Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
general	**Analysis of Raw Data:** While we appreciate receiving the aggregate data from the survey, we believe plan analysis of the survey raw data would allow for improvements that would prove beneficial to both plans and beneficiaries. To promote transparency in the process and allow for more beneficial plan improvements we request that CMS provide the survey response raw data to plans for further analysis.	*None*	No revisions made to item	The disenrollment survey is an initial effort to assess beneficiary experience with this new Medicare benefit. CMS is conducting the survey to better understand what are the key issues/challenges that beneficiaries are facing, and this information will be used to guide decisions about the administration of the Part D program. Additionally this survey will inform the design of subsequent surveys should CMS decide to continue this type of surveying in the future. CMS will further consider this comment for future surveying efforts, in the event that CMS receives funding to continue periodic surveying of Part D beneficiaries. CMS is not intending to make plan-specific results available to the public or to plans during this initial round. At this time, CMS has not determined whether it will make publicly available a national aggregated data file. CMS will be producing a final report that summarizes the key findings from the survey, and this report will be publicly available.
general	**Response Rate Calculation:** It is unclear what factors will be utilized in determining which survey responses may be disqualified and whether or not disqualified responses and incomplete surveys will be counted in the response rate. Recommendation: We recommend providing greater transparency regarding the specifics that yield the expected response rate. For example, whether or not disqualified responses and incomplete surveys will be factored into the rate. Further, we recommend that the disqualified responses and incomplete surveys not be factored into the response rate.	*None*	No revisions made to item	CMS intends to follow the same rules that are applied for the Medicare CAHPS survey. We will count any survey with a reportable item as a response.
general	**Live calls:** Commenter suggests that CMS consider doing live calls, as proposed for CTM follow-up	*None*	No revisions made to item	CMS's approach to conducting the survey involves a mail survey with phone follow-up for non-respondents. CMS believes this blended approach will work to maximize response rates and allow for a larger number of beneficiaries to be surveyed in a cost-effective manner.
general	**Languages: I**n addition to the specific recommendations outlined below, we request that CMS clarify in which languages the survey will be made available.	*None*	No revisions made to item	The survey will be available in English and Spanish.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
general (b3, b4 and c1, D1 go together)	**Sample Selection:** The sampling timeframe of July 2010-March 2011 will capture those beneficiaries that are experiencing plan changes due to recent CMS mandated changes regarding limited plans per market. These beneficiaries are experiencing an involuntary disenrollment and are not choosing to leave a plan. The survey is designed to capture why beneficiaries leave or switch plans, so should only include those that voluntarily exit a plan; or at a minimum, exclude those that are experiencing plan changes due to the termination of plans per CMS policy or changes in guidelines. It is unclear what populations CMS intends to target (voluntary vs. involuntary disenrollments). We recommend the exclusion of beneficiaries that were involuntarily disenrolled from the plan or at a minimum, those in plans that were terminated due to CMS changes in policy.	*None*	No revisions made to item	The survey will focus only on beneficiaries who voluntarily disenroll from their Part C or D plan during the Annual Election Period (AEP), the Medicare Advantage Open Enrollment Period (OEP) or the Special Election Periods (SEPs). The survey will exclude beneficiaries who disenroll from plans because of eligibility reasons, movement out of the service area and deaths. CMS maintains a set of codes that indicate whether a beneficiary is voluntarily disenrolling, and all beneficiaries who disenroll for non-voluntary reasons will be excluded from the population from which the sample will be drawn. Note: some of the disenrollment during the SEP period is "voluntary" disenrollment (such as among dually eligible beneficiaries). It is anticipated that the time from disenrollment to receipt of a survey will be approximately 3 months. This survey has been funded for a single fielding at this point in time. CMS has not yet decided whether the survey will be repeated and any future surveying is contingent on receipt of funding. There is interest at CMS in periodic surveying of this population for program improvement purposes. CMS intends to survey voluntary disenrollees as close as possible to the time of their disenrollment
general	**Sample Size:** In the sample design, small samples will still yield a higher percentage of margins of error regardless of weighting. We recommend plans with small sample sizes either not be reported, or be oversampled to get a readable sample size. In the alternative, we recommend CMS report non-weighted results along with weighted results with base sizes for review.	*None*	No revisions made to item	This is the first time this survey will be conducted, and CMS does not intend to report publicly any results. It is possible that in the future, CMS may repeat the survey and may adjust the sampling approach to generate robust estimates for plans of varying sizes and/or adjust the results to account for larger standard errors in the estimates.

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general	**Timing of Survey:** It is unclear in the documentation what the timeframe will be between the beneficiary's disenrollment and when the survey will be sent to them. We agree with CMS that is important to survey disenrollees relatively soon after their disenrollment experience. A timeframe of several months between disenrollment and surveying will severely hinder the reliability of the data based on respondent recollection. We recommend CMS reduce the timeframe between the sample extract and data collection as much as possible. We recommend no more than 3 months from time of disenrollment to the date the beneficiary receives the survey. In addition, we request CMS update the documentation regarding when the survey will be sent to beneficiaries in relation to their disenrollment date.	*None*	No revisions made to item	CMS intends to survey voluntary disenrollees as close as possible to the time of their disenrollment to minimize recall issues. It is anticipated that the time from disenrollment to receipt of a survey will be approximately 3 months.
general	**Response ordering:** Suggestion was made to revise the satisfaction scale and start with the most positive choice in the order of options for the member to choose from. This scale throughout should be flipped so the most positive point is listed first: Very Satisfied, Satisfied. Neither sat/nor dis sat, Dissatisfied, Very dissatisfied. Many of the questions use the phrase “try to get”. Recommends “seek” vs. “try to get”. “try” has a more negative connotation.	None PDP4/MA-PD4 - How often did the plan’s customer service give you the information or help you needed?	No revisions made to item	The proposed response ordering on the Part C and D disenrollment survey is consistent with the ordering of responses on the Medicare CAHPS survey. CMS seeks equivalency in the ordering of response options across the disenrollment survey and the Medicare CAHPS survey to enable comparison of scores on comparable items among those who do not disenroll (from the Medicare CAHPS survey). Prior CAHPS survey testing work revealed that the ordering of response choices matters in terms of results (refer to the paper by M. Elliott, A. Zaslavsky et al. in the 2008 issue of *Health Services Research* for more details*).*

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general	**Survey Length:** Commenter is concerned with the length of the proposed survey.	*None*	No revisions made to item	Based on standard metrics for survey administration time we estimate it will take Medicare beneficiaries about 20 minutes to complete this survey. This length is shorter than the current Medicare CAHPS surveys, which achieved an overall response rate in 2009 of 61.8%. Separately, the response rates were: Medicare Advantage = 64.1%; the fee-for-service (FFS)-prescription drug = 57.7%; fee-for-service-only = 58.3%. Previous tests of different length versions of CAHPS surveys found that response rates were not sensitive to survey length. Should the survey be used beyond the currently funded data collection effort, content may be refined to meet the agency's information needs.
