Analysis of Calendar Year 2013 Medicare Part D Reporting Requirements Data

November 2015

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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 data 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 to CMS on various matters including the cost of operations, patterns of service utilization, availability and accessibility of services, and Part D 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 aid sponsors in submitting these data, CMS provides Reporting Requirements documentation for each calendar year (CY) of collected data, with revisions and comment periods conducted per Paperwork Reduction Act 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 2015.

Table 1.1: Summary of Part D Reporting Requirements by CY, 2010-2015

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015
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	✓	✓	✓	✓	✓	✓
Pharmacy & Therapeutics (P&T) Committees/Provision of Part D Functions	✓	✓	✓			
Coverage Determinations/Exceptions	✓	✓	✓	✓		

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

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015
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 Part D sponsors in accordance with the Part D Reporting Requirements for CY 2013.

For each of these reporting sections, this report presents program-wide averages and, when available, identifies trends between CY 2012 and CY 2013 data. The metrics evaluated for each section aim to provide information about beneficiary experience, sponsor performance, and overall program functioning. A list of the key metrics included in this report is presented in Table 1.2.

Table 1.2: Reporting Sections and Key Metrics

Reporting Section	Metric	Description
Grievances	Share of plans that reported zero Part D grievances	The number of plans reporting zero Part D grievances divided by the total number of plans.
	Rate of Part D grievances per 1,000 enrollees per month	The rate of Part D grievances filed (total or by type of grievance) per 1,000 enrollees per month.
	Share of Part D grievances by category	The number of Part D grievances filed for a category divided by the total number of Part D grievances filed, weighted by Plan Year Average Enrollment.
	Percentage of Part D grievances the plan responded to on time	The number of Part D grievances the plan responded to on time divided by the total number of Part D grievances filed.
Coverage Determinations and Exceptions	Share of plans that reported zero requests	The number of plans with at least 100 enrollees reporting zero coverage determinations and exceptions requests divided by the total number of plans with at least 100 enrollees.
	Decision rate per 1,000 enrollees	The number of decisions by request type per 1,000 enrollees, weighted by Plan Year Average Enrollment.

[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.

Reporting Section	Metric	Description
	Percentage of favorable exception decisions	The number of favorable exception decisions by category (i.e., total, formulary, tier, or UM) divided by the total number of exception decisions, weighted by Plan Year Average Enrollment.
	Percentage of pharmacy transactions rejected	The number of pharmacy transactions rejected by reason (i.e., non-formulary status, prior authorization requirements, step therapy requirements, quantity limit requirements, high cost edits for compounds, high cost edits for non-compounds) divided by the total number of pharmacy transactions, weighted by Plan Year Average Enrollment.
	Percentage of plan-quarter combinations with high cost edits in place	The number of plan-quarter combinations with edits in place (i.e., for non-compounds, compounds, or both) divided by the total plan-quarter combinations.
Redeterminations	Share of plans that reported zero redeterminations	The number of plans with at least 100 enrollees reporting zero redeterminations divided by the total number of plans with at least 100 enrollees.
	Redetermination rate per 1,000 enrollees	The number of redeterminations filed with the plan per 1,000 enrollees.
	Percentage of redeterminations by outcome	The number of redeterminations by outcome for the beneficiary (i.e., fully favorable, partially favorable, not fully favorable) divided by the total 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 paid late (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 eligible MTM beneficiaries	The number of eligible MTM beneficiaries (total, in an LTC facility, or cognitively impaired) divided by the total number of beneficiaries.
	Percentage of eligible MTM beneficiaries that received a comprehensive medication review (CMR)	The number of eligible MTM beneficiaries that received a CMR divided by the total number of eligible beneficiaries.
	Percentage of CMRs by method, provider, or recipient	The number of CMRs provided by (i) method, (ii) qualified provider that performed the CMR, or (iii) recipient, divided by the total number of CMRs provided.
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.

Reporting Section	Metric	Description
	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	Enrollment requests by mechanism	The number of enrollment requests by mechanism (i.e., paper, telephone, internet, or Medicare Online Enrollment Center) divided by the total number of enrollment requests.
	Requests complete as of initial receipt	The number of enrollment or disenrollment requests complete as of initial receipt divided by total number of enrollment or disenrollment requests.
	Requests denied by sponsor	The number of enrollment or disenrollment requests denied by the sponsor divided by the total number of enrollment or disenrollment 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.[6] [7] CMS has also released public use files 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, exclusions applied to the data used in the analysis, and reporting sections utilized for public use files. Sections 3 through 9 present the main findings for each of the seven Part D reporting sections included in this report. Section 10 summarizes key results from the analysis.

[6] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
[7] As of October 2015, Part D plan reported data have been incorporated into the 2016 Star Ratings (MTM CMR rate, using 2014 reported and validated data).
[8] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.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 their 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, placeholder, and data integrity 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, if they reported "0" (placeholder) values for all data elements in multiple reporting sections, or if their reported data has integrity issues, such as data internally inconsistent or does not comply with the published requirements. When a resubmission occurs, the more recent data are utilized for validation and analysis. At the end of a given reporting year, all data submissions or resubmission must be completed by March 31 of the subsequent year.

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 more effectively assess their own performance and to make improvements to their internal data, systems, and reporting processes.

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 to assess (i) proper source documentation, (ii) proper calculation of data elements, (iii) proper procedures for data submission, (iv) proper procedures for data

[9] MTM Programs data are uploaded using Gentran or Direct Connect.
[10] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html

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 contract complied.

As shown in Table 2.1, five of the seven reporting sections included in this report underwent data validation. With the exception of Prompt Payment and Enrollment and Disenrollment data, all CY 2012 data included in this report underwent data validation in the 2013 data validation cycle and all CY 2013 data included in this report underwent data validation in the 2014 data validation cycle. Data on Prompt Payment by Part D Sponsors and 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 (DV)

Reporting Section	CY 2012 Data	CY 2013 Data
Grievances	2013 DV	2014 DV
Coverage Determinations and Exceptions	2013 DV	2014 DV
Redeterminations	2013 DV	2014 DV
Prompt Payment by Part D Sponsors	-	-
MTM Programs	2013 DV	2014 DV
LTC Utilization	2013 DV	2014 DV
Enrollment and Disenrollment	-	-

2.3 Data Validation 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 2012 and CY 2013 reporting sections that underwent validation in the 2013 or 2014 data validation cycles, contracts must have a section-specific data validation score of at least 95% to be included. If a contract passed validation for the reporting section, but failed an element-specific data validation check, the contract will be excluded from the calculations of any metrics that utilize the element(s) that failed. This may cause plan and contract counts to vary between metrics within a section.[12]

Table 2.2 displays data validation results by reporting section and CY of data. The number of contracts meeting the minimum data validation passing score increased for all sections from CY 2012 to CY 2013. The reporting section with the lowest percentage of contracts achieving a passing data validation score in both years is Grievances, with 86.2% in CY 2012 and 89.7% in CY 2013. For CY 2013 data, the MTM Programs section had the highest percentage of contracts meeting the minimum data validation passing score (99.1%), followed by LTC Utilization (97.2%), Coverage Determinations and Exceptions (96.6%), then Redeterminations (94.2%).

[11] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html
[12] For the MTM section, this also causes the number of MTM-Eligible Beneficiaries to vary between metrics.

Table 2.2: Summary of Data Validation Results by Reporting Section by Contract[13]

Reporting Section	Contract Year	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# contracts DV Score ≥ 95%	% contracts DV Score ≥ 95%	# contracts DV Score = 100%	% contracts DV Score = 100%
Grievances	2012	589	585	504	86.2%	478	81.7%
Grievances	2013	594	590	529	89.7%	435	73.7%
Coverage Determinations and Exceptions	2012	589	585	536	91.6%	489	83.6%
Coverage Determinations and Exceptions	2013	594	590	570	96.6%	529	89.7%
Redeterminations	2012	589	585	540	92.3%	527	90.1%
Redeterminations	2013	594	590	556	94.2%	552	93.6%
Prompt Payment	2012	-	-	-	-	-	-
Prompt Payment	2013	-	-	-	-	-	-
MTM Programs	2012	583	574	558	97.2%	512	89.2%
MTM Programs	2013	591	578	573	99.1%	530	91.7%
LTC Utilization	2012	566	500	483	96.6%	464	92.8%
LTC Utilization	2013	576	509	495	97.2%	480	94.3%
Enrollment and Disenrollment	2012	-	-	-	-	-	-
Enrollment and Disenrollment	2013	-	-	-	-	-	-

As data validation results are assigned at the contract level for reporting sections that are submitted at the plan level, all plans under a given contract are assigned the same score.

[13] Total number eligible for inclusion represents contracts/plans required to report for all four quarters and that met termination requirements (i.e., does not reflect size exclusions). Number included in analysis and underwent DV represents contracts/plans are excluded from analysis if they do not meet termination and/or minimum size requirements. Inclusion in DV Score = 100% must score exactly 100% (un-rounded). Sections that did not undergo DV are represented with a placeholder value (i.e., Prompt Payment and Enrollment and Disenrollment).

Table 2.3 displays corresponding plan counts for sections that are reported at the plan level. Of these three reporting sections, Grievances had the lowest percentage of plans with contracts achieving a passing data validation score in both CY 2012 and CY 2013. Redeterminations had the highest percentage of plans with contracts achieving a data validation score of exactly 100% in CY 2012 (89.4%) and CY 2013 (96.1%).

Table 2.3: Summary of Data Validation Results by Reporting Section for Plans[14]

Reporting Section	Contract Year	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# DV ≥ 95%	% DV ≥ 95%	# DV = 100%	% DV = 100%
Grievances	2012	3,171	3,116	2,339	75.1%	2,169	69.6%
Grievances	2013	3,359	3,310	2,661	80.4%	2,093	63.2%
Coverage Determinations and Exceptions	2012	3,171	3,116	2,761	88.6%	2,485	79.7%
Coverage Determinations and Exceptions	2013	3,359	3,310	3,228	97.5%	3,047	92.1%
Redeterminations	2012	3,171	3,116	2,831	90.9%	2,786	89.4%
Redeterminations	2013	3,359	3,310	3,194	96.5%	3,182	96.1%

The metrics in the 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 made due to element-specific data validation failures.

2.4 Reporting Sections Utilized for Public Use Files

As noted in the Introduction, CMS provides public use files in a continued effort to increase transparency and promote provider and plan accountability. Specifications of the public use files and a description of each section's criteria are publically available.[15] Table 2.4 lists the reporting section data utilized for public use files.

[14] Total number eligible for inclusion represents contracts/plans required to report for all four quarters and that met termination requirements (i.e., does not reflect size exclusions). Number included in analysis and underwent DV represents contracts/plans are excluded from analysis if they do not meet termination and/or minimum size requirements. Inclusion in DV Score = 100% must score exactly 100% (un-rounded).

[15] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html

Table 2.4: Reporting Sections Utilized for Public Use Files

Reporting Section	Utilized for Public Use Files
Grievances	✓
Coverage Determinations and Exceptions	✓
Redeterminations	✓
Prompt Payment by Part D Sponsors	
MTM Programs	✓
LTC Utilization	✓
Enrollment and Disenrollment	✓

To be included in this analysis, requirements are applied to each reporting section's data. For sections that are represented in the public use files, the same restrictions/exclusions apply to those sections in this analysis. For sections that are not represented in the public use files, restrictions and exclusions are applied based on the section's level of reporting.[16]

- Plan-level sections:
    - Plan required to submit for the reporting year
    - Plan not deleted before the end of the reporting year
    - Plan had year average enrollment greater than or equal to 11
    - Contract was active as of end of reporting year
- Contract-level sections:
    - Contract required to submit
    - Contract had year average enrollment greater than or equal to 11
    - Contract active as of end of reporting year

[16] Additional criteria are applied to sections that underwent data validation, including the contract must be active as of the data validation deadline and the contract must pass the section level data validation score.

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 of 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.[17]

In CY 2013, 15.8% 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 14.5% in CY 2012 (Table 3.1). Employer plans had the highest share of plans reporting zero Part D grievances in CY 2012 and CY 2013 with 23.9% and 22.3%, respectively. PDP Basic Below Benchmark plans had the largest increase in the share of plans reporting zero Part D grievances between years, with 1.1% in CY 2012 and 8.0% in CY 2013, followed by PDP Enhanced plans with 1.5% in CY 2012 and 5.6% in CY 2013.

Table 3.1: Plans Reporting Zero Part D Grievances by Organization Type, 2012-2013[18]

Organization Type	2012 Total Number of Plans	2012 Number of Plans Reporting Zero	2012 Share of Plans that Reported Zero	2013 Total Number of Plans	2013 Number of Plans Reporting Zero	2013 Share of Plans that Reported Zero
All	**2,106**	**305**	**14.5%**	**2,309**	**365**	**15.8%**
Employer	**234**	**56**	**23.9%**	**247**	**55**	**22.3%**
MA-PD	**1,408**	**229**	**16.3%**	**1,484**	**272**	**18.3%**
PDP	**464**	**20**	**4.3%**	**578**	**38**	**6.6%**
Basic Below Benchmark	89	1	1.1%	137	11	8.0%
Basic Above Benchmark	175	16	9.1%	190	13	6.8%
Enhanced	200	3	1.5%	251	14	5.6%

[17] 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).

[18] Restricted to plans with a year average HPMS enrollment of at least 100. Grievances due to CMS issues are excluded when determining plan's reported grievance count.

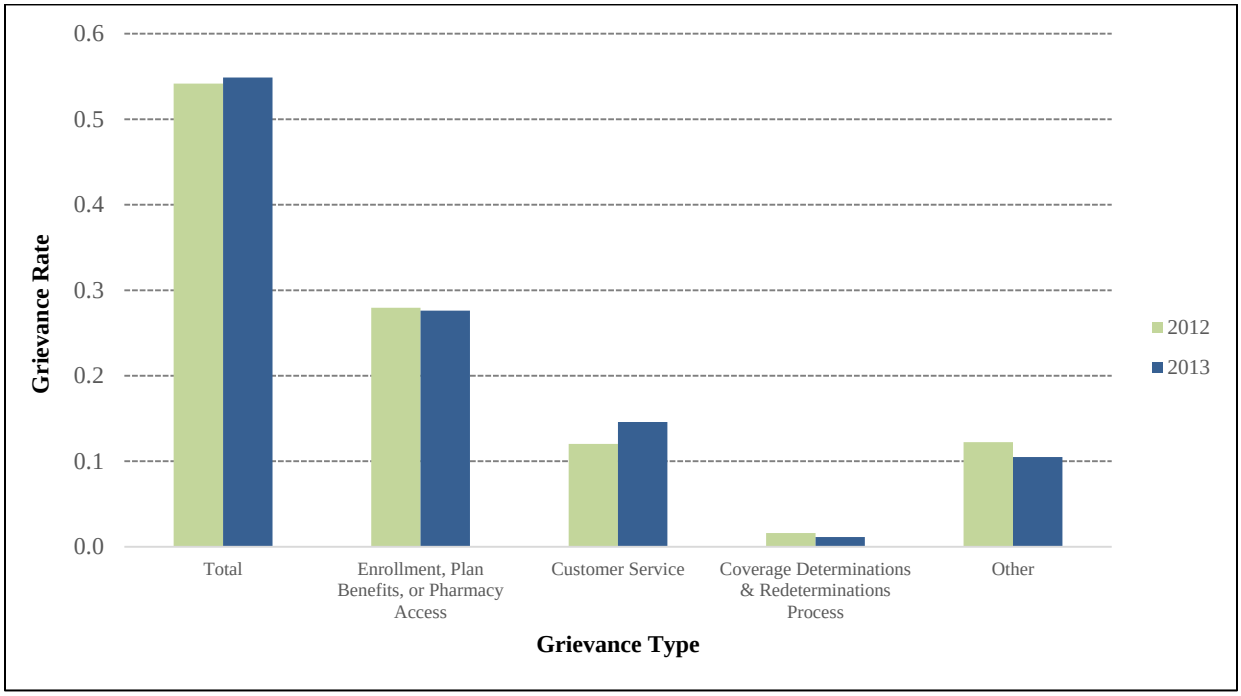
In both CY 2012 and CY 2013, most plans that reported zero Part D grievances had less than 500 enrollees (Table 3.2).

Table 3.2: Plans Reporting Zero Part D Grievances by Enrollment, 2012-2013[19]

Plan Enrollment	2012			2013		
	Total Number of Plans	Number of Plans Reporting Zero	Share of Plans that Reported Zero	Total Number of Plans	Number of Plans Reporting Zero	Share of Plans that Reported Zero
All	**2,106**	**305**	**14.5%**	**2,309**	**365**	**15.8%**
100 - 499	329	160	48.6%	378	201	53.2%
500-999	260	64	24.6%	265	80	30.2%
1,000 - 9,999	1,118	78	7.0%	1,186	83	7.0%
10,000 - 99,999	369	3	0.8%	439	1	0.2%
100,000+	30	0	0.0%	41	0	0.0%

The overall rate of Part D grievances per 1,000 enrollees per month slightly increased from 0.54 in CY 2012 to 0.55 in CY 2013 (Figure 3.1). The largest observed change was for customer service from a grievance rate of 0.12 in CY 2012 to 0.15 in CY 2013.

