Supporting Statement, Part A
OMB/PRA Submission for Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey

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SUPPORTING STATEMENT

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A. Background

Purpose of the survey: The Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey (Disenrollment Survey) focuses on beneficiaries who voluntarily disenroll from their plan. Beneficiaries can disenroll from plans during the Annual Election Period (AEP), the Medicare Advantage Disenrollment Period (MADP), and Special Election Periods (SEPs). The Centers for Medicare & Medicaid Services (CMS) developed the Disenrollment Survey to capture the reasons for disenrollment at a time that is as close as possible to the actual date of disenrollment. Through this survey, CMS seeks to: (1) obtain information about beneficiaries' expectations relative to provided benefits and services (for both MA and PDPs) and (2) determine the reasons that prompt beneficiaries to voluntarily disenroll. It is important to include such information from disenrollees as CMS assesses plan performance, because plan disenrollment can be a broad indicator of beneficiary dissatisfaction with some aspect of plan services, such as access to care, customer service, cost, benefits provided, or quality of care. Information obtained from the Disenrollment Survey also supports the quality improvement efforts of individual plans and provides data to assist consumer choice through use of the Medicare Plan Finder website. (Note, when we refer to a "plan" we focus on disenrollment from what CMS calls a contract, or H, R, or S number, not changes at the plan benefit package level.)

Each year, CMS uses the overall rate of disenrollment from MA and PDP plans as a performance measure in the annual Star Rating program for Part C and Part D contracts. The Disenrollment Survey extends the overall disenrollment rate to investigate disenrollment reasons nationally, by market/regions, by population subgroups (e.g., beneficiaries who are dually eligible for Medicare and Medicaid vs. non-duals), and by specific plans (i.e., contracts). The survey, conducted annually and is ongoing, is an important plan monitoring tool for CMS to ensure that Medicare beneficiaries are receiving high quality services from contracted providers. The information from the survey is used to track changes in the reasons Medicare

beneficiaries cite for disenrolling to monitor improvements/declines over time nationally and at the plan level. CMS uses the information obtained from the Disenrollment Survey to (1) support the quality improvement efforts of individual plans (by providing plans with a detailed, annual report showing the reasons disenrollees cited for voluntarily leaving the plan and comparing the plan's scores to regional and national benchmarks) and (2) provide Medicare beneficiaries with data (i.e., reasons cited for disenrolling from a plan and the frequency with which disenrollees cite each of the reasons) to assist annual consumer choice of plans. The results are shared with beneficiaries on the Medicare Plan Finder website (https://www.medicare.gov/find-a-plan) where they can compare the performance of plans.

CMS' survey contractor pulls a monthly sample from CMS' monthly disenrollment file (which contains the universe of voluntary disenrollments for that month) over a 12 month period for each contract, with the goal of reaching a target sample size per plan of 233 (MA plans) and 465 (PDP plans). CMS does not survey the census of all disenrollees, rather only a sample of disenrollees. The size of the sample was determined by the number needed to generate reliable estimates at the plan-level based on survey response rates, screen-in rates, and variation in responses to survey items. CMS draws a larger sample size for PDP plans due to the fact that there is less variation between PDP plans in the reasons cited for disenrolling, as compared to MA plans. CMS pulls a random sample of disenrollees from each plan each month.

The large sample drawn each year is necessitated by the dual purposes of the survey: to generate national estimates of reasons for disenrollment and to produce reliable plan-level estimates for reporting to plans and Medicare beneficiaries plan-level estimates of reasons for disenrollment. The survey results are intended to represent the population of beneficiaries who disenrolled voluntarily from Part C (MA-Only or MA-PD) or Part D (PDP) contracts during an annual period (i.e., January through December each year). To represent that population, we target an annual sample of 233 cases from each MA contract's annual voluntary disenrollment and 465 from each PDP. The 233/465 sample sizes were based on analyses the survey contractor performed to determine the number of cases required to achieve reliable estimates (i.e., reliability of 0.70 or greater[1]) of reasons for disenrollment. Beneficiaries who disenroll at

[1]Contract-level reliability is a zero-1 index with values of .7 or higher considered adequate and value of 1 being

different times of the year may tend to do so for different reasons and have somewhat different characteristics; as such, a further goal of the sample design was to represent the distribution of each contract's disenrollment across months of the year. Sampling is done month-by-month over the course of the year rather than retrospectively once all disenrollment for a contract is known for the year. In each calendar year, we estimate approximately 143,000 sampled cases (plus or minus). Across the 143,000 sampled cases, roughly 114,000 are allocated to disenrollees from MA-Only and MA-PD contracts (n~568 plans), and 29,000 to disenrollees from PDP plans (n~62 plans). The total allocated annually varies based on several factors including: 1) the total number of MA and PDP plans, as some plans terminate and new plans enter the market; and 2) fluctuations in screen-out rates and response rates.

Historical Context for the Survey: Voluntary disenrollment rates from managed care plans are often viewed as a good "summary" indicator of member satisfaction and plan quality. The Balanced Budget Act of 1997 required that the CMS publicly report two years of disenrollment rates on all Medicare + Choice (M+C) organizations. To ensure that disenrollment rates would be meaningful to beneficiaries in health plan choice, to support quality monitoring activities, and to assist in quality improvement initiatives, CMS funded the development and implementation of an annual national survey to identify the reasons that beneficiaries voluntarily leave health plans. From 2000 through 2005, CMS administered the Medicare Consumer Assessment of Health Plans (CAHPS) Disenrollment Reasons Survey for managed care organization and publicly reported information from this survey.

As the Medicare program had changed significantly since the CAHPS Disenrollment Reasons Survey was administered in 2005 (largely attributable to the 2006 implementation of Medicare's Prescription Drug, or Part D, benefit), CMS funded an effort in 2009 to develop a revised disenrollment survey to focus on beneficiary reasons for voluntarily leaving PDP and MA plans; the pilot disenrollment survey work occurred between November 2010 - July 2011 (approved under OMB CONTROL NUMBER: 0938-1113 and focused only on beneficiaries who **voluntarily disenrolled** from their MA-PD or PDP plan, excluding those who involuntarily disenrolled from contracts because of ineligibility, movement out of the contract's service area, or death. This initial survey effort served as a large-scale field test of methods

perfect. The value indicates the proportion of variation in the reported scores that is due to true differences between contracts rather than "noise" from limited sample sizes.

(data fielding, sampling, weighting, and composite construction), to understand response rates, identify any issues with the survey tool, and examine the most important reasons for disenrollment. Through this work, several improvements were identified, including refinements to survey wording regarding contract name recognition and efficiencies in the administration of the survey, and refining the sample size required to generate reliable contract-level estimates of reasons for disenrollment.

Starting in 2012, CMS moved to implementation of the survey on an annual basis to provide annual feedback to plans and to support annual choice of plans by beneficiaries. CMS expanded the survey to include disenrollees from MA-only contracts and continued to work with the survey contractor to improve screen-in rates and respondent comprehension regarding the contract that they have left. CMS, working with their contractor, designed and distributed reports to 55 PDP and 416 MA-PD contract reports based on calendar year 2013 disenrollment reasons survey data. Since 2012, has been implemented nationwide on an annual basis to generate data to provide CMS with data for contract monitoring, to produce individual plan reports that are used to inform plans' quality improvement efforts, and to produce information for Medicare beneficiaries to use when selecting plans.

To note, CMS has been collecting information since 2000 on beneficiaries' experiences with health care for Medicare managed care and traditional fee-for-service (FFS) Medicare among enrollees in plans through the Medicare Consumer Assessment of Healthcare Plans and Systems (MCAHPS) survey. Starting in 2007, the MCAHPS survey added a new section to assess prescription drug plans under the new Medicare Part D benefit and developed a new MCAHPS survey instrument for beneficiaries enrolled in PDPs. Although CMS was collecting the experiences of enrolled members, outside of consumer complaints (i.e., the Medicare Beneficiary Ombudsman and grievance and appeals process), very little was known about the reasons why beneficiaries disenroll from MA and PDP plans, information that could be used to drive improvements in care and services to Medicare beneficiaries. The Disenrollment Survey was designed to fill that information gap.

Current OMB/PRA request: CMS received its most recent clearance for the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey on October 24, 2013 (OMB control # 0938-1113). This clearance expires on October

31, 2016. CMS requests a three-year clearance (11/1/2016 through 10/31/2019) from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to continue fielding the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey. CMS requests permission to continue fielding the Disenrollment Survey annually and to approve the survey included as part of this OMB/PRA request (Attachments VI, VII, and VIII). CMS has reviewed the survey response data to assess the performance of individual items (e.g., response rates, screen-outs, item skipping); this information is used to inform survey revisions. In this OMB/PRA update request, CMS has made minor survey modifications (i.e., dropped several items) to the previously approved survey (as shown in our survey item crosswalk document that is included with this OMB/PRA update request). CMS will field the annual survey in the same manner as it has been doing since it began annual collection in 2012. CMS will continue to pull monthly samples of voluntary disenrollees from each MA and PDP plan to produce annual reports of reasons for disenrollment to use for plan feedback and improvement and beneficiary choice.

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B. Justification

B1. Need and Legal Basis

The Balanced Budget Act of 1997 required that the CMS publicly report two years of disenrollment rates on all Medicare + Choice (M+C) organizations. Disenrollment rates are a useful measure of enrollee dissatisfaction with a plan; this information is even more useful when reasons for disenrollment are provided to consumers, insurers, and other stakeholders. Advocacy organizations agree that CMS needs to report disenrollment reasons so that disenrollment rates can be interpreted correctly. (See https://www.medicarerights.org/pdf/Why-Consumers-Disenroll-from-MA.pdf as an example.) The Disenrollment Survey gives CMS, plans, and beneficiaries important information about the reasons members leave Medicare Advantage and Prescription Drug plans.

Further, 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 (Information to Facilitate Enrollment) requires CMS to conduct consumer satisfaction surveys regarding the PDP and MA contracts pursuant to section 1860D-4(d). Plan disenrollment is generally believed to be a broad indicator of beneficiary dissatisfaction with some aspect of plan services, such as access to care, customer service, cost of the plan, services, benefits provided, or quality of care.

The information generated from the disenrollment survey supports CMS' ongoing efforts to assess plan performance and provide oversight to the functioning of Medicare Advantage (Part C) and PDP (Part D) plans, which provide health care services to millions of Medicare beneficiaries. Beneficiary satisfaction (as measured in the MCAHPS survey) and dissatisfaction (as measured in the disenrollment survey) with plan performance are both important sources of information for plan monitoring and oversight. The disenrollment survey assesses different aspects of dissatisfaction (i.e., reasons why beneficiaries voluntarily left a plan), which can identify problems with plan operations; performance areas evaluated include access to care, customer service, cost, benefits provided, and quality of care. Understanding how well plans perform on these dimensions of care and service helps CMS understand whether beneficiaries are satisfied with the care they are receiving from contracted plans. When and if plans are found to be performing poorly against an array of performance measures, including beneficiary disenrollment, CMS may take corrective action.

B2. Information Users

This data collection complements the enrollee beneficiary experience data collected through the Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) survey by providing information on the reasons for disenrollment from a Medicare Advantage (with or without prescription drug coverage) or Prescription Drug Plan.

From an operations standpoint, the survey is an important plan oversight monitoring tool for CMS to ensure that Medicare beneficiaries are receiving high quality services from contracted providers.

CMS uses the information obtained from the disenrollment survey to support the quality improvement efforts of individual plans. Annually, CMS provides each plan with a detailed report showing the reasons disenrollees cited for voluntarily leaving the plan and comparing the

plan's scores to regional and national benchmarks. The detailed plan reports are available to CMS staff. See Attachment IX for sample Medicare Advantage Prescription plan report.

The disenrollment survey results are an important source of information used by CMS to monitor plan performance and to identify potential problems with plans (e.g., plans providing incorrect information to beneficiaries or creating access problems). CMS uses the results to monitor the quality of service that Medicare beneficiaries are receiving from contracted providers and to understand beneficiaries' expectations relative to provided benefits and services (for both MA and PDPs).

CMS uses the information obtained from the Disenrollment Survey to support the quality improvement efforts of individual plans by providing them with a detailed, annual report showing the reasons disenrollees cited for voluntarily leaving the plan and comparing the plan's scores to regional and national benchmarks. The plan reports contain results on individual survey items as well as composite measures of reasons for disenrollment (i.e., financial reasons, problems with prescription drug benefits and coverage, problems getting information about prescription drugs, problems getting needed care, coverage, and cost information, and problems with coverage of doctors and hospitals). Plans also see information showing disenrollment rates among subgroups of their enrolled population (e.g., duals/non-duals, elderly vs. non-elderly disabled). Plans can use the information to guide quality improvement efforts. For example, PDP and MA plans (both MA-Only and MA-PD) can make changes to the types of medications covered, to beneficiary costs, and to other plan features that impact beneficiaries to reduce the likelihood of disenrolling. A sample of the plan report is provided in the supplemental documents section of this request.

