



Analysis of Calendar Year 2015 Medicare Part D Reporting Requirements Data

April 2017

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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), Medicare Advantage Prescription Drug Plan (MA-PD), and Medicare-Medicaid Plan (MMP) 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 2016.

Table 1.1: Summary of Part D Reporting Requirements by Calendar Year, 2010-2016

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016
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	✓	✓	✓	–	–	–	–

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

1 Introduction

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Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016
Grievances	✓	✓	✓	✓	✓	✓	✓
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 for four of the seven reporting sections submitted by Part D sponsors in accordance with the Part D Reporting Requirements for CY 2015. For each of these reporting sections, this report presents program-wide averages and, when available, identifies trends between CY 2013, CY 2014, and CY 2015 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 contracts that reported zero Part D grievances	The number of contracts reporting zero Part D grievances divided by the total number of contracts.
	Rate of Part D grievances per 1,000 enrollees per month	The rate of Part D grievances filed per 1,000 enrollees per month, weighted by Contract/Plan Year Average Enrollment.
	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 Contract/Plan Year Average Enrollment.
	Percentage of Part D grievances the contract responded to on time	The number of Part D grievances the contract responded to on time divided by the total number of Part D grievances filed, weighted by Contract Year Average Enrollment.

² The Appeals reporting section was renamed 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 section was suspended in CY 2013; a revised data collection was introduced in CY 2014.

2 Introduction

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Reporting Section	Metric	Description
Coverage Determinations and Redeterminations	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 Contract/Plan Year Average Enrollment.
	Percentage of contract-quarter combinations with high cost edits in place	The number of contract-quarter combinations with edits in place (i.e., for non-compounds, compounds, or both) divided by the total contract-quarter combinations.
	Share of contracts that reported zero coverage determination requests	The number of contracts with at least 100 enrollees reporting zero coverage determinations and exception decision requests divided by the total number of contracts with at least 100 enrollees.
	Decision rate per 1,000 enrollees	The number of decisions by request type per 1,000 enrollees, weighted by Contract/Plan Year Average Enrollment.
	Percentage of coverage determination decisions by outcome	The number of coverage determination decisions by outcome (i.e., fully approved, partially approved, or adverse) divided by the total number of coverage determination decisions, weighted by Contract Year Average Enrollment.
	Share of contracts that reported zero redetermination requests	The number of contracts with at least 100 enrollees reporting zero redeterminations divided by the total number of contracts with at least 100 enrollees.
	Redetermination rate per 1,000 enrollees	The number of redeterminations filed with the contract/plan per 1,000 enrollees, weighted by Contract/Plan Year Average Enrollment.
Medication Therapy Management (MTM) Programs	Percentage of eligible MTM beneficiaries	The number of eligible MTM beneficiaries (total, met specified targeting criteria, or met other expanded criteria) 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.
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, weighted by Contract Year Average Enrollment.
	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, weighted by Contract Year Average Enrollment.
	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, weighted by Contract Year Average Enrollment.

3 Introduction

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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 is updated annually as part of CMS's Display Measures, and the percentage of eligible MTM enrollees receiving a CMR are incorporated into the Star Ratings.⁶ 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.⁷

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 6 present the main findings for each of the four Part D reporting sections included in this report. Section 7 summarizes key results from the analysis. Additionally, Appendix A presents supplemental information on exceptions and redeterminations data for CY 2013 through CY 2015.

⁶ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

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

4 Introduction

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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).⁸ 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 CMS' contractor's (Acumen) 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.⁹ 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

⁸ MTM Programs data and New Enrollments data are uploaded using Gentran or Direct Connect.

⁹ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.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.¹⁰ Scores at the reporting section level are assigned based on the share of applicable standards with which the contract complied.

As Table 2.1 shows, with the exception of Enrollment and Disenrollment data, all CY 2013 through CY 2015 data included in this report underwent data validation in the data validation cycle of the respective year. Data on Enrollment and Disenrollment is collected for monitoring purposes only and did not undergo validation for any of the three years.

Table 2.1: Reporting Sections Undergoing Data Validation (DV)

Reporting Section	CY 2013 Data	CY 2014 Data	CY 2015 Data
Grievances	2014 DV	2015 DV	2016 DV
Coverage Determinations and Redeterminations ¹¹	2014 DV	2015 DV	2016 DV
MTM Programs	2014 DV	2015 DV	2016 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 2013, CY 2014, and CY 2015 reporting sections that underwent validation in the 2014 through 2016 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 for validated sections by reporting section and calendar year of data. The percent of contracts meeting the minimum data validation passing score increased for all sections from CY 2013 to CY 2014. From CY 2014 to CY 2015, the percent of contracts meeting the minimum data validation passing score increased for the Grievances and MTM Programs sections, while it decreased slightly for Coverage Determinations and Redeterminations. The reporting section with the lowest percentage of contracts achieving a passing data validation score in all three years was Grievances, with 89.7% in CY 2013, 97.2% in CY 2014, and 98.2% in CY 2015. For CY 2015 data, the MTM Programs section had the highest percentage of contracts meeting the minimum data validation passing score (99.6%), followed by Coverage Determinations and Redeterminations (98.8%).

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

¹¹ The sections (i) Coverage Determinations and Exceptions and (ii) Redeterminations were combined in CY 2014. These two sections were both collected in CY 2013 and were included in the 2014 DV.

¹² For the MTM section, this also causes the number of MTM-Eligible Beneficiaries to vary between metrics.

6 Data Overview

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Table 2.2: Summary of Data Validation Results by Reporting Section for Contracts¹³

Reporting Section	Year	Reporting Level ¹⁴	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# DV Score ≥ 95%	% DV Score ≥ 95%	# DV Score = 100%	% DV Score = 100%
Grievances	2013	PBP	594	590	529	89.7%	435	73.7%
Grievances	2014	Contract	569	569	553	97.2%	427	75.0%
Grievances	2015	Contract	569	569	559	98.2%	418	73.5%
Coverage Determinations and Exceptions	2013	PBP	594	590	570	96.6%	529	89.7%
Redeterminations	2013	PBP	594	590	556	94.2%	552	93.6%
Coverage Determinations and Redeterminations	2014	Contract	570	570	565	99.1%	432	75.8%
Coverage Determinations and Redeterminations	2015	Contract	570	570	563	98.8%	454	79.6%
MTM Programs	2013	Contract	591	578	573	99.1%	530	91.7%
MTM Programs	2014	Contract	568	552	549	99.5%	535	96.9%
MTM Programs	2015	Contract	554	554	552	99.6%	506	91.3%

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 contracts 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 publicly available.¹⁵ Table 2.3 lists the reporting section data utilized for public use files.

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).

¹⁴ Reporting section data that was collected at the PBP-level was rolled up to the contract-level for this table.

¹⁵ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

Table 2.3 Reporting Sections Utilized for Public Use Files

Reporting Section	Utilized for Public Use Files?
Grievances	✓
Coverage Determinations and Redeterminations	✓
MTM Programs	✓
Enrollment and Disenrollment	✓

To be included in this analysis, requirements are applied to each reporting section's data. All four sections are represented in the public use files; the same restrictions used to determine inclusion in the public use files are also applied to those sections in this analysis. Due to the limited number of Medicare-Medicaid Plans (MMPs) that were active for the full 2013 and 2014 reporting years, only 2015 data submitted to CMS by MMPs were included in this report.¹⁶

¹⁶ MMPs were not required to report Enrollment and Disenrollment data for CY 2013-2015.

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. As defined by regulation at 42 CFR §423.560, 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 in a timely manner. Part D plan sponsors must notify the enrollee of the grievances decision as quickly as the enrollee's health condition requires, but no later than 30 days after the date the grievance is filed.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 CY 2014 and CY 2015, with 7.7% and 7.5% of contracts reporting zero grievances, respectively (Table 3.1). In CY 2013, Employer plans had the highest share of plans reporting zero Part D grievances (22.3%), and in CY 2014 MA-PD contracts had the highest share of contracts reporting zero Part D grievances with 8.3%. In CY 2015, MMP contracts had the highest share of contract reporting zero Part D grievances, with 21.2%, which was much higher than the rates among Employer (0.0%), MA-PD (7.0%), and PDP (2.1%) contracts.

Table 3.1: Contracts/Plans Reporting Zero Part D Grievances by Contract/Plan Type, 2013-2015¹⁸

Plan / Contract Type	2013 Total Number of Plans	2013 Share of Plans that Reported Zero	2014 Total Number of Contracts	2014 Share of Contracts that Reported Zero	2015 Total Number of Contracts	2015 Share of Contracts that Reported Zero
All	2,309	15.8%	439	7.7%	413	7.5%
Employer	247	22.3%	4	0.0%	4	0.0%
MA-PD	1,484	18.3%	386	8.3%	329	7.0%
MMP	—	—	—	—	33	21.2%
PDP	578	6.6%	49	4.1%	47	2.1%

In all three years, plans/contracts with less than 500 enrollees had the highest percentage of plans reporting zero Part D grievances, followed by plans/contracts with at least 500 but less than 1,000 enrollees (Table 3.2). In CY 2013, 53.2% of plans with less than 500 enrollees reported zero Part D grievances, compared to 30.2% of plans with at least 500 and less than 1,000 enrollees. By CY 2015, the

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 contracts with a year average HPMS enrollment of at least 100. Grievances due to CMS issues are excluded when determining a contract's reported grievance count.

9 Grievances

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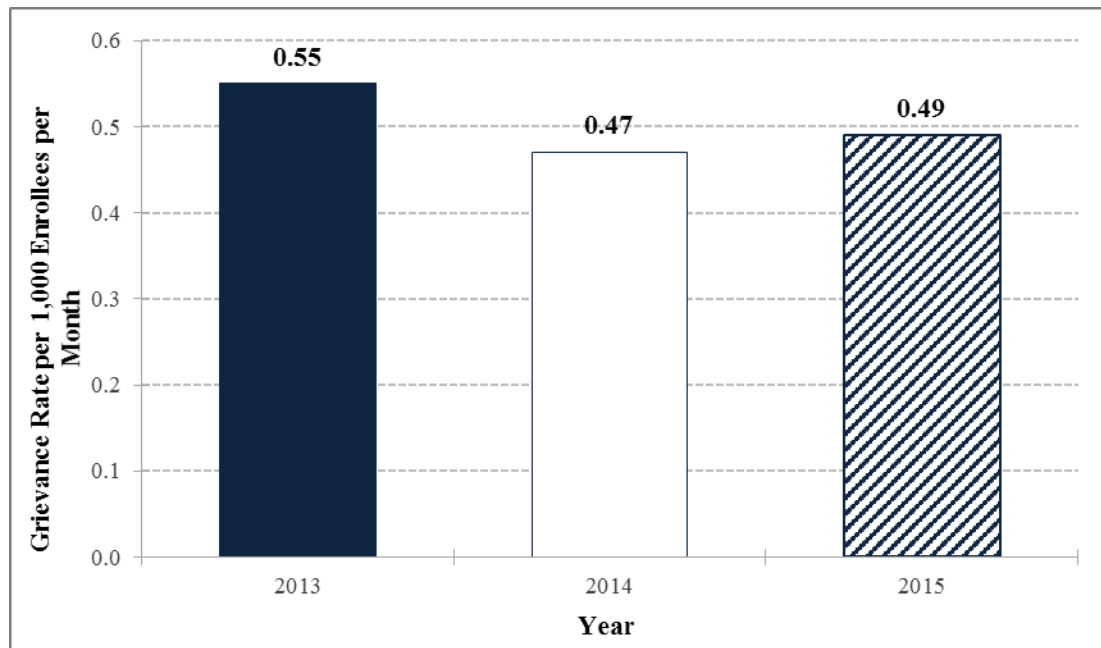
share of contracts reporting zero had decreased for both enrollment categories, to 47.2% and 20.8%, respectively. The percentage of plans/contracts with more than 10,000 enrollees reporting zero Part D grievances were marginal in comparison, comprising less than 1% in each year.

Table 3.2: Contracts/Plans Reporting Zero Part D Grievances by Enrollment, 2013-2015¹⁹

Plan / Contract Enrollment	2013 Total Number of Plans	2013 Share of Plans that Reported Zero	2014 Total Number of Contracts	2014 Share of Contracts that Reported Zero	2015 Total Number of Contracts	2015 Share of Contracts that Reported Zero
All	2,309	15.8%	439	7.7%	413	7.5%
100 - 499	378	53.2%	41	41.5%	36	47.2%
500-999	265	30.2%	21	14.3%	24	20.8%
1,000 - 9,999	1,186	7.0%	158	8.9%	160	5.0%
10,000 - 99,999	439	0.2%	192	0.0%	168	0.6%
100,000+	41	0.0%	27	0.0%	25	0.0%

The overall rate of Part D grievances decreased from 0.55 per 1,000 enrollees per month at the plan level in CY 2013 to 0.47 per 1,000 enrollees per month at the contract level in CY 2014 (Figure 3.1). In CY 2015, the overall rate of Part D grievances per 1,000 enrollees per month increased slightly to 0.49.

Figure 3.1: Grievance Rates per 1,000 Enrollees per Month, 2013-2015²⁰



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

²⁰ Measure values are weighted by Contract/Plan Year Average Enrollment. Grievances due to CMS issues are excluded when determining a contract/plan's reported grievance count.

The total number of Part D grievances filed decreased from CY 2013 (170,599) to CY 2014 (105,244), and then increased in CY 2015 (122,797) (Table 3.3). In CY 2014 and CY 2015, plan benefit, customer service, and “other” grievances comprised the largest share of Part D grievances filed in each year.

