



**Analysis of Calendar Year 2012 Medicare
Part D Reporting Requirements Data**

March 2015

This page is intentionally left blank.

TABLE OF CONTENTS

1	Introduction	1
2	Data Overview	6
2.1	Submission Process.....	6
2.2	Validation Process	6
2.3	Exclusion Criteria	7
2.4	Methodological Differences with 2012 PUFs	8
3	Grievances	12
4	Coverage Determinations and Exceptions	15
5	Redeterminations	18
6	Prompt Payment by Part D Sponsors	21
7	Medication Therapy Management Programs	23
8	Plan Oversight of Agents	26
9	Long Term Care Utilization	27
10	Enrollment and Disenrollment	29
11	Summary of Results	31

LIST OF TABLES AND FIGURES

Table 1.1:	Summary of Part D Reporting Requirements by CY, 2010-2014	1
Table 1.2:	CY 2012 Part D Reporting Sections	2
Table 1.3:	Reporting Sections and Key Metrics	3
Table 2.1:	Reporting Sections Undergoing Data Validation	7
Table 2.2:	Summary of Data Validation Results by Reporting Section	8
Table 2.3:	Methodological Differences between Report and 2012 PUFs	9
Table 3.1:	Plans with at least 100 Enrollees and Reporting Zero Part D Grievances by Plan Type, 2011-2012	12
Table 3.2:	Plans with at least 100 Enrollees and Reporting Zero Part D Grievances by Plan Enrollment, 2011-2012	13
Table 3.3:	Part D Grievance Rate per 1,000 Enrollees by Plan Type, 2011-2012	13
Table 3.4:	Percentage of Part D Grievances Responded to On-Time by Plan Type, 2011-2012.	14
Table 4.1:	Plans with at least 100 Enrollees and Reporting Zero Determinations and Exceptions by Plan Type, 2011-2012	15
Table 4.2:	Coverage Determination and Exception Request Rates per 1,000 Enrollees, 2011-2012	16
Figure 4.1:	Distribution of Coverage Determination and Exception Request Rates per 1,000 Enrollees, 2011-2012	17
Table 4.3:	Percentage of Coverage Determination and Exception Requests Approved by Request Type, 2011-2012	17
Table 5.1:	Plans with at least 100 Enrollees and Reporting Zero Redeterminations by Plan Type, 2011-2012	18
Table 5.2:	Plans with at least 100 Enrollees and Reporting Zero Redeterminations by Plan Enrollment, 2011-2012	19
Figure 5.1:	Redetermination Rates per 1,000 Enrollees by Plan Type, 2011-2012.....	19
Figure 5.2:	Distribution of Redetermination Rates per 1,000 Enrollees across Plans, 2011-2012.....	20

Table 5.3: Percentage of Redeterminations that Upheld the Initial Adverse Coverage Determination, 2011-2012	20
Table 6.1: Percentage of Paid Claims that were Electronic, 2011-2012	21
Figure 6.1: Percentage of Claims Paid Late by Claim Type, 2011-2012	22
Figure 7.1: Percentage of Beneficiaries Enrolled in an MTM Program, 2010-2012.....	23
Figure 7.2: Percentage of MTM Program Participants Who Opted Out, 2010-2012.....	24
Figure 7.3: Percentage of Eligible Non-LTC MTM Program Participants Who Received a CMR, 2010-2012	25
Table 7.1: MTM Program Benefits, 2010-2012	25
Table 8.1: Summary of Plan Oversight of Agents, 2011-2012.....	26
Table 9.1: Costs and Utilization for LTC Pharmacies, 2011-2012.....	27
Table 9.2: Costs and Utilization for Retail Pharmacies, 2011-2012.....	27
Figure 9.1: Average Cost per Formulary and Non-Formulary Prescriptions at Retail and LTC Pharmacies, 2011-2012.....	28
Figure 10.1: Percentage of Incomplete Enrollment Requests Received that are Completed within Established Timeframes, 2011-2012	29
Table 10.1: Enrollment Requests by Request Mechanism, 2012	29
Table 10.2: Enrollment and Disenrollment Requests Complete at Time of Initial Receipt, 2012	30
Table 10.3: Enrollment and Disenrollment Requests Denied by the Sponsor, 2012.....	30

1 INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) utilizes many data sources to conduct oversight and monitor performance within the Medicare Part D prescription drug benefit. One such source is the Part D Reporting Requirements, which are data reported by Part D Prescription Drug Plan (PDP) and Medicare Advantage Prescription Drug Plan (MA-PD) sponsors on various matters including the cost of operations, patterns of service utilization, availability and accessibility of services, and grievances lodged by beneficiaries. The submitted Reporting Requirements data aid CMS in better understanding the current functioning of the Part D program, including whether or not the care provided to beneficiaries meets CMS standards of quality, safety, affordability, effectiveness, and timeliness.

To assist sponsors with data submissions, CMS provides Reporting Requirements documentation for each calendar year (CY) of collected data, with revisions and comment periods conducted per Paperwork Reduction Act (PRA) requirements. CMS also releases technical guidance known as the Part D Reporting Requirements Technical Specifications to further assist sponsors with the accurate and timely submission of required data. The Technical Specifications contain additional detail on how CMS expects data to be reported and which data checks and analyses will be performed on the submitted data. The goal of these documents is to ensure a common understanding of Reporting Requirements, outline the timeframes and methods through which data must be submitted, and explain how the data will be used to achieve monitoring and oversight goals. Current Reporting Requirements and related guidance documents can be found at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html.

Periodically, CMS will revise the Reporting Requirements to expand or streamline the collected data. Table 1.1 summarizes the reporting sections collected under the Part D Reporting Requirements for each CY from 2010 through 2014.

Table 1.1: Summary of Part D Reporting Requirements by CY, 2010-2014

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014
Enrollment and Disenrollment ¹	✓	✓	✓	✓	✓
Retail, Home Infusion (HI), and Long Term Care (LTC) Pharmacy Access	✓	✓	✓	✓	✓
Access to Extended Day Supplies at Retail Pharmacies	✓	✓	✓		
Medication Therapy Management (MTM) Programs	✓	✓	✓	✓	✓
Prompt Payment by Part D Sponsors	✓	✓	✓	✓	
Pharmacy Support for Electronic Prescribing	✓	✓	✓		
Grievances	✓	✓	✓	✓	✓

¹ The Enrollment reporting section was renamed Enrollment and Disenrollment in CY 2012.

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014
Pharmacy & Therapeutics (P&T) Committees/Provision of Part D Functions	✓	✓	✓		
Coverage Determinations/Exceptions	✓	✓	✓	✓	
Appeals/Redeterminations ²	✓	✓	✓	✓	
Coverage Determinations and Redeterminations ³					✓
Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions	✓				
Long Term Care (LTC) Utilization	✓	✓	✓	✓	✓
Licensure and Solvency, Business Transactions and Financial Requirements ⁴	✓				
Fraud, Waste and Abuse Compliance Programs	✓	✓	✓	✓	
Employer/Union-Sponsored Group Health Plan Sponsors	✓	✓	✓	✓	✓
Plan Oversight of Agents ⁵	✓	✓	✓		✓

This report provides an analysis of the data submitted by PDP and MA-PD sponsors in accordance with the Part D Reporting Requirements for CY 2012. Table 1.2 summarizes the reporting sections collected under the CY 2012 Part D Reporting Requirements and indicates which sections are included in this report.

Table 1.2: CY 2012 Part D Reporting Sections

Reporting Section	Included in Report
Enrollment and Disenrollment	✓
Plan Oversight of Agents	✓
MTM Programs	✓
Prompt Payment by Part D Sponsors	✓
Grievances	✓
Coverage Determinations and Exceptions	✓
Redeterminations	✓
LTC Utilization	✓
Fraud, Waste and Abuse Compliance Programs	
Employer/Union-Sponsored Group Health Plan Sponsors	
Retail, HI, and LTC Pharmacy Access	

For each of these reporting sections, this report presents CY 2012 program-wide averages and, when available, identifies trends between CY 2011 and CY 2012 data. The metrics

² The Appeals reporting section was renamed to Redeterminations in CY 2012.

³ The Coverage Determinations/Exceptions and Redeterminations sections were combined into a single section for CY 2014.

⁴ Effective March 2009, the Licensure and Solvency, Business Transactions and Financial Requirements data were submitted into the HPMS Fiscal Soundness Module.

⁵ The Plan Oversight of Agents reporting section was suspended in CY 2013; however, a revised data collection was introduced in CY 2014.

evaluated in each section aim to provide information about beneficiary experience, sponsor performance, and overall program functioning. Table 1.3 presents the key metrics included in this report.

Table 1.3: Reporting Sections and Key Metrics

Reporting Section	Metric	Description
Grievances	Rate of grievances per 1,000 enrollees	The number of grievances filed per 1,000 enrollees per month.
	Percentage of grievances the plan responded to on time	The number of grievances the plan responded to on time, divided by the total number of grievances filed.
Coverage Determinations and Exceptions	Request rate per 1,000 enrollees	The number of requests (total or by type: prior authorization, formulary exceptions, tier exceptions, utilization management exceptions) per 1,000 enrollees.
	Percentage of requests approved	The number of approved requests (total or by type: prior authorization, formulary exceptions, tier exceptions, utilization management exceptions), divided by the number of requests received (total or by type).
Redeterminations	Redetermination rate per 1,000 enrollees	The number of redeterminations filed with the plan per 1,000 enrollees.
	Percentage of redeterminations that upheld the initial adverse coverage determination	The number of redeterminations that upheld the initial adverse coverage determination (i.e., that were not fully favorable for the beneficiary), divided by the number of redeterminations.
Prompt Payment by Part D Sponsors	Percentage of paid claims that were electronic	The number of paid electronic claims divided by the total number of paid claims.
	Percentage of claims paid late	The number of claims (total or by type: electronic or non-electronic) divided by the number of paid claims (total or by type: electronic or non-electronic).
Medication Therapy Management (MTM) Programs	Percentage of beneficiaries enrolled in an MTM program	The number of beneficiaries enrolled in an MTM program for any period of time in the reporting year, divided by total enrollment.
	Percentage of MTM program participants who opted out of an MTM program	The number of MTM program participants who opted out of enrollment in the MTM program, divided by the total number of MTM program enrollees.
	Percentage of non-LTC MTM program participants who received a comprehensive medication review (CMR) ⁶	The number of eligible non-LTC MTM program participants who received a CMR during the reporting year, divided by the total number of eligible non-LTC MTM program participants.

⁶ Prior to 2013, LTC beneficiaries were exempt from CMS' CMR requirements. Eligible beneficiaries are defined as those that are non-LTC, continuously enrolled for at least 60 days during the reporting period, and aged 18 or older as of 1/1 of the reporting year.

Reporting Section	Metric	Description
	Percentage of MTM program participants with at least one prescriber intervention	The number of eligible MTM program participants with at least one prescriber intervention, divided by the total number of MTM program participants.
	Percentage of MTM program participants with a drug therapy change	The number of eligible MTM program participants who had at least one change in drug therapy as a result of an MTM intervention, divided by the total number of MTM program participants.
Plan Oversight of Agents	Number of complaints against agents	The total number of complaints against agents licensed to sell on behalf of a parent organization.
	Number of agents investigated based on complaints	The number of agents who were investigated based on complaints.
	Number of agent-assisted enrollments	The total number of agent-assisted enrollments.
	Number of Agents Receiving Disciplinary Actions Based on Complaints	Total number of agents disciplined.
	Number of Agents Whose Selling Privileges Were Revoked	The number of agents licensed to sell on behalf of the contract's parent organization that had their selling privileges revoked based on conduct or discipline.
Long Term Care (LTC) Utilization	Average cost per formulary prescription at LTC pharmacies	The total cost of formulary prescriptions at LTC pharmacies, divided by the total number of formulary prescriptions dispensed at LTC pharmacies.
	Average cost per non-formulary prescription at LTC pharmacies	The total cost of non-formulary prescriptions at LTC pharmacies, divided by the total number of non-formulary prescriptions dispensed at LTC pharmacies.
	Average cost per formulary prescription at retail pharmacies	The total cost of formulary prescriptions at retail pharmacies, divided by the total number of formulary prescriptions dispensed at retail pharmacies.
	Average cost per non-formulary prescription at retail pharmacies	The total cost of non-formulary prescriptions at retail pharmacies, divided by the total number of non-formulary prescriptions dispensed at retail pharmacies.
Enrollment and Disenrollment	Percentage of enrollment requests received by method	The number of enrollment requests received by method (e.g., paper, telephonic), divided by the total number of enrollment requests.
	Percentage of enrollment or disenrollment requests denied	The number of enrollment or disenrollment requests denied, divided by the total number of enrollment or disenrollment requests.
	Percentage of incomplete enrollment requests that are completed within established timeframes	The number of incomplete enrollment requests received that are completed within established timeframes, divided by the total number of enrollment requests.

In addition to the analyses performed in this report, CMS has also taken additional steps to leverage the Reporting Requirements data to publicly report information on plan performance. For example, the rate of grievances filed per 1,000 enrollees per month and the percentage of eligible MTM enrollees receiving a CMR are updated annually as part of CMS's Display Measures.⁷ CMS has also released public use files (PUFs) utilizing data from some of these reporting sections in a continued effort to increase transparency and promote provider and plan accountability.⁸

The remainder of this report is organized as follows. Section 2 provides an overview of the data utilized in this analysis, including the submission and validation processes. This section also describes the exclusions applied to the data for this analysis and where there are differences with the PUF methodology. Sections 3 through 10 present the main findings for each of the eight Part D reporting sections included in this report. Section 11 summarizes key results from the analysis.

⁷ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

⁸ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

2 DATA OVERVIEW

To improve reliability for analysis purposes, the Part D Reporting Requirements data undergo a series of integrity checks as part of the submission and validation processes. Data that have not passed these integrity checks are excluded from analyses.

2.1 Submission Process

Sponsors submit most Reporting Requirements data via the Health Plan Management System (HPMS).⁹ Data can be uploaded or modified until the submission deadlines listed in CMS's Technical Specifications. Compliance with these Reporting Requirements is a contractual obligation of all Part D sponsors. Compliance requires that the data not only be submitted in a timely manner, but that they also are accurate. Only data that reflect a good faith effort by a sponsor to provide accurate responses to Part D reporting requirements will count as data submitted in a timely manner. Sponsors can expect CMS to rely more on compliance notices and enforcement actions in response to Reporting Requirement failures.

Sponsors may also make requests for resubmission, which are requests to change data after the deadline has passed. Requests for resubmission may be needed if sponsors discover an error or omission in previously reported data. Errors may be discovered by the sponsor, or the sponsor may be alerted to errors via Acumen's outlier and placeholder notification process. The outlier and placeholder notices inform sponsors if they have high or low (outlier) values relative to the rest of the Part D program or if they reported "0" (placeholder) values for all data elements in multiple reporting sections. When a resubmission occurs, the more recent data are utilized for validation and analysis.

2.2 Validation Process

Beginning with CY 2010 data, CMS requires that sponsors undergo an independent review each year to validate the data reported to CMS for selected Reporting Requirements. This data validation review helps CMS ensure that the data reported by sponsors are reliable, complete, valid, comparable, and timely. CMS uses the validated data to assess sponsor performance and to respond to inquiries from entities such as Congress, oversight agencies, and the public. Additionally, sponsors can take advantage of the data validation process to assess their own performance and to make improvements to their internal data, systems, and reporting processes.

⁹ MTM Programs data are uploaded using Gentran or Direct Connect.

The data validation process yields scores for each sponsor at the reporting section level, as well as element-specific pass or fail results for some reporting sections.¹⁰ For each reporting section, auditors record information for a total of seven standards that assess (i) proper source documentation, (ii) proper calculation of data elements, (iii) proper procedures for data submission, (iv) proper procedures for data system updates, (v) proper procedures for archiving and restoring data, (vi) proper documentation of data system changes, if applicable, and (vii) regular monitoring of the quality and timeliness of data collected by the delegated entity, if applicable.¹¹ Scores at the reporting section level are assigned based on the share of applicable standards with which the sponsor complied.

As shown in Table 2.1, six of the eight reporting sections included in this report underwent data validation. All CY 2012 data included in this report, as well as the CY 2011 LTC Utilization data, underwent data validation in the 2013 data validation cycle. All other CY 2011 data included in this report underwent data validation in the 2012 data validation cycle. Data on Prompt Payment by Part D Sponsors and on Enrollment and Disenrollment are collected for monitoring purposes only and did not undergo validation for either CY.

Table 2.1: Reporting Sections Undergoing Data Validation

Reporting Section	CY 2011 Data	CY 2012 Data
MTM Programs	2012 DV	2013 DV
Grievances	2012 DV	2013 DV
Coverage Determinations and Exceptions	2012 DV	2013 DV
Redeterminations	2012 DV	2013 DV
LTC Utilization	2013 DV	2013 DV
Plan Oversight of Agents	2012 DV	2013 DV
Enrollment and Disenrollment	-	-
Prompt Payment by Part D Sponsors	-	-

2.3 Exclusion Criteria

Contracts' inclusion in this analysis is contingent on (i) the contract submitting the required data by the specified reporting deadline, and (ii) the submitted data meeting minimum data validation requirements. Contracts that terminate on or before the applicable deadline to submit data validation results to CMS are excluded. For CY 2011 reporting sections that underwent validation in the 2012 data validation cycle, contracts must have a section-specific data validation score of at least 90% in order to be included. For CY 2011 and CY 2012 reporting sections that underwent validation in the 2013 data validation cycle, contracts must have a section-specific data validation score of at least 95% to be included.

¹⁰ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

¹¹ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

Table 2.2 displays data validation results by reporting section and CY of data. The CY 2012 reporting sections with the lowest percentage of contracts achieving a passing data validation score are Grievances, with 86%, and Plan Oversight of Agents, with 87%. The MTM Programs and LTC Utilization sections had the highest percentage of contracts meeting the minimum data validation passing score for CY 2012 data, both with 97%.

Table 2.2: Summary of Data Validation Results by Reporting Section

Reporting Section	CY 2011 Data					CY 2012 Data			
	Number of Contracts	Share Achieving Passing Score	Number Achieving DV Score			Number of Contracts	Share Achieving Passing Score	Number Achieving DV Score	
			90%	95%	100%			95%	100%
Grievances	616	92%	568	556	503	590	86%	509	483
Coverage Determinations and Exceptions	616	98%	604	533	473	589	92%	540	493
Redeterminations	616	97%	599	589	516	589	92%	544	531
Prompt Payment	<i>Not Validated</i>					<i>Not Validated</i>			
MTM Programs	614	97%	598	569	535	583	97%	567	519
Plan Oversight of Agents	15	100%	15	15	10	15	87%	13	10
LTC Utilization	550	95%	-	523	447	566	97%	550	526
Enrollment and Disenrollment	<i>Not Validated</i>					<i>Not Validated</i>			

The metrics in this report further exclude contracts' data based on element-specific data validation results. For example, it is possible that a contract can meet the minimum data validation score for a section but still receive a failing determination for at least one element under that section. To improve the accuracy of results, contracts failing element-level data validation for at least one element utilized toward a metric are excluded from that metric's calculation. As a result, the number of plans included in different metrics for the same reporting section may vary based on exclusions due to element-specific data validation failures.