We get feedback about the utility and use of the disenrollment rates and disenrollment reasons through formal means (i.e., CMS Call Letter) and informally. One example of informal means is the dedicated Disenrollment Survey mailbox. CMS receives comments and questions through its dedicated Disenrollment Survey mailbox. Plans, among submitters to the mailbox, often want more information about the survey which is a signal that plans are using information from the reports/survey. For example, plans have expressed interest in obtaining greater drill down information on performance of all plans within each plan's local market (i.e., competitors), along with the state and national benchmarks the report already includes. CMS has also received requests from plans that are consolidating, wanting survey results from the plan they are merging

with to assess plan's weaknesses and strengths; such information can help inform how the newly merged plan will conduct its operations moving forward. We have also have received requests from plans where the parent organization (i.e., sponsor) wants to use the data in the Disenrollment Survey plan reports to compare the performance for all their plans in different markets. They've asked CMS for more information from CMS to help them conduct analyses related to their business operations.

CMS' survey contractor periodically gets feedback from plans to learn whether the reports are clear and contains information of value to the plans. Plans have regularly reported that the disenrollment survey reports are very helpful and that information in the reports has helped them identify opportunities for improvement. Below are highlights from plan representative comments:

- The national comparison is very useful. I want to make sure that there are not any outliers.
- We review the report as a group to identify opportunities for improvement with a particular focus on member retention, problem solving, and quantifying issues.
- Use the report to identify opportunities to improve member services and to identify whether there is a product issue.
- Look to see where they are high on any measure and then try to link it back to changes made in the previous year.
- We identify top 5 reasons why members disenroll
- We use the report to do a year by year comparison
- We do analysis on a yearly basis on member disenrollment. We look at our own data and the plan report data and use that to project and make changes to retain members.
- Information in the report is useful for trending.

Notably, when the Disenrollment Survey was discontinued in 2005, CMS received numerous requests from plans to reinstate the survey so they could review findings for quality improvement.

CMS also makes the results publicly available to consumers to help them with their annual review and selection of a Medicare Advantage or Prescription Drug Plan. Consumers can view the overall plan disenrollment rate and the summary composite reasons cited for disenrolling (i.e., financial reasons, problems with prescription drug benefits and coverage, problems getting information about prescription drugs, problems getting needed care, coverage, and cost information, and problems with coverage of doctors and hospitals), showing the frequency with which disenrollees cited for each reason. The publicly available results of both the disenrollment

rate and disenrollment reasons are designed to assist Medicare beneficiaries' annual review and plan selection. The data are publicly available on the Medicare Plan Finder website (https://www.medicare.gov/find-a-plan/ and by clicking on the plan-level disenrollment rate).

B3. Use of Information Technology

The survey vendor will collect the data via a mail data collection strategy that involves two rounds of mailed surveys. The mailed survey will be formatted for data scanning, and data from all returned surveys will be scanned into an electronic data file. CMS is using a mailed survey for several reasons: 1) many seniors, especially older beneficiaries, are not routine, facile users of the Internet; 2) CMS does not collect or maintain current email addresses of Medicare beneficiaries that would be required to field a web-based survey; and 3) plans frequently do not have or maintain current email addresses (typically email information is collected and updated by the physician office and not transmitted to plans). Mail surveys are less costly to administer than phone surveys (with the exception of Interactive Voice Recognition (IVR) surveys which typically generate very low response rates).

As background, CMS' Disenrollment Survey contractor explored innovations that CMS might consider to improve response rates and/or to reduce costs to the federal government associated with fielding the survey, as part of its work under a previous contract. One area the contractor explored was the feasibility of conducting a web-based survey. The contractor reviewed published and unpublished literature and held discussions with representatives from two health plans (with substantial Medicare Advantage enrollment) and one provider organizations to understand current experience with or future plans related to using e-mail and electronic means of communicating (including surveying) with Medicare Advantage members.

