

**2022 Prescription Drug Plan Survey
Field Test Version**

[New items compared to current PDP survey highlighted in
yellow]

2022 Medicare Experience Survey

MEDICARE SURVEY INSTRUCTIONS

This survey asks about you and the health care you received in the last six months. Answer each question thinking about yourself and the times you got health care in person, by phone or by video call. Please take the time to complete this survey. Your answers are very important to us. Please return the survey with your answers in the enclosed postage-paid envelope to [Survey Vendor].

- If you changed your Medicare plan for 2022, answer the questions thinking about your experiences in the last 6 months of 2021.
- Answer all the questions by putting an “X” in the box to the left of your answer, like this:
 Yes
- Be sure to read all the answer choices given before marking your answer.
- You are sometimes told not to answer some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: [**→If No, Go to Question 3**]. See the example below:

EXAMPLE

1. Do you wear a hearing aid now?

- Yes
 No **→If No, Go to Question 3**

2. How long have you been wearing a hearing aid?

- Less than one year
 1 to 3 years
 More than 3 years
 I don't wear a hearing aid

3. In the last 6 months, did you have any headaches?

- Yes
 No

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. This applies to both mandatory and voluntary collections of information. The valid OMB control number for this information collection is **0938-XXXX**. The time required to complete this information collection is estimated to average **10 minutes**, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

1. Our records show that in 2021 your prescriptions were covered by the Medicare prescription drug plan named on the back page. Is that right?

- Yes →If Yes, Go to Question 3
 No

2. Please write below the name of the Medicare prescription drug plan you had in 2021 and complete the rest of the survey based on the experiences you had with that plan. (Please print)

3. In the last 6 months, did anyone from a doctor's office, pharmacy, or your prescription drug plan contact you:

- | | <u>Yes</u> | <u>No</u> |
|--|--------------------------|--------------------------|
| a. To make sure you filled or refilled a prescription? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. To make sure you were taking medicine as directed? | <input type="checkbox"/> | <input type="checkbox"/> |

4. In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?

- Never
 Sometimes
 Usually
 Always
 I did not use my prescription drug plan to get any medicines in the last 6 months

5. In the last 6 months, did you ever use your prescription drug plan to fill a prescription at your local pharmacy?

- Yes
 No →If No, Go to Question 7

6. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?

- Never
 Sometimes
 Usually
 Always

7. In the last 6 months, did you ever use your prescription drug plan to fill a prescription by mail?

- Yes
 No →If No, Go to Question 9

8. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

- Never
 Sometimes
 Usually
 Always

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

- 0 Worst prescription drug plan possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best prescription drug plan possible

About You

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

- Excellent
- Very good
- Good
- Fair
- Poor

11. In general, how would you rate your overall mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

12. What language do you mainly speak at home?

- English
- Spanish
- Chinese
- Korean
- Tagalog
- Vietnamese
- Some other language

↓
Please print: _____

13. In the last 6 months, did you spend one or more nights in a hospital?

- Yes
- No

14. In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?

- Yes
- No
- My doctor did not prescribe any medicines for me in the last 6 months

15. In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?

	Yes	No
a. Medical history.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Disability.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Age.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Culture or religion....	<input type="checkbox"/>	<input type="checkbox"/>
e. Language or accent ..	<input type="checkbox"/>	<input type="checkbox"/>
f. Race or ethnicity	<input type="checkbox"/>	<input type="checkbox"/>
g. Gender or gender identity	<input type="checkbox"/>	<input type="checkbox"/>
h. Sexual orientation....	<input type="checkbox"/>	<input type="checkbox"/>

16. Has a doctor ever told you that you had any of the following conditions?

	Yes	No
a. A heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
b. Angina or coronary heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
c. Hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer, <u>other than skin cancer</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
e. Emphysema, asthma, or COPD (chronic obstructive pulmonary disease)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Any kind of diabetes or high blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you have serious difficulty walking or climbing stairs?

- Yes
- No

18. Do you have difficulty dressing or bathing?

- Yes
- No

19. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes
- No

20. What is the highest grade or level of school that you have completed?

- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
- More than 4-year college degree

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

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

22. What is your race? Please mark one or more.

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

23. How many people live in your household now, including yourself?

- 1 person
- 2 to 3 people
- 4 or more people

24. Do you ever use the internet at home?

- Yes
- No

25. May the Medicare Program follow up with you to learn more about your health care, or to invite you to a group discussion or interview on topics related to health care?

- Yes
- No

26. Did someone help you complete this survey?

- Yes
- No → **Thank you. Please return the completed survey in the postage-paid envelope.**

27. How did that person help you? Please mark one or more.

- Read the questions to me
- Wrote down the answers I gave
- Answered the questions for me
- Translated the questions into my language
- Helped in some other way

Thank you.

Please return the completed survey in the postage-paid envelope.

[SURVEY VENDOR RETURN ADDRESS FOR MAIL PROCESSING]

Contract Name: _____

[OPTIONAL]

You may also know your plan by one of the following: