SUPPORTING STATEMENT
PDP and MA-PD Disenrollment Reasons Survey

Background

The Centers for Medicare & Medicaid Services (CMS) requests clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 for the Medicare Prescription Drug Plan (PDP) and Medicare Advantage Prescription Drug Plan (MA-PD) Disenrollment Reasons Survey.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, created a new prescription drug benefit for everyone with Medicare – known as the Medicare Prescription Drug Benefit Program or "Part D." The Part D benefit went into effect January 1, 2006; as of February 1, 2009, 26.7 million Medicare beneficiaries had enrolled in the Part D benefit. CMS is working to ensure the quality of the Part D program, and seeks through the survey to obtain information about beneficiaries' reasons for disenrolling from their chosen Part D plan, and their expectations relative to provided benefits and services. Determining the reasons for disenrollment from Part D plans will provide important information regarding potential dissatisfaction with some aspect of the plan, such as access, service, cost, quality of care, or the benefits provided. This information can be used by CMS to improve the design and functioning of the Part D program. A secondary use of the information is quality improvement and contract oversight.

A. Justification

A1. Need and Legal Basis

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides a requirement to collect and report performance data for Part D prescription drug plans. Specifically, the MMA under Sec. 1860D-4 (Beneficiary Protections for Qualified Prescription Drug Coverage) requires CMS to conduct consumer satisfaction surveys regarding PDPs and MA-PDs – pursuant to section 1860D-4(d).

A2. Information Users

This data collection complements the satisfaction data collected through the Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) survey by providing dissatisfaction data in the form of reasons for disenrollment from a Prescription Drug Plan.

The data collected in this survey can be used to improve the operation of Medicare Advantage (MA) and Part D (PDP) plans through the identification of beneficiary disenrollment reasons. To the extent that these data identify areas for improvement at the contract level they can be used to inform CMS contract oversight.

A3. Use of Information Technology

The survey vendor will collect the data via a mixed mode data collection strategy that involves two rounds of mailed surveys, followed by phone interviews. Data from all returned surveys will be scanned into an electronic data file. Computer Assisted Telephone Interview (CATI) will be used as the secondary mode of data collection if a beneficiary does not respond to two mailed requests to complete the survey.

A4. Duplication of Efforts

A survey for individuals disenrolling from a Medicare managed care plan was last fielded in 2003. No standardized survey for disenrollees from Medicare Part D plans is currently in use.

A5. Small Businesses

Survey respondents are disenrollees from Medicare Prescription Drug Plans or Medicare Advantage Prescription Drug Plans. The survey should not impact small businesses or other small entities.

A6. Less Frequent Collection

The consequence of not collecting data as soon as possible after a beneficiary disenrolls from a prescription drug plan is that the beneficiary will be less able to recall their specific reasons for disenrolling from a Medicare Part D prescription drug plan and/or their experiences under their previous drug plan. This information is critical for Medicare Part D program improvement.

A7. Special Circumstances

None of the special circumstances described on Form OMB 83-I are applicable to this survey.

A8. Federal Register/Outside Consultation

A 60-day Federal Register notice was published on April 23, 2010; five comments were received.

A9. Payment/Gifts to Respondents

This data collection will not include respondent incentive payments or gifts.

A10. Confidentiality

Individuals contacted as part of this data collection will be assured of the confidentiality of their replies under 42 U.S.C. 1306, 20 CFR 401 and 422, 5 U.S.C. 552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974), and OMB Circular A-130.

A11. Sensitive Questions

The survey does not include any questions of a sensitive nature.

A12. Burden Estimate (Hours & Wages)

Exhibit 1 shows the estimated annualized burden for respondents' time to participate in this data collection. The Medicare PDP and MA-PD Disenrollee Survey will be administered to 120,000 beneficiaries in two survey versions: 1) for stand-alone Prescription Drug Plans (PDPs), and 2) for Medicare Advantage plans with Prescription Drug coverage (MA-PDs). (See attachments 3 and 4.) We anticipate that the stand-alone Prescription Drug Plan version will be completed by about 60,000 persons, and the Medicare Advantage with Prescription Drug coverage version will be completed by about 60,000 persons. The estimated response time of 0.28 hours or 16 minutes for the stand- alone PDP version of the survey is based on the length of that survey version, a pace of 4.5 items per minute, and CMS' experience with surveys of similar length that have been fielded with Medicare beneficiaries. Similarly, the estimated response time of 0.3 hours or 18 minutes for the MA-PD plan version of the survey is based on the length of that survey version, a pace of 4.5 items per minute, and CMS' experience with surveys of similar length that have been fielded with Medicare beneficiaries. As indicated below, the total burden is estimated to be 34,800 hours.

Exhibit 1. Estimated annualized burden hours

Survey Version	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
Medicare Disenrollee Survey, Stand-alone Prescription Drug Plan Version	60,000	1	0.28	16,800
Medicare Disenrollee Survey, Medicare Advantage Plan with Prescription Drug Coverage Version	60,000	1	0.3	18,000
Total	120,000	1	-	34,800

Exhibit 2 shows the survey participants' cost burden associated with their time to complete a survey. The total cost burden is estimated to be $680,688.

Exhibit 2. Estimated annualized cost burden

Form Name	Number of Respondents	Total Burden hours	Average Hourly Wage Rate*	Total Cost Burden
Medicare Disenrollee Survey, Stand-alone Prescription Drug Plan Version	60,000	16,800	$19.56	$328,608
Medicare Disenrollee Survey, Medicare Advantage Plan with Prescription Drug Coverage Version	60,000	18,000	$19.56	$352,080
Total	120,000	34,800	-	$680,688

*Based upon the average wages, "National Compensation Survey: Occupational Wages in the United States, May 2007," U.S. Department of Labor, Bureau of Labor Statistics.

A13. Capital Cost

There are no capital costs associated with this project.

A14. Cost to Federal Government

The total cost for project design, data collection, analysis, and reporting is $2,462,540.

A15. Changes to Burden

This request seeks approval of 34,800 additional hours of respondent burden to assess satisfaction with MA-PD and PDP plans. The additional hours are required to 1) assess the experience of plan disenrollees, who represent experience that is unique and not captured by existing surveys of plan enrollees, and 2) provide sufficient response to generate contract-level reports of experience.

A16. Publication/Tabulation Dates

We anticipate that the analysis plan will include: (1) psychometric evaluation of the survey items; (2) development and evaluation of case-mix adjustment models and nonresponse weights; (3) development of adjusted MA-PD and PDP contract-level results; (4) development of national, regional, and subgroup estimates; and (5) analyses of the relationship between disenrollment rates at the contract level and evaluations of the prescription drug plan. All aspects of these analyses will be described in a final project report.

(1) Psychometric Evaluation. Analyses will include evaluation of items missing data, item distribution (including ceiling and floor effects), and assessment of contract-level reliability of items. These statistics will be computed overall, and separately by mode of administration, language, and MA-PD vs. PDP.

(2) Case-mix adjustment and nonresponse. We will begin with the case-mix model that was developed for reporting of MA-PD and PDP experiences on the CAHPS survey and assess the applicability of using that model here according to the criteria of exogeneity (only control for factors that are not a consequence of care), reliability (only adjust for factors that are precisely

measured), and parsimony (only adjust for factors that meaningfully impact scores – ones that are both predictive of individual responses within contracts, and which vary between contracts). The current model considers age, education, self-rated health status, and low income subsidy status, among other factors. We will also consider whether there are additional available factors that might be uniquely important when considering disenrollees, and will formally evaluate such candidate variables for potential inclusion into the case-mix adjustment model.

In previous analyses of Medicare Plan and Hospital CAHPS data, nonresponse weights developed from logistic regressions of nonresponse have not improved the accuracy of case-mix adjusted CAHPS estimates, and in some instances would have resulted in an appreciable loss of precision due to the design effects of weighting. While similar findings can be anticipated in this setting, we will implement similar analyses of nonresponse bias.

