



Measuring Patient Experience of Medicare Advantage Beneficiaries: Current Limitations of the Consumer Assessment Tool and Policy Recommendations

Study conducted by NORC at the University of Chicago
Commissioned by Better Medicare Alliance/Center for Innovation in Medicare Advantage

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Executive Summary

For the last several years, the Centers for Medicare & Medicaid Services (CMS) has emphasized the importance of measuring patient experience and access to care in Medicare Advantage and Prescription Drug (MA-PD) plans and tying plan payment to those metrics. For MA-PD plans, CMS relies on the MA-PD Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey as the agency's primary means of assessing patient experience. Since 2012, MA-PD CAHPS data have been included in the MA Star Ratings. As a result of recent CMS policy decisions, CAHPS survey-derived MA Star Rating measures are becoming a more heavily weighed component of health plan quality ratings and payments.

Better Medicare Alliance contracted with NORC at the University of Chicago to conduct mixed-methods research related to the MA-PD CAHPS survey and patient experience measurements to assess the accuracy and usefulness of this assessment tool. NORC conducted a nationally representative survey of 800 MA beneficiaries using AmeriSpeak®, a mixed-mode household panel. The survey sought to understand beneficiaries' perspectives and experiences with MA-PD CAHPS, including asking questions taken directly from the MA-PD CAHPS instrument and probing follow-up questions. NORC also conducted a literature review as well as qualitative interviews with 41 experts from 20 organizations representing a cross-section of health care stakeholders with experience and expertise in this area.

This report provides an in-depth description of patient experience measurement within MA-PD CAHPS and the MA Star Ratings, discusses current challenges and limitations of the MA-PD CAHPS survey as expressed by stakeholders and beneficiaries, and puts forth policy recommendations to improve the measurement of patient experience in MA.

The research finds that measuring patient experience in MA needs to be more accurate, meaningful, and actionable. Specifically, this research makes the following recommendations to achieve these goals.

Policy Recommendations:

- ▶ Modernize patient experience measurement in MA by updating the survey language to reflect the diversity of today's beneficiaries, along with the evolution of MA benefit offerings and how care is delivered today.
- ▶ Provide more granular CAHPS results to health plans while protecting beneficiary confidentiality to empower better health plan quality improvement.
- ▶ Remove MA-PD CAHPS questions from the patient experience MA Star Ratings that health plans cannot directly impact, and increase the patient experience MA Star Ratings weights from two to four, only after changes are made to modernize MA patient experience measurement.
- ▶ Explore ways to reduce burden on the beneficiary survey respondent to improve response rates. Tactics to achieve this goal include:
 - Reduce the length of the survey by removing provider-focused questions that sit outside the control of the health plan
 - Help respondents orient to the patient experiences the survey seeks to measure
 - Use appropriate financial incentives to encourage participation
 - Pilot a web-mode option
 - Test novel CAHPS scoring approaches that leverage provider CAHPS data, which, if successful, can facilitate a reduction in survey length

→ Introduction

Medicare Advantage is an option within the Medicare program that enables beneficiaries to enroll in comprehensive, integrated coverage offered by private insurers. In Traditional Medicare, beneficiaries pay separate monthly premiums for hospital, doctor, and prescription drug benefits. In MA, these benefits and premiums are rolled into one plan benefit package.¹ MA plans increasingly offer extra benefits not covered by Traditional Medicare, such as dental, vision, hearing, fitness, transportation, and healthy meals. MA has experienced a 60 percent enrollment increase since 2013, which compares to a 5 percent enrollment increase for Traditional Medicare. Today 25 million (40 percent) of Medicare beneficiaries are enrolled in MA plans; enrollment is projected to increase steadily in the years ahead as increasing numbers of Medicare beneficiaries choose MA.²

Health plans submit bids to offer MA benefits in specific counties and regions, and their bid determines the level of premiums charged to enrollees. In turn, the federal government pays health plans a risk-adjusted, per-member capitated rate to provide the hospital, doctor, and prescription drug benefits to seniors who choose to enroll in their MA plan. MA plans participate in a quality program known as the Star Ratings System, which measures plans on a 1-5 Star scale annually across a broad set of administrative, clinical, and health outcomes and patient experience measures. Plans with the highest overall Star Ratings receive bonus payments known as Quality Bonus Payments (QBP). MA plans that earn QBPs receive higher payment.

Across the health care system, research finds that improving patient experience translates to better health. Patients who feel heard and have positive care experiences have better health outcomes and are more likely to adhere to treatment plans.³ CMS uses patient experience surveys to ask Medicare beneficiaries, or their caregivers, about their experiences with doctors, hospitals, home health agencies, and medical and drug plans. CMS leverages the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) family of surveys in multiple federal programs. These surveys are developed or approved by the CAHPS Consortium, which is overseen by the Agency for Healthcare Research and Quality (AHRQ).⁴

CMS has placed increasing emphasis on the patient voice as a critical input for MA Star Ratings and plan payment. MA-PD CAHPS survey results are an important data source for MA plan contracts' annual MA Star Rating. The eight patient experience measures within the MA Star Ratings System were

1. There can be MA-only plan benefit packages (which do not include prescription drug benefits), but these packages represent a small percentage of overall MA enrollment.
2. BMA statistics. <https://www.bettermedicarealliance.org/medicare-advantage/about-medicare-advantage/>.
3. "Section 2: Why Improve Patient Experience?" AHRQ, Feb. 2020. <https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/2-why-improve/index.html>.

elevated in their relative importance by receiving a higher weighting in recent years—with the weights set to double from two to four in 2023.

As patient experience measurement has matured and gained importance, there is a growing call to action across stakeholder groups for its evolution.^{5,6} This growth and modernization is necessary so that patients, clinicians, health plans, accrediting entities, quality organizations, and policymakers can better rely on the accuracy of the results and information to drive quality as defined by CMS. This paper focuses on the need for evolution and improvement of the measurement of patient experience in Medicare Advantage.

4. “Consumer Assessment of Healthcare Providers & Systems (CAHPS).” CMS, July 2020. www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS.
5. Fishkin, R., Evans, S., Berman, E., & Burlingame, S. “It’s Time To Take Patient Experience Measurement and Reporting to a New Level: Next Steps for Modernizing And Democratizing National Patient Surveys.” Health Affairs, March 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200309.359946/full/>.
6. Tesler, R., & Sorra, J. “CAHPS Survey Administration: What We Know and Potential Research Questions.” AHRQ, Oct. 2017. www.ahrq.gov/sites/default/files/wysiwyg/cahps/about-cahps/research/survey-administration-literature-review.pdf.