general	**Question Addition:** Identify reason for leaving plan and have a choice model. i.e. leaving out "did you leave because plan communications were confusing?" If answered yes, list types of communications.. list CMS requiring communications, i.e.. Annual notice of change, welcome materials.	*None*	No revisions made to item	In previous survey work, the CAHPS Consortium has found that some survey participants have difficulty navigating grid items (items with lists of options to mark yes or no) due to the cognitive complexity of the task. We have selected the existing question format to minimize errors in marking responses, and to simplify the cognitive response task. This initial disenrollment survey is attempting to identify the primary reasons for disenrollment in an effort to better understand the operation of this new Medicare benefit. CMS anticipates that the information from this first administration will inform the development of other survey items related to reasons for disenrollment which may provide useful quality improvement information for any future survey administrations.
general	**Streamlining:** simplify and streamline this whole survey. If laid out properly, would flow better.	*None*	No revisions made to item	Careful thought was given to the layout of the survey to facilitate beneficiaries' ability to comprehend and follow the survey flow logic. In the process of designing the survey, an alternative survey layout was evaluated and was subsequently modified and streamlined to facilitate the beneficiary's ability to respond to the survey.
general	**Wording suggestion**: Many of the questions use the phrase "try to get". Recommend changing wording to "seek" vs. "try to get". "try" has a more negative connotation.	*None*	No revisions made to item	We strive to produce surveys at the lowest reading and comprehension level possible. While "try" and "seek" are synonyms, "try to get" is lower literacy, easier to comprehend language than "seek."
general	**Underlining:** Suggestion made to underling key points in questions for better emphasis (see question Q5, Q6).	*None*	No revisions made to item	In developing questionnaires to assess consumer experience with care (i.e., the CAHPS family of surveys), underlining is used as a tool to alert survey participants to differences between two adjacent questions with similar wording.

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general	**Question Addition:** We suggest adding a future likelihood question e.g. likelihood to consider using plan again/recommending plan to others.	*None*	No revisions made to item	This item would not be appropriate for a survey of disenrollment, so it was not considered for inclusion. This is an item on the Medicare CAHPS survey for drug plans.
general	**Streamlining and Question reformatting**: The 'REASONS YOU LEFT YOUR FORMER PRESCRIPTION DRUG PLAN' section could be reworked to be more efficient. Was a contributing reason for your leaving the plan related to a grid type response set: Someone enrolled you with out your knowledge? (Yes No) An error was made and ended your coverage accidentally (Yes No) A change in the prescription medications that were covered (i.e. a change in formulary) (Yes No) Plan required you to take generic vs. name brand medications (Yes No), Etc…	Numerous items	No revisions made to item	Prior experience with more than a decade of work on the CAHPS surveys indicates that some survey participants have difficulty navigating grids items (items with lists of options to mark yes or no) due to the cognitive complexity of the task. We have selected the existing question format to minimize error in marking responses to simplify the cognitive response task.
general	**Plan Identification**: Given that members sometimes switch plans within an organization, there may be beneficiary confusion when completing the survey as to which of the organization's plans is the subject of the survey. We recommend CMS clearly identify both the organization and the plan name that is the subject of the survey on both the survey and in the results that are shared with each plan.	*None*	Item has been revised	The survey will be customized for each individual, and it will reference at the beginning and at multiple places throughout the survey which MA-PD or PDP is the reference plan the beneficiary is being asked to comment on. The name that will be used is the name as published to beneficiaries (i.e., the marketing name), rather than the plan's contract name. We have expanded the first set of questions (previously Q1 & Q2) to 5 questions to ensure plan name recognition, allow beneficiaries who have not disenrolled or who moved to self-identify (as a check against the administrative data from CMS that will be used to identify the candidate sample of beneficiaires), and allow beneficiaires to write in the plan name that they dropped/switched away from. This modification does not add additional burden to respondents of the survey.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
general	**Wording Suggestion: PDP/MA-PD Introductory Paragraph** (PDP – page 10; MA-PD – page 24 refers to beneficiaries who "leave, switch or drop" prescription drug coverage. As drafted, we believe that the distinction between "leaving" and "dropping" prescription drug coverage is likely to be unclear to beneficiaries. It appears that the references to "dropping" a plan are intended to mean that the beneficiary was dropped due to involuntary disenrollment. We believe that CMS should survey only beneficiaries who voluntarily disenroll, and therefore, we recommend that CMS revise the draft by striking references to "dropping" a Part D plan. If the agency decides to include in the survey sample beneficiaries who have been involuntarily disenrolled, we recommend that the agency revise this question to clarify the distinction between "leaving" and "dropping" a plan.		No revisions made to item	The phrasing of this question is meant to be inclusive of terms a disenrollee might use. The survey will focus only on those who voluntarily disenroll from their Part D or C plans. We will rely on the CMS disenrollment database to determine eligibility for the survey, and only include those individuals who voluntarily disenroll.
