



Analysis of Calendar Year 2017 Medicare Part D Reporting Requirements Data

July 2019

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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 Part D 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 2013 through 2017.

Table 1.1: Summary of Part D Reporting Requirements by Calendar Year, 2013-2017

Reporting Section	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Enrollment and Disenrollment	✓	✓	✓	✓	✓
Retail, Home Infusion (HI), and Long Term Care (LTC) Pharmacy Access	✓	✓	✓	✓	✓
Medication Therapy Management (MTM) Programs	✓	✓	✓	✓	✓
Prompt Payment by Part D Sponsors	✓	–	–	–	–
Grievances	✓	✓	✓	✓	✓
Improving Drug Utilization Review Controls ¹	–	–	–	–	✓
Coverage Determinations/Exceptions	✓	–	–	–	–
Redeterminations	✓	–	–	–	–

¹ Improving Drug Utilization Review Controls was a new section added in CY 2017.

Reporting Section	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Coverage Determinations and Redeterminations ²	–	✓	✓	✓	✓
Long Term Care (LTC) Utilization	✓	✓	–	–	–
Fraud, Waste and Abuse Compliance Programs	✓	–	–	–	–
Employer/Union-Sponsored Group Health Plan Sponsors	✓	✓	✓	✓	✓
Plan Oversight of Agents ³	–	✓	✓	✓	–

This report provides an analysis of the data for five of the seven reporting sections submitted by Part D sponsors in accordance with the Part D Reporting Requirements for CY 2017. For each of these reporting sections, this report presents program-wide averages and, when available, identifies trends between CY 2015, CY 2016, and CY 2017 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 with at least 100 enrollees reporting zero Part D grievances divided by the total number of contracts with at least 100 enrollees.
	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 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 Year Average Enrollment.
	Percentage of Part D grievances the contract responded to on time	The number of Part D grievances with a timely response divided by the total number of Part D grievances filed, weighted by Contract Year Average Enrollment.
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 non-compounds) divided by the total number of pharmacy transactions, weighted by Contract Year Average Enrollment.
	Percentage of contract-quarter combinations with high cost edits in place for non-compounds	The number of contract-quarter combinations with high cost edits in place for non-compounds divided by the total contract-quarter combinations.
	Decision rate per 1,000 enrollees	The number of decisions by request type per 1,000 enrollees, weighted by Contract 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.

² The Coverage Determinations/Exceptions and Redeterminations sections were combined into a single section for CY 2014.

³ The Plan Oversight of Agents section was suspended in CY 2013; a revised data collection was introduced in CY 2014 and then suspended in CY 2017.

Reporting Section	Metric	Description
Coverage Determinations and Redeterminations (cont.)	Percentage of redetermination decisions by outcome	The number of redetermination decisions by outcome (i.e., fully approved, partially approved, or adverse) divided by the total number of redetermination 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 per 1,000 enrollees, weighted by Contract 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.
	Involuntarily disenrolled individuals (for failure to pay plan premium) who submitted timely requests for reinstatement for good cause	The number of disenrolled individuals who submitted a timely request for reinstatement for good cause divided by the number of involuntary disenrollments for failure to pay plan premium in the specified time period.
	Requests for reinstatement for good cause determinations that were favorable	The number of favorable good cause determinations divided by number of disenrolled individuals who submitted a timely request for reinstatement for good cause.
	Individuals reinstated after receiving a favorable good cause determinations	The number of individuals reinstated divided by the number of favorable good cause determinations.
Improving Drug Utilization Review Controls	Percentage of soft edit claims rejections that are overridden	The number of soft edit claim rejections overridden by the pharmacist at the pharmacy divided by the number of claims rejected due to the soft formulary-level cumulative opioid MED edit at POS, weighted by Plan Year Average Enrollment.
	Average number of soft edit rejected claims per beneficiary with at least one claim rejected	The number of claims rejected due to the soft formulary-level cumulative opioid MED edit at POS divided by the number of unique beneficiaries with at least one claim rejected due to the soft formulary-level cumulative opioid MED edit at POS, weighted by Plan Year Average Enrollment.
	Percentage of beneficiaries with at least one soft edit rejected claim whose edit was overridden	The number of beneficiaries with at least one soft edit claim rejection overridden by the pharmacist at the pharmacy divided by the number of unique beneficiaries with at least one claim rejected due to the soft formulary-level cumulative opioid MED edit at POS, weighted by Plan Year Average Enrollment.

Reporting Section	Metric	Description
Improving Drug Utilization Review Controls (cont)	Average number of hard edit rejected claims per beneficiary with at least one claim rejected	The number of claims rejected due to the hard formulary-level cumulative opioid MED edit at POS divided by the number of unique beneficiaries with at least one claim rejected due to the hard formulary-level cumulative opioid MED edit at POS, weighted by Plan Year Average Enrollment.
	Percent of beneficiaries with at least one hard-edit rejected claim that requested a coverage determination	The number of unique beneficiaries with at least one hard edit claim rejection that also had a coverage determination request for an opioid drug subject to the hard opioid MED edit divided by the number of unique beneficiaries with at least one claim rejected due to the hard formulary-level cumulative opioid MED edit at POS, weighted by Plan Year Average Enrollment.
	Percent of beneficiaries with at least one hard-edit rejected claim that had a favorable review of a coverage determination resulting in the coverage of an opioid drug	The number of unique beneficiaries with at least one rejected claim that also had a claim successfully processed (paid) for an opioid drug subject to the hard opioid MED edit divided by the number of unique beneficiaries with at least one claim rejected due to the hard formulary-level cumulative opioid MED edit at POS, weighted by Plan Year Average Enrollment.

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.⁴ 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.⁵

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 7 present the main findings for each of the five Part D reporting sections included in this report. Section 8 summarizes key results from the analysis. Additionally, Appendix A presents supplemental information on coverage determinations and redeterminations data for CY 2015 through CY 2017, Appendix B provides supplemental information and Appendix C describes the calculations and data elements used for each metric in the report.

⁴ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

⁵ <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. Section 2.1 discusses the process for Part D sponsors to submit Reporting Requirements data via HPMS. Section 2.2 explains the data validation process that each sponsor must undergo. Section 2.3 outlines the criteria for exclusion from this analysis and provides an overview of the contract- and plan-level data validation results. Section 2.4 details which reporting sections are included in the PUF and the restrictions applied to each reporting section's data.

2.1 Submission Process

Sponsors submit most Part D Reporting Requirements data via the Health Plan Management System (HPMS).⁶ 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 be accurate and submitted in a timely manner. 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 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 values relative to the rest of the Part D program, if they reported "0" 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.

⁶ MTM Programs data are uploaded using Gentran, TIBCO, or Connect:Direct.

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.⁷ 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 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. Scores at the reporting section level are assigned based on the share of applicable standards with which the contract complied. Starting in CY 2016, CMS began using a Likert scale for evaluating certain element-level data validation checks, in which contracts are assigned a value of 1 through 5 based on the percent of records found to have an error.⁸ In previous years, all element-level data validation checks were judged on a binary (Yes or No) scale. For the metrics in this report, if a contract scores a 1, 2 or 3 on the Likert scale or a “No” on the binary scale they are classified as failing the element-level data validation check.