RESEARCH METHODOLOGY

Experts at NORC at the University of Chicago conducted mixed-mode research from April 2020 to September 2020. The NORC team reviewed published literature about patient experience measurement, research about CAHPS surveys, and letters from a wide array of stakeholders commenting on the use of CAHPS for health plan quality measurement and payment.

NORC conducted a nationally representative survey of 800 MA beneficiaries using AmeriSpeak[®], a mixed-mode, household panel. The survey sought to understand beneficiaries' perspectives and experiences with MA-PD CAHPS. The survey included questions taken directly from the MA-PD CAHPS instrument and probing follow-up questions. The survey also asked enrollees how they chose their health plan and what they valued most about their current plan. NORC conducted five additional MA beneficiary interviews to provide direct, contextual insights that reflect what MA beneficiaries value most in terms of patient experience as they access their Medicare benefits with an MA-PD plan.

NORC then conducted qualitative interviews with 41 experts from 20 organizations representing a cross-section of health plans, providers, health plan associations, consultants with health plan marketing and health policy expertise, tech-enabled physician support platforms, and consumer advocates. The interviews were conducted from June 2020 through September 2020 and focused on opportunities for improving consumer experience measurement in MA.



CORE PRINCIPLES FOR MEASURING CONSUMER EXPERIENCE IN MA PLANS

All stakeholders interviewed for this project agreed that patient experience is important and should be measured effectively. Health plans and providers devote significant energy and resources to tracking and improving patient experience. Some plans have dedicated, cross-functional teams focused explicitly on measuring and improving patient experience, enrollee loyalty, and satisfaction. Others have assembled smaller groups of staff focused on improving patient experience, and ownership of the work is a collaborative effort across marketing, customer service, and MA Star Ratings teams.

Provider organizations talked extensively about empowering physicians to ensure care is patient-centered, using MA-PD CAHPS to measure and improve patient experience. Working to improve the experience patients have when interacting with the different facets of the health care system creates a foundation of trust, which can lead to greater patient buy-in and adherence to treatment plans. Satisfaction and loyalty typically follow, which can lead to better health.

Based on input from plans, providers, and beneficiaries, recommendations are made to improve and modernize patient experience measurement in MA. **The core principles underpinning these recommendations are that MA plans should be held accountable for patient experience measures that are meaningful, actionable, and accurate. The specific core principles are:**

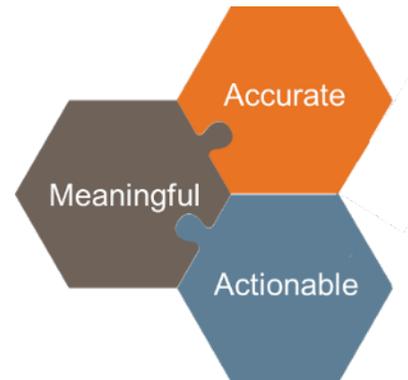
Meaningful: MA-PD plans should be measured on aspects of patient experience that members say are important to them when they choose a plan and stay in a plan. It also means designing measurement approaches that capture the diversity of beneficiaries, including those representing various demographics, socioeconomic status (SES), and health needs.

“We happen to believe that [patient experience] is a key part of the clinical model. We believe it’s part of the clinical model because if a patient is having a bad experience, that they can’t access care, if their doctors are clueless about what’s going on with them, if they’re not respectful or [they’re] dismissive, the patient doesn’t open up or share what’s going on with them and as a result you can’t manage it. Most providers will tell you that patients spend a lot of time lying in exam rooms. Lies of omission and lies of commission. You know what? You tend to be more open with people who are kind and who you trust.”

– Primary Care Organization

Actionable: Data on MA-PD patient experience should be made available in ways that allow plans to act on the results and work with their provider and pharmacy network partners to improve performance. The goal of linking patient experience to plan payment is to encourage attention to and improvement on these measures. Supplying plans with sufficiently granular CAHPS feedback is critical to enabling them to interpret and act on the information. Further, measurement should focus on patient experiences that plans have an ability to influence, placing less weight on aspects of experience that plans cannot control, such as patient wait time during physician visits.

Accurate: Data collection for patient experience measures should be designed to elicit accurate and complete information from a diverse set of beneficiaries. Following this principle ensures that a truly representative set of voices are heard and reflected. This means using methods that maximize the respondent’s ability to remember their experiences and convey them reliably.



We use these core principles in this paper as an organizing framework for identifying current limitations of the MA-PD CAHPS and to recommend improvements to patient experience measurement in the program.



BACKGROUND ON THE MA-CAHPS SURVEY AND THE STAR RATINGS SYSTEM

The Medicare CAHPS survey includes three versions of the questionnaire: MA Only, MA-PD, and PDP. For the purposes of this paper, NORC focuses on the MA-PD CAHPS survey, given that most MA enrollment is in MA-PD contracts. CMS requires MA-PD plan contracts with over 600 enrollees to hire a survey vendor to administer the survey to beneficiaries. Every year, CMS selects a random sample of beneficiaries for each eligible contract using monthly enrollment data files. To be eligible for the sample, a beneficiary must be continuously enrolled in the contract for six months or more at the time of the sample draw in January.⁷ For MA-PD contracts, the target sample size is 800 enrollees.⁸ Plans may request an oversample to the plan's discretion, up to 100 percent of their membership. The CMS selected sample is then sent to the approved MA-PD CAHPS survey vendor hired by the health plan to administer, collect, and report the data. CMS sets the annual survey administration timeline and protocols. Survey vendors submit data to CMS, which in turn calculates and performs case-mix adjustment of the survey data prior to public reporting, and shares the official contract-level results with MA-PD plans. To help ensure that comparisons between contracts reflect differences in performance rather than systematic differences in response tendency associated with respondent characteristics, CMS performs case-mix adjustment of MA-PD CAHPS survey data across the following variables: age, education, self-reported general health status, self-reported mental health status, proxy assistance or completion of the survey form, dual-eligible status, low-income subsidy eligible, and Asian language survey completion (i.e., Chinese and Vietnamese).⁹



* This composite measure is for reporting to contracts only and is not reported to consumers.

7. "MA & PDP CAHPS@ Survey Vendor Training, November 2019." Centers for Medicare & Medicaid Services, Baltimore, MD. October 19, 2020. www.MA-PDCAHPS.org.

8. Ibid. For MA contracts with 600–799 eligible enrollees, CMS will sample all eligible cases; MA contracts with 450–599 eligible enrollees have the option to participate in the survey, but participation is not required; MA contracts with fewer than 450 eligible enrollees may not participate in the survey.

9. Ibid, p. 65.

Preview result reports are emailed to MA-PD plan compliance officers in August each year. These reports summarize the contract's survey scores and compares contract scores to state and national benchmarks, CAHPS scores of competitors in the contract market areas, and FFS CAHPS scores.

Final CAHPS reports are mailed to MA-PD compliance officers in late fall. The MA-PD CAHPS survey asks questions about respondents' health care and their health plan experiences in the last six months. The MA-PD survey currently consists of 68 questions across six topical areas (shown below),^{10,11} with a maximum of an additional 12 plan-generated questions (known as supplemental questions, which must be approved by CMS).



Beginning in 2012, MA-CAHPS data were included in MA-PD Star Ratings System. Of the current 68 MA-PD CAHPS survey questions, 21 serve as primary data sources for nine Part C and Part D individual MA-PD Star Ratings measures. The table below shows the nine patient experience Star Ratings measures and the corresponding CAHPS questions that feed into those measures.

10. Some of the 68 questions are screener questions, meaning that not every respondent will answer all questions if the questions ask about health experiences within the last six months that are not applicable to them. https://ma-pdcahps.org/globalassets/ma-pdp/program-overview/2020/2020-fact-sheet_final.pdf.

11. The first two questions on the MA-PD CAHPS survey ask the respondent about the name of their health plan and are not grouped under a topical area header. It is also important to note that the way in which CAHPS data are organized and displayed varies based upon whether the audience is Medicare beneficiaries and the public, or the plans themselves. For example, while plans receive their contract score information for each MA-CAHPS measure, not all of that information is reported to the public. As an example, questions regarding how well doctors communicate and the pneumonia vaccine are reported to plans only.

Getting Needed Care

- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed it?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

Getting Appointments and Care Quickly

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as your needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Customer Service

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
- In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?
- In the last 6 months, how often were the forms from your health plan easy to fill out?

Care Coordination

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Getting Needed Prescription Drugs

- In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Rating of Healthcare Quality

- Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last 6 months?

Rating of Health Plan

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

Rating of Drug Plan

- Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?

Annual Flu Vaccine

- Have you had a yearly flu shot since July 1, 2019*

* The single CAHPS question about whether an enrollee has received an annual flu vaccine is the primary data source for the MA Stars "Staying Healthy: Screenings, Tests and Vaccines MA Star Rating Annual Flu Vaccine measure".

The five composite patient experience measures, three "member rating" CAHPS measures, and the single item flu vaccine measure that leverage CAHPS data feed into the MA-PD contracts' Star Ratings.¹²

For the last several years, CMS has communicated the agency's desire to emphasize the patient's voice to "put patients first."¹³ In MA, one of the ways the agency has sought to achieve this goal is by elevating the importance of measuring patient experience. In 2016 and 2017, CMS proposed new policies to more heavily weight the measures within the patient experience and access areas in the Star Ratings formula.¹⁴ In April 2018, CMS codified a rule that would increase the patient experience and complaints and access measure weights from one and a half to two for plan year 2021.¹⁵ In 2020, CMS finalized a policy to further change the weighting of the patient experience and access measures from two to four, starting with plan year 2023 Star Ratings. Doubling the weighting from two to four will mean that patient experience and access measures will constitute almost one third (32 percent) of a plan's overall Star Rating in 2023.^{16,17} CMS finalized this weighting increase despite receiving feedback from health plans and quality measurement organizations that the MA-PD CAHPS survey, along with a number of the policies CMS has implemented involving the survey, are in need of modernization and improvement before the agency further increases the emphasis on patient experience and access measures for plan year 2023.¹⁸

"[Patient experience, complaints, and access] measures are critically important and could benefit from greater attention from plans that increased weighting generates. However, we encourage you to not move forward on this until we have better measures in these areas. The Consumer Assessment of Health Plans Survey (CAHPS) is long and has low responses and long lags in feedback that does not target which enrollees are having what types of problems.... Once we have better measures in these areas, it would make sense to consider increasing the weights."

– National Committee Quality Assurance
Comment Letter, CY 2019 Policy and
Technical Changes to MA

12. "Medicare CAHPS Fact Sheet." Ma-PD CAHPS, June 2020. ma-pdpcahps.org/globalassets/ma-pdp/program-overview/2020/2020-fact-sheet_final.pdf.
13. "Patients over Paperwork." CMS. <https://www.cms.gov/About-CMS/Story-Page/patients-over-paperwork>.
14. Eight of 18 of these Part C and D measures slated to increase in weights (patient experience and access) are calculated using data results from specific questions from the MA-PD CAHPS survey.
15. "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program." Govinfo, April 2018. www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf.
16. "Medicare Program: Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program." Regulations.gov, June 2020. www.regulations.gov/document?D=CMS-2020-0010-0663.
17. Advisors, GHG. "Star Ratings Take Aim at Member Experience in 'Huge' Shift." GHG Insights, July 2020. www.gormanhealthgroup.com/blog/member-experience-impact-2021-Star-Ratings/.
18. Proposed Rule: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program. National Committee for Quality Assurance – DC comment letter. <https://www.regulations.gov/document?D=CMS-2017-0156-0916>.



GENERATING MEANINGFUL RESULTS

Certain opportunities to rethink components of the MA-PD CAHPS survey would provide more meaningful information to key stakeholders, such as MA-PD plans, beneficiaries, and CMS. Patient experience measurement should reflect how today's MA beneficiaries experience the care they receive. It should also measure what they value about those care experiences. MA-PD CAHPS questions need to be updated to align with current health care terminology and trends in benefit design and care delivery.

Patient experience in MA must also do more to account for the personal characteristics of the growing number of Medicare beneficiaries choosing to enroll in MA, including the marked growth in enrollment of low-income, dually eligible, and racially and ethnically diverse beneficiaries. To do that, the questions posed to beneficiaries on surveys must better reflect varied lived experiences and ask about the health care interactions that both support the maintenance of health and that are most important to them.

Reflect Modern Care Delivery: MA-PD CAHPS survey measurement must reflect changes in how health care delivery, benefit design, and health care access have evolved in recent years.