general (A6 and A8)	**Question Addition:** CMS should add a question about Part D members disenrolling from a plan because they required a combined prescription and medical benefit?	*None*	No revisions made to item	Using CMS administrative enrollment information, we can determine what proportion of individuals with PDP and FFS medical coverage switch to an MA-PD plan. Additionally, we have included an open ended question on the disenrollment survey that asks the disenrollee what was the "one most important reason" they left the plan, which should provide an opportunity to identify this type of issue if it is indeed an important issue. If, through this initial survey, it is determined that this is a common reason for disenrolling expressed by respondents, CMS will consider adding this in future disenrollment surveys should those be approved for funding.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
MA-PD11	**Wording Suggestion: (**The MA-PD 11 and 12) Members of staff/group model HMOs do not generally differentiate between the health plan and the care delivery systems. Members of staff/group model HMOs are more likely to think of these two questions as typical access questions (e.g. difficulty making appointments and wait times). Members of network/IPA model HMOs are more likely to interpret these questions as the health plan creating administrative barriers (e.g. forms to obtain and have doctors complete and fax to health plan, phone calls to be made by doctor to health plan) to members getting care from the respondents' doctors. The differences in interpretation of these questions may lead to inconsistent results. Suggest Q12 be revised as follows: "How often did the health plan make it difficult for you (e.g. forms to fill out, phone calls to be made by your doctor to the health plan, etc.) to get the care, tests, or treatment you thought you needed through the plan?"	MA-PD11 - Did you ever try to get any kind of care, tests, or treatment through the plan? MA-PD12 - How often was it easy to get the care, tests or treatment you thought you needed through the plan?	No revisions made to item	This question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS, and is based on the CAHPS work. The item performs as intended with beneficiaries and exhibits good psychometric properties. We want to retain consistency in language between the disenrollment survey items that map to the Medicare CAHPS items to allow comparison in the ratings between those who disenroll and those who do not.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
MA-PD19	**Question order:** The placement of Q19 seems problematic. It follows a string of questions about prescription drug benefits and services. The responses to this question will be heavily influenced and highly correlated to responses to the preceding prescription questions. But the respondent may also think of other aspects of the health plan. If CMS wants respondents' overall impressions of the health plan this question should be placed at the front of the questionnaire, before Q3. If, however, the intent is to obtain respondents' impressions of their former plans' Part D benefits and services, then suggest that the question be revised to instruct respondents to think about Part D benefits and services when answering the question.	MA-PD19 - 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 the plan?	No revisions made to item	This item will allow comparison of plan ratings by disenrollees to plan ratings by enrollees (via the Medicare CAHPS survey). The item placement is similar to that of the Medicare CAHPS survey.
PDP1	**Plan identification:** We suggest that CMS merge this question into the introduction.	PDP1/MA-PD1 - Our records show that you used to belong to [PLAN NAME], but no longer belong to that plan. Is that right?	No revisions made to item	This question is used to orient the survey participant to the sampled plan. If the participant does not recognize the sampled plan as a plan that he or she has recently left, we do not want them to complete the survey.
PDP1, PDP4, MA-PD3, MA-PD4	**Question Addition:** Suggestion that on questions that ask specifically about customer service that you add attributes of behavior to this listing.	*None*	No revisions made to item	This initial disenrollment survey is attempting to identify the primary reasons for disenrollment in an effort to better understand the operation of this new Medicare benefit. CMS anticipates that the information from this first administration will inform the development of other survey items related to reasons for disenrollment. This may include more detailed examination of specific attributes of customer service or plan operations. These issues will be considered based on the findings of this initial survey, and future survey work is contingent on receipt of funding.
PDP10	**Question Addition:** Consider: How often did the plan provide you with the written information the language you requested? (satisfied) Ask what language?	PDP10/MA-PD10 - How often did the plan give you written information in a language other than English?	No revisions made to item	The purpose of this question is to understand, when needed (based on previous question), how often a beneficiary received information in a language other than English. We believe the item as worded gets at how often this may/may not have been a problem for a beneficiary. We appreciate the desire for a given plan sponsor to know the specific language that is needed by a beneficiary, but that is outside the scope of this initial survey effort. Medicare Part D plan providers may wish to conduct their own survey's and quality improvement interventions with plan subscribers.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
PDP11	**Wording Suggestion:** (PDP11) "During the time you belonged to (name), were you ever prescribed a medication that the plan did not cover?"	PDP11 - Did a doctor ever prescribe a medicine for you that the plan did not cover?	No revisions made to item	This question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS and we are trying to ensure consistency with Medicare CAHPS where possible to allow comparisons in their ratings between those who disenroll and those who do not. Experience from the Medicare CAHPS survey shows that the existing wording of the item performs as intended and exhibits good psychometric properties. The referent for this question is the plan from which the beneficiary has voluntarily disenrolled, which addresses the issue identified by the commenter.
PDP12	**Wording Suggestion:** We suggest that CMS clarify this question, “How often was it easy to obtain the medications that your doctor prescribed?”	PDP12 - How often was it easy to use the plan to get the medicines your doctor prescribed?	No revisions made to item	The wording modification proposed by the commenter gets at a different issue than the issue that the survey question is seeking to address. The survey question is focused on the ease/difficulty of using the plan to get the medicines prescribed by their doctor, as opposed to whether it was easy/difficult to obtain medications prescribed by their physician. The two questions are substantively quite different. CMS' interest is understanding beneficiary issues related to using the plan to get their medications. Furthermore, this question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS and we are trying to ensure consistency with Medicare CAHPS where possible to allow comparisons in their ratings between those who disenroll and those who do not.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
PDP13	**Wording Suggestion:** Suggest this wording change for PDP13/MA_PD15 items: "Did you ever fill a prescription at a local pharmacy which utilized this plan?" Response Option 5 in PDPQ16 states that "I did not use the plan to fill a prescription at a local pharmacy." Suggest that this response option be deleted altogether. It is not needed because Q15 instructs respondents to skip Q16 if they did not use the plan to fill a prescription at a local pharmacy. Moreover, there may be some confusion with the term "local" pharmacy. It is not clear what distinction is being made by classifying a pharmacy as "local". What are "non-local" pharmacies? Does "local" depend on how far away they are from the respondents' homes? It is suggested that the term "local pharmacy" be defined for the respondent to provide a clearer question to which he/she can respond.	PDP13/MA-PD15 - Did you ever use the plan to fill a prescription at a local pharmacy?	No revisions made to item	This questions are part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS, and based on the CAHPS work. The item performs as intended with beneficiaries and exhibits good psychometric properties. We want to retain consistency in language between the disenrollment survey items that map to the Medicare CAHPS items to allow comparison in the ratings between those who disenroll and those who do not. Experience from the Medicare CAHPS survey shows that the existing wording of the items perform as intended and exhibits good psychometric properties.
