Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS® Survey

2026~~5~~ Prescription Drug Plan Survey

20265 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 20265, answer the questions thinking about your experiences in the last 6 months of 20254.
- 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 **0938-0732 (expires 11/30/2027)**. 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 20254 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 20254 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:

	Yes	No
a. To make sure you filled or refilled a prescription?	☐	☐
b. To make sure you were taking medicine as directed?	☐	☐

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 <u>mental or emotional</u> 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. Has a doctor ever told you that you had any of the following conditions?

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

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

☐ Yes
☐ No

17. Do you have difficulty dressing or bathing?

☐ Yes
☐ No

18. 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

19. 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

20. ~~Are you of Hispanic or Latino origin or descent?~~

~~☐ Yes, Hispanic or Latino~~
~~☐ No, not Hispanic or Latino~~

2~~1~~0. What is your race or ethnicity? Please mark one or more.

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African-American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or ~~other~~ Pacific Islander
☐ White

2~~2~~1. How many people live in your household now, including yourself?

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

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2~~3~~2. Do you ever use the internet at home?

- ☐ Yes
- ☐ No

2~~4~~3. 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

2~~5~~4. Did someone help you complete this survey?

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

2~~6~~5. 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: