Medicare Part D Performance Metrics
Technical Notes
April 3, 2007

I. Customer Service

A. General Notes

1. **Data Source:** Call center surveillance data collected by CMS during the first quarter of 2007 (cumulative, year-to-date).

B. Data Columns

1. **Customer Service Wait Time (mm:ss)**
   - The average time spent on hold by the call surveyor following the IVR system and before reaching a live person for the "Customer Service for Current Members – Part D" phone number associated with the contract. For calls in which the caller terminates the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is 10:00 minutes.
2. **Pharmacist Support Wait Time (mm:ss)**
   - Same as #1 above, but for the "Pharmacy Technical Help Desk" phone number.
3. **Percentage of Customer Service Calls Disconnected**
   - The number of disconnected calls divided by the total number of calls made to the "Customer Service for Current Members – Part D" phone number associated with the contract. The CMS benchmark for this measure is ≤5%.
4. **Percentage of Pharmacist Calls Disconnected**
   - Same as #3 above, but for the "Pharmacy Technical Help Desk" phone number.

II. Complaints

A. General Notes:

1. **Data Source:** Data were obtained from the Health Plan Maintenance System (HPMS) Complaint Tracking Module (CTM) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the "contract assignment/reassignment date) from November 1, 2006 through January 31, 2007. Complaint rates per 1,000 enrollees are pro-rated to a 30-day basis.
2. **Data Exclusions:** Some complaints that can not be clearly attributed to the plan are excluded; these include the following complaint types: complaints regarding 1-800-MEDICARE, Medicare websites, SHIPS, SSA, or MEDIC; facilitated enrollment issues; retroactive disenrollment issues; enrollment exceptions; complaints identified as wrong contract, wrong category, or a CMS issue missing Medicaid eligibility; or Part D premium overcharges or withholding issues. Also, the data may exclude some complaints from pharmacists or other providers received by CMS.
3. **Missing Data:** Complaint rates are not calculated for plans with enrollment less than 1000 beneficiaries.
4. **Enrollment numbers:** enrollment numbers used to calculate the complaint rate were based on enrollment at the end of the time period measured.

B. Data Columns

1. **Benefits/ Access complaints per 1,000 enrollees**
   - These complaints include the following categories:
     - Part D Card did not work at pharmacy
     - Pharmacy does not offer generic alternatives
     - Pharmacy incorrectly listed in Part D Tool
     - Sponsor/plan/provider discouraging Part D benefit usage (e.g., for certain drugs)
     - Pharmacy is located too far away
     - Access and availability
     - Explanation of Benefits (EOB) is inaccurate

- TrOOP balance unavailable
- Coordination of benefit
- 4Rx/E1
- Transition
- Part B vs. Part D coverage
- Other Benefits/Access issues

2. Enrollment/ disenrollment complaints per 1,000 enrollees

- These complaints include the following categories:
  - Delayed enrollment processing
  - Inconsistent enrollment practices in same state
  - Enrollment denied
  - Inappropriate enrollment
  - Inappropriate disenrollment
  - Beneficiary has not received Part D card or enrollment materials
  - Delay in receiving materials
  - Untimely processing of disenrollment requests
  - Difficulty switching between plans
  - Involuntarily switched to a different plan
  - Low Income Subsidy (LIS)
  - Untimely processing of enrollment requests
  - TRR/Batch File
  - Eligibility
  - Other Enrollment/Disenrollment issue

3. Pricing/ Other co-insurance complaints per 1,000 enrollees

- These complaints include the following categories:
  - Pharmacy charging more than lowest available price
  - Pharmacy charging more co-insurance than listed on the Part D Tool on their description of benefits or TrOOP
  - Subsidy-eligible enrollees charged improper co-insurance
  - Enrollees charged improper co-insurance based on formulary tier
  - Beneficiary encountering Premium Withhold issues
  - Beneficiary has lost LIS Status/Eligibility
  - Other Pricing/Co-Insurance issue

4. Other complaints per 1,000 enrollees

- These complaints include all other plan-related complaints included in the total, excluding Benefits/Access, Enrollment/Disenrollment, and Pricing/Co-insurance complaints (i.e. excluding complaints from the above sub-categories).

III. Appeals

A. General Notes

1. **Data Source:** Data were provided by the IRE (Independent Review Entity) contracted by CMS for Part D reconsiderations. IRE data were obtained for Part D appeals processed between January 1, 2006 and December 31, 2006.
2. **Missing data:** For contracts with less than 1,000 enrollees, the value for "*Rate per 10,000 Enrollees in which a Plan Did Not Make a Timely Appeals Decision"* is not calculated. Also, for contracts with 10 or fewer total cases reviewed, the value for "*Percent of Cases Where the Independent Review Entity Agreed with a Plan's Decision*" is not calculated.

B. Data Columns

1. Rate per 10,000 Enrollees in which a Plan Did Not Make a Timely Appeals Decision

- The rate of cases auto-forwarded to the IRE because decision timeframes for coverage determinations or redeterminations have been exceeded. This is calculated as [(total # of cases not meeting timeframe) / (enrollment)] * 10,000.

2. Percent of Cases Where the Independent Review Entity Agreed with a Plan's Decision

- The percent of IRE confirmations of upholding the plans' decisions. This is calculated as: (# of cases upheld) / (total # of cases reviewed).

IV. Data Systems

A. General Notes

1. Data Sources

a. 4RX Data- The 4Rx report is run after the last transaction processing update of the CMS Management Information Integrated Repository (MIIR) data base after the 3rd day of each month. It reports the percent of enrollments with a complete 4Rx record across all current enrollments as well as within the specific enrollment categories.

- 4Rx is a group of four identifiers (RxBIN, Rx PCN, Rx ID, Rx Group) submitted by plans after receipt of enrollment confirmation from CMS to facilitate the proper adjudication of Part D claims for all payers covering a beneficiary.

  1. Rx BIN - Bank Identifying Number (BIN) used for network routing,
  2. Rx ID - is the member ID assigned to the beneficiary,
  3. Rx PCN - is a number assigned by the processor,
  4. Rx Group - is the identifying number assigned to the cardholder group or employer group.

  CMS requires complete information for RX BIN and RX ID information.

b. LIS Match Rate – Data on the LIS Match Rates are obtained from a CMS contractor based on enrollment data supplied by Part D sponsors compared to February 2007 enrollment data from CMS records.

2. Missing Data:

a. 4RX Data – N/A

b. LIS Match Rate - Any contracts which exclusively service U.S. territories are excluded from the match rate analysis. Also, sponsors that did not submit data to the CMS LIS matching contractor, or whose data was rejected because of validation checks, do not have match rates available.

B. Data Columns

1. Percent of Current Members with Complete Enrollment Records Available to Pharmacists

- The percent of Medicare beneficiaries that are currently enrolled in the Part D sponsor's contract that have a complete 4Rx record.

2. LIS Match Rate

- The percent of Low-Income Subsidy (LIS) beneficiaries on CMS enrollment files that have matching enrollment and benefit records (or more favorable benefits) on plan sponsors' enrollment files. For a given low income subsidy beneficiary to be considered a match, the plan must have the beneficiary enrolled in the correct plan, must indicate that the beneficiary is eligible for a low income subsidy, and must have premium and copayment levels that match (or are more favorable than) CMS records.

V. Pricing

A. General Notes

1. **Data Source:** Data were obtained from biweekly/weekly price files submitted by Part D Sponsors for display on the Medicare Prescription Drug Plan Finder (MPDPF) in 2006, and CMS QA' analyses of these price files. The pricing availability measure represents data submitted by plans from January 2006 to September 2006. The price stability index is based on data submitted by plans in February 2006 and August 2006.
2. **Missing Data:** For some plans that did not have complete pricing data for the comparison periods or whose data were suppressed from the Plan Finder tool for the comparison periods, the value for the "*Percent of Drugs on Medicare Prescription Drug Plan Finder with Displayed Price Increases*" could not be calculated.

B. Data Columns

1. Percent of Plan's Updates Available on Medicare Prescription Drug Plan Finder

- The percentage of submission windows in which the Contract's pricing data were displayed on Plan finder. This is calculated as 100%- (# of submission windows data suppressed / total # of submission windows).

2. Percent of Drugs on Medicare Prescription Drug Plan Finder with Displayed Price Increases

- The percent of formulary items at the Generic Sequence Number (GSN) level, which had a price increase greater than the allowed threshold for price changes (>5%). For this analysis, a GSN represents a distinct generic ingredient, strength, dosage form, and route of administration; also, for a given GSN, brand and generic drugs were considered separately. Drug utilization statistics provided by Verispan were used to weight GSNs, thus more commonly used medications have greater weight in the pricing change analysis.
- Note: This measure shows how stable the plans' drug prices have appeared on the Medicare Prescription Drug Plan Finder and no comparisons have been made to the prices beneficiaries may actually pay at the pharmacy. The price stability information presented here may reflect errors made by the plan in submitting their data as well actual changes in price. It is also important to note that price stability information does not correlate to which plans may have the lowest annual costs. Other factors such as a plan's premium, deductible, and cost-sharing must also be considered.