Context: The MA-PD CAHPS survey does not reflect many of the new, patient-centered approaches to care delivery. Examples of this disconnect can be found in the current set of care coordination questions and in the lack of content addressing telehealth or virtual visits. First, the questions do not reflect advancements in health information technology (IT), such as tools that payers and providers use to communicate test results and coordinate follow-up care. Second, the questions do not contemplate the role that plans increasingly play in care coordination, care management, and navigation—instead, they focus exclusively on the provider's role in care coordination. Third, the survey instrument does not include language around the use of remote monitoring, telehealth, or virtual visits—technologies that have become vital to MA beneficiaries for staying connected to their health teams during

“We’ve heard personally from patients that this confused them. ‘Last time I was in the office I saw the nurse practitioner and I got a survey right after that and it said, “Did your doctor...” That’s one thing that needs to be modernized. ‘Did your primary care organization ask you to do these things?’ We work better in care teams.”

– Primary Care Physician speaking about a CG-CAHPS survey

the COVID-19 pandemic. In 2021, MA plans will have the ability to meet network adequacy requirements by including virtual visits from specialists in the network. Because these types of innovations are not captured in the current survey, the patient experiences of many MA beneficiaries today and in the future may not be adequately reflected in the current survey questions and subsequently in the responses.

In addition, the MA-PD CAHPS instrument lacks contemporary language to characterize the shift toward more patient-centric care interactions. For instance, the survey does not acknowledge the concept of care teams, nor does it contain questions on patient-provider shared decision-making or meaningful questions about the cost of care.

Stakeholder Feedback: A common piece of feedback from plans was that many of the MA-PD CAHPS questions feel dated in the language choices and do not accurately reflect the way that beneficiaries think about or receive care today. During the interviews, plans suggested adding questions about whether beneficiaries feel supported by the organization, whether plan benefits are helpful and useful to members, and questions to understand the need for benefits that address social determinants of health (SDOH). Plans and providers also suggested that health care today is more matrixed, with a flexible care team model that involves a multidisciplinary team of clinicians (e.g., nurse practitioners, social workers, health coaches, care managers) to treat whole-person health.

The COVID-19 pandemic presents another disconnect between the current health care reality and the MA-PD CAHPS survey, which was conducted from July through August 2020 and included questions about how care delivery and access have changed during the pandemic. According to the results, 42 percent of respondents reported having one to two health care visits over the past six months conducted over the phone or on a computer. Although before the pandemic the frequency of virtual visits was low for all populations, the pandemic will likely continue to shift the way care is delivered and the MA-CAHPS survey should evolve accordingly.

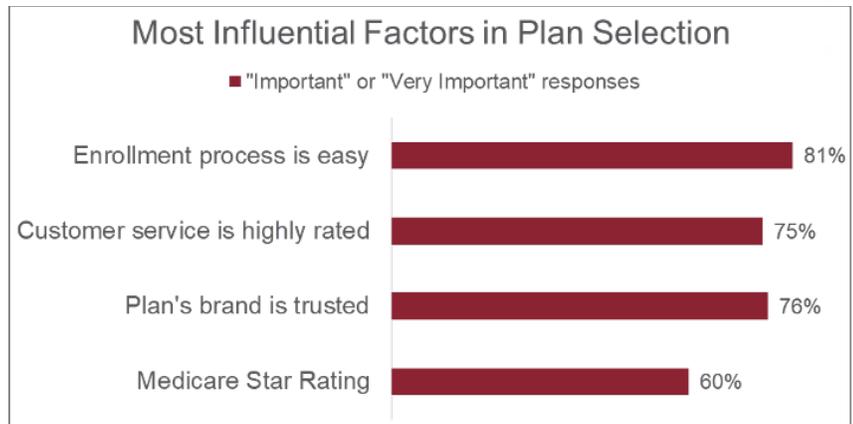
Address Topics Important to Beneficiaries: Research consistently shows that what drives most beneficiary enrollment and plan selection decisions in MA is affordability (e.g., premiums, out-of-pocket costs). Other important drivers include the brand, physician and hospital networks, customer service, supplemental benefits, or prescription drug coverage. Within customer service, beneficiaries place high value on ease of enrollment and pre-approvals, and the appeals process for denied claims. Yet, the MA-PD CAHPS survey does not address these topics.

Context: According to CMS, one of the use cases of the MA-PD CAHPS survey is to provide beneficiaries with information that helps them choose a plan, but beneficiaries indicate that what they value when selecting a plan is affordability,

brand, plan network, and covered benefits. Beneficiaries are less likely to report that patient experience measures or a plan’s overall Star Rating are important for their selections.¹⁹ While current MA patient experience measurement does include questions about plan customer service, the other highly valued plan attributes mentioned above are not included.

Stakeholder Feedback:

The beneficiary survey results showed that the current instrument is light on questions and topics that are meaningful to consumers as they select plans. While 60 percent of respondents noted that a plan’s MA Star Rating is important when it comes to selecting a plan, a larger percentage of respondents said that ease of enrollment (81 percent), brand (76 percent), and customer service (75 percent) were the most influential factors in selecting a plan.



Although customer service is one of the composite measures included in the patient experience Star Rating calculations, the questions in the MA-PD CAHPS instrument relate to whether the enrollee received help from the health plan’s customer service, if they received the information they needed, and if they were treated with courtesy or respect. According to the NORC survey, most enrollees consider ease of accessing health services (94 percent) and not denying coverage (95 percent) to be equally important to the customer service questions.



When asked about their experience with two previous MA-PD plans on a 0-10 scale, one beneficiary rated the plans with a score of one and zero. When asked about their scoring, the beneficiary replied:

“Twice they denied a claim that was very straightforward. Two different claims that were very straightforward. They should have paid those claims and I had

19. “Only 32% of Medicare Advantage Members Are Familiar with Star Ratings in 2019, Up from 22% in 2018: HealthMine Survey.” PR Newswire, May 2019. www.prnewswire.com/news-releases/only-32-of-medicare-advantage-members-are-familiar-with-star-ratings-in-2019-up-from-22-in-2018-healthmine-survey-300853044.html.

to appeal both of those. They did approve the appeal, but I'm thinking the average person isn't going to spend all that time doing the appeals. So, that was very cumbersome."

The beneficiary went on to explain the scoring for the second plan, saying they "had to get everything preapproved and it took a very long time to approve things. I should have started physical therapy right away but it took months to get it pre-approved."

Representing Diverse Membership: Patient experience measurement in MA must account for the personal characteristics of the growing number of Medicare beneficiaries choosing to enroll in MA, including the marked growth in enrollment of low-income, dually eligible, and racially and ethnically diverse beneficiaries.

Context: As MA enrollment grows, the program increasingly serves diverse populations. These populations may speak English as a second language, they may experience low health literacy, have multiple chronic conditions, and experience SDOH challenges. Around 20 percent of the total MA population are dually eligible beneficiaries, meaning they qualify for Medicare and Medicaid benefits. Nineteen percent of MA beneficiaries did not complete high school, compared to 13.5 percent in fee-for-service (FFS) Medicare.²⁰ For individuals earning less than 100 percent of the Federal Poverty Level (FPL), the likelihood of having less than a high school degree is 36 percent in MA compared with 15 percent in FFS. These beneficiaries may experience health care in profoundly different ways than higher-resourced MA beneficiaries. While CAHPS survey results are case-mix adjusted to allow for comparisons among MA plans with different enrollment compositions, the survey instrument itself may not appropriately capture the varying experiences and challenges that these diverse populations face when receiving care.

A study conducted by RAND and Westat found dramatic differences for subjective rating items among patients who took the survey in other languages.²¹ The study casts doubts on the appropriateness of cross-cultural comparisons. According to a report published by CMS in 2017, Asian and Pacific Islanders reported experiences that were worse than the experiences reported by whites for six of the patient experience measures.²² This study highlights the difference in perceptions of patient experience between respondents of different ethnicities. It also suggests that the way questions are asked on the MA-PD CAHPS survey could affect the way respondents with different life experiences answer the questions.

20. ATI Advisory. "Data Brief: Social Risk Factors Are High Among Low-Income Medicare Beneficiaries Enrolled in Medicare Advantage. September 2020. Prepared for Better Medicare Alliance. <https://www.bettermedicarealliance.org/publication/data-brief-social-risk-factors-are-high-among-low-income-medicare-beneficiaries-enrolled-in-medicare-advantage/>.
21. Elliott, M. N., et al. "Difference by Survey Language and Mode among Chinese Respondents to a CAHPS Health Plan Survey" RAND Corporation, Jan. 2012. www.rand.org/pubs/external_publications/EP201200159.html.
22. "Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage." CMS, April 2019. www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2019-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf.

Stakeholder Feedback: The issues of linguistic diversity, health literacy, and access to the survey raise concerns about whether the survey can adequately and appropriately compare the experiences of plans that serve ethnically diverse populations, dually eligible populations, or populations with significant health needs to all MA-PD plans. Two plans specifically emphasized the cultural interpretation and language challenges that the survey presents.



CREATING ACTIONABLE INSIGHTS

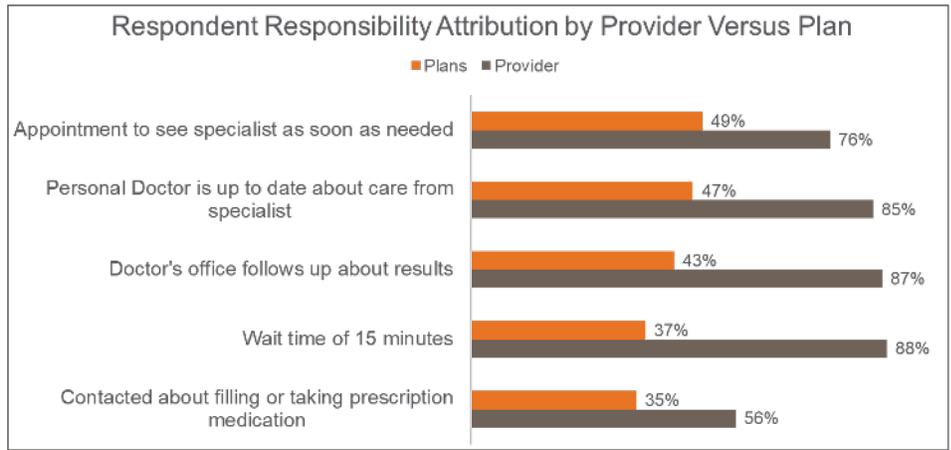
While the aggregated results of the MA-PD CAHPS survey are provided to plans, and the MA Star Ratings patient experience measure results are public, the contract-level MA-PD CAHPS results are not actionable for plans. More information that simultaneously respects enrollees' confidentiality and informs the plans about where to focus patient experience improvement activities can and should be provided to MA-PD plans.

Measure Experiences that Are in a Plan's Control: MA-PD CAHPS survey domains that feed MA Star Ratings should be within plans' control. Measures that are completely or largely controlled by the provider should not impact plan performance. While plans do control which providers are in their networks, these decisions are based on many factors—including network adequacy requirements, health outcomes, and plan payment rates—not just the quality of patient experience delivered by the provider.

Context: Measurement and patient experience scores in MA should reflect the parts of the patient experience journey that matter most to enrollees, and that are within the plans' power to control or influence. Several MA-PD CAHPS questions that feed into the patient experience MA Star Ratings measures ask about experiences that are outside the control of health plans. One particular question about whether patients were seen within 15 minutes of an appointment time sits far outside the sphere of influence for most health plans.

Stakeholder Feedback: Plans expressed strong support for the idea that they should be evaluated on patient experience measures that they have the ability to influence with compliant operational changes or quality improvement activities. Plans consistently raised the question around wait times when discussing the idea of influence and control.

Beneficiaries also do not view provider office wait times as an issue a health plan can control or influence. One beneficiary put it bluntly, saying, “I wouldn’t call my health plan about a wait time in a doctor’s office.” The beneficiary survey found that MA enrollees attributed many MA-PD CAHPS survey



questions to the responsibility of the provider versus the plan. When the survey respondents were asked who is responsible for determining wait times in a provider office, 88 percent said that the medical provider they are there to see is “somewhat” or “very responsible” for the wait time. The responses showed a similar pattern of attributing responsibility for things such as doctor’s office follow-up, appointment wait times, and reminders for prescription filling to entities other than the enrollee’s health plan.

When asked to whom they attribute responsibility for making sure their personal doctor is up to date about the care they receive from their specialists, 85 percent said their personal doctor was “somewhat” or “very responsible,” while 87 percent of respondents said their specialist was “somewhat” or “very responsible.”

Increase Data Granularity: Improving the MA-PD CAHPS feedback loop for health plans while also protecting beneficiary privacy is imperative. Plans need increased data granularity to ensure that they can act on the results to improve consumer experience.

Context: Today, approved survey vendors hired by health plans to field their annual surveys provide generalizable survey results about each qualifying health plan MA-PD contract. Health plans may request different cuts of their data from their survey vendors. CMS must approve those requests and can turn them down. For example, the CMS-set survey vendor rules do not generally allow a health plan to receive survey results. As a result, health plans cannot discern whether beneficiaries in certain geographies are experiencing challenges to accessing care, poor care coordination, or are waiting longer than 15 minutes in a provider’s office to get the care they need.²³ CMS states its rationale for not providing more granular data is due to its policy that guarantees respondents’ confidentiality in their responses.

23. The MA-CAHPS survey asks respondents to recall whether they have waited longer than 15 minutes to get the care they need.

Stakeholder Feedback: All health plans and health plan association organizations interviewed stated a strong desire for CMS to identify ways to make MA-PD CAHPS survey results more actionable and meaningful. For instance, multiple plans stated that they administer surveys in December and January to enrollees who see certain physicians or physician groups to better understand which providers are experiencing challenges in patient wait times and care coordination activities.

Given that the majority of questions asked on the MA-CAHPS survey involve provider office dynamics and provider-initiated care coordination activities, health plans develop their own internal survey operations inspired by CAHPS (e.g., conducting their own surveys across their markets, journey mapping, focus groups). This allows them to field similar questions and interpret the results at a granular network level to make quality improvements.

And without more data about which providers are contributing to patient experience scores (in either positive or negative ways), health plans lack critical information that could be used to affect change in this area.

→ IMPROVING ACCURACY OF RESPONSES

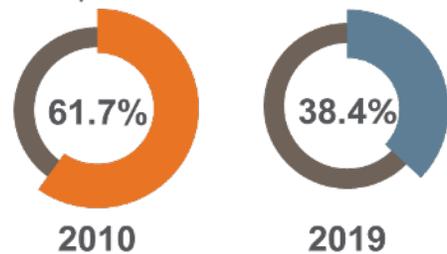
Survey methods research has long demonstrated ways in which surveys can produce accurate and reliable information. Length, question formation, page layout, use of incentives, and survey mode all impact response and completion rates. The MA-PD CAHPS survey is primarily a paper-mode mailed survey of older adults. It is long and is fielded up to six months after rendered services. CMS does not allow the use of incentives to encourage survey completion. Taken together, these factors may negatively impact the accuracy of responses. This research points to opportunities for improvement in each of these areas.

Improving Response Rates: The MA-PD CAHPS survey needs to be shortened and offered via the internet to improve response rates.

Context. The current sample size for all MA-PD contracts is 800 enrollees. If a plan's total enrollment is between 600 and 800, all eligible cases will be surveyed. If a contract has fewer than 600 eligible enrollees, plans may have the option to not field the survey.²⁴ According to the MA-PD CAHPS website, the response rate for the MA-CAHPS surveys (MA-Only, MA-PD, and PDP-only) has seen a gradual but consistent decline since the introduction of the survey. Most notably though, in 2019, the survey saw an all-time low response rate of 38.4 percent, compared to 61.7 percent in 2010.²⁵ While response rates have been declining across the field of survey research, it is essential to understand changes in data quality over time. Unfortunately, unlike other major surveys administered by CMS, the MA-PD CAHPS survey does not report on longitudinal data quality metrics like sample composition and differences in characteristics between respondents and non-respondents. Falling response rates without additional information about data quality pose a reliability problem for the MA-PD CAHPS survey.

Stakeholder Feedback. Plans expressed concern about declining survey response rates, considering the potential bias that small sample sizes and shrinking response rates may have on their CAHPS scores, which in turn impact their Star Ratings. Plans and quality measure experts suggested the length of the survey is one potential reason for the low response rates.

Response Rates Over Time



24. "Quality Assurance Protocols and Technical Specifications." Medicare Advantage and Prescription Drug Plan (MA& PDP) CAHPS Survey. CMS, Nov. 2019. <https://www.ma-pdpcahps.org/globalassets/ma-pdp/home-page/2020-mapdp-cahps-qapts-v10---complete-manual---508-compliant.pdf>.

25. CAHPS Survey National Response Rates." MA-PDP CAHPS, Oct. 2019. www.ma-pdpcahps.org/globalassets/ma-pdp/comparative-data/current-and-historic-overall-response-rates.pdf.

MA-PD CAHPS research by RAND in 2019 looked at the correlation between mail survey length and layout with response rates. RAND found that shorter survey length and fewer supplemental questions have a strong, positive relationship with response propensity, when controlling for beneficiary characteristics.²⁶ Specifically, RAND’s research found that for every six questions added to the survey, response rates declined by more than one percentage point. The effect becomes more pronounced among certain minority groups and when the survey is administered over the phone.

Other researchers have also examined the reliability and validity of Clinician and Group CAHPS (CG CAHPS) survey results when a reduced number of questions are posed to respondents. These researchers concluded that certain survey topic areas (known as domains and comprising multiple questions) could be reduced to as few as one or two questions and still maintain reliability.²⁷ This research is promising and should be replicated in the MA-PD CAHPS survey instrument.

Another potential reason for decreasing response rates is the mode—in this case, a paper mail survey with phone follow-up for non-respondents. The MA beneficiary survey found three out of four respondents (76 percent) said their preferred method to receive and complete a survey is web/email. MA beneficiary respondents reported that mail (30 percent) and phone (54 percent) were the least preferred method of receiving and completing a survey. As discussed by the MA and Part D contract Star Ratings technical expert panel convened by CMS in May 2018, providers and plans have expressed dissatisfaction with CAHPS’s mode of administration. The discussion summary states that CMS is currently testing web-based and mixed-method surveys across different settings and populations, and that CMS is committed to exploring this further.²⁸



Most preferred method to receive survey is web/mail

26. Burkhart, Q. et al. “Associations of Mail Survey Length and Layout with Response Rates.” *Medical Care Research and Review: MCRR*, U.S. National Library of Medicine, Nov. 2019. pubmed.ncbi.nlm.nih.gov/31747849/. 12

27. Tesler, R., & Sorra, J. “CAHPS Survey Administration: What We Know and Potential Research Questions.”

28. Damberg, C. L., & Paddock, S. M. “RAND Medicare Advantage (MA) and Part D Contract Star Ratings Technical Expert Panel May 31st 2018 Meeting.” RAND Corporation, August 2018. www.rand.org/pubs/conf_proceedings/CF391.html.

In interviews, plans expressed a desire to see a pilot project that would add a web-based component to the MA-CAHPS survey, particularly as more seniors who are comfortable with the internet age-in to Medicare. Importantly, some plans, plan associations, and consumer advocates pointed out that the survey should not transition entirely to web, given the lack and cost of internet access and technology proficiency for some seniors, particularly those living in rural areas or with low SES. Rather, a web-mode should be made available as an option for beneficiaries who would prefer it.