Figure 3.1: Grievance Rates per 1,000 Enrollees per Month by Grievance Type, 2012-2013[20]



The number of plans reporting at least one Part D grievance and the total number of Part D grievances filed increased from CY 2012 to CY 2013 (Table 3.3). Enrollment, plan benefits, or pharmacy

[19] Restricted to plans with a year average HPMS enrollment of at least 100. Grievances due to CMS issues are excluded when determining plan's reported grievance count.

[20] Measure values are weighted by Plan Year Average Enrollment. Grievances due to CMS issues are excluded from the 2013 rates. No such category was reported in 2012.

access comprised the largest share of Part D grievances filed in CY 2012 with 47.2% and CY 2013 with 48.3%. In both years, the second largest share of grievances were filed due to customer service with around 29%, followed by other grievances with slightly more than 20%, then grievances related to coverage determinations and redeterminations process with around 3%.

Table 3.3: Part D Grievances by Category, 2012-2013[21]

Category	2012				2013			
	Total Number of Plans	Number of Plans Reporting At Least One Grievance	Total Number of Grievances	Share of Grievances	Total Number of Plans	Number of Plans Reporting At Least One Grievance	Total Number of Grievances	Share of Grievances
Total	**2,277**	**1,847**	**130,383**	**100.0%**	**2,484**	**1,983**	**170,599**	**100.0%**
Enrollment, Plan Benefits, or Pharmacy Access	2,277	1,564	68,281	47.2%	2,484	1,728	87,979	48.3%
Customer Service	2,277	1,313	28,896	28.7%	2,484	1,387	46,298	28.8%
Coverage Determinations & Redeterminations Process	2,277	584	3,670	2.9%	2,484	680	3,630	2.6%
Other	2,277	1,313	29,536	21.2%	2,484	1,442	32,692	20.3%

The percentage of Part D grievances responded to on time remained high in both years, decreasing slightly from 99.2% in CY 2012 to 98.9% in CY 2013 (Table 3.4). Employer plans showed the largest decrease in this metric, decreasing 0.9 percentage points from 99.1% of grievances responded to on time in CY 2012 compared to 98.2% in CY 2013.

Table 3.4: Percentage of Part D Grievances the Plan Responded to On Time by Organization Type, 2012-2013[22]

Organization Type	2012		2013	
	Percentage Timely	Number of Plans Included	Percentage Timely	Number of Plans Included
All	**99.2%**	**1,828**	**98.9%**	**1,957**
Employer	**99.1%**	**187**	**98.2%**	**197**
MA-PD	**98.9%**	**1,182**	**98.6%**	**1,214**
PDP	**99.5%**	**459**	**99.4%**	**546**
Basic Below Benchmark	99.6%	88	99.7%	126
Basic Above Benchmark	99.5%	161	99.0%	178
Enhanced	99.5%	210	99.4%	242

[21] Measure values are weighted by Plan Year Average Enrollment. Grievances due to CMS issues are excluded from 2013. No such category was reported in 2012.

[22] Measure values are weighted by Plan Year Average Enrollment. Grievances due to CMS issues are excluded from the 2013 rates. No such category was reported in 2012.

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.[23] [24]

In CY 2012, four plans with at least 100 enrollees reported zero determinations and exceptions requests, compared to six plans in CY 2013 (Table 4.1).

Table 4.1: Plans Reporting Zero Requests by Organization Type, 2012-2013[25]

Organization Type	2012 Total Number of Plans	2012 Number of Plans Reporting Zero	2012 Share of Plans that Reported Zero	2013 Total Number of Plans	2013 Number of Plans Reporting Zero	2013 Share of Plans that Reported Zero
All	**2,549**	**4**	**0.2%**	**2,969**	**6**	**0.2%**
Employer	**279**	**2**	**0.7%**	**301**	**2**	**0.7%**
MA-PD	**1,592**	**2**	**0.1%**	**1,743**	**3**	**0.2%**
Basic	306	0	0.0%	334	0	0.0%
Enhanced	1,286	2	0.2%	1,409	3	0.2%
PDP	**678**	**0**	**0.0%**	**925**	**1**	**0.1%**
Basic Below Benchmark	161	0	0.0%	196	0	0.0%

[23] Beginning in 2010, the technical specifications document clarified that requests for exceptions to prior authorization criteria are classified as utilization management exceptions requests.

[24] Reporting of UM exceptions was separated into three subcategories for 2013 (i.e., Prior Authorization Exceptions, Step Therapy, and Quantity Limits).

[25] Restricted to plans with a year average HPMS enrollment of at least 100.

Organization Type	2012 Total Number of Plans	2012 Number of Plans Reporting Zero	2012 Share of Plans that Reported Zero	2013 Total Number of Plans	2013 Number of Plans Reporting Zero	2013 Share of Plans that Reported Zero
Basic Above Benchmark	215	0	0.0%	279	0	0.0%
Enhanced	302	0	0.0%	450	1	0.2%

All plans with at least 100 enrollees that reported zero determinations and exceptions in CY 2012 and CY 2013 had less than a year average HPMS enrollment of 1,000 total enrollees (Table 4.2). Of the six plans with at least 100 enrollees that reported zero determinations and exceptions in CY 2013, five plans had less than a year average HPMS enrollment of 500 total enrollees.

Table 4.2: Plans Reporting Zero Requests by Enrollment, 2012-2013[26]

Plan Enrollment	2012 Total Number of Plans	2012 Number of Plans Reporting Zero	2012 Share of Plans that Reported Zero	2013 Total Number of Plans	2013 Number of Plans Reporting Zero	2013 Share of Plans that Reported Zero
All	**2,549**	**4**	**0.2%**	**2,969**	**6**	**0.2%**
100 - 499	370	2	0.5%	438	5	1.1%
500-999	300	2	0.7%	317	1	0.3%
1,000 - 9,999	1,334	0	0.0%	1,523	0	0.0%
10,000 - 99,999	503	0	0.0%	643	0	0.0%
100,000+	42	0	0.0%	48	0	0.0%

The rate of prior authorization request rate per 1,000 enrollees slightly decreased from 61.2 in CY 2012 to 58.9 in CY 2013 (Table 4.3). The total exception request rate per 1,000 enrollees – comprised of formulary exceptions, tier exceptions, and UM exceptions – increased from 69.4 in CY 2012 to 87.7 in CY 2013. Of the three different exception request types, formulary exception requests were the most common in both years, with 41.4 requests per 1,000 enrollees in CY 2012 and 49.2 in CY 2013. The second highest rate in both years was for UM exception requests, with 23.6 requests per 1,000 enrollees in CY 2012 and 34.3 in CY 2013. The rate of tier exception requests continued to occur much less frequently than the other request types and slightly decreased between years, with 4.5 requests per 1,000 enrollees in CY 2012 and 4.0 in CY 2013.

Table 4.3: Decision Rates per 1,000 Enrollees by Request Type, 2012-2013[27]

Request Type	2012 Request Rate	2012 Number of Plans Included	2013 Request Rate	2013 Number of Plans Included

[26] Restricted to plans with a year average HPMS enrollment of at least 100.

[27] Measure values are weighted by Plan Year Average Enrollment. Reporting of UM Exceptions was separated into three subcategories for 2013 (i.e., Prior Authorization Exceptions, Step Therapy, and Quantity Limits).

Request Type	2012 Request Rate	2012 Number of Plans Included	2013 Request Rate	2013 Number of Plans Included
Prior Authorizations	**61.2**	**2,757**	**58.9**	**3,196**
Total Exceptions	**69.4**	**2,731**	**87.7**	**3,172**
Formulary Exceptions	41.4	2,756	49.2	3,226
Tier Exceptions	4.5	2,751	4.0	3,218
UM Exceptions	23.6	2,742	34.3	3,182

The percentage of favorable exception decisions increased from 62.1% in CY 2012 to 66.4% in CY 2013 (Table 4.4). The largest increase in favorable exception decisions was for formulary exceptions, increasing nearly 8 percentage points from 59.3% in CY 2012 to 67.2% in CY 2013. The percentage of favorable formulary exception decisions increased for all plan types. PDP Enhanced plans had the largest increase in percentage of favorable exception decisions from 43.7% in CY 2012 to 67.3% in CY 2013. PDP Enhanced plans also had the largest decrease in the percentage of favorable tier exception decisions from 38.7% in CY 2012 to 27.1% in CY 2013.

