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

Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey

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 MA or PDP plan. Beneficiaries can disenroll from plans during the Annual Election Period (AEP) which runs from October 15 – December 7 each year, the Medicare Advantage Open Enrollment Period (MA OEP) that runs January 1 – March 31 each year, and Special Election Periods (SEPs). The Centers for Medicare & Medicaid Services (CMS) developed the Disenrollment Survey to capture the reasons for disenrollment as close as possible to the actual date of a beneficiary's disenrollment. Through this survey, CMS seeks to: (1) obtain information about beneficiaries' experiences 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 contract performance, because disenrollment can be a broad indicator of beneficiary dissatisfaction with some aspect of their plan's[1] 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 contracts and provides data to assist consumer choice.

Each year, CMS uses the overall rate of disenrollment from MA and PDP contracts as a performance measure in the annual Star Rating program for Part C and Part D contracts. In 2022, among contracts with at least 1,000 enrolled members, 6.1 million beneficiaries voluntarily disenrolled from contracts, with disenrollment rates varying widely across contracts. MA disenrollment rates ranged from <1% to 60% and PDP disenrollment rates from 2% to 40%. The Disenrollment Survey extends measurement of 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, those with

[1] 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.

or without chronic conditions), and by specific contracts.

CMS uses the information obtained from the Disenrollment Survey for several purposes. The survey results are an important contract monitoring tool for CMS to ensure that Medicare beneficiaries are receiving high quality services from contracted providers. CMS uses information from the survey to track changes in the reasons Medicare beneficiaries cite for disenrolling to monitor improvements/declines over time nationally and at the contract level. CMS also uses the disenrollment survey results to support the quality improvement efforts of individual contracts by providing them with a detailed annual report showing the reasons disenrollees cited for voluntarily leaving the contract and comparing the contract's scores to regional and national benchmarks. Additionally, CMS uses the contract-specific results of the survey to provide Medicare beneficiaries with information (i.e., reasons cited for disenrolling from a plan and the frequency with which disenrollees cite each reason) to assist beneficiaries with their annual consumer choice of health and drug plans.

CMS's survey contractor pulls a monthly sample from CMS's 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 achieving 65 (MA contracts) and 130 (PDP contracts) completed responses. CMS does not survey 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 contract-level based on survey response rates, screen-in rates, and variation in responses to survey items. CMS draws a larger sample size for PDP contracts because there is less variation between PDP contracts in the reasons cited for disenrolling, as compared to MA contracts. CMS pulls a random sample of disenrollees from each contract 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 contract-level estimates for reporting to contracts and Medicare beneficiaries the 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). The 65/130 number of target cases were based on analyses the survey contractor performed to determine the number of completed

responses required to achieve reliable estimates (i.e., reliability of 0.60 or greater[2]) of reasons for disenrollment. Beneficiaries who disenroll at different times of the year may do so for different reasons and have somewhat different characteristics (e.g., a higher fraction of dually eligible beneficiaries disenroll outside of the Annual Election Period AEP as they are eligible to disenroll during the Special Election Period); 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 160,000 sampled cases. Across the 160,000 sampled cases, roughly 143,000 are allocated to disenrollees from MA-Only and MA-PD contracts (approximately 678 contracts), and 17,000 to disenrollees from PDP contracts (approximately 34 contracts). The total allocated annually varies based on several factors including: 1) the total number of MA and PDP contracts, as some contracts terminate and new contracts 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 why 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 organizations 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

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[2]Contract-level reliability is a zero to 1 index that indicates the proportion of variation in the reported scores that is due to true differences between contracts rather than "noise" from limited sample sizes. Reliability below 0.60 is considered very low.

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 (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, 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 annual implementation of the survey to provide yearly feedback to contracts 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 from which they disenrolled.

Since 2012, the survey has been implemented nationwide on a continuous basis to generate data to provide CMS with data for contract monitoring, to produce individual contract reports that are used to inform contracts' quality improvement efforts, and to produce information for Medicare beneficiaries to use when selecting health and drug 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 (Medicare CAHPS) survey. Starting in 2007, the Medicare CAHPS survey added a new section to assess prescription drug plans under the new Medicare Part D benefit and developed a new Medicare CAHPS 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.

