Consequently, 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 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.

Because the suppression threshold of 100 respondents significantly reduces the number of health plans for whom results are reported, CMS will be exploring possible statistical methods, such as small area estimation, for improving the accuracy of point estimates for 2002 survey results.

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.gov 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 the percentage was rounded to zero decimal places. If the percentage did not equal the adjusted voluntary disenrollment rates, the percentages were 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.

Prior to the posting of results from the 2000 Reasons Survey on the Medicare Web site in March 2002, we prepared and sent a “public report” preview to each Medicare health plan in January 2002. This report contained the same information that CMS posted on the Medicare Web site in March. 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 the information was posted on the Medicare Web site.

Research on Presentation of Data to Health Plans—In an effort to make the Medicare CAHPS Disenrollment Reasons Survey Annual Health Plan reports as useful as possible to plans, health plan representatives were asked to provide feedback on the annual report. A representative sample of plans was identified to achieve a variety of plans according to number of M+C enrollees, Medicare voluntary disenrollment rates in the year 2000 (high ≥ 25 percent; mid-range ~ 10 percent; low ≤ 5 percent), and location. Project staff contacted plan representatives in February, March, and April 2002.

Responses were obtained using phone interviews or, in some cases, written replies to questions. The interviews and questions were designed to solicit information on report content and format, report distribution, and report usage. Thirty-three respondents representing 27 plans completed either the phone interview or a written questionnaire. These 27 plans included at least one from each of the 10 CMS regions. Average Medicare enrollment for the participating plans was 76,600 members with a range from 1,359 to 656,099 Medicare enrollees. This reflected year 2000 enrollment among all M+C plans, which ranged from 897 to 656,099 M+C enrollees. The average disenrollment rate among the 27 participating plans was 13 percent with a range from 2 percent to 45 percent. Thirteen of the final 27 plans had a percentage of voluntary disenrollees citing cost or care as a reason for leaving the plan that was significantly higher than their state’s average.
Respondents included individuals with a variety of job titles. Most commonly, respondents worked in quality improvement (QI), with titles ranging from QI Specialist to Vice-President of QI. Other respondents held positions in marketing and sales (e.g., Director of Medicare Marketing or Managing Director of Medicare Sales), government programs or operations (e.g., Manager of Government Programs, Operations Manager), research and analysis (including respondents at both staff and managerial levels), and member services.

The interviews started with general questions about the report and then asked more specific questions about how individuals at the plan would use the report and about the content and format of each section of the report. Respondents also gave feedback on the timing and distribution of the reports. The interviews also included some discussion about reactions to the groupings of reasons for disenrollment. With only a few exceptions, respondents appreciated the need to group the reasons and had no objections to how reasons were grouped.

Information from the interviews resulted in a list of suggested changes to the report. (For more details see Booske and Frees, 2002). Many of these changes were incorporated into the 2001 Annual Disenrollment Reasons report and distributed to health plans at the end of 2002.
SECTION 4
THE 2000 MEDICARE CAHPS DISENROLLMENT ASSESSMENT SURVEY

4.1 Overview of Sample Design and Data Collection

The 2000 Assessment Survey was conducted for the first time in 2000 to collect data about sample members’ experiences with their former Medicare managed care health plans, including their overall ratings of those plans. The sample population for this survey comprised Medicare beneficiaries who voluntarily chose to leave their Medicare managed care health plan during May, June, or July 2000. This sampling window was chosen to correspond to the Medicare CAHPS Managed Care Enrollee Survey implementation schedule. The Assessment Survey was administered as a mail survey with a telephone follow-up of nonrespondents. This section provides general information about major activities conducted. Detailed information about each of these activities is provided in Survey Results and Reporting for the 2000 Medicare CAHPS Disenrollment Assessment Survey (Lynch et al., 2003b).

Sample Design—CMS and the Medicare CAHPS project teams developed the sample design for the Medicare CAHPS Managed Care Enrollee Survey to allow CAHPS outcomes to be compared between plans, as well as between Medicare managed care and Original Medicare. Each managed care plan constituted a reporting unit. In cases where a contract covered a wide geographic area, some plans (reporting units) were further defined by geographic location. Thus, a single plan with wide geographic coverage in a large state might have multiple reporting units. Within each reporting unit, a simple random sample was drawn of plan enrollees who had been enrolled in the plan for 6 months or longer. For the 2000 Enrollee Survey, approximately 600 Medicare beneficiaries were sampled from each of 381 reporting units. To be included in the 2000 Enrollee Survey sample, health plans had to have been in operation as of July 1, 1999.

The Assessment Survey of disenrollees was designed to mirror the Enrollee Survey by sampling at the same rate from each reporting unit. This had the benefit of minimizing design effects when the survey results from the two surveys were combined. However, since some plans had a small number of disenrollees, and because the Assessment Survey and Disenrollment Reasons Surveys are conducted at the same time, the Assessment Survey project team used a strategy that would ensure that sampling could support both surveys. Exhibits 4-1 and 4-2 illustrate the sampling strategy for the Disenrollment Assessment and Reasons Surveys for two hypothetical health plans, one with a large enrollment and one with small enrollment. Note that in both exhibits, the number of completed Assessment Survey cases is less than 40, a size too small to support good estimates. However, as illustrated in Exhibit 4-3, Assessment Survey cases are combined with the Enrollee Survey cases to produce combined, unbiased estimates for total plan enrollment during the reference period.

The 2000 Assessment Survey sample consisted of 31,041 Medicare beneficiaries representing a total of 281 managed care health plans. The reporting unit for the Assessment Survey was the plan. Once the Enrollee project team determined the sampling ratio for each
Exhibit 4-1
Hypothetical Plan with 10,000 Members Enrolled in Year 2000 and 11% Disenrollment Rate

<table>
<thead>
<tr>
<th></th>
<th>8,900 Still Enrolled</th>
<th>1,100 Disenrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Enrollee Ratings Sample</td>
<td>n = 600 p = 0.067</td>
<td>Disenrollee Assessment Sample n = 74 p = 0.067</td>
</tr>
<tr>
<td>Disenrollee Reasons Sample</td>
<td>n = 388 p = 0.353</td>
<td></td>
</tr>
</tbody>
</table>

For Unbiased Ratings Estimate: n = 674
Disenrollee Cases Used: n = 462

NOTE: The sampling rates between the Enrollee Survey and Disenrollee Assessment are equal. When the data are weighted, the design effects will be minimized.