2.4 Methodological Differences with 2012 PUFs

As previously noted, CMS has released PUFs utilizing data from some of these reporting sections in a continued effort to increase transparency and promote provider and plan accountability.

Table 2.3 outlines the differences between the methodologies employed for this report and for the CY 2012 PUFs. In future years, CMS will work to further align methodologies where possible.

Table 2.3: Methodological Differences between Report and 2012 PUFs

Reporting Section	Summary of Difference	Details of Difference	
		Report	PUF
Plan Oversight of Agents	Inclusion of reporting section	This reporting section is included in this report.	This reporting section is not included in the PUF.
Prompt Payment by Part D Sponsors	Inclusion of reporting section	This reporting section is included in this report.	This reporting section is not included in the PUF.
Enrollment and Disenrollment	Minimum enrollment or denominator criteria	No exclusions are made based on minimum enrollment.	Contracts with an average monthly enrollment of less than 11 over the full reporting year are excluded.
Grievances	Minimum enrollment or denominator criteria	<p>The following metrics do not have any exclusions based on minimum enrollment:</p> <ul style="list-style-type: none"> Grievance rate per 1,000 enrollees (Table 3.3) Percentage of grievances responded to on time (Table 3.4) <p>The following metric excludes plans with an average monthly enrollment of less than 100 over the full reporting year:</p> <ul style="list-style-type: none"> Plans reporting zero grievances (Table 3.1 and Table 3.2) 	Plans with an average monthly enrollment of less than 11 over the full reporting year are excluded.
Coverage Determinations and Exceptions	Minimum enrollment or denominator criteria	<p>The following metrics do not have any exclusions based on minimum enrollment:</p> <ul style="list-style-type: none"> Coverage determination and exception request rates per 1,000 enrollees (Table 4.2 and Figure 4.1) Percentage of coverage determination and exception requests approved (Table 4.3) <p>The following metric excludes plans with an average monthly enrollment of less than 100 over the full reporting year:</p> <ul style="list-style-type: none"> Plans reporting zero determination and exception requests (Table 4.1) 	Plans with an average monthly enrollment of less than 11 over the full reporting year are excluded.

Reporting Section	Summary of Difference	Details of Difference	
		Report	PUF
Redeterminations	Minimum enrollment or denominator criteria	<p>The following metrics do not have any exclusions based on minimum enrollment:</p> <ul style="list-style-type: none"> • Redetermination request rates per 1,000 enrollees (Figure 5.1 and Figure 5.2) • Percentage of redeterminations that upheld the original coverage determination (Table 5.3) <p>The following metric excludes plans with an average monthly enrollment of less than 100 over the full reporting year:</p> <ul style="list-style-type: none"> • Plans reporting zero redetermination requests (Table 5.1 and Table 5.2) 	Plans with an average monthly enrollment of less than 11 over the full reporting year are excluded.
LTC Utilization	Minimum enrollment or denominator criteria	No exclusions are made based on the number of beneficiaries in LTC facilities.	Contracts whose number of reported beneficiaries in LTC facilities for whom Part D drugs have been provided (Element C) in a reporting period is less than 11 are excluded for that period's data.
LTC Utilization	Validation of NPI-level data	<p>Prior to aggregating the NPI-level data from Element D, the following exclusions are made:</p> <ul style="list-style-type: none"> • Records that report non-zero data in multiple records for the same combination of contract, NPI, and chain code. • Records where the NPI cannot be mapped to a valid NPI. 	NPI-level data from Element D are aggregated to the contract-period level based on how they are reported by the contract. No data validation checks/exclusions are performed.
MTM Programs	Minimum enrollment or denominator criteria	All metrics for this reporting section exclude contracts with a denominator value of less than 11.	Contracts with fewer than 11 MTM enrolled beneficiaries in a single age bracket (under 65, 65-74, 75-84, 85+) are suppressed.
MTM Programs	Validation of HICN-level data	<p>For the purposes of the CMR rate (Figure 7.3), the following exclusions are made:</p> <ul style="list-style-type: none"> • Records with enrollment start dates before 1/1/2012 or after 12/31/2012 • Records with HICNs that could not be mapped to a valid beneficiary • Multiple records reported for the same beneficiary in a single contract's file 	Data are included based on how they were reported by the contract. No data validation checks/exclusions are performed.

Reporting Section	Summary of Difference	Details of Difference	
		Report	PUF
MTM Programs	Data source for beneficiary age	For the purposes of the CMR rate (Figure 7.3), the beneficiary's age is calculated as of 1/1 of the reporting period utilizing the date of birth on file in the Enrollment Database. ¹²	Age bracket is calculated based on the beneficiary's age as of 12/31/2012 utilizing the contract-reported date of birth.

¹² The methodology used to determine beneficiary age for the CMR rate in this report is the same as that utilized for the display measure (Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews).

3 GRIEVANCES

The Medicare Prescription Drug, Improvement, and Modernization Act requires that Part D plan sponsors establish procedures for resolving enrollee grievances and track and maintain records on all grievances received. Pursuant to Title 42, Part 423, Subpart M of the Part D regulation, a grievance is any complaint or dispute, other than one that involves a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. To help CMS assess whether enrollees are satisfied with the provision of Part D benefits and whether sponsors address beneficiary complaints in a timely manner, Part D plans report the total number enrollee grievances filed during the benefit year, as well as the number of grievances that the plan resolved timely. Grievance dispositions are generally considered timely if the plan notifies the enrollee of its decision no later than 30 days after the date the grievance is filed, based on the enrollee’s health condition.¹³

In CY 2012, 14.5% of plans with an average monthly enrollment of 100 or more over the full year reported that no grievances related to the Part D benefit were filed, compared to 12.4% in CY 2011 (Table 3.1). Employer plans had the highest share of plans reporting zero Part D grievances in CY 2011 and CY 2012 with 18.4% and 23.9%, respectively.

Table 3.1: Plans with at least 100 Enrollees and Reporting Zero Part D Grievances by Plan Type, 2011-2012

Organization Type	2011			2012		
	Total Number of Plans Included	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero	Total Number of Plans Included	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero
All	2,753	341	12.4%	2,107	305	14.5%
Employer	272	50	18.4%	234	56	23.9%
MA-PD	1,593	244	15.3%	1,408	229	16.3%
PDP	888	47	5.3%	464	20	4.3%
PDP Basic Below Benchmark	197	2	1.0%	89	1	1.1%
PDP Basic Above Benchmark	248	18	7.3%	175	16	9.1%
PDP Enhanced	443	27	6.1%	200	3	1.5%
Point-of-Sale (POS) Contractor	-	-	-	1	0	0.0%

¹³ There are 2 exceptions to the 30-day timeframe: (1) plans may take an extension of up to 14 days in limited circumstances pursuant to the requirements at 42 CFR §423.564(e) (2), and (2) expedited grievances related to the plan’s refusal to process an enrollee’s request for an expedited pre-service coverage determination or redetermination must be responded to within 24 hours per 42 CFR §423.564(f).

In both CY 2011 and CY 2012, most plans that had at least 100 enrollees and reported zero Part D grievances had less than 1,000 enrollees (Table 3.2).

Table 3.2: Plans with at least 100 Enrollees and Reporting Zero Part D Grievances by Plan Enrollment, 2011-2012

Enrollment Category	2011		2012	
	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero
All	341	100.0%	305	100.0%
100 - 999 Enrollees	241	70.7%	224	73.4%
1,000 - 9,999 Enrollees	95	27.9%	78	25.6%
10,000 - 99,999 Enrollees	5	1.5%	3	1.0%

The overall Part D grievance rate per 1,000 enrollees per month decreased from 0.7 in CY 2011 to 0.5 in CY 2012 (Table 3.3). The largest decrease observed was for PDP Basic Below Benchmark plans, whose grievance rates changed from 0.7 per 1,000 enrollees in CY 2011 to 0.2 per 1,000 enrollees in CY 2012.

Table 3.3: Part D Grievance Rate per 1,000 Enrollees by Plan Type, 2011-2012¹⁴

Organization Type	2011		2012	
	Grievance Rate	Number of Plans Included	Grievance Rate	Number of Plans Included
All	0.7	3,007	0.5	2,320
Employer	0.6	341	0.4	295
MA-PD	0.5	1,733	0.3	1,536
PDP	0.8	933	0.8	488
PDP Basic Below Benchmark	0.7	197	0.2	89
PDP Basic Above Benchmark	1.1	266	1.1	180
PDP Enhanced	0.8	470	0.6	219
POS	-	-	0.1	1

The percentage of Part D grievances responded to on time remained high in both years, increasing slightly from 98.4% in CY 2011 to 99.2% in CY 2012 (Table 3.4). Employer plans showed the largest increase in this metric, increasing 2.5 percentage points from 96.6% of grievances responded to on time in CY 2011 compared to 99.1% in CY 2012.

¹⁴ Data are weighted by plan year average HPMS enrollment.