Survey Content and Composite Measures: The MA and PDP Disenrollment Reasons Survey includes three versions, directed respectively at disenrollees in three different types of plans:

- Medicare Advantage-only (MA-Only) plans (46 questions)
- Medicare Advantage Health and Drug (MA-PD) plans (60 questions)
- Medicare Prescription Drug Plans (PDPs) (49 questions)

As an example, the MA-PD Survey is organized into the following sections:

- Your Former Health Plan (2 questions)
- Getting Information or Help from Your Former Health Plan (2 questions)
- Getting Health Care and the Prescription Medicines You Needed from Your Former Health Plan (9 questions)
- Reasons You Left Your Former Health Plan (27 questions)
- Other Reasons for Leaving Your Former Health Plan (4 questions)
- About You (15 questions)

CMS combines questions on related reasons for disenrollment into composite (summary) measures, which are reported to contracts along with individual survey items. Table 1 describes the composites measures constructed and reported by survey type.

Table 1: Composite Measures by Survey Type

Composite Measures	**MA-Only Survey**	**MA-PD Survey**	**PDP Survey**
Financial Reasons for Disenrollment	Yes	Yes	Yes
Problems Getting the Plan to Provide and Pay for Needed Care	Yes	Yes	No
Problems with Coverage of Doctors and Hospitals	Yes	Yes	No
Problems Getting Information and Help from the Plan	No	Yes	Yes
Problems with Prescription Drug Benefits and Coverage	No	Yes	Yes

Table 2 displays how individual survey questions on the MA-PD survey instrument map into the composite measures.

Table 2: Composite Measures and Individual Items that Map to Composites

Composite Measure	MA-PD Survey Questions Included in the Composite
Financial Reasons for Disenrollment	• Did you leave your former plan because the dollar amount you had to pay each time you filled or refilled a prescription (copayment) went up? (Q15) • Did you leave your former plan because you found a plan with a lower copayment for prescription drugs? (Q16) • Did you leave your former plan because you found a plan with a lower copayment for doctors' visits? (Q18) • Did you leave your former plan because the monthly premium (fee) went up? (Q19) • Did you leave your plan because you found a plan with a lower monthly premium? (Q20) • Did you leave your former plan because a change in your personal finances meant you could no longer afford the plan? (Q 21) • Did you leave your former plan because it turned out to be more expensive than you expected? (Q23)
Problems with Coverage of Doctors and Hospitals	• Did you leave your former plan because the doctors or other health care providers you wanted to see did not belong to the plan? (Q33) • Did you leave your former plan because clinics or hospitals you wanted to go to for care were not covered by the plan? (Q34)
Problems Getting the Plan to Provide and Pay for Needed Care	• Did you leave your former plan because you were frustrated by the plan's approval process for care, tests, or treatment? (Q30) • Did you leave your former plan because you had problems getting the care, tests, or treatment you needed? (Q31) • Did you leave your former plan because you had problems getting the plan to pay a claim? (Q32) • Did you leave your former plan because it was hard to get information from the plan about which health care services were covered or how much a specific test or treatment would cost? (Q35)

Composite Measure	MA-PD Survey Questions Included in the Composite
Problems Getting Information and Help from the Plan	• Did you leave your former plan because you did not know whom to contact when you had a problem filling or refilling a prescription? (Q28) • Did you leave your former plan because it was hard to get information from the plan about which prescription medicines were covered or how much a specific medicine would cost? (Q29) • Did you leave your former plan because you were unhappy with how the plan handled a question or complaint? (Q36) • Did you leave your former plan because you could not get the information or help you needed from the plan? (Q37) • Did you leave your former plan because their customer service staff did not treat you with courtesy and respect? (Q38)
Problems with Prescription Drug Benefits and Coverage	• Did you leave your former plan because they changed the list of prescription medicines they cover? (Q21) • Did you leave your former plan because the plan refused to pay for a medicine your doctor prescribed? (Q23) • Did you leave your former plan because you had problems getting the medicines your doctor prescribed? (Q25) • Did you leave your former plan because it was difficult to get brand name medicines? (Q26) • Did you leave your former plan because you were frustrated by the plan's approval process for medicines your doctor prescribed? (Q27)

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 12, 2023 (OMB Control Number: 0938-1113). This clearance expires on December 31, 2024. CMS requests a three-year clearance (01/01/2025 through 12/31/2027) from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to continue annual fielding the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey. CMS requests OMB's approval of the survey included as part of this OMB/PRA request (Attachments IV, V, and VI). CMS has reviewed the survey response data to assess the performance of individual items (e.g., response rates, screen-outs, item skipping). CMS reviewed past survey data along with its regular review of feedback from both Medicare beneficiaries and contract representatives. Based on this information, CMS proposes survey modifications to reduce respondent burden

(i.e., dropped eight items from the MA-PD version; dropped four items from the MA-Only version; and dropped six items from the PDP version) in this OMB/PRA update request to the previously approved survey (as shown in our survey item crosswalk document).