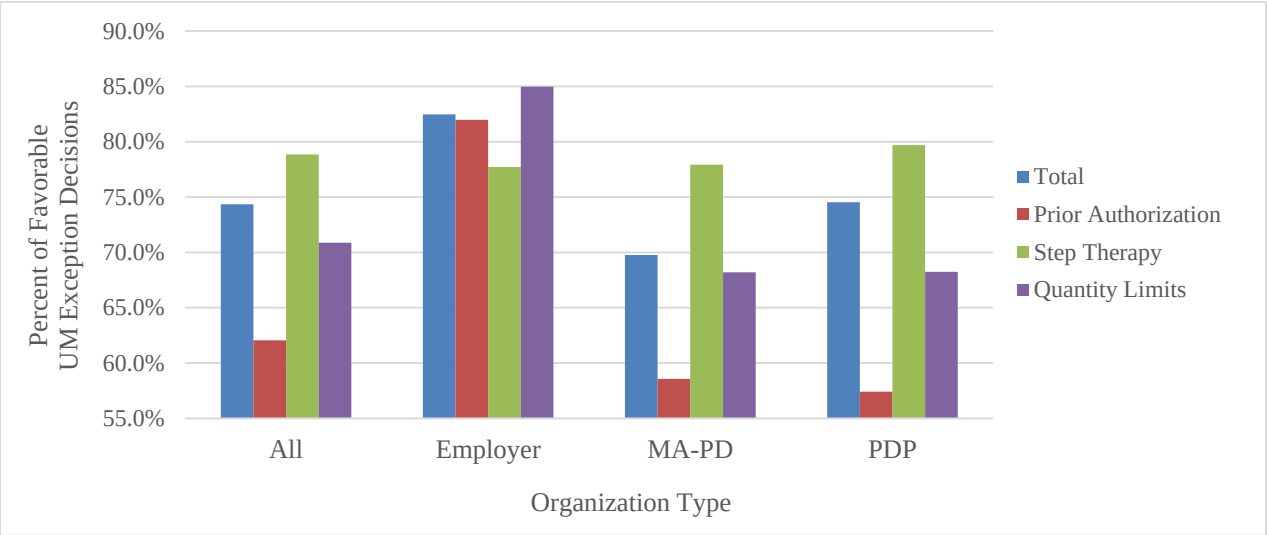
Table 4.4: Percentage of Favorable Exception Decisions by Organization Type, 2012-2013[28]

Organization Type	Category							
	Total		Formulary		Tier		UM	
	2012	2013	2012	2013	2012	2013	2012	2013
All	**62.1%**	**66.4%**	**59.3%**	**67.2%**	**33.6%**	**32.7%**	**72.3%**	**74.4%**
Employer	**73.8%**	**76.3%**	**68.5%**	**76.9%**	**54.4%**	**53.5%**	**79.2%**	**82.5%**
MA-PD	**60.4%**	**62.7%**	**57.1%**	**64.2%**	**38.0%**	**34.2%**	**70.7%**	**69.8%**
Basic	63.7%	70.5%	60.0%	69.0%	31.5%	33.2%	75.4%	76.7%
Enhanced	59.9%	61.2%	56.6%	63.2%	38.8%	34.3%	69.8%	68.3%
PDP	**60.6%**	**65.7%**	**59.1%**	**66.0%**	**25.9%**	**25.8%**	**71.9%**	**74.5%**
Basic Below Benchmark	57.6%	60.2%	54.1%	58.2%	21.8%	20.9%	72.0%	69.2%
Basic Above Benchmark	67.1%	74.2%	69.3%	73.6%	23.5%	29.9%	75.6%	84.7%
Enhanced	50.9%	64.3%	43.7%	67.3%	38.7%	27.1%	62.8%	71.8%

Reporting of UM exceptions was separated into three subcategories for 2013 (i.e., Prior Authorization Exceptions, Step Therapy, and Quantity Limits). In CY 2013, step therapy had the largest percentage of favorable UM exception decisions with 78.9%, followed by quantity limits with 70.9%, then prior authorizations with 62.1% (Figure 4.1).

[28] Measure values are weighted by Plan Year Average Enrollment. Reporting of UM Exceptions was separated into three subcategories for 2013 (i.e., Prior Authorization Exceptions, Step Therapy, and Quantity Limits).

Figure 4.1: Percentage of Favorable UM Exception Decisions, 2013[29]



The most common reason for the rejection of pharmacy transactions in CY 2013, was non-formulary status, with 1.8% of pharmacy transactions rejected (Table 4.5). The second most common pharmacy transaction rejection reason in CY 2013, involved prior authorization requirements, with 0.6% of pharmacy transactions rejected, followed by 0.5% of pharmacy transactions rejected because of quantity limit requirements.

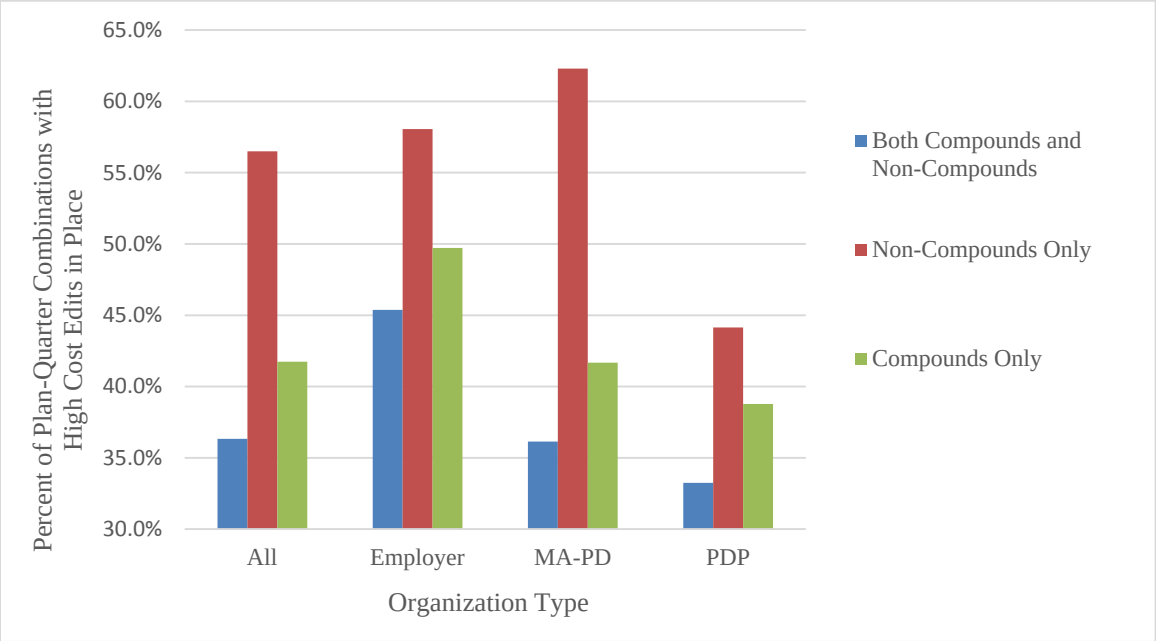
Table 4.5: Percentage of Pharmacy Transactions Rejected, 2013[30]

Organization Type	Reason for Rejected Transaction					
	Non-Formulary Status	Prior Authorization Requirements	Step Therapy Requirements	Quantity Limit Requirements	High Cost Edits for Compounds	High Cost Edits for Non-Compounds
All	**1.8%**	**0.6%**	**0.2%**	**0.5%**	**0.0%**	**0.0%**
Employer	**0.7%**	**0.9%**	**0.3%**	**0.5%**	**0.0%**	**0.0%**
MA-PD	**1.5%**	**0.5%**	**0.2%**	**0.6%**	**0.0%**	**0.0%**
Basic	2.1%	0.6%	0.2%	0.9%	0.0%	0.0%
Enhanced	1.4%	0.5%	0.2%	0.6%	0.0%	0.0%
PDP	**2.3%**	**0.5%**	**0.1%**	**0.4%**	**0.0%**	**0.0%**
Basic Below Benchmark	2.1%	0.4%	0.1%	0.4%	0.0%	0.0%
Basic Above Benchmark	2.5%	0.6%	0.1%	0.6%	0.0%	0.0%
Enhanced	2.3%	0.4%	0.1%	0.3%	0.0%	0.0%

In CY 2013, non-compounds had the largest percentage of plan-quarter combinations with high cost edits in place across all organization types (Figure 4.2). The overall percentage of plan-quarter combinations with high cost edits in place for non-compounds was 56.5%, the percentage for compounds was 41.7%, and the percentage for both compounds and non-compounds was 36.3%.

[29] Measure values are weighted by Plan Year Average Enrollment.
[30] Measure values are weighted by Plan Year Average Enrollment.

Figure 4.2: Percentage of Plan-Quarter Combinations with High Cost Edits in Place, 2013[31]



[31] Since a single plan can change its response across quarters, this table presents the count of plan-quarter combinations with each response.

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.

While the total number of plans with at least 100 enrollees increased from 2,634 in CY 2012 to 2,979 in CY 2013, the number of plans with at least 100 enrollees reporting zero redeterminations decreased from 231 in CY 2012 to 223 in CY 2013 (Table 5.1). As such, the share of plans with at least 100 enrollees reporting zero redeterminations decreased from 8.8% in CY 2012 to 7.5% in CY 2013. Employer plans maintained the largest share of plans with at least 100 enrollees that reported zero redeterminations, with 16.5% in CY 2012 and 15.5% in CY 2013, followed by MA-PD plans with 8.2% in CY 2013, then PDP plans with 3.7% in CY 2013.

Table 5.1: Plans Reporting Zero Redeterminations by Organization Type, 2012-2013[32]

Organization Type	2012 Total Number of Plans	2012 Number of Plans Reporting Zero	2012 Share of Plans that Reported Zero	2013 Total Number of Plans	2013 Number of Plans Reporting Zero	2013 Share of Plans that Reported Zero
All	**2,634**	**231**	**8.8%**	**2,979**	**223**	**7.5%**
Employer	**284**	**47**	**16.5%**	**304**	**47**	**15.5%**
MA-PD	**1,639**	**165**	**10.1%**	**1,724**	**141**	**8.2%**
Basic	292	35	12.0%	331	32	9.7%
Enhanced	1,347	130	9.7%	1,393	109	7.8%
PDP	**711**	**19**	**2.7%**	**951**	**35**	**3.7%**
Basic Below Benchmark	184	1	0.5%	213	8	3.8%
Basic Above Benchmark	196	6	3.1%	287	11	3.8%
Enhanced	331	12	3.6%	451	16	3.5%

In CY 2012 and CY 2013, the largest share of plans with at least 100 enrollees reporting zero redeterminations had less than 500 total enrollees (Table 5.2). This enrollment category comprised 33.9% of plans with at least 100 enrollees reporting zero redeterminations in CY 2012 and 30.9% in CY 2013.

[32] Restricted to plans with a year average HPMS enrollment of at least 100.

Table 5.2: Plans Reporting Zero Redeterminations by Enrollment, 2012-2013[33]

Enrollment	2012			2013		
	Total Number of Plans	Number of Plans Reporting Zero	Share of Plans that Reported Zero	Total Number of Plans	Number of Plans Reporting Zero	Share of Plans that Reported Zero
All	**2,634**	**231**	**8.8%**	**2,979**	**223**	**7.5%**
100 - 499	387	131	33.9%	431	133	30.9%
500 - 999	304	41	13.5%	317	36	11.4%
1,000 - 9,999	1,386	54	3.9%	1,541	49	3.2%
10,000 - 99,999	516	5	1.0%	642	5	0.8%
100,000+	41	0	0.0%	48	0	0.0%

The overall rate of redeterminations per 1,000 enrollees increased from 7.4 in CY 2012 to 7.8 in CY 2013 (Table 5.4), indicating that beneficiaries more often filed for redetermination in CY 2013 than in CY 2012.

Table 5.3: Redetermination Rates per 1,000 Enrollees by Plan Type, 2012-2013[34]

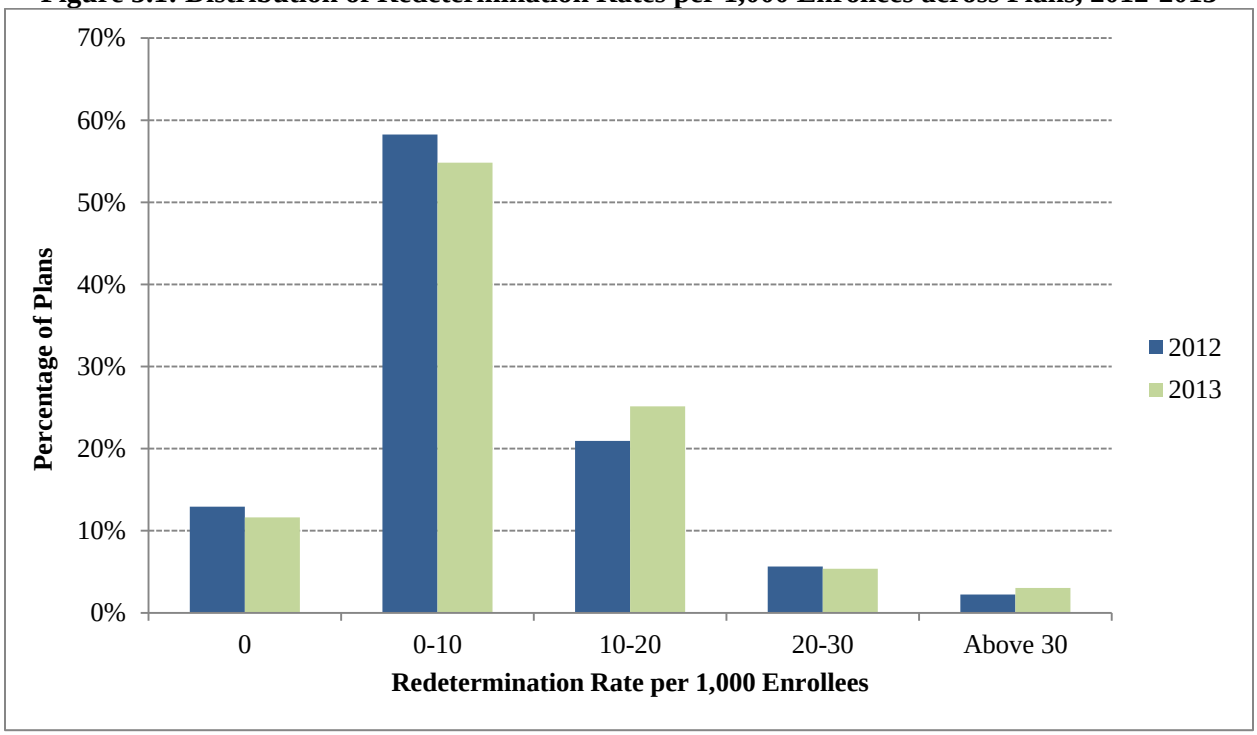
Organization Type	2012 Measure Value	2012 Number of Plans	2013 Measure Value	2013 Number of Plans
All	**7.4**	**2,831**	**7.8**	**3,190**
Employer	**6.6**	**332**	**5.7**	**351**
MAPD	**5.8**	**1,759**	**6.9**	**1,838**
Basic	7.7	317	8.2	360
Enhanced	5.5	1,442	6.6	1,478
PDP	**8.8**	**740**	**8.9**	**1,001**
Basic Below Benchmark	9.5	185	9.7	213
Basic Above Benchmark	7.7	202	7.4	311
Enhanced	9.5	353	9.3	477

In both years, most plans had a redetermination rate per 1,000 enrollees greater than zero and less than ten, with 58.2% of plans in CY 2012 and 54.8% of plans in CY 2013 (Figure 5.1). The share of plans with a redetermination rate greater than thirty requests per 1,000 enrollees was only 2.2% in CY 2012 and 3.0% in CY 2013.

[33] Restricted to plans with a year average HPMS enrollment of at least 100.

[34] Measure values are weighted by Plan Year Average Enrollment.

Figure 5.1: Distribution of Redetermination Rates per 1,000 Enrollees across Plans, 2012-2013



The percentage of redeterminations with fully favorable outcomes decreased between years from 74.2% in CY 2012 to 72.2% in CY 2013 (Table 5.4), indicating plans were slightly less likely to overturn their original determination in CY 2013 than in CY 2012. As such, the percentage of redeterminations with not fully favorable outcomes increased from 25.8% in CY 2012 to 27.8% in CY 2013. PDP Enhanced plans experienced the largest increase in not fully favorable outcomes between years, from 19.0% in CY 2012 to 28.5% in CY 2013.

Table 5.4: Percentage of Redeterminations by Outcome and Organization Type, 2012-2013[35]

Organization Type	2012		2013	
	Fully Favorable	Not Fully Favorable	Fully Favorable	Not Fully Favorable
All	**74.2%**	**25.8%**	**72.2%**	**27.8%**
Employer	**61.3%**	**38.7%**	**60.7%**	**39.3%**
MAPD	**71.4%**	**28.6%**	**71.5%**	**28.5%**
Basic	70.3%	29.7%	72.3%	27.7%
Enhanced	71.6%	28.4%	71.4%	28.6%
PDP	**79.0%**	**21.0%**	**76.2%**	**23.8%**
Basic Below Benchmark	84.6%	15.4%	83.8%	16.2%
Basic Above Benchmark	72.7%	27.3%	73.8%	26.2%
Enhanced	81.0%	19.0%	71.5%	28.5%

[35] Measure values are weighted by Plan Year Average 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 any 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.[36] 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 increased from 89.9% in CY 2012 to 92.3% in CY 2013 (Table 6.1). Employer organizations had the highest percentage of paid claims that were electronic in both CY 2012 and CY 2013, at 99.9% both years. However, the number of Employer organization contracts included in the analysis was relatively low with just 8 contracts in CY 2012 and 7 contracts in CY 2013. MA-PD organizations had the second highest percentage of paid claims that were electronic in both years, at 90.3% in CY 2012 and 91.9% in CY 2013.