Table 3.4: Percentage of Part D Grievances Responded to On-Time by Plan Type, 2011-2012¹⁵

Organization Type	2011		2012	
	Percentage Timely	Number of Plans Included	Percentage Timely	Number of Plans Included
All	98.4%	2,487	99.2%	1,830
Employer	96.6%	241	99.1%	188
MA-PD	98.3%	1,381	98.9%	1,182
PDP	98.9%	865	99.5%	459
PDP Basic Below Benchmark	98.7%	195	99.6%	88
PDP Basic Above Benchmark	99.2%	241	99.5%	161
PDP Enhanced	98.9%	429	99.5%	210
POS	-	-	100.0%	1

¹⁵ Data are weighted by plan year average HPMS enrollment.

4 COVERAGE DETERMINATIONS AND EXCEPTIONS

The Part D regulations at 42 C.F.R. Part 423, Subpart M set forth the requirements related to coverage determinations, including formulary and tiering exceptions. A coverage determination is any decision made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled. Exceptions are a type of coverage determination. As defined in Chapter 18 of the Prescription Drug Benefit Manual, a tiering exception involves a request to obtain a non-preferred drug at more favorable cost-sharing terms applicable to preferred drugs. A formulary exception involves a request for coverage of a drug that is not on the plan's formulary or an exception to the application of utilization management (UM) tools, such as prior authorization, step therapy or quantity limits. Coverage determinations and exceptions data provide valuable information on whether beneficiaries can successfully request and obtain coverage for medically necessary Part D drugs, including obtaining exceptions to plan coverage policies. As such, CMS requires that sponsors report the number of prior authorization and exception requests received and the number of requests approved. Plans report data on coverage determination requests for prior authorization and on three different types of exception requests: non-formulary exceptions, tiering exceptions, and other UM exceptions.¹⁶

In CY 2011, only one plan with at least 100 enrollees reported zero determinations and exceptions requests, compared to four plans in CY 2012 (Table 4.1). In both years, these plans had fewer than 1,000 total enrollees.

Table 4.1: Plans with at least 100 Enrollees and Reporting Zero Determinations and Exceptions by Plan Type, 2011-2012

Organization Type	2011			2012		
	Total Number of Plans Included	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero	Total Number of Plans Included	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero
All	2,391	1	0.0%	2,549	4	0.2%
Employer	259	1	0.4%	279	2	0.7%
MA-PD	1,220	0	0.0%	1,592	2	0.1%
PDP	912	0	0.0%	678	0	0.0%

¹⁶ Beginning in 2010, the technical specifications documentation clarified that requests for exceptions to prior authorization criteria are classified as UM exceptions requests.

The overall rate of reported coverage determination and exception requests¹⁷ per 1,000 enrollees decreased from 177.7 in CY 2011 to 130.7 in CY 2012 (Table 4.2). Of the four different request types included in the reporting, requests to meet prior authorization criteria were the most common in both years, with 71.5 requests per 1,000 enrollees in CY 2011 and 61.2 requests per 1,000 enrollees in CY 2012. The second highest rate in CY 2012 was for requests for non-formulary drugs (41.4), followed by requests for exceptions to UM requirements (23.6). Although the rate of tier exception requests increased slightly between years, this request type continued to occur much less frequently than the other request types, at just 4.5 requests per 1,000 enrollees in CY 2012.

Table 4.2: Coverage Determination and Exception Request Rates per 1,000 Enrollees, 2011-2012¹⁸

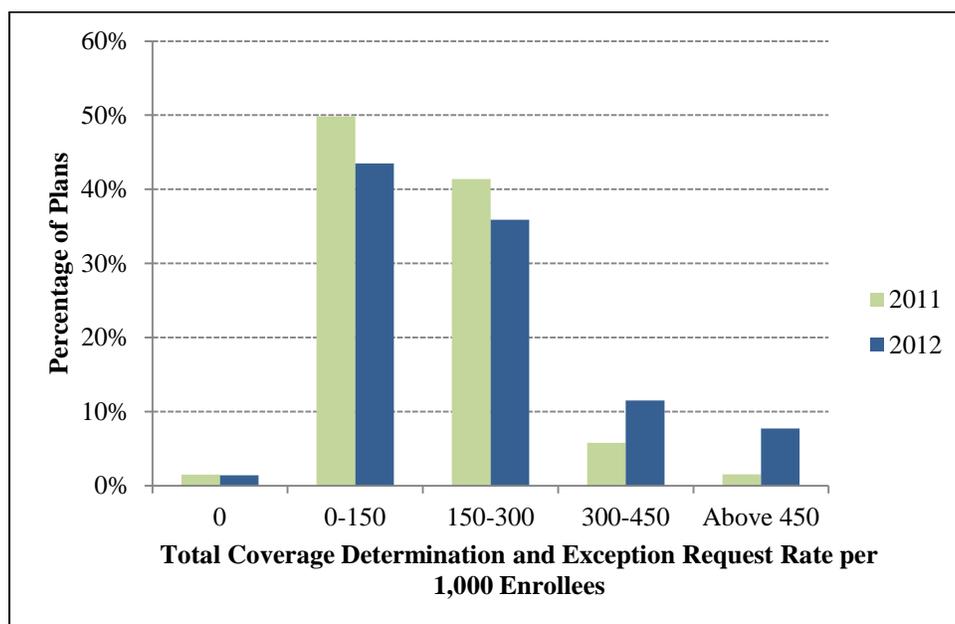
Request Type	2011		2012	
	Request Rate	Number of Plans Included	Request Rate	Number of Plans Included
All	177.7	2,620	130.7	2,780
Prior Authorization	71.5	2,735	61.2	2,807
Formulary Exceptions	62.8	3,282	41.4	2,806
Tier Exceptions	2.1	3,276	4.5	2,801
UM Exceptions	34.1	2,774	23.6	2,791

In CY 2011, 49.9% of plans had a total coverage determination and exception request rate per 1,000 enrollees greater than zero but less than 150 (Figure 4.1), compared to 43.5% in CY 2012.

¹⁷ Includes the total of the four different request types included in the reporting - prior authorization, non-formulary exceptions, tier exceptions, and UM exceptions.

¹⁸ Data are weighted by plan year average HPMS enrollment.

Figure 4.1: Distribution of Coverage Determination and Exception Request Rates per 1,000 Enrollees, 2011-2012¹⁹



The overall percentage of approved coverage determination and exception requests increased slightly between years, from 67.6% in CY 2011 to 68.2% in CY 2012 (Table 4.3). Of the four request types, tier exception requests had the largest decrease in approved requests between years, from 37.1% of requests approved in CY 2011 to 33.6% in CY 2012. The percentage of formulary exception requests approved increased from 52.1% in CY 2011 to 59.3% in CY 2012.

Table 4.3: Percentage of Coverage Determination and Exception Requests Approved by Request Type, 2011-2012

Request Type	2011		2012	
	Percentage Approved	Number of Plans Included	Percentage Approved	Number of Plans Included
All	67.6%	2,537	68.2%	2,626
Prior Authorization	74.3%	2,643	73.1%	2,735
Formulary Exceptions	52.1%	2,961	59.3%	2,514
Tier Exceptions	37.1%	2,022	33.6%	1,858
UM Exceptions	71.2%	2,492	72.3%	2,550

¹⁹ Data are weighted by plan year average HPMS enrollment.

5 REDETERMINATIONS

The Part D regulations at 42 C.F.R. Part 423, Subpart M set forth the requirements related to redeterminations. As defined in §423.560, a redetermination is the review of an adverse coverage determination made by the plan. A redetermination is the first of five levels of appeal in the Part D appeals process, and the redetermination is made by the plan sponsor. An enrollee who has received an adverse coverage determination has the right to a redetermination, which plans must issue pursuant to the timeframes, notice and other requirements at §423.590. The reported redeterminations data indicate how many adverse coverage determinations are appealed by enrollees, and how successful enrollees are in obtaining a favorable outcome at this stage of the appeals process. Part D plan sponsors are required to submit data on the total number of redeterminations requested and how many resulted in a full or partial reversal of the plan's original coverage determination.

The share of plans with at least 100 enrollees that reported receiving zero redeterminations decreased from 11.4% in CY 2011 to 8.8% in CY 2012 (Table 5.1). The share of employer plans and overall share of PDP plans both decreased around 4.5 percentage points between years. PDP Enhanced plans experienced the largest decrease of all PDP plans, with 10.2% in CY 2011 compared to 3.6% in CY 2012.

Table 5.1: Plans with at least 100 Enrollees and Reporting Zero Redeterminations by Plan Type, 2011-2012

Organization Type	2011			2012		
	Total Number of Plans Included	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero	Total Number of Plans Included	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero
All	2,944	335	11.4%	2,634	231	8.8%
Employer	285	60	21.1%	284	47	16.5%
MA-PD	1,655	203	12.3%	1,639	165	10.1%
PDP	1,004	72	7.2%	711	19	2.7%
PDP Basic Below Benchmark	228	4	1.8%	184	1	0.5%
PDP Basic Above Benchmark	295	19	6.4%	196	6	3.1%
PDP Enhanced	481	49	10.2%	331	12	3.6%

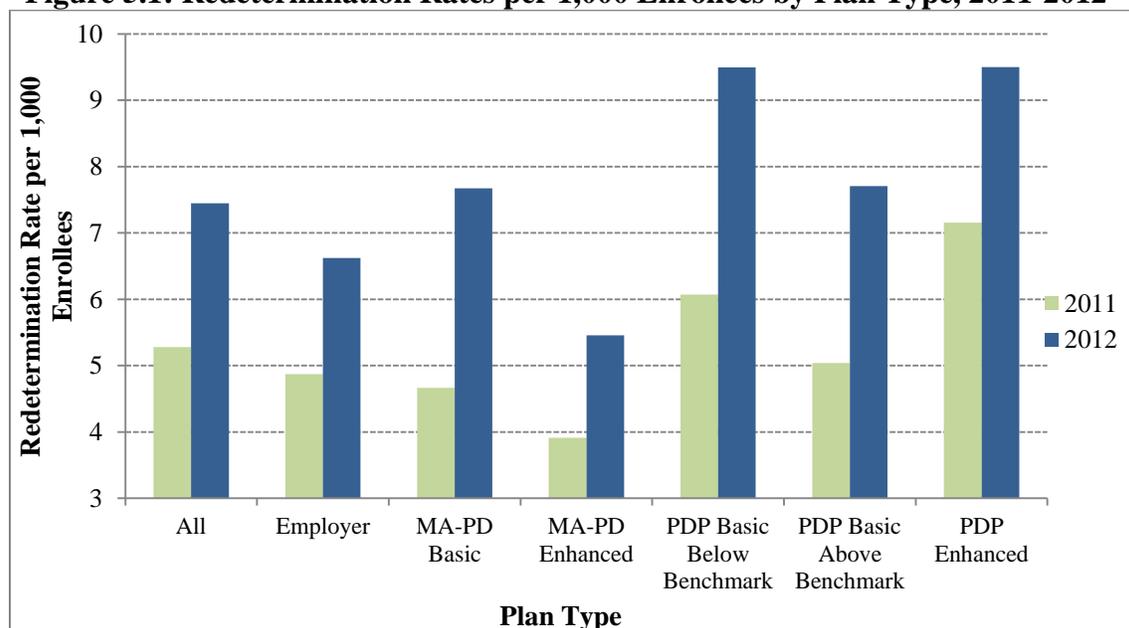
In CY 2011 and CY 2012, the largest share of plans with at least 100 enrollees reporting zero redeterminations had less than 1,000 total enrollees (Table 5.2). This enrollment category comprised 75.8% of plans with at least 100 enrollees reporting zero redeterminations in CY 2011 and 74.5% in CY 2012.

Table 5.2: Plans with at least 100 Enrollees and Reporting Zero Redeterminations by Plan Enrollment, 2011-2012

Enrollment Category	2011		2012	
	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero	Number of Plans Reporting Zero	Share of Total Plans that Reported Zero
All	335	100.0%	231	100.0%
100 - 999 Enrollees	254	75.8%	172	74.5%
1,000 - 9,999 Enrollees	78	23.3%	54	23.4%
10,000 - 99,999 Enrollees	3	0.9%	5	2.2%

The overall rate of redeterminations per 1,000 enrollees increased from 5.3 in CY 2011 to 7.4 in CY 2012 (Figure 5.1), indicating that beneficiaries filed for redetermination more often in CY 2012 than in CY 2011.

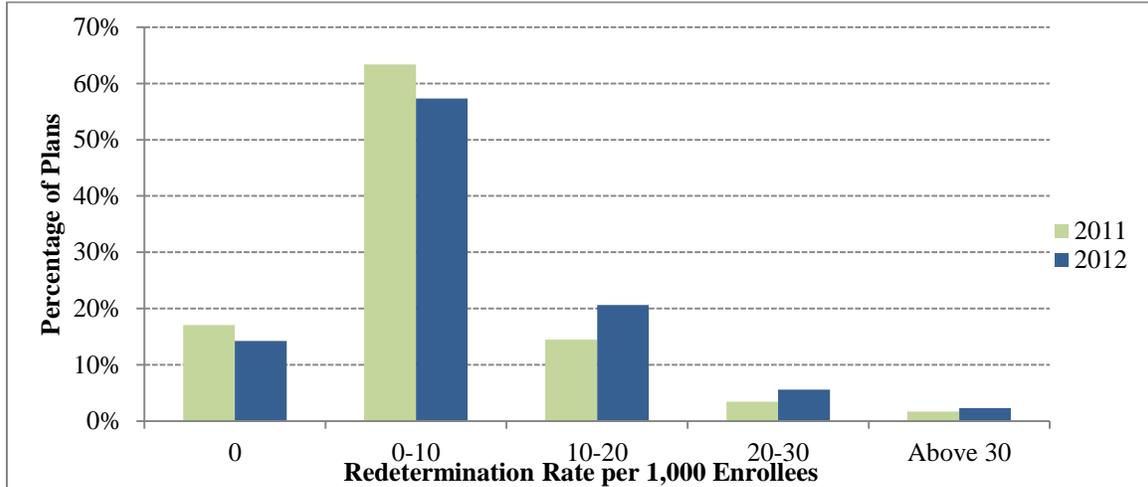
Figure 5.1: Redetermination Rates per 1,000 Enrollees by Plan Type, 2011-2012²⁰



In both years, most plans had a redetermination rate per 1,000 enrollees greater than zero and less than ten; this was the case for 63.4% of plans in CY 2011 and 57.3% of plans in CY 2012 (Figure 5.2). The share of plans with a redetermination rate greater than thirty requests per 1,000 enrollees was only 1.6% in CY 2011 and 2.3% in CY 2012.

²⁰ Data are weighted by plan year average HPMS enrollment.

Figure 5.2: Distribution of Redetermination Rates per 1,000 Enrollees across Plans, 2011-2012



The percentage of redeterminations that upheld the initial adverse coverage determination (i.e., that were not fully favorable for the beneficiary) decreased from 26.8% in CY 2011 to 25.8% in CY 2012 (Table 5.3). PDP plans experienced a decrease between years from 23.7% to 21.0%.

Table 5.3: Percentage of Redeterminations that Upheld the Initial Adverse Coverage Determination, 2011-2012²¹

Organization Type	2011	2012
All	26.8%	25.8%
Employer	38.9%	38.7%
MA-PD	29.5%	28.6%
PDP	23.7%	21.0%
PDP Basic Below Benchmark	22.3%	15.4%
PDP Basic Above Benchmark	28.3%	27.3%
PDP Enhanced	21.1%	19.0%

²¹ Data are weighted by plan year average HPMS enrollment.

6 PROMPT PAYMENT BY PART D SPONSORS

Part D sponsors are expected to adhere to certain requirements when paying claims submitted by network pharmacies. These requirements outline the timeframes under which the sponsor must pay the claim, depending on whether the claim was electronically or non-electronically submitted. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added requirements with regard to prompt payment by Part D sponsors for all clean claims submitted by network pharmacies within specified timeframes for electronic and all other (non-electronically submitted) claims. Consistent with section 1860D-12(b)(4)(A)(ii) of the Act, a clean claim is defined as a claim that has no defect or impropriety – including any lack of required substantiating documentation – or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Payment is expected to be made within 14 calendar days of receipt for electronic claims and within 30 calendar days of receipt of non-electronic claims.²² Receipt of an electronic claim is defined as the date on which the claim is transferred, and receipt of a non-electronically submitted claim as the 5th calendar day after the postmark day of the claim or the date specified in the time stamp of the transmission, whichever is sooner. To monitor whether sponsors are meeting these guidelines, CMS collects data on the number of total, electronic, and non-electronic claims, as well as the number of electronic and non-electronic claims that were not paid timely.

The overall percentage of paid claims that were electronic remained at 89.8% in both CY 2011 and CY 2012 (Table 6.1). MA-PD organizations showed a slight increase from 89.2% in 2011 to 90.3% in 2012, while PDPs showed the opposite trend, decreasing from 90.1% in 2011 to 89.4% in 2012.

Table 6.1: Percentage of Paid Claims that were Electronic, 2011-2012²³

Organization Type	2011		2012	
	Percentage Electronic	Number of Contracts Included	Percentage Electronic	Number of Contracts Included
All	89.8%	619	89.8%	598
Employer	99.9%	9	99.9%	8
MA-PD	89.2%	539	90.3%	522
PDP	90.1%	70	89.4%	67
POS	18.6%	1	27.8%	1

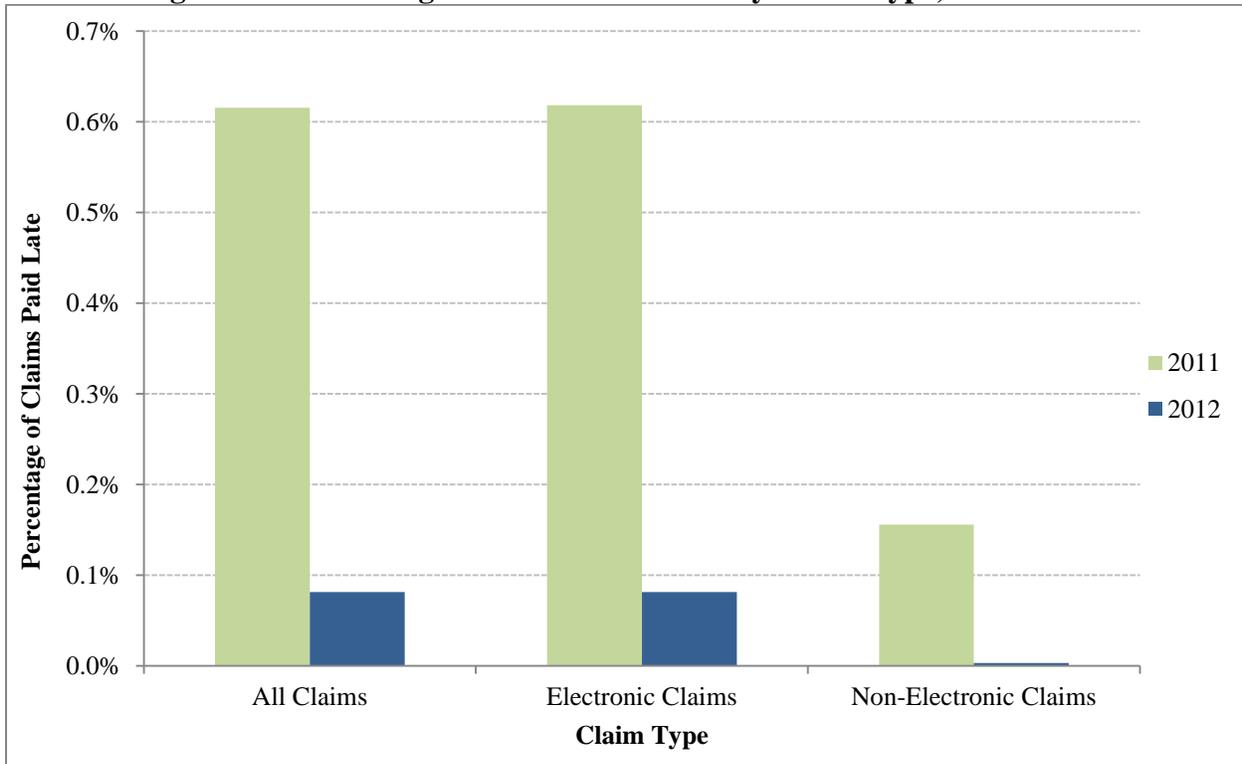
The percentage of total claims paid late decreased from 0.6% in CY 2011 to 0.1% in CY 2012 (Figure 6.1). This is attributable to a decline in the percentage of electronic claims paid

²² <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2012PartDReportingRequirementsFinal122011.pdf>

²³ Data are weighted by contract year average HPMS enrollment.

late from 0.6% in CY 2011 to 0.1% in CY 2012 and in the percentage of non-electronic claims paid late from 0.2% in CY 2011 to nearly 0.0% in CY 2012.

Figure 6.1: Percentage of Claims Paid Late by Claim Type, 2011-2012²⁴



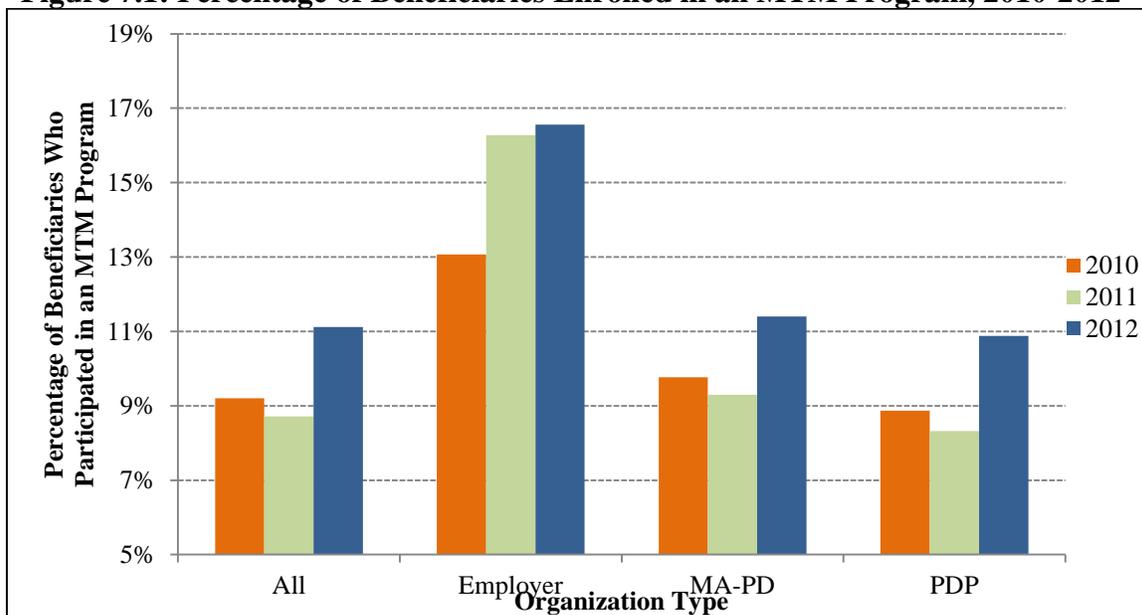
²⁴ Data are weighted by contract year average HPMS enrollment.

7 MEDICATION THERAPY MANAGEMENT PROGRAMS

The regulations at 42 C.F.R. Part 423, Subpart D set forth the requirements for Part D sponsors related to medication therapy management (MTM) programs, which were expanded in 2010. As defined in §423.153, targeted beneficiaries for MTM programs have multiple chronic diseases, are taking multiple medications, and are likely to reach a predetermined cost threshold for their medications in a given year. To evaluate sponsors' offerings of these services, CMS collects detailed MTM program data from Part D sponsors on the beneficiaries identified as eligible for MTM, whether the beneficiary opted out of the MTM program and, if so, why, and whether or not enrolled beneficiaries received annual reviews or targeted interventions as part of the sponsor's MTM program.

The percentage of beneficiaries who were enrolled in an MTM program for any length of time at any point during the reporting year decreased from CY 2010 to CY 2011, but then increased to 11.1% in CY 2012 (Figure 7.1). Employer organizations exhibited continued increases over these three years, with an overall increase of 3.5 percentage points from CY 2010 to CY 2012. MA-PDs and PDPs followed the overall trend and decreased from CY 2010 to CY 2011, then increased in CY 2012.

Figure 7.1: Percentage of Beneficiaries Enrolled in an MTM Program, 2010-2012²⁵

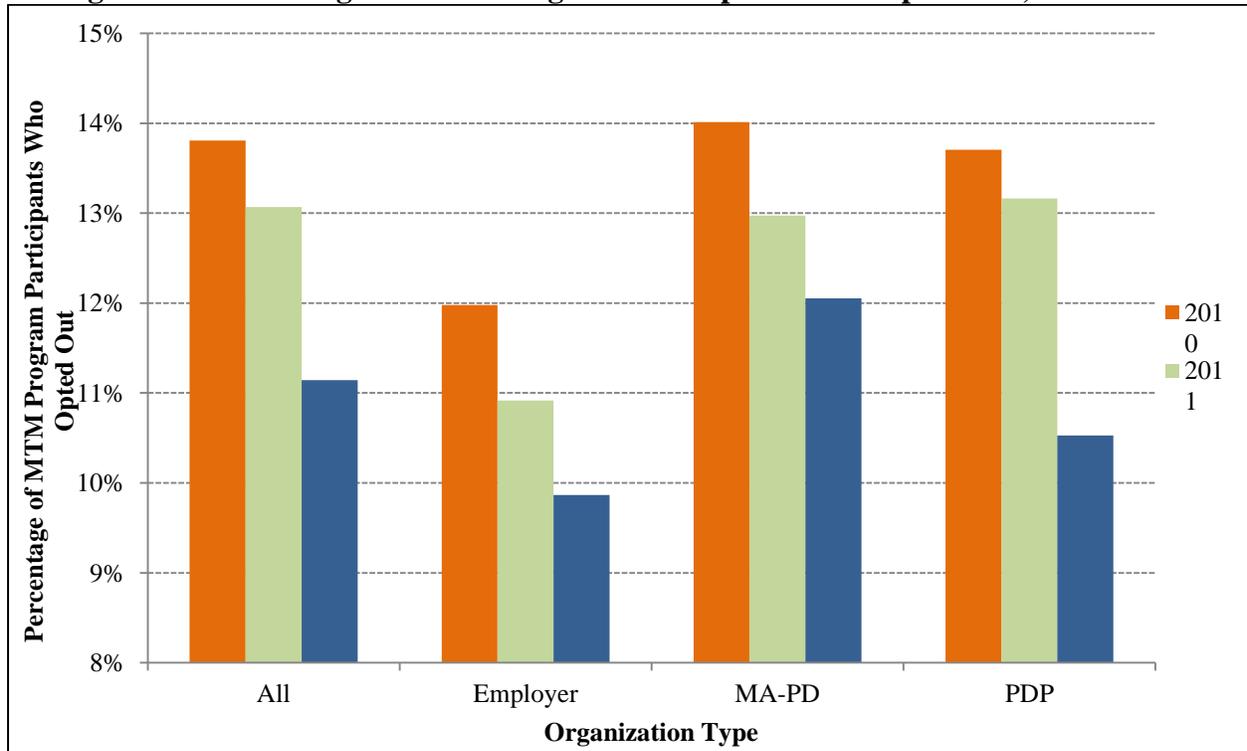


The percentage of MTM program participants who opted out of the MTM program continued to decrease from CY 2010, dropping from 13.1% in CY 2011 to 11.1% in CY 2012

²⁵ CY 2010 and CY 2011 data utilizes MTM Aggregate File. All years' data are weighted by contract year average HPMS enrollment.

(Figure 7.2). PDP organizations had the largest decrease in the share of beneficiaries opting out, from 13.7% in CY 2010 to 13.2 percent in CY 2011 to 10.5% in CY 2012.

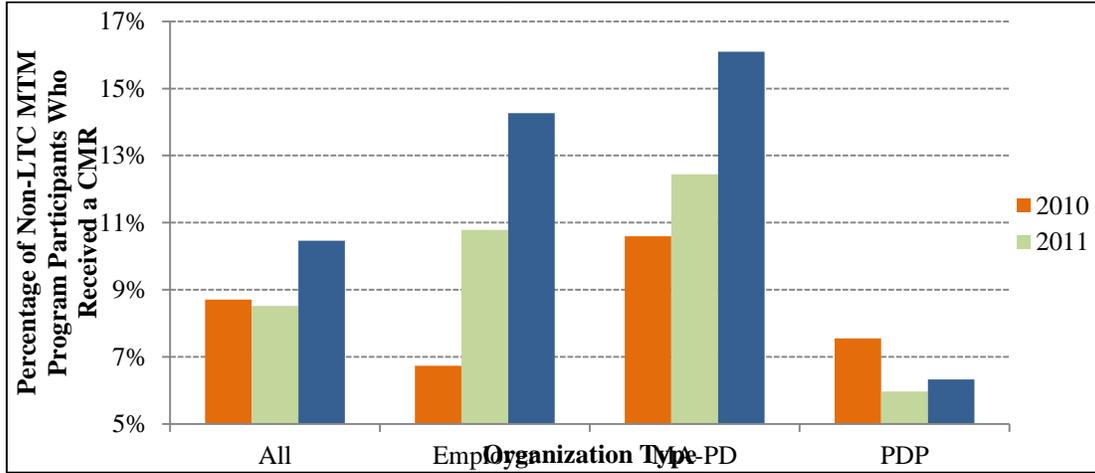
Figure 7.2: Percentage of MTM Program Participants Who Opted Out, 2010-2012²⁶



The percentage of eligible non-LTC MTM program participants that received a CMR increased from 8.5% in CY 2011 to 10.5% in CY 2012, after falling slightly from 8.7% in CY 2010 (Figure 7.3). Both Employer and MA-PD organizations showed increases over this time period. While the CMR rate for PDPs decreased from 7.6% in CY 2010 to 6.0% in CY 2011, this rate showed an increase to 6.3% in CY 2012.

²⁶ CY 2010 and 2011 data utilizes MTM Aggregate File. All years' data are weighted by the number of eligible of MTM program participants.

Figure 7.3: Percentage of Eligible Non-LTC MTM Program Participants Who Received a CMR, 2010-2012²⁷



The percentage of MTM participants with a drug therapy change increased from 11.2% in CY 2010 to 12.3% in CY 2011 to 15.0% in CY 2012 (Table 7.1), while the percentage of MTM participants with at least one prescriber intervention increased slightly to 32.8% in CY 2012, after a more substantial increase from 25.1% in CY 2010 to 32.6% in CY 2011.

Table 7.1: MTM Program Benefits, 2010-2012²⁸

Organization Type	2010		2011		2012	
	Percentage of Eligible MTM Program Participants with at Least One Prescriber Intervention	Percentage of Eligible MTM Program Participants with a Drug Therapy Change	Percentage of Eligible MTM Program Participants with at Least One Prescriber Intervention	Percentage of Eligible MTM Program Participants with a Drug Therapy Change	Percentage of Eligible MTM Program Participants with at Least One Prescriber Intervention	Percentage of Eligible MTM Program Participants with a Drug Therapy Change
All	25.1%	11.2%	32.6%	12.3%	32.8%	15.0%
Employer	53.0%	8.0%	52.7%	11.7%	62.2%	13.5%
MA-PD	22.6%	9.5%	33.8%	14.1%	31.9%	16.0%
PDP	26.2%	12.5%	31.4%	11.2%	33.1%	14.4%

²⁷ Data are weighted by the number of CMR-eligible enrollees.

²⁸ Data are weighted by the number of eligible MTM program participants.

8 PLAN OVERSIGHT OF AGENTS

Sponsors are required to comply with state requests for information about the performance of licensed agents or brokers in the event of a state investigation into the individual's conduct. While states oversee agent licensing, CMS monitors agent complaints to determine if sponsors are properly investigating complaints and imposing disciplinary actions, as well as reporting poor conduct to the state, if required.

To determine whether Part D sponsors are monitoring their marketing agents and pursuing disciplinary actions as needed, CMS requires that sponsors report data on beneficiary complaints against marketing agents and sponsors' oversight efforts. Sponsors report the number of complaints filed against agents in the HPMS Complaint Tracking Module (CTM) or directly with the sponsor. Sponsors also report their responses to these complaints, such as investigating agents and revoking agents' selling privileges via the Part D Reporting Requirements. Since all contracts in parent organizations with at least one MA-PD contract report these data as part of the Part C Reporting Requirements, this section only applies to PDP contracts in parent organizations that do not include any MA-PDs.²⁹ A total of 15 PDPs fall in this category for CY 2011 and 13 PDPs for CY 2012.

Only one complaint against an agent was reported in each year for CY 2011 and CY 2012 (Table 8.1). The number of agents receiving disciplinary actions based on complaints increased from 8 in CY 2011 to 26 in CY 2012, while the number of agent assisted-enrollments decreased from 50,764 in CY 2011 to 36,520 in CY 2012.

Table 8.1: Summary of Plan Oversight of Agents, 2011-2012

Metric	2011	2012
Number of Complaints Reported to State by Contract	1	1
Number of Agents Investigated Based on Complaints	76	68
Number of Agents Receiving Disciplinary Actions Based on Complaints	8	26
Number of Agents Whose Selling Privileges Were Revoked	5	4
Number of Agent-Assisted Enrollments	50,764	36,520

²⁹ Please see the report entitled *Analysis of Calendar Year 2012 Medicare Part C Reporting Requirements Data* for an analysis of the Plan Oversight of Agents data reported for parent organizations with at least one MA-PD contract.

9 LONG TERM CARE UTILIZATION

CMS collects various data on sponsors' LTC and retail costs and utilization. The data collected under this reporting section include summary data on the number of LTC and retail pharmacies in the service area, the number of beneficiaries in LTC facilities for whom Part D drugs have been provided, and the number and cost of the formulary and non-formulary prescriptions dispensed from retail pharmacies. CMS also collects more detailed data for each LTC pharmacy, including the pharmacy name, pharmacy identification number, and the number and cost of the formulary and non-formulary prescriptions dispensed from the given pharmacy.

The total number of 31-day equivalent formulary prescriptions dispensed at LTC pharmacies decreased from 107.5 million in CY 2011 to 81.3 million in CY 2012 (Table 9.1). The total number of non-formulary prescriptions dispensed at LTC pharmacies decreased between years from 1.5 million to 800,000. The average cost per formulary prescription increased, from \$56 in CY 2011 to \$73 in CY 2012, as did the average cost per non-formulary prescription, which increased from \$142 to \$241 between years.

Table 9.1: Costs and Utilization for LTC Pharmacies, 2011-2012

Metric	2011	2012
Total Number of 31-Day Equivalent Formulary Prescriptions Dispensed	107,540,783	81,276,132
Total Cost of Formulary Prescriptions	\$6,027,656,445	\$5,902,416,036
Cost per Formulary Prescription	\$56.05	\$72.62
Number of 31-Day Equivalent Non-Formulary Prescriptions Dispensed	1,499,601	810,612
Total Cost of Non-Formulary Prescriptions	\$213,543,468	\$195,326,109
Cost per Non-Formulary Prescription	\$142.40	\$240.96

For retail pharmacies, while the number of 30-day equivalent non-formulary prescriptions dispensed and the total cost of non-formulary prescriptions both decreased, the average cost per non-formulary prescription increased, from \$126 in CY 2011 to \$208 in CY 2012 (Table 9.2). Increases in the total number of 30-day equivalent formulary prescriptions dispensed and the total cost of formulary prescriptions are also observed. The average cost per formulary prescription remained stable at approximately \$57 in both years.

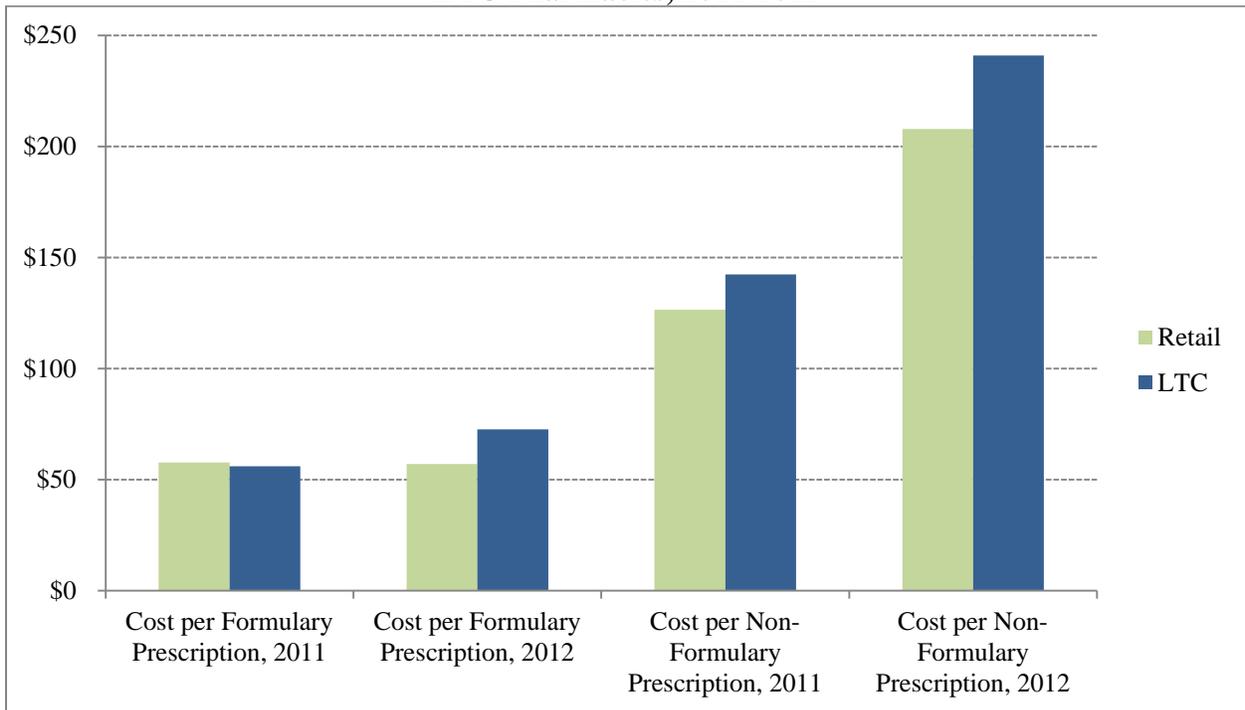
Table 9.2: Costs and Utilization for Retail Pharmacies, 2011-2012