The Disenrollment Reasons Survey is currently available in Spanish and English. All residents of Puerto Rico received Spanish-language versions of the survey. The remainder of disenrollees received an English-language version but can request a Spanish-language version of the survey, though few disenrollees typically ask for a Spanish-language version of the survey.

Potential respondents for the Disenrollment Reasons Survey share similar demographics to the Medicare Advantage and Prescription Drug Plan CAHPS Survey (Medicare CAHPS). The Medicare CAHPS survey identified that of the 276,789 respondents to the 2023 MA survey, most were likely to respond in English (95.23%) followed by Spanish (4.35%). The next highest number of responses were in Chinese (0.34%) and Vietnamese (0.04%). The Disenrollment Reasons Survey proposes adding two new language options in 2025: 1) Traditional Chinese (appropriate for this survey's older target audience compared with simplified Chinese); and Vietnamese along with the previously-available Spanish option. Further, CMS is revising the prenotification and cover letter to alert respondents to all language options (Attachments I, II).

For any contract(s) with a significant number of beneficiaries who prefer Chinese language materials, we plan to include copies of both English and Chinese versions of survey materials in each mailing envelope.

Should CMS identify other contracts with a significant number of beneficiaries with a language preference other than English, we will propose similar mailing practices.

CMS will continue to look for ways to identify language preferences among health and drug plan disenrollees and potential survey respondents to translate the survey into additional languages over time.

CMS will field the annual survey in the same manner as it has been doing since the last OMB approval October 12, 2023. CMS will continue to pull monthly samples of voluntary disenrollees from MA and PDP contracts to produce annual reports of reasons for disenrollment to use for contract feedback and improvement and beneficiary choice.

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 beneficiary 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, contracts, 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's ongoing efforts to assess contract 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 (i.e., 32 million for Part C coverage and 22 million for standalone Part D coverage).[3] Beneficiary experiences of care (as measured in the Medicare CAHPS 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, coverage, benefits provided, and quality of care. Understanding how well contracts perform on these dimensions of care and service helps CMS understand whether beneficiaries are satisfied with the care they are receiving from contracted

[33] https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-contract-and-enrollment-summary-report, Data as of December 2023.

plans. When and if contracts 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 (Medicare CAHPS) survey by providing information on the reasons for disenrollment from a Medicare Advantage (with or without prescription drug coverage) or Prescription Drug Plan.

The Disenrollment Survey results are an important source of information used by CMS to monitor contract performance and to identify potential problems (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 get from contracted plans and their providers and to understand beneficiaries' expectations relative to provided benefits and services for MA and PDPs. CMS uses information from the Disenrollment Survey to support quality improvement efforts of individual contracts.

Annually, CMS provides contracts with a detailed report showing the reasons disenrollees cited for voluntarily leaving the contract and comparing the contract's scores to regional and national benchmarks. The annual contract reports include results on individual survey items and composite measures of disenrollment reasons (i.e., financial reasons, problems with prescription drug benefits and coverage, problems getting information and help from the plan, problems getting the plan to provide and pay for needed care, and problems with coverage of doctors and hospitals). Contracts also see information showing disenrollment rates among subgroups of their enrolled population (e.g., duals/non-duals, elderly vs. non-elderly disabled). Contracts can use the information to guide quality improvement efforts. For example, PDP and MA contracts (both MA-Only and MA-PD) can identify problem areas; make changes to how medications are covered, to beneficiary costs, and to other plan features that impact beneficiaries; and reduce the likelihood of disenrolling.

CMS gets feedback about the utility of the disenrollment reasons survey and annual report through formal means and informally, particularly through the dedicated Disenrollment Survey mailbox. Each year, particularly around the time of annual report distribution, contracts reach out through the Disenrollment Survey mailbox to request more information about the

survey and the report. This signals that contracts are using information from the reports and survey. For example, contracts have expressed interest in obtaining greater drill down information on performance of all contracts within their local market (i.e., competitors), along with the state and national benchmarks the report already includes. CMS has also received requests from contracts that are consolidating, wanting survey results from the contract they are merging with to assess weaknesses and strengths. Such information can help inform how the newly merged contract will conduct its operations moving forward. We have also received requests from contracts where the parent organization (i.e., sponsor) wants to use the data in the Disenrollment Survey contract reports to compare the performance for all their contracts in different markets. They've asked for more information from CMS to help them conduct analyses related to their business operations. CMS also hears from contracts that they are awaiting receipt of the contract reports in early fall, as they consider whether and how to change services and benefits for the upcoming year.

CMS's survey contractor periodically requests feedback from contracts to learn whether the reports are clear and contains information of value to the contracts. Contracts report 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 contract representative comments:

- To look at main reasons why members disenroll and to identify areas in need of improvement. Also, to think about strategies for improvement, changes we can make. I like to see how we compare nationally but also locally, so I can see where we are better or worse.
- The reports provide strong product feedback. Why we have lost members. The information informs continuous improvement.
- We do our own internal analysis. We do our own disenrollment surveys. A lot of the things in the disenrollment report here – we know that already. But where the report's helpful is how it shows differences from the national average. How we are doing compared to our competition. That can help us focus in; are these problems that everyone is facing, or are they unique to us?
- We also look at mainland-U.S. averages for disenrollment reasons in the plan reports. We want to know if there is anything we can learn from what is happening in the [mainland] states? If there are big causes of disenrollment in the states, we want to make sure we try and avoid those in Puerto Rico. We try to follow best practices.
- We look at the report to make sure issues have been resolved. We look at our contract average, the national average disenrollment rate, and then reasons behind it to inform product development. The average nationally can obscure what is happening locally, so we

> like how the report compares how their contract performs compared to the state average/state comparisons. Those are very helpful. Because most of our plans are state based, the national averages are not as informative.

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

CMS regularly gets feedback from consumers through informal and formal means, including through beneficiary letters and cognitive testing. Through interviews, consumers have shared they want to get information from Medicare on the reasons why other people left a plan they're considering joining. For example, they want to know whether others left due to problems with coverage of doctors or prescription drugs or negative experiences with the plan's customer service.

CMS also makes results publicly available so consumers and stakeholders can view the overall contract disenrollment rate and the summary composite reasons cited for disenrolling (i.e., financial reasons, problems with prescription drug benefits and coverage, problems getting information and help from the plan, problems getting the plan to provide and pay for needed care, and problems with coverage of doctors and hospitals), showing the frequency with which disenrollees cited for each reason.

B3. Use of Information Technology

The survey vendor collects the data via a mail data collection strategy that involves an initial pre-alert letter notifying the beneficiary that they will receive a survey (mailed 3 days prior to the first survey mailing) followed by two rounds of mailed surveys over an 8-week field period. The first survey is mailed approximately 4 weeks after the date of disenrollment. The mailed survey is formatted for data scanning, and data from all returned surveys is scanned into an electronic data file. CMS uses a mailed survey protocol for several reasons: 1) many seniors, especially older beneficiaries, are not routine, facile users of the Internet; 2) CMS does not collect or maintain email addresses of Medicare beneficiaries that would be required to field a web survey, where CMS is the entity fielding the survey; and 3) plans do not always have or maintain current email addresses (typically email information is collected and updated by physician offices 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).

CMS's Disenrollment Survey contractor explored innovations that CMS might consider to improve response rates, improve the representativeness of respondents, and/or reduce costs to the federal government associated with fielding the survey. One area that CMS has and is continuing to explore is the feasibility of augmenting the current fielding methodology to incorporate a web-based survey mode. At present, it would be challenging to implement a web-based survey in the context of the Disenrollment Survey because CMS lacks email addresses for most Medicare beneficiaries. Obtaining email addresses from the MA and PDP plans would be problematic given that beneficiaries disenroll monthly throughout the year and it would be administratively difficult to request monthly lists of email addresses from 600+ plans from which beneficiaries disenrolled. It would be particularly challenging to receive the email files from plans in a timely way so as not to adversely delay getting surveys out to disenrollees. Such delays between time of disenrollment and survey delivery have a negative impact on response rates.