(3) Adjusted Contract-Level Estimates. We will produce adjusted estimates of the prevalence of reasons, both absolutely (using information on contract-level rates of applicable disenrollment) and among applicable disenrollees. We will also describe the most important reasons for disenrollment and the number of reasons indicated. We will develop tests of each contract against its corresponding national MA-PD or PDP average to identify outliers, including contracts that might serve as models for best practices, as well as those that might benefit from additional attention.

(4) National, Regional, and Subgroup Estimates. Appropriate adjustments will be utilized to produce national and regional estimates of the reasons for disenrollment. Hierarchical variance-component models will assess the extent to which variation in each measure reflects sponsors, contracts within sponsors, geography, and interactions between geography and contracts and sponsors. Such analyses will both identify the structure of variation, and may suggest the potential for cost savings in subsequent surveys, if contract main effects and contract by geographic interactions are small.

Individuals who receive the low income subsidy differ from other beneficiaries with respect to Part D in a number of important ways, including (but not limited to): (1) different prior experiences with prescription drug coverage; (2) autoenrollment into Part D coverage; and (3) different disenrollment timing options. Previous work has identified racial/ethnic differences in experience with Part D coverage, and variations in experiences for vulnerable subgroups of beneficiaries that include: (1) those receiving the low income subsidy; (2) beneficiaries with no high school degree; (3) disabled beneficiaries; and (4) individuals who are 85 and older. We will assess differences in the prevalence of reasons for disenrollment nationally across these subgroups, and will use mixed random and fixed effect models to assess the extent to which any differences in experience are consistent across contracts. Such analyses may identify subgroups and contracts which might especially benefit from CMS outreach and intervention.

Additional analyses may consider the role of enrollment history as a predictor of disenrollment, and may distinguish beneficiaries on the basis of whether they were changing between PDP and MA-PD systems, or within those systems. Particular attention will be devoted to distinguishing the roles of the Part D and non-Part D aspects of Medicare experiences in these decisions.

(5) Contract-Level Linkages to Medicare CAHPS Results. Substantial insight may be gained by linking disenrollment survey data to corresponding data from the Medicare CAHPS Health Plan survey at the contract level. This could be done by linking publicly-reported data from the latter survey to the more detailed disenrollment data to be generated by the current survey approach. The extent to which contract-level disenrollment rates for the applicable reasons and the reasons themselves do (or do not) correlate with contract-level CAHPS beneficiary assessments has important implications for the extent to which current CAHPS scores reflect the experiences of all beneficiaries with a given contract, and may influence CMS' future interest in reporting disenrollment information.

Analyses that compare a limited set of CAHPS Part D items from the disenrollment surveys to corresponding items as answered in the Medicare CAHPS survey for the same contracts could estimate disenrollment behavior as a function of beneficiary experiences. These analyses would provide a complementary source of information to disenrollees' directly reported reasons for disenrollment. Analyses that broke this information down by beneficiary subgroup might determine whether different groups (those eligible for low income subsidy, racial/ethnic subgroups) use different criteria or thresholds for disenrollment decisions.

Exhibit 3 details the timeline for data collection, analysis and delivery of the analytic report.

Exhibit 3. Timeline

Task	Planned Start Date	Planned End Date
Sample selection and file preparation	Upon OMB approval	290 days after OMB approval
Data collection	30 days after OMB approval	384 days after OMB approval
Data analysis	230 days after OMB approval	420 days after OMB approval
Prepare and submit data analysis report	300 days after OMB approval	450 days after OMB approval

Publication of Results: CMS may confidentially share sponsor or contract-level disenrollment estimates with individual plan sponsors for quality improvement purposes. However, sponsor or contract-level disenrollment data from this survey will not be made publicly available to Medicare beneficiaries or the general public. CMS may present more general disenrollment data and patterns in a publicly available report format.

A17. Expiration Date

The expiration date for OMB approval of this information collection will be displayed on the survey.

A18. Certification Statement

There are no exceptions to the certification statement identified in item 19 of OMB Form 83-I associated with this data collection effort.