Table 3.3: Part D Grievances by Category, 2013-2015²¹

Category	Year	Total Number of Plans / Contracts	Number of Plans/Contracts Reporting At Least One Grievance	Total Number of Grievances	Share of Grievances
Total	2013	2,484	1,983	170,599	100%
Enrollment, Contract Benefits, or Pharmacy Access (2013 only)	2013	2,484	1,728	87,979	48.3%
Customer Service	2013	2,484	1,387	46,298	28.8%
Coverage Determinations & Redeterminations Process	2013	2,484	680	3,630	2.6%
Other	2013	2,484	1,442	32,692	20.3%
Total	2014	450	408	105,244	100%
Enrollment / Disenrollment	2014	450	182	5,355	4.4%
Plan Benefit	2014	450	367	30,104	30.2%
Pharmacy Access	2014	450	247	7,179	10.1%
Marketing	2014	450	186	2,134	2.7%
Customer Service	2014	450	335	29,718	25.2%
Coverage Determinations & Redeterminations Process	2014	450	226	4,583	5.3%
Quality of Care	2014	450	201	4,685	3.8%
Other	2014	450	311	21,486	18.4%
Total	2015	434	393	122,797	100.0%
Enrollment / Disenrollment	2015	434	154	6,253	6.9%
Plan Benefit	2015	434	351	35,579	27.1%
Pharmacy Access	2015	434	230	8,532	10.9%
Marketing	2015	434	167	2,087	2.2%
Customer Service	2015	434	307	38,503	25.4%
Coverage Determinations & Redeterminations Process	2015	434	225	6,958	5.3%
Quality of Care	2015	434	174	5,632	3.9%
Other	2015	434	283	19,253	18.4%

²¹ Measure values are weighted by Contract/Plan Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

11 Grievances

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The total percentage of Part D grievances responded to within the required 30 day or 24-hour timeframe slightly decreased from CY 2013 to CY 2015, however, it remained over 98% in all three years (Table 3.4). Similarly, the percentage of Part D grievances responded to in a timely manner was high across all categories in all three years. In CY 2013, there was little variation in percentage of timely decisions among the grievance categories. In CY 2014 and CY 2015, expedited grievances had the lowest percentage of timely decisions with 88.8% and 89.3%, respectively. In CY 2014, enrollment/disenrollment and coverage determination & redetermination process grievances had the highest percentage of timely decisions with 99.5% and 99.0%, respectively, while in CY 2015, pharmacy access, marketing, and coverage determination & redetermination process grievances categories had the highest percentages, with 99.4%, 99.1%, and 99.0%, respectively.

Table 3.4: Percentage of Part D Grievances the Contract/Plan Responded to On Time by Grievance Type, 2013-2015²²

Grievance Type	2013	2014	2015
Total	98.9%	98.5%	98.3%
Enrollment, Plan Benefits, or Pharmacy Access	98.9%	—	—
Enrollment / disenrollment	—	99.5%	98.9%
Plan Benefit	—	98.7%	98.6%
Pharmacy Access	—	98.5%	99.4%
Marketing	—	98.5%	99.1%
Customer Service	98.7%	98.8%	98.4%
Coverage Determinations & Redeterminations Process	98.7%	99.0%	99.0%
Quality of Care	—	98.7%	97.4%
Other	99.0%	98.4%	98.8%
Expedited	—	88.8%	89.3%

²² Measure values are weighted by Contract/Plan Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

12 Grievances

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4 COVERAGE DETERMINATIONS AND REDETERMINATIONS

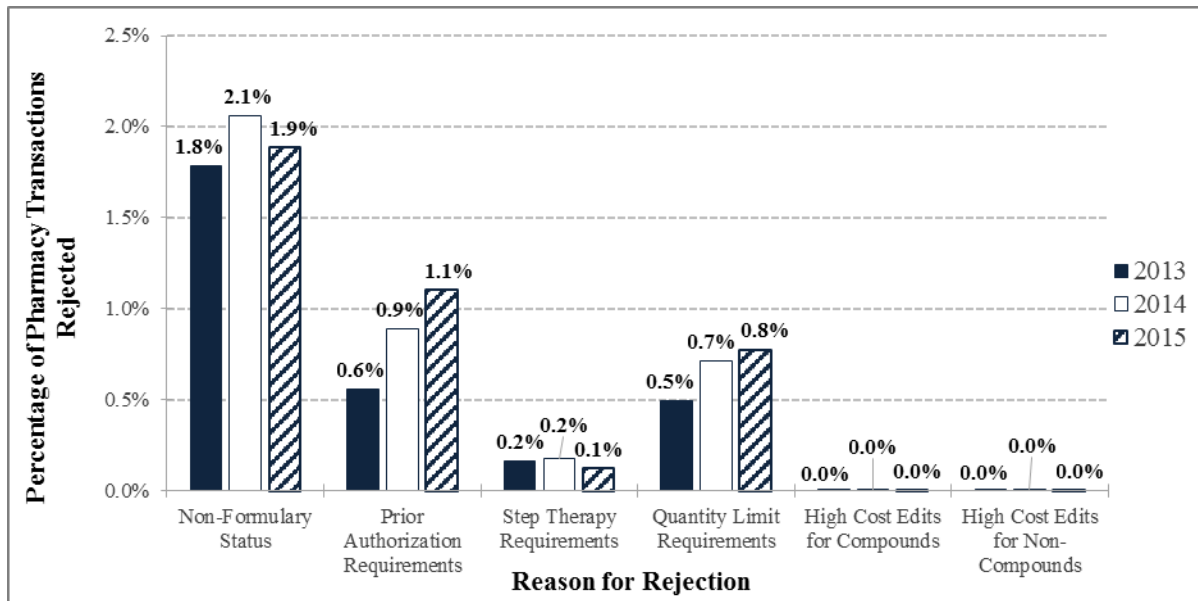
In CY 2014, the Part D Reporting Requirements for Coverage Determinations and Exceptions were combined with Redeterminations. This combined section also includes several elements related to point of sale claims transaction, which are not treated as coverage determinations in Part D. The Part D regulations related to point of sale claims processing are set forth at 42 C.F.R. Part 423, Subparts C and D. Part D plan sponsors report data on pharmacy claims that are rejected at the point of sale for the following six reasons: non-formulary status, prior authorization requirements, step therapy requirements, quantity limit requirements, high cost edits for compounds and high cost edits for non-formulary compounds.

The requirements related to coverage determinations, including formulary and tiering exceptions can be found in 42 CFR Part 423, Subpart M. A coverage determination is any decision made by or on behalf of a Part D plan sponsor, or its delegated entity, regarding payment or benefits to which an enrollee believes he or she is entitled. Exceptions are a type of coverage determination. As described 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. Plan data on rejected claims and coverage determinations, including exceptions, provides valuable information on whether beneficiaries can successfully request and obtain coverage for medically necessary Part D drugs, including obtaining exceptions to plan coverage policies when medically necessary, and whether those decisions are made in a timely manner. As such, CMS requires that sponsors report the number of coverage determination decisions made during the reporting period and the number of decisions by outcome.

The Part D regulations at 42 C.F.R. Part 423, Subpart M also 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 request a redetermination. The plan sponsor must issue a decision 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 fully favorable, partially favorable or adverse decision.

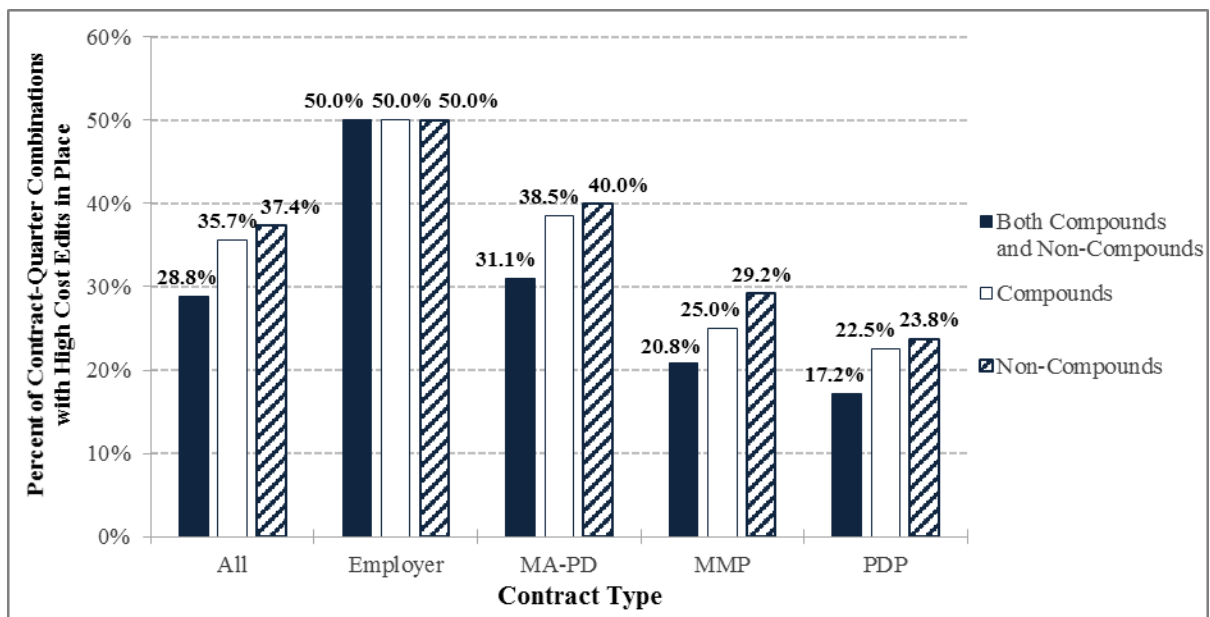
The most common reason for rejection of pharmacy transactions in CY 2013, CY 2014, and CY 2015 was non-formulary status, with 1.8%, 2.1%, and 1.9%, respectively (Figure 4.1).

Figure 4.1: Percentage of Pharmacy Transactions Rejected, 2013-2015²³



In CY 2015, 37.4% of all contract-quarter combinations had high cost edits in place for non-compounds, while 35.7% had high cost edits in place for compounds (Figure 4.2).

Figure 4.2: Percentage of Contract-Quarter Combinations with High Cost Edits in Place, 2015²⁴



²³ Measure values are weighted by Contract/Plan Year Average Enrollment.

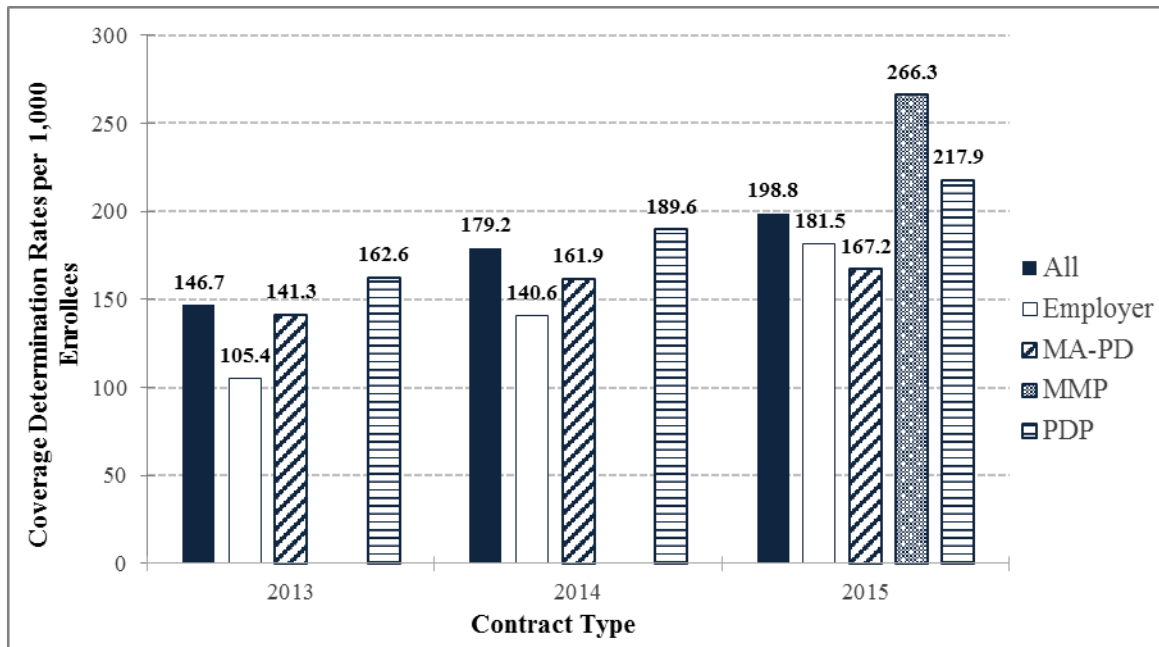
²⁴ Since a single contract can change its response across quarters, this figure presents the share of contract-quarter combinations with each response.

14 Coverage Determinations and Redeterminations

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The overall rate of coverage determinations per 1,000 enrollees increased from CY 2013 (146.7) to CY 2014 (179.2) to CY 2015 (198.8) (Figure 4.3). All contract types exhibited increases in their coverage determination rates in each year, with PDP contracts having the highest coverage determination rates in CY 2013 and CY 2014 and MMP contracts having the highest rates in CY 2015.

Figure 4.3: Coverage Determination Rates per 1,000 Enrollees, 2013-2015²⁵



In CY 2015, 63.7% of coverage determinations decisions were fully favorable, 0.4% were partially favorable, and 36.3% were adverse (Table 4.1), with Employer, MA-PD, and PDP contracts following a similar pattern. In comparison, MMP contracts had a higher percent of fully favorable outcomes (73.3%) and lower percent of adverse outcomes (26.7%).

Table 4.1: Percentage of Coverage Determinations by Outcome and Contract Type, 2015²⁶

Contract Type	Percent Fully Favorable	Percent Partially Favorable	Percent Adverse
All	63.7%	0.4%	36.3%
Employer	62.7%	0.3%	37.3%
MA-PD	63.3%	0.7%	36.7%
MMP	73.3%	0.3%	26.7%
PDP	63.8%	0.3%	36.2%

²⁵ Measure values are weighted by Contract/Plan Year Average Enrollment. The sum of prior authorization decisions and exception decisions is used to approximate the total number of determination decisions in 2012 and 2013.

²⁶ Measure values are weighted by Contract Year Average Enrollment.

15 Coverage Determinations and Redeterminations

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Of plans with at least 100 enrollees, 7.5% of plans reported zero redeterminations in CY 2013 (Table 4.2). Between CY 2014 and CY 2015, the percentage of MA-PD contracts with at least 100 enrollees reporting zero redeterminations declined, from 3.8% to 1.9%. During the same period, the percentage of PDP and Employer contracts with at least 100 enrollees reporting zero redeterminations remained constant, at 1.7% for PDPs and 0.0% for Employers. In CY 2015, MMP contracts had the highest share of contracts reporting zero redeterminations, with 2.6%, followed by MA-PDs and PDPs, with 1.9% and 1.7%, respectively.

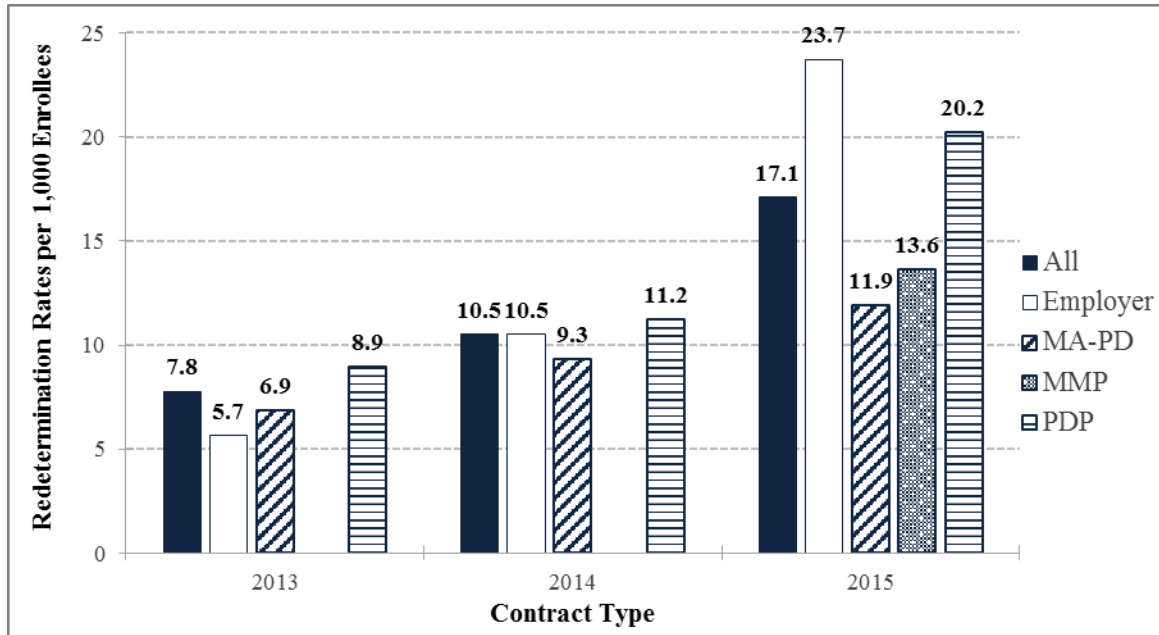
Table 4.2: Contracts/Plans Reporting Zero Redeterminations by Contract/Plan Type, 2013-2015²⁷

Contract / Plan Type	2013 Total Number of Plans	2013 Number of Plans Reporting Zero	2013 Share of Plans Reporting Zero	2014 Total Number of Contracts	2014 Number of Contracts Reporting Zero	2014 Share of Contracts Reporting Zero	2015 Total Number of Contracts	2015 Number of Contracts Reporting Zero	2015 Share of Contracts Reporting Zero
All	2,979	223	7.5%	534	19	3.6%	531	10	1.9%
Employer	304	47	15.5%	6	0	0.0%	4	0	0.0%
MA-PD	1,724	141	8.2%	469	18	3.8%	430	8	1.9%
MMP	—	—	—	—	—	—	38	1	2.6%
PDP	951	35	3.7%	59	1	1.7%	59	1	1.7%

²⁷ Restricted to contracts/plans with a year average HPMS enrollment of at least 100.

In CY 2013, the redetermination rate per 1,000 enrollees at the plan-level was 7.8 (Figure 4.4). Starting in CY 2014, this section was reported at the contract-level, and from CY 2014 to CY 2015, the rate increased, from 10.5 to 17.1. In CY 2013 and CY 2014, PDPs had the highest redetermination rates, but in CY 2015, Employers had the highest rate.

Figure 4.4: Redetermination Rates per 1,000 Enrollees by Year and Contract/Plan Type, 2013-2015²⁸



In CY 2015, 69.6% of redeterminations decisions were fully favorable, while 0.5% were partially favorable, and 30.4% were not fully favorable (Table 4.3). Compared to all other contract types, MMP contracts exhibited different rates of fully favorable, partially favorable, and not fully favorable redetermination decisions. MMPs had the lowest percentage of fully favorable outcomes (61.7%) and had the highest percent of partially favorable (2.8%) and not fully favorable (38.3%) outcomes.

Table 4.3: Percentage of Redeterminations by Outcome and Contract Type, 2015²⁹

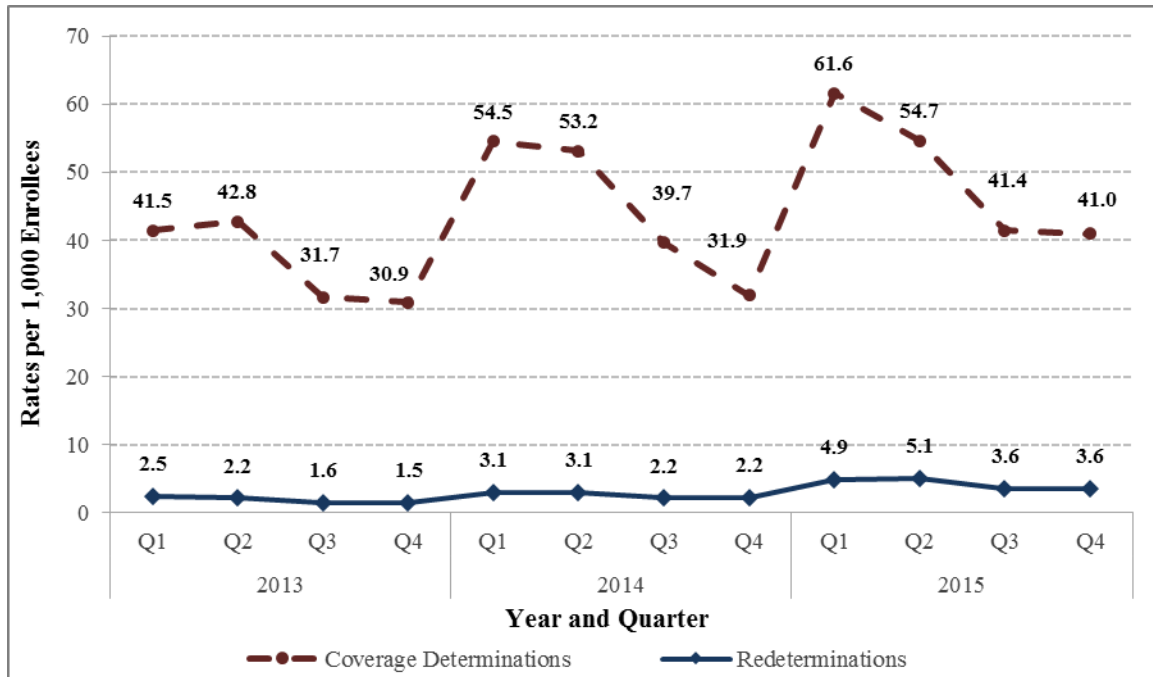
Contract Type	Percent Fully Favorable	Percent Partially Favorable	Percent Not Fully Favorable
All	69.6%	0.5%	30.4%
Employer	70.7%	0.4%	29.3%
MA-PD	66.8%	0.5%	33.2%
MMP	61.7%	2.8%	38.3%
PDP	71.4%	0.5%	28.6%

²⁸ Measure values are weighted by Contract/Plan Year Average Enrollment.

²⁹ Measure values are weighted by Contract Year Average Enrollment.

As expected, the rates of coverage determinations and redeterminations per 1,000 enrollees decrease during each year, from Quarter 1 to Quarter 4, and then increase again in the first quarter of the next contract year (Figure 4.5).

Figure 4.5: Coverage Determination and Redetermination Rates per 1,000 Enrollees by Quarter, 2013-2015³⁰



Among withdrawn coverage determinations and redeterminations, dismissed coverage determinations and redeterminations, and reopened coverage determinations and redeterminations, dismissed coverage determinations had the highest rate per 1,000 enrollees in CY 2015 (9.1), followed by withdrawn coverage determinations (3.0) (Table 4.4). MMP and PDP contracts had the highest decision rates per 1,000 enrollees for all but one decision type, with a significantly higher dismissed coverage determination rate (21.1 and 12.8 per 1,000 enrollees, respectively). MA-PD contracts had the next highest dismissed coverage determination rate (3.0 per 1,000 enrollees).

Table 4.4: Withdrawn, Dismissed, and Reopened Rates per 1,000 Enrollees by Contract Type, 2015³¹

Contract Type	Withdrawn Coverage Determinations	Dismissed Coverage Determinations	Reopened Coverage Determinations	Withdrawn Redeterminations	Dismissed Redeterminations	Reopened Redeterminations
All	3.0	9.1	0.2	0.6	0.4	0.1
Employer	0.7	0.7	0.3	0.3	0.0	0.0
MA-PD	2.6	3.0	0.2	0.4	0.1	0.1
MMP	13.1	21.1	0.3	0.8	0.4	0.1
PDP	3.2	12.8	0.2	0.8	0.6	0.1

³⁰ Measure values are weighted by Contract/Plan Year Average Enrollment.

³¹ Measure values are weighted by Contract Year Average Enrollment.

5 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 who meet specific criteria for the MTM program as specified by CMS in § 423.153(d). Some sponsors also offer enrollment in the MTM program to other members who do not meet the specific CMS targeting criteria based on other plan-specific targeting criteria within the reporting period.³² CMS collects information on beneficiaries enrolled in MTM programs that meet either of these criteria.

The total rate of beneficiaries eligible for an MTM program based on standard program criteria or other expanded plan-specific targeting criteria in CY 2013, CY 2014, and CY 2015 were 12.3%, 12.6%, and 12.9%, respectively (Table 5.1). MA-PD contracts had the highest eligibility rate in in CY 2013 and CY 2014, with 16.4% and 13.8%, respectively. In CY 2015, MMPs had the highest eligibility rate, with 24.6%.

Table 5.1: Percentage of Beneficiaries Eligible for an MTM Program, 2013-2015³³

Contract Type	2013 Total Number of MTM-Eligible Beneficiaries	2013 Eligibility Rate	2013 Number of Contracts	2014 Total Number of MTM-Eligible Beneficiaries	2014 Eligibility Rate	2014 Number of Contracts	2015 Total Number of MTM-Eligible Beneficiaries	2015 Eligibility Rate	2015 Number of Contracts
All	4,362,122	12.3%	568	4,593,431	12.6%	534	4,801,887	12.9%	541
Employer	15,987	11.7%	7	15,300	11.3%	6	9,743	9.0%	5
MA-PD	2,097,127	16.4%	493	1,856,966	13.8%	468	1,940,782	14.1%	430
MMP	—	—	—	—	—	—	83,046	24.6%	47
PDP	2,249,008	10.1%	68	2,721,165	12.0%	60	2,768,316	12.0%	59

³² In 2015, almost 24% of MTM programs use expanded eligibility requirements beyond CMS' minimum requirements. 2015 MTM Program Fact Sheet. Accessed at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2015-MTM-Fact-Sheet.pdf>

³³ Eligibility rates utilize year average HPMS enrollment. Rates greater than 100% are capped at 100%.

19 Medication Therapy Management Programs

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Over 290,000 additional beneficiaries were enrolled in MTM programs in CY 2015 based on expanded criteria above the minimum requirements set by CMS. In CY 2015, the percent of enrollees that were MTM-eligible and met the specified targeting criteria per CMS Part D requirements was 12.1%, and an additional 0.8% of all enrollees were MTM-eligible and met other expanded criteria (Table 5.2).

Table 5.2: Percentage of Beneficiaries Eligible for an MTM Program by Criteria, 2015³⁴

Contract Type	Year	Met Specified Targeting Criteria, Total Number of MTM-Eligible Beneficiaries	Met Specified Targeting Criteria, Eligibility Rate	Met Other Expanded Criteria, Total Number of MTM-Eligible Beneficiaries	Met Other Expanded Criteria, Eligibility Rate
All	2013	3,648,473	10.4%	713,649	2.0%
Employer	2013	15,987	11.7%	0	0.0%
MA-PD	2013	1,500,729	11.9%	596,398	4.7%
MMP	2013	–	–	–	–
PDP	2013	2,131,757	9.5%	117,251	0.5%
All	2014	4,328,976	11.9%	264,455	0.7%
Employer	2014	15,300	11.3%	0	0.0%
MA-PD	2014	1,619,873	12.0%	237,093	1.8%
MMP	2014	–	–	–	–
PDP	2014	2,693,803	11.9%	27,362	0.1%
All	2015	4,506,475	12.1%	295,412	0.8%
Employer	2015	9,725	9.01%	18	0.0%
MA-PD	2015	1,697,217	12.3%	243,565	1.8%
MMP	2015	62,424	19.9%	20,622	5.0%
PDP	2015	2,737,109	11.9%	31,207	0.1%

Among beneficiaries eligible for MTM under the specified targeting criteria, the share receiving a Comprehensive Medication Review (CMR) increased from 15.5% in CY 2013 to 19.2% in CY 2014, and then continued to increase to 27.0% in CY 2015 (Table 5.3). While this increase occurred in both MA-PD and PDP plans, the rate rose faster for MA-PDs. The CMR receipt rate for beneficiaries eligible for MTM under expanded targeting criteria was substantially lower than for beneficiaries eligible under the specified criteria.

³⁴ Eligibility rates utilize year average HPMS enrollment. Rates greater than 100% are capped at 100%. Met specified targeting criteria (per CMS-Part D requirements) indicates Element G = Yes. Met Other Expanded Targeting Criteria indicates Element G = No.

Table 5.3: Percentage of Eligible MTM Beneficiaries that Received a CMR, 2013-2015^{35, 36}

Contract Type	2013 CMR Rate, All	2013 CMR Rate, Met Specified Targeting Criteria	2013 CMR Rate, Met Other Expanded Targeting Criteria	2014 CMR Rate, All	2014 CMR Rate, Met Specified Targeting Criteria	2014 CMR Rate, Met Other Expanded Targeting Criteria	2015 CMR Rate, All	2015 CMR Rate, Met Specified Targeting Criteria	2015 CMR Rate, Met Other Expanded Targeting Criteria
All	13.1%	15.5%	1.6%	18.1%	19.2%	1.2%	25.4%	27.0%	2.3%
Employer	15.1%	15.1%	–	12.9%	12.9%	–	26.1%	26.0%	100.0%
MA-PD	16.3%	22.7%	1.5%	27.9%	32.3%	0.6%	38.0%	43.8%	1.7%
MMP	–	–	–	–	–	–	24.3%	29.8%	7.8%
PDP	9.8%	10.3%	2.1%	11.5%	11.5%	7.3%	16.5%	16.6%	5.3%

The most common method for conducting CMRs was by telephone in CY 2013 (85.2%), CY 2014 (83.2%), and CY 2015 (84.5%), followed by face-to-face with 14.7%, 16.7%, and 15.5% in CY 2013, CY 2014, and CY 2015, respectively (Table 5.4). Telehealth consultation and other methods were marginal in comparison, each comprising less than 0.1% of all CMRs conducted. In CY 2013 and CY 2014, MA-PD organizations were more likely to conduct a face-to-face CMR than Employer or PDP organizations; however, in CY 2015, PDP organizations had a slightly higher percentage than MA-PDs.

Table 5.4: Percentage of CMRs by Method and Contract Type, 2013-2015

Method	Year	All Organizations	Employer Organizations	MA-PD Organizations	MMP Organizations	PDP Organizations
Face-to-Face	2013	14.7%	2.1%	17.7%	–	9.9%
Face-to-Face	2014	16.7%	0.0%	22.8%	–	6.9%
Face-to-Face	2015	15.5%	0.0%	15.5%	12.3%	15.8%
Telephone	2013	85.2%	97.9%	82.1%	–	90.1%
Telephone	2014	83.2%	100.0%	77.1%	–	93.1%
Telephone	2015	84.5%	100.0%	84.5%	87.7%	84.2%
Telehealth Consultation	2013	0.1%	0.0%	0.1%	–	0.0%
Telehealth Consultation	2014	0.0%	0.0%	0.0%	–	0.0%
Telehealth Consultation	2015	0.0%	0.0%	0.0%	0.0%	0.0%
Other	2013	0.1%	0.0%	0.1%	–	0.0%
Other	2014	0.1%	0.0%	0.1%	–	0.0%
Other	2015	0.0%	0.0%	0.0%	0.0%	0.0%

³⁵ CY 2013-2015 CMR metric specifications exclude beneficiaries that were in hospice at any point during the reporting year according to the Enrollment Database. 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 are excluded. Met specified targeting criteria (per CMS-Part D requirements) indicates Element G = Yes. Met Other Expanded Targeting Criteria indicates Element G = No.

³⁶ A dash denotes a metric was incalculable, either due to no data or due to a denominator of 0.

21 Medication Therapy Management Programs

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Overall, in CY 2015, the largest percentage of CMRs were performed by MTM Vendor In-House Pharmacists (34.0%), followed by MTM Vendor Local Pharmacists (21.1%) and Plan Sponsor Pharmacists (16.5%) (Table 5.5). While “Other” providers comprised 38.0% of CMRs performed for Employer plans in CY 2015, this category of provider was marginal for MA-PD, MMP, and PDP plans, comprising just less than 0.3% of each organization type.

Table 5.5: Percentage of CMRs by Qualified Provider that Performed the CMR, 2015

Provider	All	Employer	MA-PD	MMP	PDP
Physician	0.9%	0.0%	1.5%	0.9%	0.0%
Registered Nurse	2.1%	0.0%	1.4%	2.1%	3.2%
Licensed Practical Nurse	0.2%	0.0%	0.3%	0.0%	0.0%
Nurse Practitioner	3.3%	0.0%	5.3%	2.2%	0.0%
Physician's Assistant	0.0%	0.0%	0.0%	0.0%	0.0%
Local Pharmacist	9.1%	0.0%	3.5%	6.8%	18.4%
LTC Consultant Pharmacist	0.4%	0.0%	0.1%	0.0%	1.1%
Plan Sponsor Pharmacist	16.5%	0.0%	25.0%	19.8%	2.4%
PBM Pharmacist	7.4%	0.0%	5.4%	11.2%	10.6%
MTM Vendor Local Pharmacist	21.1%	0.0%	23.8%	28.6%	16.5%
MTM Vendor In-House Pharmacist	34.0%	62.0%	29.9%	22.3%	41.0%
Hospital Pharmacist	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist - Other	4.9%	0.0%	3.8%	6.1%	6.5%
Other	0.3%	38.0%	0.1%	0.0%	0.3%

The most common recipient of a CMR was the beneficiary with 90.4% in CY 2013, 88.9% in CY 2014, and 87.4% in CY 2015, followed by caregiver, other authorized individual, then beneficiary’s prescriber (Table 5.6). Among cognitively impaired beneficiaries receiving a CMR, the most common recipient was a caregiver with 57.9% in CY 2013, 51.2% in CY 2014, and 71.6% in CY 2015. The share of CMRs given directly to cognitively impaired beneficiaries increased by nearly 20 percentage points from CY 2013 to CY 2014, but then decreased by more than 17 percentage points in CY 2015, while the share for other authorized individuals decreased from 27.2% to 13.1% to 8.7% across the three calendar years.

Table 5.6: Percentage of CMRs by Recipient, 2013-2015

Recipient	2013 All Beneficiaries	2013 Cognitively Impaired Beneficiaries	2014 All Beneficiaries	2014 Cognitively Impaired Beneficiaries	2015 All Beneficiaries	2015 Cognitively Impaired Beneficiaries
Beneficiary	90.4%	11.5%	88.9%	33.3%	87.4%	15.9%
Beneficiary's Prescriber	0.1%	3.3%	0.1%	2.4%	0.6%	3.7%
Caregiver	6.1%	57.9%	8.0%	51.2%	10.4%	71.6%
Other Authorized Individual	3.5%	27.2%	3.0%	13.1%	1.6%	8.7%

6 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, MA 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.³⁷

Enrollment requests can be completed via paper, telephone, internet, or the Medicare Online Enrollment Center (OEC). Most enrollment requests were received via paper with 32.5% in CY 2013, 34.7% in CY 2014, and 28.1% in CY 2015 (Table 6.1). In CY 2013 and CY 2014, the second most common form of request was telephonic with 21.8% and 23.6%, respectively, and then closely followed by OEC with 21.2% and 21.1%, respectively. In CY 2015, the percent of requests received via OEC increased slightly, to 22.2%, while the percentage of telephonic requests decreased, to 22.1%.

Table 6.1: Enrollment Requests by Request Mechanism, 2013-2015

Request Mechanism	2013 Percent Of Requests	2014 Percent Of Requests	2015 Percent Of Requests
Paper	32.5%	34.7%	28.1%
Telephonic	21.8%	23.6%	22.1%
Internet	6.8%	8.6%	10.6%
OEC	21.2%	21.1%	22.2%

The percentage of enrollment requests completed at the time of initial receipt slightly increased in each year, from 94.2% in CY 2013 to 94.7% in CY 2014 to 95.4% in CY 2015 (Table 6.2). The percentage of disenrollment requests that were complete at the time of initial receipt increased from 77.6% in CY 2013 to 78.6% in CY 2014, and then decreased to 75.9% in CY 2015.

Table 6.2: Enrollment and Disenrollment Requests Complete, 2013-2015

Request Type	2013 Percent Complete at Initial Receipt	2014 Percent Complete at Initial Receipt	2015 Percent Complete at Initial Receipt
Enrollment	94.2%	94.7%	95.4%
Disenrollment	77.6%	78.6%	75.9%

³⁷ Measure values are weighted by HPMS Contract Year Average Enrollment.

Less than two percent of enrollment requests were denied by the sponsor in each year (Table 6.3). The percentage of disenrollment requests denied by the sponsor increased from 11.7% in CY 2013 to 12.5% in CY 2015.