Exhibit 4-2
Hypothetical Plan with 10,000 Members and 11% Disenrollment Rate

8,900 Annual Enrollees
Managed Care Enrollee Ratings Sample
Sample Size = 600
p = 0.067

1,100 Annual Disenrollees

<table>
<thead>
<tr>
<th>Quarter</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disenrollee Reasons Sample</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample Size</td>
<td>78</td>
<td>77</td>
<td>78</td>
<td>155</td>
<td>388</td>
</tr>
<tr>
<td>Completes</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>80</td>
<td>200</td>
</tr>
<tr>
<td>p =</td>
<td>0.071</td>
<td>0.071</td>
<td>0.071</td>
<td>0.141</td>
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</tr>
<tr>
<td>Disenrollee Assessment Sample</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample Size</td>
<td>74</td>
<td></td>
<td></td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Completes</td>
<td>(1,100 * 0.067)</td>
<td>38</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p =</td>
<td>0.071</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Sampling occurs proportionally to the overall disenrollment rate in 1999. This plan has enough disenrollees to support both surveys.
### Exhibit 4-3
Hypothetical Plan with 1,500 Members and 13% Disenrollment Rate

1,305 Annual Enrollees  
Managed Care Enrollee Ratings Sample  
Sample Size = 600  
p = 0.460

195 Annual Disenrollees

<table>
<thead>
<tr>
<th>Disenrollee Reasons Sample</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Size</td>
<td>39</td>
<td>13¹</td>
<td>39</td>
<td>78</td>
<td>169</td>
</tr>
<tr>
<td>Completes</td>
<td>28</td>
<td>9</td>
<td>28</td>
<td>56</td>
<td>121</td>
</tr>
<tr>
<td>( p = )</td>
<td>0.205</td>
<td>0.067</td>
<td>0.205</td>
<td>0.410</td>
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</table>

### Disenrollee Assessment Sample  
(Ideal)

<table>
<thead>
<tr>
<th>Sample Size</th>
<th>90</th>
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<tbody>
<tr>
<td>Completes</td>
<td>65</td>
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<tr>
<td>( p = )</td>
<td>0.461</td>
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</table>

### Disenrollee Assessment Sample  
(Practical)

<table>
<thead>
<tr>
<th>Sample Size</th>
<th>26²</th>
</tr>
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<tbody>
<tr>
<td>Completes</td>
<td>18</td>
</tr>
<tr>
<td>( p = )</td>
<td>0.133</td>
</tr>
</tbody>
</table>

¹ April disenrollees.  
² Maximum available.

**NOTE:** Sampling occurs proportionally to the overall disenrollment rate in 1999. This plan has few disenrollees and adjustments must be made in the 2nd quarter to support both surveys.
health plan, RTI project statisticians developed and submitted to CMS sampling specifications for selecting the Assessment Survey sample from each plan. CMS selected the sample for the 2000 Assessment using sampling specifications provided by RTI. All Medicare beneficiaries who had voluntarily left their managed care plan between May and July 2000 after having been continuously enrolled in the plan for at least 6 months were eligible to be included in the survey sample. Deceased sample members were removed from the sampling frame before the sample was selected. In addition, sample members who moved out of their sample plan's service area were also removed from the Assessment Survey sampling frame.

**Survey Instrument**—The 2000 Assessment Survey was conducted as a mail survey with a telephone follow up for nonrespondents. The Assessment Survey mail questionnaire contained 93 questions, most of which were the same as those included in the 2000 CAHPS Medicare Managed Care Enrollee Survey. However, the wording of questions in the 2000 Assessment Survey was changed so that sample members were asked to report on their experience when they were members of the plan or during the last few months before they left the plan. The major difference between the questionnaires used in the Medicare CAHPS Managed Care Enrollee and the Assessment Surveys is that the questions about health status were different. The Assessment Survey questionnaire also contained a question to determine the most important reason the sample member disenrolled from the sample health plan. A copy of the questionnaire is included in Appendix C.

In addition to the core CAHPS questions, the Assessment Survey questionnaire contained questions to identify (and screen out) sample members who were considered “involuntary” disenrollees. The screening questions were designed to identify involuntary disenrollees, which, for the Assessment Survey, were defined as those who left the plan because they moved out of the plan’s service area or the plan was no longer offered. Deceased and institutionalized sample members identified during the data collection period were excluded from the survey.

The telephone survey instrument used in telephone follow-up with mail survey nonrespondents was designed to mirror the mail survey instrument as closely as possible and was conducted using computer-assisted telephone interviewing (CATI). Both the mail and telephone survey instruments were customized so that they were plan-specific for each respondent. Both the mail survey and telephone survey instruments were translated into Spanish and were available upon request, as either a hard-copy questionnaire or a Spanish-language telephone interview.

**Data Collection Methods and Results**—We conducted data collection and data processing activities on the 2000 Assessment Survey from October 6, 2000, through February 21, 2001. During survey implementation, we used the same multiwave survey process that was used in the Medicare CAHPS Managed Care Enrollee Survey and the Disenrollment Reasons Survey. This process involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. The cover letters included with each mailing to sample members were printed on CMS letterhead and signed by the CMS Administrator. All letters included the name of the RTI data collection coordinator and the project’s toll-free telephone number that sample members could call if they had questions about the survey. We
attempted to conduct a telephone interview with all sample members who did not respond to the mail survey. Telephone data collection activities were conducted from January 7, 2001, through February 21, 2001. The 2000 Assessment Survey telephone interview averaged 25 minutes in duration.

We obtained an overall response rate of 54.8 percent in the 2000 Assessment Survey. The response rate was calculated using the following formula:

\[
\text{Numerator} = \text{the number of completed interviews} \\
\text{Denominator} = \text{All sample members included in the sample minus} \\
\quad \quad \quad \quad \quad \text{those considered ineligible (i.e., institutionalized, deceased,} \\
\quad \quad \quad \quad \quad \quad \quad \quad \quad \quad \quad \text{involuntary disenrollees)}
\]

As indicated previously, involuntary disenrollees for the Assessment Survey were those who left the plan because they moved out of the plan’s service area and those who reported that the plan stopped serving their area.

Approximately 28 percent of the sample members were ineligible to participate in the survey; that is, the sample members had died or become institutionalized after the sample was selected, or they were considered involuntary disenrollees. Involuntary disenrollees include sample members who reported the plan stopped serving the area or they moved out of the plan’s service area. Sample members who reported that they did not disenroll from the sample plan or they were not on Medicare were considered ineligible for survey participation. Other sample members considered ineligible for the survey were those who marked yes to two or more of the questions designed to identify involuntary disenrollees. Approximately 6 percent of the sample refused to participate in the survey. We were unable to contact 3 percent of mail survey nonrespondents after repeated attempts, and 0.5 percent promised to complete and return the mail questionnaire when they were contacted by telephone but did not. Another 0.7 percent were physically or mentally incapable of participating in the interview, and 0.6 percent did not speak English or Spanish (language barriers). We were unable to obtain a telephone number for 21.9 percent of the mail survey nonrespondents.

Nonresponse Analysis and Weighting—We conducted nonresponse analysis on the 2000 Assessment 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 models used for nonresponse analysis of Assessment Survey data are similar to those used in the 2000 Reasons Survey; however, the models for the Assessment Survey, of course, involved different sample members with different characteristics, and the models used different coefficients for beta parameters although they were in the same direction and magnitude as those used in the 2000 Reasons Survey.

We simultaneously added to the model demographic characteristics, 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 (age), keeping variables with p-values of .20 or less. The final logistic regression model contained the independent variables – age, race, dual eligibility, and address
type (post office box, rural route, and other addresses) and the design variable, which was the Enrollee Survey sampling unit.

Analysis of the data revealed differences between disenrollees who returned the survey and those who did not. Those who were older, disabled (under age 65), female, and non-White were less likely to respond. Response rates also varied significantly by Census region. Sample members from the Middle Atlantic (NJ, NY, PA) and the South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) were less likely to respond than were those living in the Pacific region (AK, CA, HI, OR, WA). Those who live in metropolitan statistical area (MSA) counties had a lower response rate than those living in non-MSA counties. Addresses were also related to response rates. Sample cases with addresses consisting of a post office box or apartment number had proportionally fewer respondents, as did abnormally short or long addresses.

In a logistic regression model, the strongest apparent factors related to not obtaining a completion are race and dual eligibility. Other strong detractors from a completion are addresses with a post office box and age. Those younger than 65 (disabled Medicare beneficiaries) and the very elderly had significantly lower odds of response. Note that the data in logistic regression models are limited to what is available for respondents and nonrespondents. In such scenarios, it is quite possible that age, race, and Medicaid status are surrogates for other effects that could not be included in the model (e.g., health status, education, and income).

After adjusting for all of these effects, plan variations were modest. Before any adjustments were made, plan-level response rates varied from about 29 percent to 88 percent (among plans with a sample size of at least 20). However, after statistically adjusting for beneficiary characteristics, the predicted response rates ranged from 56 percent to 79 percent. Response rates by demographic characteristics and other information resulting from this analysis are shown in Exhibit 4-4.

4.2 Reporting Survey Results to Consumers and Health Plans

During the winter and spring of 2001, the CAHPS Disenrollment Assessment project team worked closely with CMS and the Medicare CAHPS Managed Care Enrollee Survey and the Medicare CAHPS FFS project teams to coordinate the analysis and distribution (via the Medicare Health Plan Compare Web site) of health plan comparative data from all three surveys. The three teams met biweekly to resolve issues, coordinate analysis objectives, and ensure the prompt and efficient delivery and receipt of data files between the organizations. In addition, the Medicare CAHPS Managed Care and Assessment Survey project teams worked together to develop a template for reporting the results from analysis of the combined data (Managed Care Enrollee and Assessment Surveys) to health plans. In addition, all three teams worked closely together to revise the questionnaires used in the three Medicare CAHPS projects to make the questionnaires more comparable for the annual implementation of these surveys in 2001.

**Weighting for Consumer and Health Plan Reporting**—RTI project staff created a data file with combined data from the 2000 Medicare CAHPS Managed Care Enrollee and Assessment Surveys and then prepared weights that reflected the proportion of enrollees and disenrollees included for each health plan. The purpose of developing these weights was for
### Exhibit 4-4
Assessment Survey Response Rates by Demographic Characteristics

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Total Sample</th>
<th>Respondent Sample</th>
<th>Response Rates Among Eligibles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>(%)</td>
<td>(n)</td>
</tr>
<tr>
<td>Overall</td>
<td>USA</td>
<td>31,041</td>
<td>100.0</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>13,347</td>
<td>43.0</td>
</tr>
<tr>
<td>(EDB)</td>
<td>Female</td>
<td>17,694</td>
<td>57.0</td>
</tr>
<tr>
<td>Age Group</td>
<td>&lt; 65</td>
<td>3,574</td>
<td>11.5</td>
</tr>
<tr>
<td>(EDB)</td>
<td>65-69</td>
<td>8,176</td>
<td>26.3</td>
</tr>
<tr>
<td></td>
<td>70-74</td>
<td>7,258</td>
<td>23.4</td>
</tr>
<tr>
<td></td>
<td>75-79</td>
<td>5,574</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td>≥ 80</td>
<td>6,459</td>
<td>20.8</td>
</tr>
<tr>
<td>Race</td>
<td>White</td>
<td>24,369</td>
<td>78.5</td>
</tr>
<tr>
<td>(EDB)</td>
<td>Black</td>
<td>4,527</td>
<td>14.6</td>
</tr>
<tr>
<td></td>
<td>Other/Unknown</td>
<td>2,145</td>
<td>6.9</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>Yes</td>
<td>4,070</td>
<td>13.1</td>
</tr>
<tr>
<td>(EDB)</td>
<td>No</td>
<td>26,971</td>
<td>86.9</td>
</tr>
</tbody>
</table>