Table 6.1: Percentage of Paid Claims that were Electronic, 2012-2013[37]

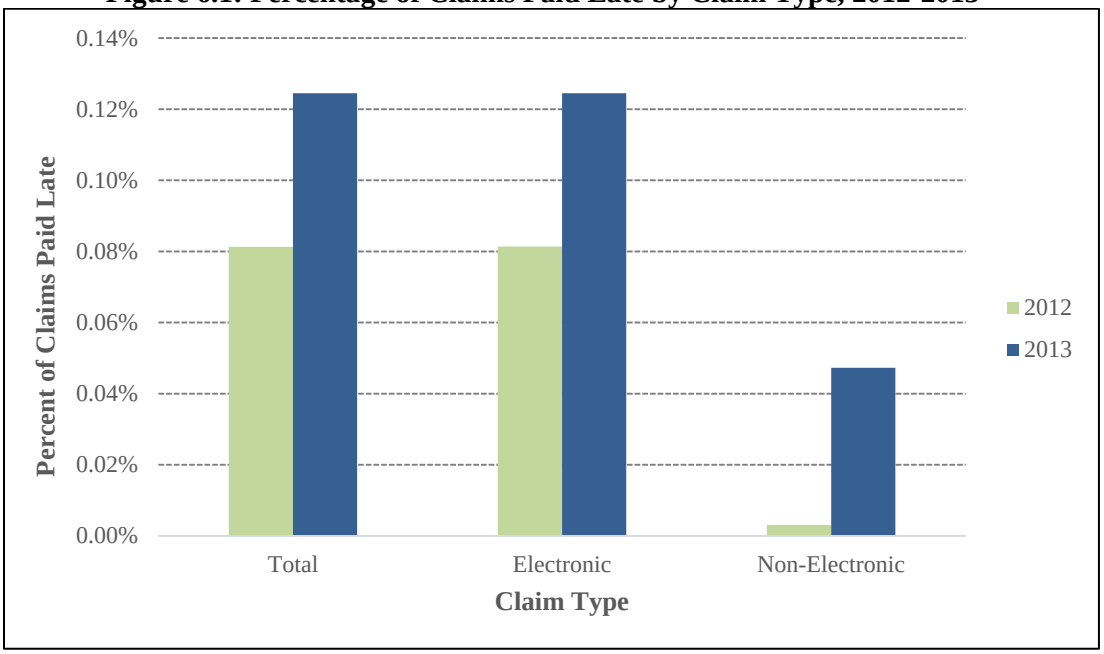
Organization Type	2012 Measure Value	2012 Number of Contracts	2013 Measure Value	2013 Number of Contracts
All	**89.9%**	**594**	**92.3%**	**592**
Employer	99.9%	8	99.9%	7
MA-PD	90.3%	519	91.9%	516
PDP	89.4%	67	92.4%	69

The percentage of total claims paid late remained relatively low and stable from 0.08% in CY 2012 to 0.12% in CY 2013 (Figure 6.1). The percentage of electronic claims paid late was 0.08% in CY 2012 and 0.12% in CY 2013, and the percentage of non-electronic claims paid late was 0.003% in CY 2012 and 0.047% in CY 2013.

[36] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY13-Part-D-Reporting-Requirements-.pdf

[37] Measure values are weighted by Contract Year Average Enrollment.

Figure 6.1: Percentage of Claims Paid Late by Claim Type, 2012-2013[38]



[38] Measure values are weighted by Contract Year Average 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. 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 Part D covered 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.

Sponsors are required to target beneficiaries for the MTM program who meet specific criteria as specified by CMS in § 423.153(d). Some sponsors also offer enrollment in the MTM program to other members based on other plan-specific targeting criteria within the reporting period who do not meet the specific CMS targeting criteria.[39] CMS began to collect information on beneficiaries enrolled in MTM programs based on expanded criteria in 2013. In 2012, the number of eligible MTM beneficiaries only includes beneficiaries that met the specified criteria per CMS-Part D requirements, while in 2013, this category also includes beneficiaries that met other expanded targeting criteria.

The total rate of beneficiaries eligible for an MTM program based on standard program criteria per CMS-Part D requirements was 11.1% in CY 2012 (

[39] In 2013, almost one-quarter of MTM programs use expanded eligibility requirements beyond CMS' minimum requirements. 2013 MTM Program Fact Sheet. Accessed at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2013-MTM-Fact-Sheet.pdf

Table 7.1). Employer plans had the largest eligibility rate in CY 2012 with 16.6%, followed by MA-PD plans with 11.4%, then PDP plans with 10.9%.

Table 7.1: Percentage of Beneficiaries Eligible for an MTM Program, 2012[40] [41]

Organization Type	2012 Total Number of MTM-Eligible Beneficiaries[42]	2012 Eligibility Rate	2012 Number of Contracts
All	**3,166,780**	**11.1%**	**546**
Employer	27,435	16.6%	8
MA-PD	1,301,302	11.4%	473
PDP	1,838,043	10.9%	65

Over 700,000 additional beneficiaries were enrolled in MTM programs in CY 2013 based on expanded criteria above the minimum requirements set by CMS. In CY 2013, the percent of enrollees that were MTM-eligible and met the specified targeting criteria per CMS Part D requirements was 10.4%, and an additional 2.0% of all enrollees were MTM-eligible and met other expanded criteria (Table 7.2). Employer plans had the largest decrease in eligibility rate, from 16.6% in CY 2012 to 11.7% in CY 2013.

Table 7.2: Percentage of Beneficiaries Eligible for an MTM Program, 2013[43]

Organization Type	2013						
	All			Met the Specified Targeting Criteria per CMS-Part D Requirements (Element G = Yes)		Other Expanded Criteria (Element G = No)	
	Total Number of MTM-Eligible Beneficiaries	Eligibility Rate	Number of Contracts	Total Number of MTM-Eligible Beneficiaries	Eligibility Rate	Total Number of MTM-Eligible Beneficiaries	Eligibility Rate
All	**4,362,122**	**12.3%**	**568**	**3,648,473**	**10.4%**	**713,649**	**2.0%**
Employer	15,987	11.7%	7	15,987	11.7%	0	0.0%
MA-PD	2,097,127	16.4%	493	1,500,729	11.9%	596,398	4.7%
PDP	2,249,008	10.1%	68	2,131,757	9.5%	117,251	0.5%

The total percentage of beneficiaries who met the specified targeting criteria and were in an LTC facility was 5.0% in CY 2012 (Table 7.3). PDP plans had the largest percentage, with 7.1% of the 1.8 million MTM-eligible beneficiaries in an LTC facility.

[40] Eligibility rates greater than 100% are capped at 100%.
[41] In 2012, number of eligible MTM beneficiaries only includes beneficiaries that met the specified criteria per CMS-Part D requirements; in 2013, this category includes beneficiaries that met the specified criteria per CMS-Part D requirements or other expanded plan-specific targeting criteria.
[42] Met the specified targeting criteria per CMS-Part D requirements.
[43] Eligibility rates utilize year average HPMS enrollment. Rates greater than 100% are capped at 100%.

Table 7.3: Percentage of Eligible MTM Beneficiaries in an LTC Facility, 2012[44]

Organization Type	2012 Total Number of MTM-Eligible Beneficiaries	2012 Percent LTC	2012 Number of Contracts
All	**3,166,780**	**5.0%**	**546**
Employer	27,435	0.7%	8
MA-PD	1,301,302	2.2%	473
PDP	1,838,043	7.1%	65

Compared to 5.0% in CY 2012, 8.6% of the beneficiaries that met specified targeting criteria per CMS Part D requirements were in an LTC facility in CY 2013 (Table 7.4). Employer plans had the largest increase in percentage of eligible MTM beneficiaries in an LTC facility, with 0.7% in CY 2012 and 6.3% in CY 2013. Of the eligible beneficiaries that met other expanded criteria in CY 2013, MA-PD plans had 12.3% in an LTC facility, compared to PDP plans with only 3.1%.

Table 7.4: Percentage of Eligible MTM Beneficiaries in an LTC Facility, 2013

Organization Type	2013						
	All			Met the Specified Targeting Criteria per CMS-Part D Requirements (Element G = Yes)		Other Expanded Criteria (Element G = No)	
	Total Number of MTM-Eligible Beneficiaries	Percent LTC	Number of Contracts	Total Number of MTM-Eligible Beneficiaries	Percent LTC	Total Number of MTM-Eligible Beneficiaries	Percent LTC
All	**4,230, 415**	**9.0%**	**549**	**3,544,340**	**8.6%**	**686,075**	**11.1%**
Employer	15,987	6.3%	7	15,987	6.3%	0	-
MA-PD	2,070,999	7.7%	475	1,478,798	5.8%	592,201	12.3%
PDP	2,143,429	10.3%	67	2,049,555	10.6%	93,874	3.1%

In CY 2013, 0.25% of eligible MTM beneficiaries were cognitively impaired (Table 7.5). Of the eligible MTM beneficiaries that met specified targeting criteria, 0.29% were cognitively impaired. Conversely, of the eligible MTM beneficiaries that met other expanded criteria, only 0.03% were cognitively impaired. PDP plans had the largest percent of cognitively impaired MTM-eligible beneficiaries that did not meet the specified targeting criteria, with 0.14% in CY 2013.

[44] In 2012, number of eligible MTM beneficiaries only includes beneficiaries that met the specified criteria per CMS-Part D requirements; in 2013, this category includes beneficiaries that met the specified criteria per CMS-Part D requirements or other expanded plan-specific targeting criteria.

Table 7.5: Percentage of Eligible MTM Beneficiaries that are Cognitively Impaired, 2013[45]

Organization Type	All 2013, Total Number of MTM-Eligible Beneficiaries	All 2013, Percent Cognitively Impaired	All 2013, Number of Contracts	Met Specified Targeting Criteria 2013, Total Number of MTM-Eligible Beneficiaries	Met Specified Targeting Criteria 2013, Percent Cognitively Impaired	Met Other Expanded Criteria 2013, Total Number of MTM-Eligible Beneficiaries	Met Other Expanded Criteria 2013, Percent Cognitively Impaired
All	**4,362,122**	**0.25%**	**568**	**3,648,473**	**0.29%**	**713,649**	**0.03%**
Employer	15,987	0.07%	7	15,987	0.07%	0	-
MA-PD	2,097,127	0.24%	493	1,500,729	0.33%	596,398	0.01%
PDP	2,249,008	0.26%	68	2,131,757	0.27%	117,251	0.14%

The overall rate of eligible MTM beneficiaries that received a Comprehensive Medication Review (CMR) was 10.5% in CY 2012 (Table 7.6). PDP plans had the lowest CMR rate in CY 2012 with 6.3%, while Employer plans and MA-PD plans had 14.3% and 16.1%, respectively.

Table 7.6: Percentage of Eligible MTM Beneficiaries that Received a CMR, 2012[46] [47]

Organization Type	2012 Number of Eligible MTM Beneficiaries	2012 CMR Rate	2012 Number of Contracts
All	**2,822,038**	**10.5%**	**528**
Employer	25,930	14.3%	8
MA-PD	1,172,911	16.1%	458
PDP	1,623,197	6.3%	62

Compared to 10.5% in CY 2012, 15.5% of the beneficiaries that met specified targeting criteria per CMS Part D requirements received a CMR in CY 2013 (

[45] 2013 Element G = Y indicates beneficiaries that met the specified targeting criteria per CMS-Part D requirements. 2013 Element G = N indicates beneficiaries that met other expanded criteria.

[46] 2012 CMR requirements exclude beneficiaries designated as LTC according to sponsor-submitted MTM data (2012 Element G = 'Y'). 2013 CMR requirements exclude beneficiaries that were in hospice at any point during the reporting year according to the Enrollment Database. Both 2012 and 2013 exclude beneficiaries that were not 18 years or older as of the start of the reporting period (according to the contract-reported DOB) or that were not enrolled in MTM for at least 60 days in the reporting period.

[47] In 2012, number of eligible MTM beneficiaries only includes beneficiaries that met the specified criteria per CMS-Part D requirements; in 2013, this category includes beneficiaries that met the specified criteria per CMS-Part D requirements or other expanded plan-specific targeting criteria.

Table 7.7). MA-PD plans had the largest increase in CMR rate for eligible beneficiaries between years, with 16.1% in CY 2012 and 22.7% in CY 2013. Of the beneficiaries who met other expanded criteria in CY 2013, only 1.6% received a CMR.

Table 7.7: Percentage of Eligible MTM Beneficiaries that Received a CMR, 2013[48] [49]

Organization Type	All 2013, Number of Eligible MTM Beneficiaries	All 2013, CMR Rate	All 2013, Number of Contracts	Met Specified Targeting Criteria 2013, Number of Eligible MTM Beneficiaries	Met Specified Targeting Criteria 2013, CMR Rate	Met Other Expanded Criteria 2013, Number of Eligible MTM Beneficiaries	Met Other Expanded Criteria 2013, CMR Rate
All	**3,822,286**	**13.1%**	**556**	**3,149,926**	**15.5%**	**672,360**	**1.6%**
Employer	13,821	15.1%	7	13,821	15.1%	0	-
MA-PD	1,887,873	16.3%	484	1,319,766	22.7%	568,107	1.5%
PDP	1,920,592	9.8%	65	1,816,339	10.3%	104,253	2.1%

As the most common method in CY 2013, 85.2% of CMRs were conducted by telephone, followed by 14.7% conducted face-to-face (Table 7.8). In CY 2013, MA-PD organizations were more likely to conduct a face-to-face CMR than Employer or PDP organizations. Telehealth consultation and other methods were marginal in comparison, each comprising 0.1% of all CMRs conducted.

Table 7.8: Percentage of CMRs by Method, 2013

Method	All Organizations	Employer Organizations	MA-PD Organizations	PDP Organizations
Face-to-Face	14.7%	2.1%	17.7%	9.9%
Telephone	85.2%	97.9%	82.1%	90.1%
Telehealth Consultation	0.1%	0.0%	0.1%	0.0%
Other	0.1%	0.0%	0.1%	0.0%

Overall, in CY 2013, the largest percentage of CMRs were performed by an MTM vendor in-house pharmacist (23.9%), followed by plan sponsor pharmacist (22.7%), then PBM pharmacist (19.1%), and finally MTM vendor local pharmacist (14.4%) (

[48] 2012 CMR requirements exclude beneficiaries designated as LTC according to sponsor-submitted MTM data (2012 Element G = 'Y'). 2013 CMR requirements exclude beneficiaries that were in hospice at any point during the reporting year according to the Enrollment Database. Both 2012 and 2013 exclude beneficiaries that were not 18 years or older as of the start of the reporting period (according to the contract-reported DOB) or that were not enrolled in MTM for at least 60 days in the reporting period.
[49] 2013 Element G = Y indicates beneficiaries that met the specified targeting criteria per CMS-Part D requirements. 2013 Element G = N indicates beneficiaries that met other expanded criteria.

Table 7.9). While other providers comprised 41.7% of CMRs performed for Employer plans, this category of provider was marginal for MA-PD and PDP plans, comprising just 0.1% of each organization type.

Table 7.9: Percentage of CMRs by Qualified Provider that Performed the CMR, 2013

Provider	All Organizations	Employer Organizations	MA-PD Organizations	PDP Organizations
Physician	2.0%	0.0%	3.2%	0.0%
Registered Nurse	1.2%	0.0%	1.5%	0.7%
Licensed Practical Nurse	0.6%	0.0%	0.5%	0.8%
Nurse Practitioner	0.0%	0.0%	0.0%	0.0%
Physician's Assistant	0.0%	0.0%	0.0%	0.0%
Local Pharmacist	7.2%	4.5%	1.9%	16.0%
LTC Consultant Pharmacist	0.3%	0.0%	0.0%	0.7%
Plan Sponsor Pharmacist	22.7%	0.0%	34.7%	3.2%
PBM Pharmacist	19.1%	45.6%	13.5%	27.9%
MTM Vendor Local Pharmacist	14.4%	0.0%	20.5%	4.7%
MTM Vendor In-House Pharmacist	23.9%	5.6%	19.1%	31.8%
Hospital Pharmacist	0.0%	0.0%	0.0%	0.0%
Pharmacist - Other	8.5%	2.6%	4.9%	14.3%
Other	0.3%	41.7%*	0.1%	0.1%

*Such as student pharmacists under the direct supervision of a pharmacist.

.In CY 2013, the overall most common recipient of a CMR was the beneficiary with 90.4%, followed by the caregiver with 6.1%, then other authorized individual with 3.5%, then the beneficiary's prescriber with just 0.1% (Table 7.). Of LTC beneficiaries receiving a CMR, the most common recipient was a beneficiary with 52.9%. Of cognitively impaired beneficiaries receiving a CMR, the most common recipient was a caregiver with 57.9%.

Table 7.10: Percentage of CMRs by Recipient, 2013

Recipient	All Beneficiaries	Cognitively Impaired Beneficiaries	LTC Beneficiaries
Beneficiary	90.4%	11.5%	52.9%
Beneficiary's Prescriber	0.1%	3.3%	1.5%
Caregiver	6.1%	57.9%	34.5%
Other Authorized Individual	3.5%	27.2%	11.1%

8 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 and 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 81.4 million in CY 2012 to 80.5 million in CY 2013 (Table 8.1). The total number of non-formulary prescriptions dispensed at LTC pharmacies increased between years from 810,500 in CY 2012 to 1 million in CY 2013. The average cost per formulary prescription stayed the same between years at $72. While the average cost per non-formulary prescription decreased from $240 in CY 2012 to $217 in CY 2013, the total cost of non-formulary prescriptions increased by more than 23 million between years.

Table 8.1: Costs and Utilization for LTC Pharmacies, 2012-2013

Metric	2012 Measure Value	2012 Number of Contracts	2013 Measure Value	2013 Number of Contracts
Total Number of 31-Day Equivalent Formulary Prescriptions Dispensed	81,435,093	477	80,523,322	489
Total Cost of Formulary Prescriptions	$5,910,230,114	477	$5,821,275,928	489
Average Cost per Formulary Prescription	$72.58	477	$72.29	489
Number of 31-Day Equivalent Non-Formulary Prescriptions Dispensed	810,539	477	1,005,736	489
Total Cost of Non-Formulary Prescriptions	$195,179,741	477	$218,358,708	489
Average Cost per Non-Formulary Prescription	$240.80	477	$217.11	489

The total number of 30-day equivalent formulary prescriptions dispensed at retail pharmacies increased from 845 million in CY 2012 to nearly 1.1 billion in CY 2013; the total cost of formulary prescriptions increased by $14.8 billion between years (

Table 8.2). The total number of 30-day equivalent non-formulary prescriptions dispensed at retail pharmacies nearly doubled between years, from 7.7 million in CY 2012 to 13 million in CY 2013; the total cost of non-formulary prescriptions increased by $1 billion between years. The average cost per formulary prescription slightly increased from $57 in CY 2012 to $58 in CY 2013, while the average cost per non-formulary prescription decreased between years from $208 to $200, respectively.

Table 8.2: Costs and Utilization for Retail Pharmacies, 2012-2013

Metric	2012 Measure Value	2012 Number of Contracts	2013 Measure Value	2013 Number of Contracts
Total Number of 30-Day Equivalent Formulary Prescriptions Dispensed	844,519,823	483	1,078,762,960	495
Total Cost of Formulary Prescriptions	$48,073,575,186	482	$62,878,818,901	495
Average Cost per Formulary Prescription	$57.06	482	$58.29	495
Number of 30-Day Equivalent Non-Formulary Prescriptions Dispensed	7,696,030	483	13,222,598	494
Total Cost of Non-Formulary Prescriptions	$1,601,828,584	483	$2,645,909,840	493
Average Cost per Non-Formulary Prescription	$208.14	483	$200.15	492

9 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. Beginning in CY 2012, Medicare Advantage Organizations (MAOs) are required to report data to CMS on their processing of enrollment and disenrollment requests, enabling CMS to evaluate whether the procedures followed by the sponsor fall in accordance with CMS requirements. Only MAOs and 1876 cost plans that do not offer a Part D benefit are to report these data under the Part C requirements; all other organizations report via the Part D requirements.[50]

Enrollment requests can be completed via paper, telephone, internet,[51] or Medicare Online Enrollment Center (OEC). As shown in Table 9.1, most enrollment requests were received via paper with 30.4% in CY 2012 and 32.5% in CY 2013. In CY 2012, the second most common form of request was telephonic with 22.8% then closely followed by OEC with 18.2%. In CY 2013, telephonic and OEC were the second and third most common forms of request, both around 21%.

Table 9.1: Enrollment Requests by Request Mechanism, 2012-2013

Request Mechanism	Percent of Requests	
	2012	2013
Paper	30.4%	32.5%
Telephonic	22.8%	21.8%
Internet	7.9%	6.8%
OEC	18.2%	21.2%

The percentage of enrollment requests that were complete at the time of initial receipt in CY 2012 and CY 2013 were approximately 94% (Table 9.2). The percentage of disenrollment requests that were complete at the time of initial receipt increased from CY 2012 (55.2%) to CY 2013 (77.6%).

Table 9.2: Enrollment and Disenrollment Requests Complete, 2012-2013

Request	Percent Complete at Initial Receipt	
	2012	2013
Enrollment	93.9%	94.2%
Disenrollment	55.2%	77.6%

Less than two percent of enrollment requests were denied by the sponsor in both CY 2012 and CY 2013 (Table 9.3). The percentage of disenrollment requests denied by the sponsor increased from CY 2012 (8.6%) to CY 2013 (11.8%).

Table 9.3: Enrollment and Disenrollment Requests Denied by the Sponsor, 2012-2013

Request	Percent Denied by Sponsor	
	2012	2013
Enrollment	1.6%	1.8%
Disenrollment	8.6%	11.8%

[50] Enrollment and disenrollment measure values are weighted by HPMS contract year average enrollment
[51] Guidance on "internet" enrollment revised to "electronic" enrollment for CY 2014.

10 SUMMARY OF RESULTS

The results of this analysis reveal that there have been improvements in several reporting areas from CY 2012 to CY 2013.

Grievances

The overall share of plans with at least 100 enrollees that reported zero Part D grievances increased from CY 2012 to CY 2013. The overall Part D grievance rate per 1,000 enrollees, the number of plans reporting at least one Part D grievance, and the total number of Part D grievances filed increased from CY 2012 to CY 2013. Enrollment, Plan Benefits, or Pharmacy Access comprised the largest share of Part D grievances filed in both CY 2012 and CY 2013. The percentage of Part D grievances the plan responded to on-time slightly decreased between years, however, the percentage of Part D grievances responded to on time remained very high in both years.

Coverage Determinations and Exceptions

The number of plans with at least 100 enrollees reporting zero determinations and exception requests increased from CY 2012 to CY 2013, however, this number is marginal compared to the total number of plans. All plans with at least 100 enrollees that reported zero determinations and exceptions both years had less than 1,000 total enrollees. The prior authorization request rate per 1,000 enrollees slightly decreased from CY 2012 to CY 2013, while the total exception request rate – comprised of formulary exceptions, tier exceptions, and UM exceptions – increased between years. The overall percentage of favorable exception decisions increased from CY 2012 to CY 2013, with the largest increase in favorable exception decisions between years for formulary exceptions. The overall most common reason that pharmacy transactions were rejected in CY 2013 was for non-formulary status. In CY 2013, non-compounds had the largest percentage of plan-quarter combinations with high cost edits in place across all organization types.

Redeterminations

The percentage of redeterminations with fully favorable outcomes was lower in CY 2013 than in CY 2012. In both years, most plans had a redetermination rate per 1,000 enrollees greater than zero and less than 10. The overall share of plans reporting zero redeterminations decreased from CY 2012 to CY 2013. In both years, plans with less than 1,000 enrollees had the largest share of plans with at least 100 enrollees that reported zero redeterminations.

Prompt Payment by Part D Sponsors

The overall percentage of paid claims that were electronic remained relatively high and slightly increased from CY 2012 to CY 2013. The percentage of total claims paid late remained relatively low and stable from CY 2012 to CY 2013.

MTM Programs

In 2012, the number of eligible MTM beneficiaries only includes beneficiaries that met the specified criteria per CMS-Part D requirements, while in 2013, this category also includes beneficiaries that met other expanded targeting criteria. With consideration for the differing criteria between years, the overall eligibility rate of beneficiaries who met specified targeting criteria slightly decreased from CY 2012 to CY 2013. Conversely, the number of MTM-eligible beneficiaries in an LTC facility increased between years. In CY 2013, MA-PD and PDP plans had the largest share of MTM-eligible beneficiaries that are cognitively impaired, however, the percentage was overall relatively low with only about 0.25% cognitively impaired. The overall rate of MTM-eligible beneficiaries that received a CMR increased between years. In CY 2013, overall, the most common method to receive a CMR was via telephone, the largest percentage of CMRs were performed by an MTM vendor in-house pharmacist, and the most common recipient of a CMR was the beneficiary.

LTC Utilization

The total number of 31-day equivalent formulary prescriptions dispensed at LTC pharmacies decreased from CY 2012 to CY 2013, while the total number of non-formulary equivalent formulary prescriptions dispensed at LTC pharmacies increased between years. Both the 30-day equivalent formulary and non-formulary prescriptions dispensed at retail pharmacies increased from CY 2012 to CY 2013.

Enrollment and Disenrollment

In CY 2012 and CY 2013, most enrollment requests were received via paper, followed by telephone and OEC. Nearly all enrollment requests were complete at the time of initial receipt and less than two percent of enrollment requests were denied by the sponsor in both years. While the percentage of disenrollment requests that were complete at the time of initial receipt increased between years, the percentage of disenrollment requests denied by the sponsor also increased.