Metric	2011	2012
Total Number of 30-Day Equivalent Formulary Prescriptions Dispensed	766,618,630	856,626,524
Total Cost of Formulary Prescriptions	\$44,262,820,213	\$48,850,645,250
Cost per Formulary Prescription	\$57.74	\$57.03
Number of 30-Day Equivalent Non-Formulary	15,024,182	7,797,112

Metric	2011	2012
Prescriptions Dispensed		
Total Cost of Non-Formulary Prescriptions	\$1,900,284,928	\$1,620,652,400
Cost per Non-Formulary Prescription	\$126.48	\$207.85

Comparing LTC to retail pharmacies within and across years reveals that the average cost per prescription is generally higher for LTC pharmacies, except when looking at the cost per formulary prescription in 2011 (Figure 9.1). In this case, the cost per formulary prescription for retail pharmacies (\$57.74) is slightly higher than for LTC pharmacies (\$56.05). The cost differential between retail and LTC pharmacies is largest for the CY 2012 cost per non-formulary prescription, at \$207.85 for retail and \$240.96 for LTC.

Figure 9.1: Average Cost per Formulary and Non-Formulary Prescriptions at Retail and LTC Pharmacies, 2011-2012

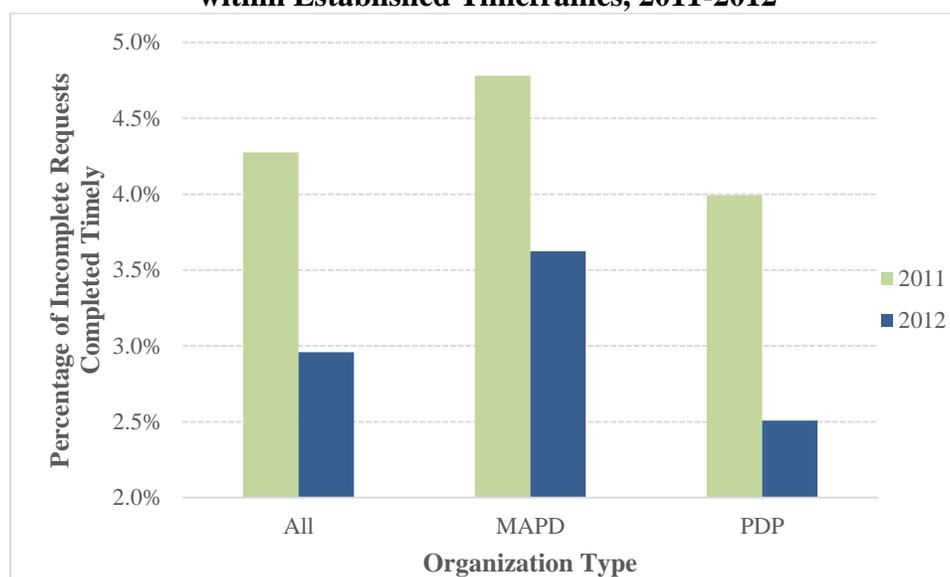


10 ENROLLMENT AND DISENROLLMENT

Sponsors are required to report data to CMS on their processing of enrollment and disenrollment requests so that CMS can evaluate whether the sponsors' procedures are in accordance with requirements. In CY 2011, the collected data only included information on enrollment requests. In CY 2012, this Reporting Requirement was expanded to include additional information on enrollment requests and information on disenrollment requests.

The percentage of incomplete enrollment requests received by the sponsor that were completed within established timeframes decreased from 4.3% in CY 2011 to 3.0% in CY 2012 (Figure 10.1).

Figure 10.1: Percentage of Incomplete Enrollment Requests Received that are Completed within Established Timeframes, 2011-2012



In CY 2012, MA-PD organizations reported that 54% of enrollment requests were paper enrollment requests, compared to just 14% for PDPs (Table 10.1). PDPs had more requests via telephone and the Medicare Online Enrollment Center (OEC), at 27% and 28% of PDP enrollment requests received via these methods, respectively.

Table 10.1: Enrollment Requests by Request Mechanism, 2012

Organization Type	Percentage of Enrollment Requests by Request Mechanism			
	Paper	Telephonic	Internet	OEC
All	30.4%	22.8%	7.9%	18.2%
MA-PD	54.1%	16.9%	5.8%	3.8%
PDP	14.4%	26.9%	9.3%	28.0%

The percentage of enrollment requests that were complete at the time of initial receipt in CY 2012 was higher than the corresponding percentage of disenrollment requests (Table 10.2).

Table 10.2: Enrollment and Disenrollment Requests Complete at Time of Initial Receipt, 2012

Organization Type	Percentage of Requests Complete at Time of Initial Receipt	
	Enrollment	Disenrollment
All	93.9%	55.2%
MA-PD	92.4%	64.6%
PDP	94.9%	48.7%

The percentage of disenrollment requests that were denied by the sponsor for any reason in CY 2012 exceeded the percentage of enrollment requests denied (Table 10.3).

Table 10.3: Enrollment and Disenrollment Requests Denied by the Sponsor, 2012

Organization Type	Percentage of Requests Denied	
	Enrollment	Disenrollment
All	1.6%	8.6%
MA-PD	2.1%	5.4%
PDP	1.2%	10.7%

11 SUMMARY OF RESULTS

The results of this analysis reveal that there have been improvements in several reporting areas from CY 2011 to CY 2012.

Grievances

The overall grievance rate per 1,000 enrollees decreased from CY 2011 to CY 2012, while the percentage of grievances the plan responded to on-time increased. The percentage of plans with at least 100 enrollees that reported receiving zero grievances increased from CY 2011 to CY 2012.

Coverage Determinations and Exceptions

Beneficiaries requested coverage determination and exceptions less frequently in CY 2012 than in CY 2011, exhibited by a decrease in the total request rate per 1,000 enrollees between years. The overall percentage of requests approved increased from CY 2011 to CY 2012, indicating slightly more frequent favorable outcomes for beneficiary exception requests.

Redeterminations

The redetermination rate per 1,000 enrollees increased from CY 2011 to CY 2012. The percentage of redeterminations that upheld the initial adverse coverage determination (i.e., that did not result in fully favorable outcomes for the beneficiary) decreased between years. The overall share of plans reporting zero redeterminations decreased from CY 2011 to CY 2012. Most plans reporting zero redeterminations in these years were plans with fewer than 1,000 enrollees.

Prompt Payment by Part D Sponsors

The percentage of total claims paid late decreased from CY 2011 to CY 2012, while the percentage of claims that were electronic remained stable.

MTM Programs

The overall percentage of non-LTC MTM program participants who received a CMR decreased slightly from CY 2010 to CY 2011, but increased from CY 2011 to CY 2012. The percentage of MTM beneficiaries that received a prescriber intervention and the percentage of MTM beneficiaries that received a drug therapy change both increased from CY 2010 through CY 2012. Additionally, the share of beneficiaries opting out of the MTM program decreased continually from CY 2010 to CY 2012. Although the percentage of beneficiaries who participated in an MTM program slightly decreased from CY 2010 to CY 2011, a substantial increase in MTM program participation was observed between CY 2011 and CY 2012.

However, MTM participation and CMR completion rates remain low, representing areas for improvement in future years.

Plan Oversight of Agents

The number of complaints against agents remained nearly negligible in both years, while the number of agent assisted enrollments decreased from CY 2011 to CY 2012. However, the total number of contracts required to report such information remained low in both CY 2011 to CY 2012.

LTC Utilization

The total number of 31-day equivalent formulary and non-formulary prescriptions dispensed at LTC pharmacies decreased from CY 2011 to CY 2012, as did the number of 30-day equivalent non-formulary prescriptions dispensed at retail pharmacies. The average cost per prescription generally remains higher at LTC pharmacies than at retail pharmacies.

Enrollment and Disenrollment

In CY 2011, the collected data for this section only included information on enrollment requests; in CY 2012, this Reporting Requirement was expanded to also include additional information on enrollment requests and information on disenrollment requests. The percentage of incomplete enrollment requests received by the sponsor that were completed within established timeframes decreased from CY 2011 to CY 2012. In CY 2012, MA-PD organizations reported that the majority of enrollment requests were completed via paper, followed by telephonic, internet, and then OEC requests. The largest share of enrollment requests for PDP organizations in CY 2012 were completed via OEC, followed by telephonic, paper, and then internet requests. The percentage of enrollment requests that were complete at the time of initial receipt in CY 2012 was higher than the corresponding percentage of disenrollment requests. The percentage of disenrollment requests that were denied by the sponsor for any reason in CY 2012 exceeded the percentage of enrollment requests denied.