| I. New England | 2,129 | 6.8 | 892 | 7.3 | 60.0 |
| II. Middle Atlantic | 4,838 | 15.6 | 1,938 | 15.9 | 54.1 |
| III. East North Central | 3,584 | 11.5 | 1,418 | 11.6 | 54.1 |
| IV. West North Central | 939 | 3.0 | 377 | 3.1 | 61.1 |
| V. South Atlantic | 8,752 | 28.2 | 3,415 | 28.0 | 53.0 |
| VI. East South Central | 1,106 | 3.6 | 393 | 3.2 | 50.5 |
| VII. West South Central | 3,218 | 10.4 | 1,213 | 9.9 | 54.2 |
| VIII. Mountain | 2,165 | 7.0 | 834 | 6.8 | 55.8 |
| IX. Pacific | 4,310 | 13.9 | 1,728 | 14.2 | 57.4 |
analyzing the combined data to obtain plan-comparative information that would be reported to consumers and to the health plans. Weights were created separately for enrollees and disenrollees. The weights are simple population-based weights that represent the numbers of individuals in each of their respective populations. When both data sources are combined, the enrollee and disenrollee weights are proportionally correct and represent the plan’s true composition of enrollees and disenrollees.

The weight was calculated at the health plan’s state and county level, which is consistent with how beneficiaries were sampled. The number of eligible beneficiaries at the county level was divided by the number of respondents in that county. So not only do the weight sums represent the number of individuals within that plan, they are also adjusted to the county level. Due to time constraints in getting reports generated in a quick, timely manner, these weights were not response-propensity adjusted for other factors such as age, race, or sex.

**Consumer Reporting**—The Medicare CAHPS Managed Care Enrollee project team took the lead in analyzing the combined Assessment and Enrollee survey data to generate plan-comparative information that would eventually be reported to consumers. The Assessment Survey project team also used the combined 2000 Assessment and Enrollee file to run the CAHPS Macro on two ratings and four composites. The two ratings are Rating Health Plan and Rate Health Care, and the four composites are Doctors Communication, Getting Care Needed, Getting Care Quickly, and Staff Respect. The output from the CAHPS Macro was compared to the output of the CAHPS Macro run performed by the Enrollee project team, and the output produced by both teams was considered final when the output generated by each team matched. The output containing ratings and composite scores from the combined data were merged into an Excel template and submitted to CMS.

**Health Plan Reporting**—Each year, the Medicare CAHPS Managed Care Enrollee project team prepares and distributes an annual report for each M+C organization that participated in that year’s enrollee survey. For the first time in late summer 2001 the annual health plan report that the Enrollee team prepared and distributed to the health plans included data from those who stayed in the plan (from the 2000 Enrollee Survey) as well as those who left (from the 2000 Assessment Survey). The Assessment Survey project team worked with the Enrollee project team in winter and spring 2001 to revise the template that had been used for health plan reporting in previous survey years so that it would contain information about both surveys (methods, the survey samples, response rates, questionnaires used, etc) and the presentation of that information in the report. We then wrote and provided to the Enrollee team separate sections of the report on the methodology, implementation, sample disposition, and results of the Assessment Survey.

4.3 Subgroup Analysis

Analysis on the 2000 Assessment Survey data consisted of examining disenrollees’ assessments of their health plans compared to those of beneficiaries still enrolled in the plan, with a focus on differences between selected subgroups. The main purpose of this descriptive analysis was to compare managed care enrollee and disenrollee CAHPS ratings and composite response distributions both overall (for various subgroups), and at the national level only.

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Disenrollee subgroup sample sizes at the plan level for the Assessment survey were too small to make comparisons between disenrollees and enrollees; therefore we conducted this comparison on a national level only. The results of this descriptive analysis were discussed with the technical expert panel for this project and with CMS but were not shared with the health plans or Medicare beneficiaries.

We prepared descriptive tables to show the distribution of responses of disenrollees and enrollees on each of the four CAHPS ratings and proxies of each of the five CAHPS composites. We examined four CAHPS ratings, including ratings of health plan, health care from provider, personal doctor, and specialists. We also examined five CAHPS composites, including plan customer service, courteous and helpful office staff, getting needed care, getting care quickly, and doctor communication composites. We further explored these differences by looking at subgroups within each sample to determine whether differences between the two samples were concentrated or exacerbated in one or more subgroups. The following are notable findings resulting from the comparisons of Assessment Survey sample disenrollees to Medicare CAHPS Managed Care Enrollee Survey sample members.

The largest differences between disenrollees and enrollees overall were in the health plan rating, then the health care from provider rating, and then in third place, the getting needed care composite. Disenrollees rate their health plan, the health care they got from their provider, and the problems they had getting needed care considerably different from the enrollees of those same plans. Disenrollees’ ratings are lower and they indicate having bigger problems with their health care.

The largest differences between subgroups of enrollees and disenrollees occurred in (1) the under-65 age group, (2) those with higher levels of education, (3) those in excellent health, and (4) those with much better health than 1 year ago. For each, disenrollees had substantially lower evaluations of their health plan or care than did enrollees across most of the four ratings items and five composites.
REFERENCES


APPENDIX A

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APPENDIX B

2000 MEDICARE CAHPS® DISENROLLMENT REASONS SURVEY QUESTIONNAIRE
2000 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: HCFA, 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

Please go to the top of the next page and begin with Question 1.
1. Our records show that, for part of the last 6 months, you were covered by [MEDICARE HEALTH PLAN NAME], but that you left that Medicare health plan. Is that right?
   □ Yes → Go to Question 5 on Page 2
   □ No → Go to Question 2 below

2. Are you still covered by [MEDICARE HEALTH PLAN NAME]?
   □ Yes → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.
   □ No → Go to Question 3 in the next column

3. Did you recently leave a different Medicare health plan?
   □ Yes → Go to Question 4 below
   □ No → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.