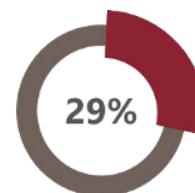
Some plans and provider groups have implemented alternative methods of collecting information about patient experience and satisfaction with their care through the use of Net Promotor Score (NPS). A number of plans and providers that NORC interviewed reported relying on NPS as a real-time indicator of whether they are meeting the needs of their beneficiaries. CMS recently solicited feedback on adding NPS as a potential future Star Ratings measure and reported that many commenters were opposed to adding NPS as a future Star Ratings metric. CMS said that commenters shared volatility and reliability concerns, in addition to concerns about NPS duplicating existing MA-PD CAHPS questions, which have shown to be correlated with the NPS questions.²⁹ That said, numerous providers, plans, and quality measurement experts that NORC interviewed expressed support for studying how an NPS metric might compare to the current MA-PD CAHPS patient experience Health Plan Rating and Health Care Rating measures. They wanted to learn whether a single NPS score could replace the three CAHPS 0-10 rating questions.

Supporting Respondent Recall: Changes in the fielding approach could help beneficiaries remember their experiences with plans and providers to improve accuracy of their responses.

Context. Age, disability, and overall cognitive facility play a role in respondents' ability to accurately answer survey questions. In the MA-PD CAHPS, respondents are asked to recall their health care experience over the past six months. The survey instrument is general and asks about experiences with "your personal doctor" or "specialist" but does not name the beneficiary's physician or specialist.

"I think [the addition of web mode] would have to be phased in. Today, 60 percent of our customers have smartphones. Just a few years ago, that number was tremendously lower. I think the industry is going there, I think it makes it easier. We tend to serve underserved beneficiaries; in our traditional markets, our core population is from inner cities, rural, lower income, etc.... How do plans compare if they serve different populations? Are we going to [be] put in a situation where we're not going to be successful because we have an underserved population who is looking for paper surveys? Directionally, I love the idea, but some testing would need to happen."

– National Committee Quality Assurance –
Large Health Plan



Respondents reporting not feeling "very confident" to recall wait time

29. Announcement of CY 2021 MA Capitation Rates and Part C and D Payment Policies. <https://www.cms.gov/files/document/2021-announcement.pdf>.

It also asks whether members received their flu³⁰ and pneumonia vaccine since July of the prior year.

Stakeholder Feedback. Many plans raised the concern over the accuracy of the six-month recall window, particularly with older adults. Further, stakeholders were concerned about the lack of specificity around which “personal doctor” or “specialist” the respondent should address in their answers. Plans reacted positively to the idea that CMS would allow survey vendors to include the name of the patient’s primary care practitioner or specialist in the question text, as a way to ensure the beneficiaries are recalling and reflecting on visits that occurred with the correct provider and within the timeframe, instead of only the most memorable or most recent visit with any provider. It is common practice for CG CAHPS surveys to insert the name of a particular clinician or physician group to “help orient the patient to the care he or she received.”³¹ Claims data could be leveraged to identify particular clinicians or physician groups most frequently visited by the MA-PD enrollee within the prior six months, and that clinician or group name would be added to the survey to facilitate better recall.

When MA enrollees were asked about ways to improve their recall ability when answering a CAHPS question about their care experiences, the NORC AmeriSpeak® MA beneficiary survey found that 82 percent of respondents reported that it would be easier to remember the details of their experience if they were reminded of the specific visits they had. This is true for those beneficiaries with multiple chronic conditions who see multiple clinicians over a six-month time period. It also impacts individuals who experience intense, prolonged care episodes (such as those receiving treatment for cancer or those who have end-stage renal disease [ESRD]), who may have many health interactions over a period of weeks and months. The beneficiary feedback highlights the lack of specificity and long recall window in the current MA-CAHPS survey.

Another MA-PD CAHPS survey question that was flagged by stakeholders for potential recall challenges related to in-office wait times. “In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?” When MA-PD beneficiaries were asked about their ability to recall the amount of time waiting to be seen for their care, 29 percent reported not feeling “very confident” in their ability to recall the wait time.

“One of the things that frustrated me when I was going through cancer, and having a lot of appointments: You visited a hospital on such and such a date. I may have had multiple appointments that day. If I had to take a survey about something that happened six months ago, it would be very general and based upon my impression of a doctor at that time.”

– Beneficiary

30. The question on whether the member received their annual flu shot is one that feeds directly into the MA Star Ratings (measure C-03 Yearly Flu Vaccine) from the CAHPS survey, though it is weighted as a process measure 1) rather than a patient experience measure and 2) in the Stars formula.

31. “2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey via CMS-Approved Survey Vendor Reporting.” QPP, 2018. qpp.cms.gov/resource/2018%20CAHPS%20for%20MIPS%20Survey%20Overview%20Fact%20Sheet.

At least two plans shared examples of internal initiatives that they believed highlighted the challenges of the recall window for their enrollees. Both plans compared their MA-PD CAHPS survey results about whether enrollees received a flu vaccine and contract-level claims data. Both plans saw higher levels of flu vaccine compliance in their claims data than the lower percentage in their MA-PD CAHPS survey results. The following year, both plans launched member outreach campaigns to remind beneficiaries to get the flu vaccine, and when appropriate, to remind them that they had indeed received one that year. After these campaigns, both plans indicated they saw improvement in their MA-PD CAHPS survey results, in alignment with their claims data. Although the flu vaccine question on the MA-PD CAHPS is not weighted as a patient experience measure, the recall problems that these examples highlight are relevant to the patient experience questions asked on the survey.

“One of our contracts was underperforming on flu shots. We went through an exercise and put in a new outreach and incentive program for our physicians, and from a claims perspective (recognizing there are a lot of ways to get flu shots that don’t show up in claims), we saw the highest rate of flu shots from a claims perspective in market history ... yet our flu shot CAHPS scores in that market actually dropped that year. The next year, we did the same program but added in an interactive voice response reminder that they had a flu shot, and our CAHPS scores improved immediately.”

– Large Health Plan

→ POLICY RECOMMENDATIONS AND NEXT STEPS

Based on this in-depth research with health plans, provider groups, consumer advocates, and MA beneficiaries, the following policy recommendations will modernize the CAHPS-based consumer experience measures by making the survey more accurate, meaningful, and actionable.

→ **RECOMMENDATION:** Modernize patient experience measurement in MA.