B4. Duplication of Efforts

This is the only disenrollment reasons survey sponsored by CMS being fielded currently to recent disenrollees from MA and PDP plans. In feedback received from contracts, they indicated the information contained in the reports is complementary to other information they compile related to member complaints and member retention efforts.

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 details about the plan the beneficiary has disenrolled from.

Further, it is important that contracts, beneficiaries and CMS have access to recent information on reasons for disenrollment to guide decision making. In the OMB approval dated December 10, 2020, as a term of clearance, OMB requested that when four years of data are available, CMS evaluate the **within plan temporal variability** in quality scores available to consumers and adjust the frequency of the data collection accordingly. Additionally, OMB requested that CMS look at the temporal and geographic variability in the distribution of disenrollment reasons **across all plans** (analyses will include comparisons at the 10th, 25th, 50th, 75th, 90th percentiles) to assess changes over time and the utility of annual surveying.

In response to this request from OMB, CMS examined the following:

(1) contract-level variability in reasons for disenrollment composite scores over time;

(2) geographic-level variability in the distribution of disenrollment reasons over time; and

(3) the degree to which disenrollment reasons composites predict future disenrollment.

The analyses (details of which can be found in Attachment VII) show that annual survey data collection provides timely, contract-specific information to inform contract quality improvement and beneficiary choice of contracts. Because MA and PDP contracts often change from year-to-year in the services and plan benefit package options they provide, it is important that performance data be as current as possible for consumers to make decisions and for contracts to understand how their members rate their performance. We find that performance and disenrollment reason information vary sufficiently year-to-year, and using data from even one year before, much less two or three years before, may not capture the latest reasons for disenrollment. Given the observed changes in the quality scores both at the contract-level and regionally (i.e., changes in percentile categories identified by OMB) across time, there is significant utility to CMS, contracts, and beneficiaries in continuing to collect the disenrollment reasons information on an annual basis. The findings of variability across years between contracts and between states suggest the value of frequent administration and

reporting of the disenrollment reasons survey, given that there are often substantial changes for contracts and states in one year. Additionally, there is a demonstrable, predictive link between the proportion of non-financial reasons cited by disenrollees in one year and the subsequent year's contract-level disenrollment rate; this highlights the utility of providing the most recent disenrollment reasons information to contracts, who are focused on minimizing disenrollment.

B7. Special Circumstances

This collection doesn't contain any special circumstances.

B8. Federal Register/Outside Consultation

The Agency's 60-day Federal Register notice was published in the Federal Register (89 FR 18411) on Wednesday March 13, 2024. CMS received comments from one health insurer and provided responses in the attached document. There are no changes to the survey based on comments received.

The Agency's 30-day Federal Register notice was published in the Federal Register (89 FR 57901) on Tuesday July 16, 2024.

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 2023 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/current/oes_nat.htm#00-0000). In this regard, the following table presents the 2023 median 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	Median Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
All Occupations	00-0000	$23.11	$23.11	$46.22

We adjusted our employee hourly wage estimates by a factor of 100 percent to account for fringe benefit costs, which is a rough adjustment because fringe benefits and overhead costs vary significantly from employer to employer, and methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the median 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 160,000 beneficiaries in calendar-year 2024 (approximately 145,000 MA-PD and MA-Only disenrollees and 15,000 PDP disenrollees) using three survey versions: Medicare Advantage with Prescription Drug Plan or MA-PD version (Attachment IV); (2) Stand Alone Prescription Drug Plan or PDP version (Attachment V); and (3) Medicare Advantage Only or MA-Only version (Attachment VI).

We anticipate an annual overall response rate of approximately 22-27% given multiple previous years' experience, and use a two-year average response rate from 2022 and 2021 to estimate the number of anticipated annual responses. The two-year average MA response rate is 22.1% and the two-year average PDP response rate is 26.7%. The estimated average response time of 0.16 hours or 9.6 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's experience with surveys of similar length that were fielded with Medicare beneficiaries. Similarly, the estimated average response time of 0.19 hours or 11.6 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's 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 (42 vs. 52 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 6,730 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	4,005	1	0.16	641
Medicare Disenrollee Survey, Medicare Advantage (MA-PD and MA-Only	32,045	1	0.19	6,089
Total	36,050	1	-	6,730

Note: the number of respondents was computed as follows using average response rates from 2021 and 2022: (145,000 MA sampled * .221 response rate)= 32,045 respondents. (15,000 PDP sampled * .267 response rate) = 4,005 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 $311,061.