4. What is the name of the Medicare health plan you recently left? (Please print neatly.)

   ________________________________

   We would like to know about your experience with [MEDICARE HEALTH PLAN NAME]. If that plan was not the last health plan you left, answer Questions 5 through 57 thinking about the last plan you left, that is, the plan you named on the line in Question 4 above.

   Please go to Page 2 and continue with the information in the left column.
The next questions ask about reasons you may have had for leaving [MEDICARE HEALTH PLAN NAME].

Just as it is important for us to learn why you left [MEDICARE 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 to 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.

### PLAN AVAILABILITY

5. Some people leave their Medicare health plan because their former employer no longer offers the plan. Did you leave [MEDICARE HEALTH PLAN NAME] because your former employer no longer offered [MEDICARE HEALTH PLAN NAME] to you?

- □ Yes → Go to Question 8 on Page 3
- □ No
- □ I was not enrolled in this plan through a former employer.

6. Some people leave their Medicare health plan because they moved and now live outside the area where the plan is available. Did you leave [MEDICARE HEALTH PLAN NAME] because you moved and now live outside the area where this plan was available?

- □ Yes → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.
- □ No

7. Some people leave their Medicare health plan because the health plan stopped offering services to people with Medicare in the area where you live. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan stopped serving people with Medicare who live in your area?

- □ Yes → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.
- □ No
8. A premium is the amount that you pay to receive health care coverage from a health plan. Some health plans charge a premium to people on Medicare who are enrolled in that health plan.

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

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

12. Did you leave [MEDICARE 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

DOCTORS AND OTHER HEALTH PROVIDERS

A doctor or other health care provider can be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse or anyone else you would see for health care.
13. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan doctors or other health care providers did not explain things in a way you could understand?

☐ Yes
☐ No

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

☐ Yes
☐ No

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

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

☐ Yes
☐ No

ACCESS TO CARE

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No
20. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get special medical equipment when you needed it?
   □ Yes
   □ No

21. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get home health care when you needed it?
   □ Yes
   □ No

22. Did you leave [MEDICARE 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

23. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get an appointment for regular or routine health care as soon as you wanted?
   □ Yes
   □ No

24. Did you leave [MEDICARE 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

25. Did you leave [MEDICARE 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**

26. Did you leave [MEDICARE HEALTH PLAN NAME] because you thought you were given incorrect or incomplete information at the time you joined the plan?
   □ Yes
   □ No

27. Did you leave [MEDICARE HEALTH PLAN NAME] because after you joined the plan, it wasn’t what you expected?
   □ Yes
   □ No
28. Did you leave [MEDICARE 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

29. Did you leave [MEDICARE 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.

30. Did you leave [MEDICARE 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.

31. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan would not pay for a medication that your doctor had prescribed?
   - Yes
   - No

   COSTS AND BENEFITS

32. Did you leave [MEDICARE HEALTH PLAN NAME] because another plan would cost you less?
   - Yes
   - No

33. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan would not pay for some of the care you needed?
   - Yes
   - No

34. Did you leave [MEDICARE HEALTH PLAN NAME] because another plan offered better benefits or coverage for some types of care or services?
   - Yes
   - No
35. 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 [MEDICARE 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.

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.

36. Did you leave because [MEDICARE 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.

37. Did you leave because [MEDICARE 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

38. Did you leave [MEDICARE 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 complaint?

☐ Yes
☐ No

39. Did you leave [MEDICARE 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

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

☐ Yes
☐ No

41. Besides the reasons already asked about in Questions 5-40, are there any other reasons you left [MEDICARE HEALTH PLAN NAME]?

☐ Yes → Go to Question 42 below
☐ No → Go to Question 43 on Page 9

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

________________________________________
________________________________________
________________________________________

Go to Question 43 on Page 9
43. What was the one most important reason you left [MEDICARE HEALTH PLAN NAME]? (Please print neatly.)

__________________________________________

__________________________________________

__________________________________________

Go to Question 44 below

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

☐ Yes

☐ No

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

☐ 1 month or less

☐ 2 months

☐ 3 months

☐ 4 months

☐ 5 months

☐ 6 months or more

See Instruction Box 1 at the top of Page 10.
46. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], how many times did you go to a doctor’s office or clinic to get care for yourself? Do not count times you went to an emergency room to get care for yourself.

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

Go to Question 48 on Page 11

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

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

- [ ] Yes
- [ ] No
48. Think about all the health care you got from all doctors and other health providers in the 6 months before you left [MEDICARE HEALTH PLAN NAME].

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

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

49. Think about all your experience with [MEDICARE HEALTH PLAN NAME].

Use any number from 0 to 10 where 0 is the worst Medicare health plan possible, and 10 is the best Medicare health plan possible. How would you rate [MEDICARE HEALTH PLAN NAME]?

☐ 0 → Worst Medicare health plan possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 → Best Medicare health plan possible
50. When you were a member of [MEDICARE HEALTH PLAN NAME], was there ever a time when you strongly believed that you needed and should have received health care or services that [MEDICARE HEALTH PLAN NAME] or your doctor decided not to give to you?

☐ Yes

☐ No → Go to Instruction Box 2 on Page 13

51. Did you receive information in writing from [MEDICARE HEALTH PLAN NAME] or your doctor on how to file a formal complaint about their decision not to provide the health care or services that you strongly believed that you needed?

☐ 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.

52. 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.

Go to Instruction Box 2 on Page 13
INSTRUCTION BOX 2

An appeal is a formal complaint about a Medicare health plan’s decision not to provide or pay for health care services or equipment or to stop providing health care services or equipment.

When answering Questions 53 through 57, please think about the time when you were a member of [MEDICARE HEALTH PLAN NAME].

53. As far as you know, did you have the right to appeal if [MEDICARE HEALTH PLAN NAME] decided not to provide or pay for care and services that you believed you needed?

☐ Yes
☐ No

54. As far as you know, did your doctor have the right to appeal if [MEDICARE HEALTH PLAN NAME] decided not to provide or pay for health care and services that you believed you needed?

☐ Yes
☐ No

55. As far as you know, if your appeal was denied, would [MEDICARE HEALTH PLAN] automatically refer it to another organization for an independent review?

☐ Yes
☐ No

56. As far as you know, did you have the right to ask for another review by a judge if this independent organization turned down your appeal to [MEDICARE HEALTH PLAN NAME]?

☐ Yes
☐ No

57. Did you ever file an appeal with [MEDICARE HEALTH PLAN NAME]?

☐ Yes
☐ No
ABOUT YOU

This last set of questions asks for your views about your health. These questions will help our researchers understand the characteristics of the group of people who have answered this survey.

58. In general, how would you rate your overall 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 performing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

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

The following two questions ask whether your work or other regular daily activities have been affected in the past 4 weeks because of your physical health.

60. Does your health now limit you in climbing several flights of stairs?

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

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 could do as a result of your physical health?

☐ Yes
☐ No
63. 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 following two questions ask whether your work or other regular daily activities have been affected in the past 4 weeks by any emotional problems, such as feeling depressed or anxious.

64. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems?

- Yes
- No

65. During the past 4 weeks, have you not done work or other activities as carefully as usual because of any emotional problems?

- Yes
- No

The next few 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. 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

71. What is your age now?

☐ 64 or younger
☐ 65 to 69
☐ 70 to 74
☐ 75 to 79
☐ 80 or older

72. Are you male or female?

☐ Male
☐ Female
73. 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

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

☐ Yes, Hispanic or Latino
☐ No, not Hispanic or Latino

75. What is your race? Please mark one or more boxes.

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

76. Did anyone help you complete this questionnaire?

☐ Yes → Go to Question 77 below
☐ No → Go to Question 78 on Page 18

77. How did that person help you? Please mark all that apply.

☐ Read the questions to me
☐ Wrote down the answers I gave
☐ Answered the questions for me
☐ Translated the questions into my language
☐ Helped me in some other way ➔ On the lines below, please tell us how that person helped you. (Please print neatly.)

____________________________
____________________________

Continue with Question 78 on Page 18
78. 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.
2000 Medicare Satisfaction Survey

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 20 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: HCFA, 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

Please go to the top of the next page and begin with Question 1.
1. Our records show that, for part of the last 6 months, you were covered by [MEDICARE HEALTH PLAN NAME] but that you left that Medicare health plan. Is that right?

☐ Yes → Go to Question 5 on Page 2

☐ No → Go to Question 2 below

2. Are you still covered by [MEDICARE HEALTH PLAN NAME]?

☐ Yes → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.

☐ No → Go to Question 3 in the next column

3. Did you recently leave a different Medicare health plan?

☐ Yes → Go to Question 4 below

☐ No → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.

4. What is the name of the Medicare health plan you recently left? (Please print neatly.)

________________________________________________________________________

We would like to know about your experience with [MEDICARE HEALTH PLAN NAME]. If that plan was not the last health plan you left, answer Questions 5 through 72 thinking about the last plan you left, that is, the plan you named on the line in Question 4 above.

Please go to Page 2 and continue with the information in the left column.
REASONS YOU LEFT [MEDICARE HEALTH PLAN NAME]

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

PLAN AVAILABILITY

5. Some people leave their Medicare health plan because their former employer no longer offers the plan. Did you leave [MEDICARE HEALTH PLAN NAME] because your former employer no longer offered [MEDICARE HEALTH PLAN NAME] to you?
   □ Yes → Go to Question 8 on Page 3
   □ No
   □ I was not enrolled in this health plan through a former employer.

6. Some people leave their Medicare health plan because they moved and now live outside the area where the plan is available. Did you leave [MEDICARE HEALTH PLAN NAME] because you moved and now live outside the area where that plan was available?
   □ Yes → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.
   □ No

7. Some people leave their Medicare health plan because the health plan stopped offering services to people with Medicare in the area where you live. Did you leave [MEDICARE HEALTH PLAN NAME] because this plan stopped serving people with Medicare who live in your area?
   □ Yes → Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.
   □ No → Go to Question 8 on Page 3
8. 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.

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

__________________________________________________

__________________________________________________

__________________________________________________

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

☐ Yes

☐ No

Go to Question 11 on Page 4
11. How many months or years in a row were you in [MEDICARE HEALTH PLAN NAME]?

- [ ] 1 month or less
- [ ] 2 months
- [ ] 3 months
- [ ] 4 months
- [ ] 5 months
- [ ] 6 up to 12 months
- [ ] 12 up to 24 months
- [ ] 2 years up to 5 years
- [ ] 5 years up to 10 years
- [ ] More than 10 years

Go to Instruction Box 1 in the next column.

12. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], was [MEDICARE HEALTH PLAN NAME] the health plan you used for all or most of your health care?

- [ ] Yes
- [ ] No

YOUR PERSONAL DOCTOR OR NURSE

The next questions are about the health care you got while you were a member of [MEDICARE HEALTH PLAN NAME]. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.
13. A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant.

When you joined [MEDICARE HEALTH PLAN NAME] or at any time while you were a member of that plan, did you get a new personal doctor or nurse?

☐ Yes

☐ No → Go to Question 15 in the next column

14. With the choices [MEDICARE HEALTH PLAN NAME] gave you, how much of a problem, if any, was it to get a personal doctor or nurse you were happy with?

☐ A big problem

☐ A small problem

☐ Not a problem

☐ I didn’t get a new personal doctor or nurse while I was in [MEDICARE HEALTH PLAN NAME].

15. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you have one person you thought of as your personal doctor or nurse?

☐ Yes

☐ No → Go to Question 22 on Page 7

16. Was this person a general doctor, a specialist doctor, a physician assistant, or a nurse?

☐ General doctor (Family Practice or Internal Medicine)

☐ Specialist doctor

☐ Physician assistant

☐ Nurse

☐ I didn’t have a personal doctor or nurse at that plan.
17. How many months or years have you been going to the personal doctor or nurse you had while you were in [MEDICARE HEALTH PLAN NAME]?

- [ ] Less than 6 months
- [ ] 6 up to 12 months
- [ ] 12 up to 24 months
- [ ] 2 up to 5 years
- [ ] 5 years or more
- [ ] I didn’t have a personal doctor or nurse while at that plan.

18. Did the personal doctor or nurse you had while you were in [MEDICARE HEALTH PLAN NAME] know the important facts and decisions about your health care?

- [ ] Yes
- [ ] No
- [ ] I didn’t have a personal doctor or nurse while at that plan.

19. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you have a physical or medical condition that seriously interfered with your ability to work or manage your day-to-day activities?

- [ ] Yes
- [ ] No → Go to Question 21 on Page 7

20. Did the personal doctor or nurse you had while you were in [MEDICARE HEALTH CARE PLAN] understand how any health problems you had affected your day-to-day life?

- [ ] Yes
- [ ] No
- [ ] I didn’t have any health problems or I didn’t have a personal doctor or nurse.
21. How would you rate the personal doctor or nurse you had in the 6 months before you left [MEDICARE HEALTH PLAN NAME]?

Use any number from 0 to 10 where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible.

☐ 0 → Worst personal doctor or nurse possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 → Best personal doctor or nurse possible

☐ I didn’t have a personal doctor or nurse while I was in [MEDICARE HEALTH PLAN NAME].

---

GETTING HEALTH CARE FROM A SPECIALIST

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

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

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

☐ Yes
☐ No → Go to Question 24 on Page 8

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

☐ A big problem
☐ A small problem
☐ Not a problem

☐ I didn’t need to see a specialist in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
24. In the 6 months before you left
[MEDICARE HEALTH PLAN NAME],
how many times did you go to
specialists for care for yourself?

☐ None → Go to Question 27 on
   Page 9
☒ 1
☒ 2
☒ 3
☒ 4
☒ 5 to 9
☐ 10 or more

25. In the 6 months before you left
[MEDICARE HEALTH PLAN NAME],
was the specialist you saw most
often the same doctor as your
personal doctor?

☐ Yes
☐ No
☐ I didn’t have a personal doctor or I
didn’t see a specialist in the 6
   months before I left [MEDICARE
   HEALTH PLAN NAME].

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

Use any number from 0 to 10 where
0 is the worst specialist possible,
and 10 is the best specialist possible.

☐ 0 → Worst specialist possible
☒ 1
☒ 2
☒ 3
☒ 4
☒ 5
☒ 6
☒ 7
☒ 8
☒ 9
☐ 10 → Best specialist possible
☐ I didn’t see a specialist in the 6
   months before I left [MEDICARE
   HEALTH PLAN NAME].
27. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you call a doctor’s office or clinic during regular office hours to get help or advice for yourself?

☐ Yes

☐ No → Go to Question 29 in the next column

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

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I didn’t call for help or advice during regular office hours in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you make any appointments with a doctor or other health provider for regular or routine health care?

☐ Yes

☐ No → Go to Question 31 on Page 10

30. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], when you needed regular or routine health care, how often did you get an appointment as soon as you wanted?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I didn’t need an appointment for regular or routine care in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
31. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you have an illness or injury that needed care right away from a doctor’s office, clinic, or emergency room?

[ ] Yes
[ ] No → Go to Question 33 below

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

[ ] Never
[ ] Sometimes
[ ] Usually
[ ] Always

[ ] I didn’t need care right away for an illness or injury in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

[ ] None

[ ] Number of times (Write in)

34. In the 6 months before you left [MEDICARE 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 → Go to Question 45 on Page 13
[ ] 1
[ ] 2
[ ] 3
[ ] 4
[ ] 5 to 9
[ ] 10 or more

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

[ ] A big problem
[ ] A small problem
[ ] Not a problem

[ ] I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
36. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

☐ A big problem
☐ A small problem
☐ Not a problem
☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

37. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], how often did you wait in the doctor’s office or clinic more than 15 minutes past your appointment time to see the person you went to see?

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

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

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

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

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
40. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], how often did doctors or other health providers listen carefully to you?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

☐ Never
☐ Sometimes
☐ Usually
☐ Always

☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

☐ Never
☐ Sometimes
☐ Usually
☐ Always

☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

☐ Never
☐ Sometimes
☐ Usually
☐ Always

☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
44. How would you rate all the health care you got in the last 6 months before you left [MEDICARE HEALTH PLAN NAME] from all doctors and other health providers?

Use any number from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible.

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

☐ I had no visits in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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OTHER HEALTH SERVICES

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

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

☐ Yes
☐ No → Go to Question 47 on Page 14

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

☐ A big problem
☐ A small problem
☐ Not a problem

☐ I didn’t need to get any special medical equipment in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
47. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy?

☐ Yes

☐ No → Go to Question 49 below

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

☐ A big problem

☐ A small problem

☐ Not a problem

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

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

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

☐ Yes

☐ No → Go to Question 51

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

☐ A big problem

☐ A small problem

☐ Not a problem

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

51. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], did you get any new prescription medicine or refill a prescription?

☐ Yes

☐ No → Go to Question 54 on Page 15
52. In the 6 months before you left the plan, how much of a problem, if any, was it to get your prescription medicine from [MEDICARE HEALTH PLAN NAME]?

☐ A big problem
☐ A small problem
☐ Not a problem
☐ I didn’t get any prescriptions in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
☐ My health plan does not cover my prescription medicines.

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

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ I didn’t get any prescriptions in the 6 months before I left [MEDICARE HEALTH PLAN NAME].
☐ My health plan does not cover my prescription medicines.

54. In the 6 months before you left the plan, did you look for any information in written materials from [MEDICARE HEALTH PLAN NAME]?