To ensure the survey measures aspects of patient experience that are important to MA beneficiaries, CMS should undertake a thorough review of the MA-PD CAHPS instrument and consider the following:

- ▶ Include questions that address the evolution of the care team so that beneficiaries may provide feedback on their experience with multiple members of their care team (e.g., nurses, physician assistants, social workers, therapists).
- ▶ Include questions that speak to the care coordination, care management, and navigation roles payers increasingly play for their MA members.
- ▶ Include questions that ask about patient experience with virtual appointments and visits, which may include ease of scheduling the virtual visit, timely follow-up from the provider and/or plan on the virtual visit, and overall satisfaction with the virtual visit.
- ▶ Modify questions to capture health IT advancements that payers and providers use to communicate test results and coordinate follow-up care.
- ▶ Consider additional user testing to address and account for the ways that individuals from different cultural backgrounds perceive care and how they respond to standardized survey questions.
- ▶ Include questions that capture the factors beneficiaries say are most important to them when choosing a plan, such as affordability and the provider network.

Across all stakeholders, NORC heard resounding feedback and suggestions for CMS to modernize patient experience measurement in MA. As described in detail above, the MA-PD CAHPS survey was originally developed in the late 1990s, and though the survey instrument has undergone revisions, many of the core questions remain. Based on this study's findings, the recommendations call for CMS to update various components of the MA-PD CAHPS, taking into account the realities of today's quickly evolving health care system such as the growth in the use of technology due to the COVID-19 pandemic, the evolution of the care team model, the increased use of care coordination, and the growth in cultural and linguistic diversity of the MA population. More recently, CMS developed additional CAHPS and CAHPS-

inspired surveys (i.e., CAHPS for ACOs, CAHPS for MIPS, the Qualified Health Plan [QHP] Enrollee Satisfaction Survey). which could serve as a model for where and how MA-PD CAHPS questions should evolve.

➔ **RECOMMENDATION:** Provide more granular CAHPS results to health plans while protecting beneficiary confidentiality to empower better quality improvement.

One reason the MA-PD CAHPS survey was developed was to help health plans identify areas for quality improvement. In order to allow health plans to use the survey data more meaningfully, CMS should:

- ▶ Empower the MA-PD CAHPS survey vendors, or designate another third-party, to provide de-identified CAHPS results that provide more actionable information to the plans. This should include more information about providers, respondent demographics, and geographies, but not beneficiary identifiable information.

We consistently heard across health plan interviews that health plans do not receive enough information related to their performance on the MA-PD CAHPS survey. The lack of granular data feedback contributes to challenges around targeting quality improvement strategies to fill those gaps in plan or provider operations that could improve patient experience. Consequently, to make up for the lack of actionable data, health plans spend administrative resources to conduct their own patient experience research to mimic CAHPS. More can and should be done to make the MA-CAHPS results actionable to help improve patient experience.

➔ **RECOMMENDATION:** Remove MA-PD CAHPS questions from the patient experience MA Star Ratings that health plans cannot directly impact, and increase the patient experience MA Star Ratings weights from two to four only after changes are made to modernize MA patient experience measurement.

Given the growing importance that Parts C and D patient experience measures play in the MA Star Ratings, CMS should work quickly to implement the following changes:

- ▶ Pause the MA Stars patient experience weight increase set to take effect in 2023.
- ▶ Questions that feed into the Parts C and D patient experience measures

should be closely reviewed to ensure they address issues that MA plans can influence. If they cannot be influenced, CMS should remove those questions from the survey, and remove them as data sources for the Parts C and D patient experience measures.

The qualitative research highlighted that many questions on the MA-PD CAHPS survey ask about experiences that are outside of the control of the plans. Similarly, the AmeriSpeak® MA beneficiary survey responses show a similar pattern of attributing responsibility for things asked about in the survey to entities other than the MA-PD plan.

→ RECOMMENDATION: Explore ways to reduce burden on the beneficiary survey respondent to improve response rates and data quality.

In order to help reverse the significant downward response rate trend, CMS should consider implementing the following solutions:

- ▶ Publish more thorough data quality assessments describing sample composition and changes over time, consistent with the Office of Management and Budget requirements for other federal surveys.
- ▶ Conduct a transparent exercise with MA-PD plans and survey methods experts to test the validity and reliability of reducing the number of MA-PD CAHPS questions.
 - This could include studying the removal of provider-focused MA-PD CAHPS questions from the MA-PD CAHPS survey instrument that overlap with questions from the CAHPS for ACOs or CAHPS for MIPS instruments, which are part of the Medicare physician Quality Payment Program (QPP).
 - It could also include removing questions from the MA-PD CAHPS survey instrument that can be captured using alternative methods of data collection for patient experience, such as NPS or through Healthcare Effectiveness Data and Information Set (HEDIS) measures (e.g., for the annual flu vaccination measure).
- ▶ Conduct a pilot program that adds a web-mode MA-PD CAHPS option to assess impact on completion rates.
- ▶ In line with survey method best practices, test the addition of a modest financial incentive for survey respondents (e.g., a dollar bill or nominal gift card) to increase completion rates.
- ▶ Add visit information to the MA-PD CAHPS survey to assist with orienting the respondent to the care they have received in the last six months. CMS should look to the CAHPS for ACOs and CAHPS for MIPS surveys as models for the MA-PD CAHPS survey to mirror questions related to supplying visit information.

Increasing response rates across the full spectrum of the MA population needs to be prioritized and may only be possible if the CAHPS survey is rationalized and streamlined to reduce survey fatigue among respondents. As noted earlier, prior research on CAHPS instruments has shown that reducing the length of the survey is correlated with higher response rates, thereby more accurately capturing beneficiaries' experiences. Many questions on the MA-PD CAHPS are similar to the CAHPS for ACOs and CAHPS for MIPS that are now reported to CMS for purposes of the new Medicare physician payment structure under QPP. Therefore, CMS should consider ways to take the results of the provider-based questions from those surveys, aggregate the results to each plan's physician network, and impute those scores into the relevant portion of the provider-focused patient experience measures within the MA Star Ratings methodology. By removing these questions and inputting them from other CMS survey results, the MA-PD CAHPS survey could be shortened significantly, which would give it greater capacity to capture information from MA enrollees about plan-specific experiences or simply to reduce the overall length of the survey.

→ CONCLUSION

Stakeholders across the health care ecosystem embrace the value that measuring and improving patient experience brings to patients. This research comes to the same conclusion, and thus suggests that patient experience measurement in MA needs to evolve to be more accurate, meaningful, and actionable. The research highlights significant limitations in the current MA-CAHPS survey. Given that MA CAHPS is used as the primary data source for the MA Star Ratings System, there is cause for action. The findings in this report indicate resounding agreement for the need to modernize measurement in CAHPS. Until that is done, it is premature to materially increase the weights associated with the patient experience measures in the MA Star Ratings. The comprehensive set of policy recommendations give policymakers a clear path forward to improve how MA patient experience information is collected, what is measured, and how results are transmitted to health plans.