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	4,005	641	$46.22	$29,627
Medicare Disenrollee Survey, Medicare Advantage (MA-PD and MA-Only	32,045	6089	$46.22	$281,434
Total	36,050	6,730	-	$311,061

*Based upon the median hourly wage for "All Occupations" (Occupation Code 00-000) of $23.11 per hour, as shown on the U.S. Bureau of Labor Statistics website (May 2023 National Occupational Employment and Wage Estimates), plus an estimate of fringe based on 100% of the median hourly wage https://www.bls.gov/oes/current/oes_nat.htm (last accessed on 5/21/2024).

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 approximately $2,000,000.

B15. Changes to Burden

This request seeks approval of an estimated 6,730 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.

CMS's contractor analyzed responses to the individual disenrollment survey items to assess the number of beneficiaries screening out of the survey and reasons for screen out, and to identify potential problems with specific survey items (i.e., inappropriate skips or large fraction of missing responses). Further, they reviewed items that contributed to orienting the respondent to the range of experiences they had with the plan from which they disenrolled.

CMS proposes to delete eight items from the MA-PD survey; four items from the MA-only survey, and six items from the PDP survey to reduce respondent burden. We propose deleting the following items:

- Did you ever try to get information or help from your former plan's customer service? (MA-PD Q3; MA-only Q3; PDP Q3)
- How often did your former plan's customer service give you the information or help you needed? (MA-PD Q4; MA-only Q4; PDP Q4)
- Did you make an appointment to see a specialist? (MA-PD Q6; MA-only Q6)
- How often did you get an appointment to see a specialist as soon as you needed? (MA-PD Q7; MA-only Q7)
- Did you ever use your former plan to fill a prescription at a pharmacy? (MA-PD Q9; PDP Q6)
- How often was it easy to use your former plan to fill a prescription at a pharmacy? (MA-PD Q10; PDP Q7)
- Did you ever use your former plan to fill any prescriptions by mail? (MA-PD Q11; PDP Q8)
- How often was it easy to use your former plan to fill prescriptions by mail? (MA-PD Q12; PDP Q9)

These revisions do not change any requirements and reduce the time needed for individual respondents to complete the survey and the overall estimate of total burden hours for all respondents.

The proposed revisions result in 1+ minute reduction in our estimated completion time per survey depending on plan type.

On an annualized basis, the estimate of total respondent burden hours is reduced from the estimate provided in our 2023 OMB application. Estimated annualized cost burden has also decreased since our last OMB application due to the reduction in respondent burden hours and a decrease in the adjusted hourly wage due to changing from using mean hourly wage estimates to median hourly wage estimates from the Bureau of Labor Statistics website (https://www.bls.gov/oes/current/oes_nat.htm#00-0000).

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) The survey contractor provides CMS with contract-level scores on reasons for leaving composites in July. (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 in September of each year.

For surveys of beneficiaries who disenrolled from their contracts in calendar-year 2022 for example, the schedule proceeded as follows:

- April 2023 – finished data collection for surveys from calendar year 2022 (January 2022 through December 2022)
- May-June 2023 – conducted data cleaning and processing of 2022 survey results
- June/July 2023 – computed weights and calculated contract-level estimates of reasons for leaving composites and single items; applied weighting and case-mix adjustment to derive estimates
- July/August 2023 – prepared 2022 contract-level estimates of reasons for leaving composites, which CMS posted to the plan preview page later in the summer and to CMS website in October 2023)
- September 2023 – distributed contract-level reports of survey results from 2022 disenrollees to the contract's Medicare Compliance Officers

We anticipate a similar schedule for 2025 for processing and publishing the results of surveys of beneficiaries who disenrolled from their contracts in calendar-year 2024. This process repeats annually.

B17. Expiration Date

The current expiration date is December 31, 2024. 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 IV, V, and VI) 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. Prenotification Letter

Attachment II. Wave 1 Cover Letter

Attachment III. Wave 2 Cover Letter

Attachment IV. MA-PD Survey

Attachment V. Stand Alone PDP Survey

Attachment VI. MA-Only Survey

Attachment VII. Analyses Regarding Year-to-Year Variability of Disenrollment Reason Scores