☐ Yes
☐ No → Go to Question 56 on Page 16

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

☐ A big problem
☐ A small problem
☐ Not a problem
☐ I didn’t look for information from [MEDICARE HEALTH PLAN NAME] in the 6 months before I left that plan.
56. In the 6 months before you left the plan, did you call [MEDICARE HEALTH PLAN NAME]’s customer service to get information or help?

☐ Yes

☐ No → Go to Question 59 in the next column

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

☐ A big problem

☐ A small problem

☐ Not a problem

☐ I didn’t call customer service at [MEDICARE HEALTH PLAN NAME] in the 6 months before I left that plan.

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

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I didn’t call customer service at [MEDICARE HEALTH PLAN NAME] in the 6 months before I left that plan.

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

☐ Yes

☐ No → Go to Question 62 on Page 17
60. How long did it take for [MEDICARE HEALTH PLAN NAME] to resolve your complaint?

☐ Same day
☐ 1 week
☐ 2 weeks
☐ 3 weeks
☐ 4 or more weeks
☐ I am still waiting for it to be settled.

☐ I didn’t have any complaint or problem in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

☐ Yes
☐ No
☐ I am still waiting for it to be settled.

☐ I didn’t have any complaint or problem in the 6 months before I left [MEDICARE HEALTH PLAN NAME].

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

In the 6 months before you left the plan, did you have any experiences with paperwork for [MEDICARE HEALTH PLAN NAME]?

☐ Yes
☐ No → Go to Question 64 on Page 18

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

☐ A big problem
☐ A small problem
☐ Not a problem

☐ I didn’t have any experience with paperwork for [MEDICARE HEALTH PLAN NAME] in the 6 months before I left the plan.
64. How would you rate all your experience with [MEDICARE HEALTH PLAN NAME]?

Use any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible.

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

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

☐ Yes
☐ No → Go to Instruction Box 2 on Page 19

66. Did you receive information in writing from [MEDICARE HEALTH PLAN NAME] or your doctor on how to file a formal complaint about their decision not to provide the health care or services that you strongly believed that you needed?

☐ 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.
67. 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.

Go to Instruction Box 2 in the next column

INSTRUCTION BOX 2

An appeal is a formal complaint about a Medicare health plan’s decision not to provide or pay for health care services or equipment or to stop providing health care services or equipment.

When answering Questions 68 through 72, please think about the time when you were a member of [MEDICARE HEALTH PLAN NAME].

68. As far as you know, did you have the right to appeal if [MEDICARE HEALTH PLAN NAME] decided not to provide or pay for care and services that you believed you needed?

☐ Yes
☐ No

69. As far as you know, did your doctor have the right to appeal if [MEDICARE HEALTH PLAN NAME] decided not to provide or pay for health care and services that you believed you needed?

☐ Yes
☐ No
70. As far as you know, if your appeal was denied, would [MEDICARE HEALTH PLAN NAME] automatically refer it to another organization for an independent review?

☐ Yes
☐ No

71. As far as you know, did you have the right to ask for another review by a judge if this independent organization turned down your appeal to [MEDICARE HEALTH PLAN NAME]?

☐ Yes
☐ No

72. Did you ever file an appeal with [MEDICARE HEALTH PLAN NAME]?

☐ Yes
☐ No

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**ABOUT YOU**

This last set of questions asks for your views about your health. These questions will help our researchers understand the characteristics of the group of people who have answered this survey.

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

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

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

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

☐ Yes, limited a lot
☐ Yes, limited a little
☐ No, not limited at all
75. Does your health now limit you in climbing several flights of stairs?
   - Yes, limited a lot
   - Yes, limited a little
   - No, not limited at all

The following two questions ask whether your work or other regular daily activities have been affected in the past 4 weeks because of your physical health.

76. During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?
   - Yes
   - No

77. During the past 4 weeks, were you limited in the kind of work or other activities you could do as a result of your physical health?
   - Yes
   - No

78. 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 following two questions ask whether your work or other regular daily activities have been affected in the past 4 weeks by any emotional problems, such as feeling depressed or anxious.

79. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems?
   - Yes
   - No

80. During the past 4 weeks, have you not done work or other activities as carefully as usual because of any emotional problems?
   - Yes
   - No
The next few questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

81. How much of the time during the past 4 weeks have you felt calm and peaceful?
   - All of the time
   - Most of the time
   - A good bit of the time
   - Some of the time
   - A little of the time
   - None of the time

82. How much of the time during the past 4 weeks did you have a lot of energy?
   - All of the time
   - Most of the time
   - A good bit of the time
   - Some of the time
   - A little of the time
   - None of the time

83. How much of the time during the past 4 weeks have you felt downhearted and blue?
   - All of the time
   - Most of the time
   - A good bit of the time
   - Some of the time
   - A little of the time
   - None of the time

84. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
   - All of the time
   - Most of the time
   - Some of the time
   - A little of the time
   - None of the time
85. **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

86. **What is your age now?**

- [ ] 64 or younger
- [ ] 65 to 69
- [ ] 70 to 74
- [ ] 75 to 79
- [ ] 80 or older

87. **Are you male or female?**

- [ ] Male
- [ ] Female

88. **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

89. **Are you of Hispanic or Latino origin or descent?**

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

90. **What is your race? Please mark one or more boxes.**

- [ ] White
- [ ] Black or African-American
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] American Indian or Alaska Native
91. Did anyone help you complete this questionnaire?

☐ Yes → Go to Question 92 below

☐ No → Go to Question 93 below

92. How did that person help you?
Please mark all that apply.

☐ Read the questions to me
☐ Wrote down the answers I gave
☐ Answered the questions for me
☐ Translated the questions into my language
☐ Helped me in some other way → On the lines below, please tell us how that person helped you.
(Please print neatly.)

........................................................................................................................................................................
........................................................................................................................................................................

93. 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.

[Blank space for telephone number]

THANK YOU
Please mail your completed questionnaire in the postage-paid envelope.