Table 6.3: Enrollment and Disenrollment Requests Denied by the Sponsor, 2013-2015

Request Type	2013 Percent Denied by Sponsor	2014 Percent Denied by Sponsor	2015 Percent Denied by Sponsor
Enrollment	1.8%	1.4%	1.4%
Disenrollment	11.7%	11.9%	12.5%

7 SUMMARY OF RESULTS

The results of this analysis reveal that there have been improvements in several reporting areas from CY 2013 to CY 2015, while other areas have potential for improvement in future years.

Grievances

The percentage of plans/contracts reporting zero Part D grievances decreased significantly between CY 2013 and CY 2014 and maintained this lower level into CY 2015. In all three years, most plans/contracts reporting zero Part D grievances had less than 500 enrollees. The number of plans/contracts with more than 10,000 enrollees reporting zero Part D grievances was marginal in comparison, comprising less than 1% in each year.

The total number of Part D grievances filed decreased from CY 2013 to CY 2014, and then slightly increased in CY 2015. The majority of grievances were filed as plan benefit, customer service, or “other” grievances. The percentage of Part D grievances responded to on time remained high across all categories, with the exception of expedited grievances, in CY 2013, CY 2014, and CY 2015.

Coverage Determinations and Redeterminations

The percent of plans/contracts reporting zero coverage determinations and exceptions was negligible. This percent was higher for redeterminations, but the percent of plans/contracts decreased over the three years. The overall rate of coverage determinations per 1,000 enrollees increased from CY 2013 to CY 2015, as did the rate of redeterminations per 1,000 enrollees. Additionally, from CY 2013 to 2015, coverage determination rates and redetermination rates per 1,000 enrollees both exhibited a trend of decreasing from Quarter 1 to Quarter 4 within a year, and then increasing from Quarter 4 to Quarter 1 of the following year. The majority of coverage determination outcomes and redetermination outcomes were fully favorable outcomes, followed by adverse outcomes.

The most common reason for the rejection of pharmacy transactions in CY 2013, CY 2014, and CY 2015 was non-formulary status, followed by prior authorization requirements and quantity limit requirements. In CY 2015, a slightly higher percentage of contract-quarter combinations had high cost edits in place for non-compounds in comparison to high cost edits for compounds.

MTM Programs

The total rate of beneficiaries eligible for an MTM program based on standard program criteria or other expanded plan-specific targeting criteria slightly increased from CY 2013 to CY 2014, and then increased again in CY 2015. MA-PD contracts had the highest eligibility rates in CY 2013 and CY 2014. In CY 2015, MMP contracts had the highest eligibility rates, followed by MA-PDs.

The overall percent of eligible MTM beneficiaries that received a Comprehensive Medication Review (CMR) increased from CY 2013 to CY 2015. Employer, MA-PD, and PDP contracts experienced an overall increase from CY 2013 to CY 2015. The CMR receipt rate for beneficiaries eligible for MTM under expanded targeting criteria was substantially lower than for beneficiaries eligible under the specified criteria.

The most common method for conducting CMRs was by telephone in all years, followed by face-to-face; telehealth consultation and other methods were marginal in comparison. Overall, in CY 2015, the largest percentage of CMRs were performed by MTM Vendor In-House Pharmacists, followed by MTM Vendor Local Pharmacists and Plan Sponsor Pharmacists. The most common recipient of a CMR in all years was the beneficiary, followed by the caregiver. For cognitively impaired beneficiaries receiving a CMR, the most common recipient was a caregiver in all three years.

Enrollment and Disenrollment

Most enrollment requests were received via paper in CY 2013, CY 2014, and CY 2015. In CY 2013 and CY 2014, the second most common form of request was telephonic, closely followed by OEC, but in CY 2015, OEC requests were slightly more common than telephonic requests. Almost all enrollment requests were complete at the time of initial receipt in all three years, increasing slightly in each year. The percentage of disenrollment requests that were complete at the time of initial receipt increased from CY 2013 to CY 2014, but then decreased in CY 2015. This percentage of disenrollment requests was significantly lower than the percentage of enrollment requests in all years. A very small share of enrollment requests were denied by the sponsor in each year while in comparison, the percentage of disenrollment requests denied was much higher, and increased over the three year window.

8 APPENDIX A

The following tables provide additional information regarding exceptions and redeterminations data reported by contracts participating in Medicare Part D from 2013 to 2015.

Appendix Table 1: Redeterminations Data, 2013-2015^{38 39}

Year	Number of Contracts	Number of Redeterminations	Number Fully Approved	Number Partially Approved	% Fully or Partially Approved
2013	563	269,581	211,479	1,491	79.0%
2014	594	379,652	290,695	2,445	77.2%
2015	574	638,386	472,107	2,835	74.4%

Appendix Table 2: Exceptions Data, 2013⁴⁰

Type of Exception	Number of Contracts	Number of Pharmacy Rejections	Number of Coverage Determinations Requested	% Coverage Determinations Requested	Number of Coverage Determinations Approved	% Coverage Determinations Approved
Total	578	Not Reported	5,172,907	N/A	3,552,816	68.7%
Prior Authorizations for Formulary Medications	578	12,316,502	2,084,538	20.9%	1,583,511	76.0%
Prior Authorizations Exceptions	578		494,682		202,785	41.0%
Quantity Limits Exceptions	578	13,779,759	435,061	3.2%	295,782	68.0%
Step Therapy Exceptions	578	5,369,960	295,450	5.5%	242,193	82.0%
Exceptions for Formulary Medications	578	44,213,981	1,721,740	3.9%	1,184,038	68.8%
Tier Exceptions	578	Not Reported	141,436	N/A	44,507	31.5%

Appendix Table 3: Exceptions Data for Pharmacy Rejections, 2014-2015⁴¹

Year	Number of Contracts	Number of Pharmacy Rejections due to Non-Formulary Status	Number of Pharmacy Rejections due to Prior Authorization	Number of Pharmacy Rejections due to Step Therapy	Number of Pharmacy Rejections due to Quantity Limits
2014	594	41,085,637	19,049,005	3,549,419	14,565,320
2015	574	40,762,226	23,637,266	2,665,274	15,800,725

³⁸ Includes standard and expedited requests for redetermination and excludes requests subsequently withdrawn.

³⁹ Inclusion in this table is only dependent on receiving a passing data validation score of at least 95% for the section. Element-specific data validation results were not used to determine inclusion.

⁴⁰ Inclusion in this table is only dependent on receiving a passing data validation score of at least 95% for the section. Element-specific data validation results were not used to determine inclusion.

⁴¹ Inclusion in this table is only dependent on receiving a passing data validation score of at least 95% for the section. Element-specific data validation results were not used to determine inclusion.

Appendix Table 4: Exceptions Data for Coverage Determinations, 2014-2015⁴²

Year	Number of Contracts	Number of Coverage Determinations	Number Fully Approved	Percent Fully Approved	Number Partially Approved	Percent Partially Approved	Number Adverse	Percent Adverse
2014	594	6,530,181	4,610,286	70.6%	35,185	0.5%	1,884,710	28.9%
2015	574	7,446,084	4,784,961	64.3%	33,314	0.4%	2,627,809	35.3%

⁴² Inclusion in this table is only dependent on receiving a passing data validation score of at least 95% for the section. Element-specific data validation results were not used to determine inclusion.