A recent hospital CAHPS (HCAHPS) experiment conducted by Elliott et al. (2012)[2] evaluated the effectiveness of web/mail mode (i.e., a mail invitation to participate by web, with the web-link provided in the invitation letter, with a mail survey available upon request). This study found that the web/mail mode yielded half the response rate of mail mode and produced compositionally different respondents. The Pew Internet and American Life Project (Zickuhr, 2012)[3] found that 59 percent of older adults (>65 years of age) used the Internet, though this

[2] Elliott MN, Brown J, Lehrman WG, Beckett MK, Hambarsoomian K, Giordano L, Goldstein E. 2012. A Randomized Experiment Investigating the Suitability of Speech-Enabled IVR and Web Modes for Publicly Reported Surveys of Patients' Experience of Hospital Care. *Medical Care Research and Review* 70(2): 165-84.

[3] Zickuhr, K, and Madden, M. 2012. Older adults and internet use. *Pew Internet & American Life Project*

varied by beneficiary characteristics (e.g., age, education, and income), suggesting that a shift to web-based surveying would have uneven penetration across the Medicare population with low penetration among older and poorer beneficiaries. Shifting to email-based surveys presents challenges among the senior population, in that seniors may not use the Internet because they never learned to, because of physical problems, or because they cannot afford the technology.

Added to this, discussions with health plans and the medical group revealed barriers to email communication, including surveys. Health plans said they were interested in using e-mail and the Internet to communicate with and survey their Medicare enrollees, but currently do not. Both plans contacted rely primarily on snail-mail for general communication and phone and mail for surveys. A key hurdle cited by the plans for moving toward web-based communication is that they do not have complete, up-to-date e-mail addresses for their Medicare members. One plan estimated that about 30 percent of their current MA-Only and MA-PD enrollees gave an e-mail address when they enrolled, 65 percent of which were valid. Another problem cited by plans is that when they contact MA members by e-mail, only about 10-50 percent of e-mails are opened depending on the subject line. The medical group reported they collect and regularly update e-mail addresses, although they were unsure for how many Medicare members they had valid e-mail addresses. The medical group does not share email addresses with the plans it contracts with.

B4. Duplication of Efforts

A survey for individuals disenrolling from a Medicare managed care or Prescription Drug Plan is being fielded on an ongoing basis. This is the only disenrollment reasons survey sponsored by CMS being fielded currently to recent disenrollees from Medicare Advantage and standalone Prescription Drug Plans. CMS's disenrollment survey contractor has talked to plans (<9 plans) at various points between 2013 and 2017 regarding the design of the disenrollment survey plan report; during these discussions almost no plan reported attempting to field their own disenrollment surveys. CMS also has not received questions from disenrollees or plans about multiple surveys.

B5. Small Businesses

Survey respondents are Medicare beneficiaries who disenroll from Medicare Prescription Drug Plans (PDPs), and Medicare Advantage plans (both MA-Only plans and MA-

PD plans). The survey should not impact small businesses or other small entities.

B6. Less Frequent Collection

The consequence of not collecting data as soon as possible after a beneficiary disenrolls from a health or prescription drug plan is that the beneficiary will be less able to recall their specific reasons for disenrolling from a PDP or MA plan and their experiences under their previous plan, information that is critical for program improvement. PDP and MA plans (both MA-Only and MA-PD) can make changes to the types of medications covered, to beneficiary costs, and to other plan features that impact beneficiaries. It is therefore useful that CMS survey on an ongoing monthly basis, sampling from the most recent set of disenrollees to enhance recall as to the reasons for disenrollment and the plan the beneficiary has disenrolled from.

Substantial variation year-to-year in both disenrollment rates and reasons for disenrollment may occur for an individual plan based on changes the plan makes (including changing the mix of providers included in the plan's network, consolidation of two plans into one, changes in cost sharing, changes in medications included in the plan's formulary, changes in the plan benefit packages offered—such as adding or dropping a D-SNP—which would lead to different mix of patients). In addition, plans may be actively making changes in response to the scores they receive in the Star Ratings program as well as disenrollment rates and reasons for disenrollment information. Such changes could affect beneficiary retention (disenrollment rates), the types of problems cited, and the frequency with which a plan's members would cite problems.

We have observed that the mix of patients in a contract can shift substantially year-to-year; a contract that has few dual-eligible members may see a sudden increase in those members if they begin to offer a D-SNP benefit package. Similarly, some plans change their benefit package offerings and there is a reduction in plan's members who are dually eligible for Medicare and Medicaid. When such changes occur, the reasons cited for disenrolling will change year-to-year.

Conducting the survey annually has the potential to be informative should something related to the plan's operations go wrong in a given year. This is critical to CMS' continued ongoing monitoring of plan's performance. Also, shifting to a cycle of surveying every 2-3 years could leave Medicare beneficiaries uninformed and vulnerable to selecting a poor performing plan due to outdated data. When four years of data are available, CMS will evaluate the within plan

temporal variability in quality scores available to consumers and adjust the frequency of the data collection accordingly. CMS will look at the temporal and geographic variability in the distribution of disenrollment reasons across all plans (analyses will including comparisons at the 10^{th}, 25^{th}, 50^{th}, 75^{th}, 90^{th} percentiles). If there is very little change in the quality scores across time, CMS will consider collecting the information less frequently.

B7. Special Circumstances

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

B8. Federal Register/Outside Consultation

The Agency's 60-day Federal Register notice was published on Friday, March 25, 2016. In response to public comments received, CMS subsequently revised the MA-Only and MA-PD surveys by adding a response option on the MA versions of the survey (i.e., Question #10 on MA-PD survey and Question #6 on the MA-Only survey: "*How often was it easy to get the care, tests, or treatment you needed through your former plan?*") that reads "*I did not try to get any kind of care, tests, or treatment through my former plan.*" By adding this response option, it improves consistency across the survey, by mirroring the response option offered for other questions items on the survey with "yes/no" screeners. These response options are included because respondents sometimes miss the skip instruction. These revisions do not change any requirements or the burden estimates.

B9. Payment/Gifts to Respondents

None. This data collection will not include respondent incentive payments or gifts.

B10. 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.

B11. Sensitive Questions

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

B12. Burden Estimate (Hours & Wages)

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2015 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage for "All Occupations," the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
All Occupations	00-0000	$23.23	$23.23	$46.46

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent to account for fringe benefit costs. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden Estimates

Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this data collection. The Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey will be administered to 142,431 beneficiaries in calendar- year 2016 (113,260 MA disenrollees and 29,171 PDP disenrollees) using three survey versions:

(1) Medicare Advantage with Prescription Drug Plan Coverage or MA-PD version (attachment 6 in supporting statement B); (2) Stand Alone Prescription Drug Plan or PDP version (attachment 7 in supporting statement B); and (3) Medicare Advantage Only or MA-Only version (attachment 8 in supporting statement B). We anticipate an annual response rate of approximately 40% based on previous years' experience. For example, in 2015, MA response rates were 40.1% and PDP response rates were 39.2%, for a total overall response rate of 39.9%.The estimated response time of 0.2 hours or 12 minutes for the PDP version of the survey is based on the length of that survey version, a pace of 4.5 items per minute, standardized survey instructions, and CMS' experience with surveys of similar length that were fielded with Medicare beneficiaries. Similarly, the estimated response time of 0.23 hours or 14 minutes for the two MA versions of the survey (MA-PD and MA-Only) is based on the length of the MA-PD survey version, a pace of 4.5 items per minute, and CMS' experience with surveys of similar length that were fielded with Medicare beneficiaries. Note: although the MA-Only survey instrument is shorter than the MA-PD survey instrument (45 vs. 63 items), for this burden estimate we are assuming that all MA disenrollees will fill out the MA-PD (longer) version because there are only a very small number of MA-Only plans and we know that MA-Only surveys make up a minority of the total MA sample. As indicated below, the total burden hours are estimated to be 12,754 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 (PDP) Version	11,668	1	0.2	2,334
Medicare Disenrollee Survey, Medicare Advantage (MA-PD and	45,304	1	0.23	10,420
Total	56,972	1	-	12,754

Note: the number of respondents was computed as follows using data from the 2016 sample: (113,260 MA sampled * .40 response rate)= 45,304 respondents. (29,171 PDP sampled * .40 response rate)= 11,668 respondents.

Exhibit 2 shows the survey participants' cost burden associated with their time to complete a survey. The total cost burden is estimated to be $592,551.