PDP15	**Wording suggestion:** Did you ever use the plan's mail order pharmacy to fill a prescription?	PDP15/MA-PD17 - Did you ever use the plan to fill any prescriptions by mail?	No revisions made to item	We sought simplicity in wording in this item and throughout the survey. The modified wording offered by the commenter does not improve the readability and we will retain the original item. Additionally, this question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS and we are trying to ensure consistency with Medicare CAHPS where possible to allow comparisons in their ratings between those who disenroll and those who do not. Experience from the Medicare CAHPS survey shows that the existing wording of the item performs as intended and exhibits good psychometric properties.
PDP16	**Wording Suggestion:** Response Option 5 in Q18 (MA-PD version) states that "I did not use the plan to fill a prescription by mail." Suggest that this response option be deleted altogether. It is not needed because Q17 instructs respondents to skip Q18 if they did not use the plan to fill a prescription by mail.	PDP15/MA-PD17 - Did you ever use the plan to fill any prescriptions by mail? PDP16/MA-PD18 - How often was it easy to use the plan to fill prescriptions by mail?	No revisions made to item	We have found from our previous survey work that a small number of beneficiaries do not follow the appropriate skip logic. Thus we provide what is in effect a "not applicable" response.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
PDP17	**Wording suggestion:** Consider using "satisfaction with plan" vs. worst prescription drug plan possible. Flip scale to positive on top. Add neutral point. Throughout the rest of the survey references are made to "the plan" vs. "prescription drug plan". Make consistent. Reword "worst." 2nd comment: These questions ask the beneficiary to rate the plan on a scale where 0 is the worst possible plan and 10 is the best possible plan. The addition of a free form follow-up question asking the beneficiary what aspects of the plan were most important to his/her rating would provide information that would be useful to the plan in evaluating areas where performance could be strengthened or modifications could be made to meet beneficiary needs or preferences. We recommend that CMS add such a question.	PDP17/MA-PD19 - 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 the plan?	No revisions made to item	This question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS, and have been well tested in prior CAHPS work. The item performs as intended with beneficiaries and exhibits good psychometrics properties. We want to retain consistency in language between the disenrollment survey items that map to the Medicare CAHPS items to allow comparison in the ratings between those who disenroll and those who do not. Because of the substantial expense associated with entering, coding and analyzing open-ended responses, CMS has sought to minimize open-ended questions in the survey. The single open-ended question on the survey focuses on understanding what was the most important reason for disenrollment. We also believe that the "most important reason" for disenrollment will be highly correlated with the overall rating item, and will in effect, serve to address the issue raised by the commenter.
PDP18	**Wording suggestion:** Suggestion that the survey be modified to clarify if members were auto-facilitated, this question is meant to target agent and brokers and from our experience members who are facilitated into a plan often have this belief.	PDP18/MA-PD20 - Did you leave the plan because you found out that someone had signed you up for the plan without your permission?	No revisions made to item	Using CMS administrative enrollment information, we can determine which individuals are autoenrolled because their plan is now above the LIS benchmark. These individuals will be excluded at the front end of the survey process and would not be included in the sample frame.
PDP18	**Wording suggestion:** In the introductory paragraph before Q20, suggest the addition of a statement explaining that respondents might have multiple reasons for switching and/or dropping their former plan and that CMS is interested in capturing all their reasons.	PDP18/MA-PD20 - Did you leave the plan because you found out that someone had signed you up for the plan without your permission?	No revisions made to item	We believe the recommended wording change is unnecessary, as the introductory text indicates that people leave for different reasons (and then we proceed with asking about an array of possible reasons that a beneficiary can check).
PDP20	**Question reformatting:** Financial reasons should be bundled together. Perhaps ask, did your leaving the plan have anything related to costs/prices, affordability or anything financial? Y/N -> if no skip out of section. A "premium"...	PDP20 - A premium is the amount that you pay to have prescription medicine coverage from a prescription drug plan. Some prescription drug plans charge a premium to people on Medicare who are enrolled in that prescription drug plan. Did you leave the plan because the monthly premium for prescription medicine coverage went up?	No revisions made to item	We appreciate the suggested alternative but perceive that it would result in a more complex survey question structure than currently exists.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
PDP21	**Wording suggestion:** We suggest that CMS rephrase this question or remove entirely. Were you disenrolled from the plan because you failed to pay your premium, members do not opt into disenrolling if they are not paying their Part D premiums.	PDP21/MA-PD23 - Did you leave the plan because you stopped paying the monthly premium for the plan?	No revisions made to item	This item is a quality check and that is the reason for its inclusion. Beneficiaries who failed to pay their premiums would not be in the sample, and this is a means to verify the quality of the administrative data used to generate the sample frame.
PDP23	**Highlighting text:** A "formulary" is the…	PDP23 - A formulary is the list of prescription medicines covered by a prescription drug plan. Did you leave the plan because of a change in the formulary?	No revisions made to item	We appreciate the desire to highlight the word formulary, but believe the quotation marks are not necessary.
PDP24	**Wording suggestion:** Replace “temporary limit” with “donut hole”.	PDP24/MA-PD26 - Did you leave the plan because you hit the temporary limit (also called the "coverage gap") when you had to pay all of the costs of your prescription medicines up to a yearly limit?	Item has been revised	Did you leave [PLAN NAME] because you hit the temporary limit (also called the “coverage gap” or “donut hole”) when you had to pay all of the costs of your prescription medicines up to a yearly limit?