Exhibit 2. Estimated annualized cost burden

Survey Version	Number of Respondents	Total Burden hours	Adjusted Hourly Wage Rate*	Total Cost Burden
Medicare Disenrollee Survey, Stand Alone Prescription Drug Plan Version	11,668	2,334	$46.46	$108,438
Medicare Disenrollee Survey, Medicare Advantage (MA-PD and MA-Only	45,304	10,420	$46.46	$484,113
Total	56,972	12,754	-	$592,551

*Based upon the mean hourly wage for "All Occupations" (Occupation Code 00-000) of $23.23 per hour, as shown on the U.S. Bureau of Labor Statistics website, plus an estimate of fringe based on 100% of the mean hourly wage https://www.bls.gov/oes/current/oes_nat.htm#00-0000 (last accessed on 2/6/2017)..

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B13. Capitol Cost

We have no capital costs

B14. Cost to Federal Government

The total cost for design, data collection, analysis, and contract-level report production per year is $1,649,028.

B15. Changes to Burden

This request seeks approval of an estimated 15,032 hours of respondent burden per year to assess reasons for disenrollment from MA and PDP contracts. The actual respondent burden is subject to change between years depending on shifts in number of PDP and MA contracts and/or changes in response rates from year-to-year. It is important to maintain flexibility and consider larger sample sizes that will preserve adequate contract-level reporting reliabilities in the event of increases in the number of PDP and MA contracts and/or declines in response rates.

Proposed changes to the 2016 Disenrollment Survey instruments are detailed in the attached crosswalks. A handful of items have been deleted due to low rates of endorsement, or because the information is available through administrative sources and thus not necessary to

include in the “about you” section of the survey. One item on the effect of Star ratings on disenrollment decisions has been added. In general, revisions have been made to make items easier to for respondents to understand. However, these revisions do not change our estimated completion time per survey.

On an annualized basis, the estimate of respondent burden is reduced from the estimate provided in our 2013 OMB application due to -- (1) a reduction in response rates from 50% (2013 OMB application assumption) to 40% (based on observed response rates for the survey in years 2014 and 2015) and (2) reduction in the number of items on the current survey instruments compared with 2013 instruments.

B16. Publication/Tabulation Dates

The general schedule for publication of results from the PDP and MA plan disenrollment reasons surveys is as follows. (1) Survey fielding for the prior year’s disenrollee surveys is completed in April. (2) Data cleaning and processing is completed in May, and (3) calculation of contract-level estimates for reasons of leaving composites and single items is conducted in June/July, including weighting and case-mix adjustment). (4) RAND provides CMS with contract-level scores on reasons for leaving composites that are posted to drill-downs on Medicare Plan Finder in July (and CMS posts to the plan preview page in the summer and to Medicare Plan Finder in the Fall of each year). (5) Individual contract-level reports on results from surveys from the previous year’s disenrollees are distributed to the health and prescription drug plans by e-mail and FedEx in late July/early August.

For surveys of beneficiaries who disenrolled from their contracts in calendar-year 2015 for example, the schedule will proceed as follows:

- April 2016 – data collection for surveys from 2015 (January 2015 through
- December 2015) disenrollees is completed
- May 2016 – data cleaning and processing of 2015 survey results is completed
- June/July 2016 – calculation of contract-level estimates of reasons for leaving composites and single items, including weighting and case-mix adjustment
- July 2016 – RAND provides 2015 contract-level estimates of reasons for leaving composites to CMS (CMS posts to the plan preview page later in the summer and to Medicare Plan Finder in the Fall)

- July/August 2016 – distribution of contract-level reports of survey results from 2015 disenrollees to the plan Medicare Compliance Officers

We anticipate a similar schedule for 2017 for processing and publishing the results of surveys of beneficiaries who disenrolled from their contracts in calendar-year 2016. This process repeats annually.

B17. Expiration Date

The current expiration date is 10/31/2016. CMS will display the new expiration date for OMB approval of this information collection on the survey, once OMB approval has been obtained (see attachments VI, VII, and VIII) which now include text "The valid OMB control number for this information collection is 0938-1113 (Expires: TBD)."

B18. 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.

C. List of Attachments

Attachment I. MA-PD Prenotification Letter

Attachment II. PDP Prenotification Letter

Attachment III. MA-Only Prenotification Letter

Attachment IV. Wave 1 Cover Letter

Attachment V. Wave 2 Cover Letter

Attachment VI. MA-PD Survey

Attachment VII. Stand Alone PDP Survey

Attachment VIII. MA-Only Survey

Attachment IX. Plan Report Sample