PDP25	**Wording suggestion:** Question 25 asks, “Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up?” We believe that the reference to a prescription the enrollee “filled or refilled” is likely to be confusing to beneficiaries. Asking about “refilling” the same prescription would yield information about the beneficiary’s concerns with the cost for the same drug dosage, strength, and supply subsequent to the initial fill and could be useful. However, the reference to “filling” prescriptions may appear to ask the beneficiary to compare the cost of prescriptions for different drugs. As a result beneficiary responses to the question may not be either informative or actionable. Recommend that CMS revise the question by deleting the words “filled or”.	PDP25/MA-PD27 - Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up?	No revisions made to item	The goal of this item is to understand whether a beneficiary left a plan because the amount they had to pay (i.e., the copayment) for prescriptions went up, regardless of whether it was an initial fill of a medication or a refill. We do not wish to exclude respondents who might have experienced a copay increase when they went in with a new order for a previous drug. It is not the intent of this question to ask the beneficiary to compare the cost of prescriptions for different drugs.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
PDP28	**Question Addition:** What is this referring to? Add a question. Did the plan offer you an alternative med to the one not on the formulary? Did we actively try to get a coverage med… • PDP Questions #28, #29 and #31 (page 10) and MA-PD Questions #31, #32, and #34 (page 26). The survey asks three questions about problems the enrollee experienced in obtaining coverage of medicines his/her doctor prescribed. These questions appear to address related and overlapping issues. For clarity and to provide additional information about the beneficiary's experience, we recommend that CMS make the following revisions: + Retain PDP question #29 and retain MA-PD question #32, "Did you leave the plan because you had problems getting the medicines your doctor prescribed?" + Add a note to indicate that if the answer is no, the beneficiary should skip the following question; and + Combine PDP questions #28 and #31 and combine MA-PD questions #31 and #34 into a set of questions organized in a check list/grid	PDP28/MA-PD31 - Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed? PDP31/MA-PD34 - Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on their formulary?	No revisions made to item	The modified wording offered by the commenter would raise the complexity of the question being asked and we seek to maintain simplicity to facilitate understanding. The survey item seeks to elicit a potential reason why the beneficiary disenrolled, in terms of not being able to get their medicine (irrespective of whether the plan offered an alternative). The purpose of this question is not to evaluate the +/- of any given plan's formulary. Prior experience over the past decade with the CAHPS survey indicates that some survey participants have difficulty navigating grids items (items with lists of options to mark yes or no) due to the cognitive complexity of the task. We have selected the existing question format to minimize error in marking responses to simplify the cognitive response task.
PDP29	**Clarification requested:** Please clarify the intent of this question, did you leave your plan because the medications that your doctor prescribed were not on the plan's formulary? The question as is has many different interpretations.	PDP29/MA-PD32 - Did you leave the plan because you had problems getting the medicines your doctor prescribed?	No revisions made to item	The modified wording offered by the commenter would raise the complexity of the question being asked. The survey item seeks to elicit a potential reason why the beneficiary disenrolled, in terms of not being able to get the medicines their doctor prescribed.
PDP3	**Wording Suggestion:** Change to: Did you ever seek customer service from [PLAN NAME]'s for any reason? "Customer service" refers to information / assistance provided from staff about what is covered, how to use the plan, etc.	PDP3/MA-PD3 - Customer service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from [PLAN NAME]'s customer service?	No revisions made to item	The Survey Design Project conducted by RTI in 1995 explored the placement of definitions within survey questions. The project found that the most effective placement is for definitions to appear first.

Question # for sorting	Comment	Survey Question Referenced in Comment	Revision Status	Response
PDP3	**Plan Identification:** Statement Preceding Question 3, pp 5 & 20 Issue: In the statement that immediately precedes question 3 in both surveys, it is explained to beneficiaries that the questions are about their "former" health plan. However, the beneficiary may not recall the former plan, especially if the time from the actual disenrollment to the survey is more than several weeks. Recommendation: To assure comprehension regarding what plan the questions refer to, we recommend inserting the drug or health plan name into the sentence that immediately precedes question 3.	PDP3/MA-PD3 - Customer service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from [PLAN NAME]'s customer service?	No revisions made to item	We appreciate the suggestion but perceive that the insertion of the former plan name in question 3 will promote recognition of the plan.
PDP3	**Wording suggestion:** The definition of “customer service” in this question does not seem adequate and does not reflect what people think of when they refer to “customer service.” Customer service departments provide more services and functions than simply handing out information. As such, the provided definition seems confusing. Suggest the revision of the definition of customer service in Q3 to provide the respondents with a more accurate description of customer service such as the following: “Customer service is a department within your former health plan responsible for answering questions about your membership, benefits, grievances and appeals.”	PDP3/MA-PD3 - Customer service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from [PLAN NAME]'s customer service?	No revisions made to item	This question is in the Medicare CAHPS survey and will allow comparison of survey participants across the various surveys.

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PDP30	**Wording suggestion:** This question does not follow current guidance, possible misinterpretation from beneficiaries that plans make them take a generic because they are cheaper. Plans are not allowed to mandate the use of generics for members, suggest removing this question. Questions 30 (PDP) & 33 (MA-PD), pp 10, 26. Issue: The question asks if the beneficiary left the plan because the plan "required" them to take a generic medicine. However, plans cannot require beneficiaries to take a generic medicine. Recommendation: We recommend revising the question by replacing the word "required" with "wanted."	PDP30/MA-PD33 - Did you leave the plan because the plan required you to take a generic medicine when you preferred the brand name medicine?	Item has been revised	Did you leave the plan because it was difficult to get brand name medicines?
PDP31, PDP32	**Wording suggestion:** Clarify and use member materials…i.e. coverage determination process. (questions PDP31/MA-PD34 & PDP32/MA-PD35)	PDP31/MA-PD34 - Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on their formulary? PDP32/MA-PD35 - Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription	No revisions made to item	The "coverage determination process" language (i.e., language typically used by the health plans) is complex and not language that most Medicare beneficiaries would understand. The existing question is written in simple, easy to understand language, and its goals is to elicit whether beneficiaries disenrolled due to difficulties they experienced with the plan approval processes for medications not on the formulary.
PDP34	**Item deletion:** Redundant to #36.	PDP34/MA-PD43 - Did you leave the plan because you were unhappy with how the plan handled a question or complaint?	No revisions made to item	This question is measuring a separate dimension (handling of questions/complaints) vs. #36 which asks about whether the customer service staff treated the beneficiary with courtesy and respect. We do not feel the two items are repetitive.

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PDP35	**Question Addition:** Questions 35 (PDP) & 44 (MA-PD), pp 11, 27 Issue: It would be beneficial for plans understand the method of contact the beneficiary used. Improvements could then be targeted to appropriate staff. Recommendation: We recommend capturing the method of contact between the beneficiary and the plan. For example, by phone to plan customer service, website, via a sales agent, etc.	PDP35/MA-PD44 - Did you leave the plan because you could not get the information or help you needed from the plan?	No revisions made to item	This initial disenrollment survey is attempting to identify the primary reasons for disenrollment in an effort to better understand the operation of this new Medicare benefit. CMS anticipates that the information from this first survey administration will inform the development of other survey items related to reasons for disenrollment. This may include more detailed examination of specific attributes of customer service or plan operations. These issues will be considered based on the findings of this initial survey, and future survey work is contingent on receipt of funding.
PDP36	**Question addition:** At the end of the section entitled “Other Reasons for Leaving Your Former Health Plan”, the survey asks the respondent in Q53 “What was the one most important reason you left [PLAN NAME]?” Suggest that a similar question should be asked in the section entitled “Reasons You Left Your Former Health Plan” after Q45: “Which of the above is the most important reason you left [PLAN NAME]?”	PDP36/MA-PD45 - Did you leave the plan because their customer service staff did not treat you with courtesy and respect?	No revisions made to item	We perceive that adding such a question would be duplicative of the existing question.
PDP37	**Question ordering:** Moved as first question in section	PDP37/MA-PD46 - Did you leave [PLAN NAME] because it wasn't what you expected?	No revisions made to item	We appreciate the suggested alternative location but think the current placement of the item is satisfactory.
PDP37	**Plan Identification:** throughout survey, e.g., Questions 37 (PDP) & 46 (MA-PD), pp 12, 28. Issue: It is unclear whether CMS will be populating the plan name by using the plan's contract name or the name of the plan as published to beneficiaries. Beneficiaries will not understand which plan is referred to if the CMS contract name is used. Recommendation: We strongly recommend the use of the plan name that is published to, and recognized by, the beneficiary. In addition, we request that the documentation be clarified as to which name is used.	PDP37/MA-PD46 - Did you leave [PLAN NAME] because it wasn't what you expected?	No revisions made to item	The survey will be customized for each individual, and it will reference at the beginning and at multiple places throughout the survey which MA-PD or PDP is the reference plan the beneficiary is being asked to comment on. The name that will be used is the name as published to beneficiaries (i.e., the marketing name), rather than the plan's contract name.

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PDP37	**Text Modification:** Before Q46, suggest that an introductory paragraph similar to that located before Q20 be added. The introductory paragraph should contain a statement explaining that respondents might have multiple reasons for switching and/or dropping their former plan and that CMS is interested in capturing all their reasons.	PDP37/MA-PD46 - Did you leave [PLAN NAME] because it wasn't what you expected?	No revisions made to item	We have reviewed this comment and believe that the suggested change is unnecessary and does not further clarify or provide additional assistance to the individual completing the survey
PDP39	**Streamlining and Question reformatting:** List for the reasons they left…instead of having so many questions.	PDP39/MA-PD48 - Did you leave the plan because a family member or friend told you that another prescription drug plan was a better plan?	No revisions made to item	Prior CAHPS experience indicates that some survey participants have difficulty navigating grids items (items with lists of options to mark yes or no) due to the cognitive complexity of the task. We have selected the existing question format to minimize error in marking responses to simplify the cognitive response task.
PDP49	**Wording Suggestion and clarification on question purpose:** In general, how would you rate your overall physical health? Personal questions. Are these necessary for this type of survey.	PDP49/MA-PD59 - In general, how would you rate your overall health?	No revisions made to item	This is a standardized measure, used across several CMS and CAHPS surveys and will allow CMS to compare responses across the various surveys. The variable is used to casemix adjust the patient populations managed by different providers/plans.
PDP4	**Wording suggestion:** Many of the questions use the phrase “try to get”. Recommends “seek” vs. “try to get”. “try” has a more negative connotation.	PDP4/MA-PD4 - How often did the plan’s customer service give you the information or help you needed?	No revisions made to item	We strive to produce surveys at the lowest reading and comprehension level possible. While "try" and "seek" are synonyms, "try to get" is lower literacy, easier to comprehend language than "seek." Additionally, based on prior experience with the CAHPS surveys, the rationale for the ordering of response items is to promote greater variation in responses.

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PDP4	**Question addition:** Question 4. Issue: We believe the definition of customer service as defined in question 3, "information you get from staff" is rather broad. The responses then, to question 4 are not as helpful to plans as they could be. It is difficult to make needed improvements if the plan cannot identify the staffing area that responded to the inquiry. We recommend either capturing the method of contact between the beneficiary and the plan or designing the responses to be more specific about what staff/area was contacted. For example, sales agent, plan customer service, etc. The definition of "customer service" as set forth in Q3 is problematic when combined with the wording of Q4. Substituting in the definition from Q3 gives you the following: "How often did information you get from the plan's staff give you the information or help you needed?" Suggest that the definition in Q3 be revised as set explained above in Comment 3 to provide respondents with a more precise definition and as such, more logical language in Q4	PDP4/MA-PD4 - How often did the plan's customer service give you the information or help you needed?	No revisions made to item	This initial disenrollment survey is attempting to identify the primary reasons for disenrollment in an effort to better understand the operation of this new Medicare benefit. CMS anticipates that the information from this first administration will inform the development of other survey items related to reasons for disenrollment which may provide useful quality improvement information in future survey administrations. We appreciate the desire of Part D plans to obtain drill down information which we are unable to accommodate in this first survey. The results of this question will allow plans to identify where further investigation may be needed by QI or QA staff to inform improvements to customer service. This question is in the Medicare CAHPS survey and will allow comparison of survey participants across the various surveys.
PDP41	**Wording suggestion:** This is unclear (are you referring to unique Rxs or how many transactions? and scale is too limited. Also need to specify if Long term only or all? Perhaps do as write in and limit time frame (past 3/or in typical month). In the past 3 months, thinking about all the prescriptions you have filled for your own personal use, how many have you filled. In your answer please include all prescription medications you take on an on-going or long term basis as well as those taken for a short period.	PDP51/MA-PD61 - In the last 12 months, how many different prescription medicines did you fill or have refilled?	No revisions made to item	The purpose of this item is to enable analyses of the results by different subpopulations of beneficiaries (e.g., those with complex health needs as compared to relatively simple health needs); as such it is an analytic variable that will allow us to stratify the results. Because we are looking for "orders of magnitude" differences in the number of medications a beneficiary is taking, we believe that the proposed item can be reliably reported by a beneficiary and is suitable for the proposed "use" purposes.

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PDP44	**Analytic issue:** If the respondent was a long-term member of the plan (e.g., joined the health plan five or more years ago), then the information collected from this member will not reflect current attributes of the health plan. Analysis of these questions should be stratified by respondents' length of membership in the plan. For example, scores should only be reported for respondents who have been with the health plan two years or less.	PDP44/MA-PD54 - An insurance agent or broker sells insurance for your health, your home, or your car. Did an insurance agent or broker ever call you without your asking them to, to tell you about insurance for prescription medicines? PDP45/MA-PD55 - Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for prescription medicines? PDP46/MA-PD56 - Did you decide to leave [PLAN NAME] because of information you got from an insurance agent or broker? PDP47/MA-PD57 - Did an insurance agent or broker give you any information that was not correct? PDP48/MA-PD58 - What kind of information was not correct?	Item has been revised to clarify the terminology regarding agents	CMS's goal for this group of questions is to understand the experiences of the overall population of disenrollees. CMS is interested in knowing whether beneficiaries were inappropriately contacted or given information about a prescription drug plan that was not correct at any point during their enrollment with the plan from which they voluntarily disenrolled. This issue is relevant regardless of the length of time a beneficiary was enrolled with their Part C or D plan. We are not modifying our analytic approach to limit analyses to the subset of beneficiaries who have been with a Part C or D plan two years or less. We did modify the wording on the introduction to clarify terminology: "Different kinds of people sell health insurance. Insurance may be sold by independent insurance agents or brokers who don't work for the health plan OR by plan representatives who work directly for the plan. Did an insurance agent, broker, or plan representative ever call you without your asking them to, to tell you about insurance for prescription medicines?"

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PDP44	**Clarification:** There is a section containing five questions (#44-48) about agent/broker activity that may not be relevant or valid for all plans. Many PDPs don't use agents and even if an agent contacted a member, it does not mean that the agent was affiliated with the member's plan.	PDP44/MA-PD54 - An insurance agent or broker sells insurance for your health, your home, or your car. Did an insurance agent or broker ever call you without your asking them to, to tell you about insurance for prescription medicines? PDP45/MA-PD55 - Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for prescription medicines? PDP46/MA-PD56 - Did you decide to leave [PLAN NAME] because of information you got from an insurance agent or broker? PDP47/MA-PD57 - Did an insurance agent or broker give you any information that was not correct? PDP48/MA-PD58 - What kind of information was not correct?	Item has been revised to clarify the terminology regarding agents	These items do not link agents or brokers to a specific plan. They provide information that may inform further follow-up effort by CMS as the items will yield information on the role and interaction with agents and brokers which may or may not vary by geographic region. CMS is concerned about incorrect information being provided by sales representatives from the beneficiary's current plan as well as from sales representatives from competing plans who may be soliciting new members. **Modified wording on the introduction (PDP44/MA-PD55) to this set of questions to clarify terminology:** "Different kinds of people sell health insurance. Insurance may be sold by independent insurance agents or brokers who don't work for the health plan OR by plan representatives who work directly for the plan. Did an insurance agent, broker, or plan representative ever call you without your asking them to, to tell you about insurance for prescription medicines?"

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PDP45	**Wording suggestion:** Questions 45 (PDP) & 55 (MA-PD), pp 13, 29 Issue: We believe the location of the underlining does not emphasize the key point of the question. CMS does not prohibit visits to the home, but prohibits visits to the home without the beneficiary asking the agent or broker to do so. Also, the questions contain extraneous language--the word "you" after "visit your home." Recommendation: We recommend removing the underlining from "visit your home" and instead, underlining "without your asking." In addition, we suggest removing the word "you" from the question. The question would then read: "Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for prescription medicines?"	PDP45/MA-PD55 - Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for prescription medicines?	No revisions made to item	The underlining is designed to highlight the specific wording differences between Questions 45 and 55 and the similarly worded Questions 44 and 54.
PDP5	**Wording suggestion**: Did you ever try to get (seek) information from the plan about which prescription medicines were covered?	PDP5/MA-PD5 - Did you ever try to get information from the plan about which prescription medicines were covered?	No revisions made to item	We strive to produce surveys at the lowest reading and comprehension level possible. While "try" and "seek" are synonyms, "try to get" is lower literacy, easier to comprehend language than "seek."
PDP51	**Wording suggestion:** In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same (a certain) condition or problem?	PDP52/MA-PD62 - In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?	No revisions made to item	This is a standard CAHPS question and we seek to maintain comparability to allow CMS to compare/contrast the results from this survey of disenrollees with the Medicare CAHPS results for beneficiaries who do not disenroll.
PDP53	**Wording suggestion:** Consider: Thinking of the condition for which you've seen a doctor 3 or more times in the past 12 months, has this condition lasted for 3 months or longer?	PDP53/MA-PD63 - Is this a condition or problem that has lasted for at least 3 months?	No revisions made to item	This is a standard CAHPS question and we seek to maintain comparability to allow CMS to compare/contrast the results from this survey of disenrollees with the Medicare CAHPS results for beneficiaries who do not disenroll. Additionally, prior CAHPS experience shows this items performs well.

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PDP54	**Clarification**: For the condition above? "Has your doctor prescribed medication for this condition?"	PDP54/MA-PD64 - Do you now need or take medicine prescribed by a doctor?	No revisions made to item	This item is not intended to reference the prior two questions about whether the person has a condition for which they've seen their doctor 3 or more time and whether the condition has lasted for at least 3 months (questions 52 and 53 on the PDP version and 62 and 63 on the MA-PD version). Those two questions are used as analytic variables to stratify results between those beneficiaries with more complex medical needs and those without. Question PDP-52/MA-PDP64 asks the beneficiary a different question about whether they now need to take a prescription medication. This is a standard CAHPS question and we seek to maintain comparability to allow CMS to compare/contrast the results from this survey of disenrollees with the Medicare CAHPS results for beneficiaries who do not disenroll.
PDP56	**Question addition:** The list should be expanded	PDP56/MA-PD66 - Has a doctor ever told you that you had any of the following conditions?	No revisions made to item	The purpose of this item is to enable analyses of the results by different subpopulations of beneficiaries (e.g., those with few/no comorbid conditions vs. those with many). We have focused on identifying conditions that are widespread in the population and have significant chronic impact. This variable will be used to stratify the results of the survey.
PDP57	**Wording suggestion:** Consider, in what year were you born?	PDP57/MA-PD67 - What is your age?	No revisions made to item	We capture age as a categorical response to minimize missing data due to nonresponse.
PDP59	**Wording suggestion:** Some college or 2-year degree or other trade school	PDP59/MA-PD69 - What is the highest grade or level or school that you have completed?	No revisions made to item	This is a standardized measure, used across several CMS and CAHPS surveys and will allow comparison of survey participants across the various surveys.

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PDP6	**Wording suggestion:** How often did the plan give you all the information you needed about which prescription medicines were covered? 5 N/A - I did not seek information about which prescription medicines were covered Response Option 5 in both questions starts as follows: "I did not try and get information about …." Suggest that language be revised as follows: "I did not try to get …." This revision is a grammatical improvement and agrees with the text of the question. In the alternative, suggest that this response option be deleted altogether. It is not needed because Q5 and Q7 instruct respondents to skip Q6 or Q7 if they did not try to get information about prescription medicines.	PDP6/MD-PD6 - How often did the plan give you all the information you needed about which prescription medicines were covered? PDP8/MA-PD8 - How often did the plan give you all the information you needed about how much you would have to pay for a prescription medicine?	No revisions made to item	We strive to produce surveys at the lowest reading and comprehension level possible. While "try" and "seek" are synonyms, "try to get" is lower literacy, easier to comprehend language than "seek." We have found from our previous survey work that a small number of beneficiaries do not follow the appropriate skip logic. Thus we provide what is in effect a "not applicable" response. Question wording has been modified to read: "I did not try to get information about which prescription medicines were covered"
PDP60	**Question addition**: ASK INCOME? EMPLOYMENT/MARITAL STATUS?	PDP60/MA-PD70 - Are you of Hispanic or Latino origin or descent?	No revisions made to item	Income and education are highly correlated, and given the sensitivity of asking about income, we have focused on education (which proxies for income). Additionally, income is not a reliable indicator for retired people as the computation of this is more complex regarding what assets to include (e.g., what's in their bank account, their home value, etc.). We are able to bring in income via census data imputation based on the beneficiaries geographic region. We do not believe that marital status or employment provide additional useful information about understanding differences in disenrollment for various sub-populations.
PDP61	**Wording suggestion:** "1= Caucasian "	PDP61/MA-PD71 - What is your race? Please mark one or more.	No revisions made to item	The survey uses the classifications for race approved and required by OMB.
PDP62	**Wording suggestion and ordering:** Suggest items PDP62/MA-PD72 be moved up to language section. Do these choices reflect the population? Suggest re ordering based on frequency (e.g. Eng, Spanish…). Suggest making the list more complete. Missing Portuguese, French, Japanese.	PDP62/MA-PD72 - What language do you mainly speak at home?	No revisions made to item	The purpose of this question is to understand whether the beneficiary is English speaking or not, for analysis purposes. At the end of this question we provide an open-ended response to allow the beneficiary to write in other languages than what appear on the list. The list is organized alphabetically.

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PDP64	**Question addition:** Questions 64 (PDP) & 74 (MA-PD). Issue: It would be helpful for plans to understand who took the survey, for example, if the respondent is a care provider, the beneficiary, a family member, etc. We recommend asking what role the respondent fills, for example, if the respondent is a care provider, the beneficiary, a family member, etc.	PDP64/MA-PD74 - How did that person help you? Please mark one or more.	No revisions made to item	The Medicare CAHPS survey contains two questions that seek to determine "whether the beneficiary had any assistance completing the survey" and "how this person helped." We have included these same questions on the disenrollment survey for consistency. The questions will be used to examine whether there are differences in the case mix of patient populations served by the Part C and D plans that should be considered in generating scores. As background, in the Medicare CAHPS work, this variable has not proven to be a major case mix adjustment variable, as there is little variation plan-to-plan in responses to this set of variables. The "who" helped the beneficiary complete the survey has been retired from Medicare CAHPS and was not considered here given space constraints and other items that were deemed higher priority.
PDP7	**Wording suggestion**: Did you ever try to get information from the plan about pricing or how much you would have to pay for a prescription medicine?	PDP7/MA-PD7 - Did you ever try to get information from the plan about how much you would have to pay for a prescription medicine?	No revisions made to item	This question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS and we are trying to ensure consistency with Medicare CAHPS where possible to allow comparisons in their ratings between those who disenroll and those who do not. Experience with the PDP item set in Medicare CAHPS shows the time wording performs as intended and exhibits good psychometric properties.
PDP8	**Wording suggestion:** How often did the plan give you all the information you needed about pricing or how much you would have to pay for a prescription medicine? 5 N/A - did not seek information about pricing/how much I would have to pay for a prescription medicine	PDP8/MA-PD8 - How often did the plan give you all the information you needed about how much you would have to pay for a prescription medicine?	No revisions made to item	This question is part of the Prescription Drug Plan (PDP) item set in Medicare CAHPS and we are trying to ensure consistency with Medicare CAHPS where possible to allow comparisons in their ratings between those who disenroll and those who do not. Experience with the PDP item set in Medicare CAHPS shows the time wording performs as intended and exhibits good psychometric properties.
PDP9	**Wording suggestion:** Did you ever need written information from the plan in a language other than English? (They might need it but didn't ask.). Response Option 5 in Q10 states that "I did not need written information in a language other than English." Recommend that this response option be deleted altogether. It is not needed because Q9 instructs respondents to skip Q10 if they did not need written information from the plan in a language other than English.	PDP9/MA-PD9 - Did you ever need written information from the plan in a language other than English? PDP10/MA-PD10 - How often did the plan give you written information in a language other than English?	No revisions made to item	We appreciate the comment. We believe that the item as worded gets at whether the beneficiary needed information from the plan in a language other than English. This item is a "gate" item for the subsequent question that asks whether the plan provided the beneficiary with information in a different language. We have found from our previous survey work that a small number of beneficiaries do not follow the appropriate skip logic. Thus we provide what is in effect a "not applicable" response.