As Table 2.1 shows, with the exception of Enrollment and Disenrollment, all CY 2015 through CY 2017 data included in this report underwent data validation during the validation cycle of the respective year. Data on Enrollment and Disenrollment are 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 2015 Data	CY 2016 Data	CY 2017 Data
Grievances	2016 DV	2017 DV	2018 DV
Coverage Determinations and Redeterminations	2016 DV	2017 DV	2018 DV
MTM Programs	2016 DV	2017 DV	2018 DV
Enrollment and Disenrollment	–	–	–
Improving Drug Utilization Review Controls	–	–	2018 DV

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. Prior to CY 2016, contracts that terminate on or before the applicable data validation deadline are excluded. For CY 2016 and CY 2017, contracts that submitted data but were not required due to termination were included if all other inclusion criteria were met. For CY 2015 through CY 2017 reporting sections, contracts that underwent validation in the 2016, 2017, or 2018 cycles 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 was 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.⁹

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

⁸ For more information on the Likert scale, reference the Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual, available at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

⁹ For the MTM section, this also causes the number of MTM-Eligible Beneficiaries to vary between metrics.

Table 2.2 displays data validation results for validated reporting sections and calendar year of data. The percent of contracts receiving a passing DV score stayed consistent across all years for all reporting sections, while the percent of contracts achieving a DV score of 100% score varied across years. For all three reporting sections that underwent DV, nearly all contracts received a passing DV score (DV Score \geq 95%), with MTM having the highest pass rate of over 99% every year. The percent of contracts achieving a DV score of 100% for the Grievances reporting section continually increased from 73.5% in CY 2015 to 85.3% in CY 2016 to 91.4% in CY 2017. The percentage of contracts achieving a DV score of 100% was highest in the MTM Programs reporting section in all three years, and exhibited a similar trend as the Grievances section, increasing from 91.3% in CY 2015 97.1% in CY 2016, then increasing to 98.1% in CY 2018. The share of contracts achieving a DV score of 100% for Coverage Determination and Redeterminations increased from 79.6% in CY 2015 to 84.2% in CY 2016, then decreased to 83.9% in CY 2017. The share of contracts achieving both a passing DV score and a DV score of 100% were high for the Improving Drug Utilization Review Controls section in CY 2017, at 99.4% and 95.0%, respectively.

Table 2.2: Summary of Data Validation Results by Reporting Section for Contracts, 2015-2017¹⁰

Reporting Section	Year	Reporting Level	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# DV Score \geq 95%	% DV Score \geq 95%	# DV Score = 100%	% DV Score = 100%
Grievances	2015	Contract	569	569	559	98.2%	418	73.5%
Grievances	2016	Contract	556	556	546	98.2%	474	85.3%
Grievances	2017	Contract	535	535	532	99.4%	489	91.4%
Coverage Determinations and Redeterminations	2015	Contract	570	570	563	98.8%	454	79.6%
Coverage Determinations and Redeterminations	2016	Contract	556	556	549	98.7%	468	84.2%
Coverage Determinations and Redeterminations	2017	Contract	535	535	526	98.3%	449	83.9%
MTM Programs	2015	Contract	554	554	552	99.6%	506	91.3%
MTM Programs	2016	Contract	554	554	553	99.8%	538	97.1%
MTM Programs	2017	Contract	523	523	523	100.0%	513	98.1%
Improving Drug Utilization Review Controls	2017	PBP	522	522	519	99.4%	496	95.0%

Table 2.3 displays corresponding plan counts for the Improving Drug Utilization Review Controls section, which was the only section reported at the plan level that underwent data validation. The

¹⁰ Total number eligible for inclusion represents contracts 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 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). In CY 2016 and in CY 2017, contracts that submitted data but were not required to submit due to termination were included in this table if all other inclusion criteria were met.

percentage of plans with contracts achieving a passing data validation score for Improving Drug Utilization Review Controls was 99.9% in CY 2017, with 97.9% of plans achieving a data validation score of 100%.

Table 2.3: Summary of Data Validation Results by Reporting Section for Plans, 2017¹¹

Reporting Section	Year	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# of Plans DV Score ≥ 95%	% of Plans DV Score ≥ 95%	# of Plans DV Score = 100%	% of Plans DV Score = 100%
Improving Drug Utilization Review Controls	2017	3,182	3,182	3,178	99.9%	3,116	97.9%

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 publicly available.¹² Table 2.4 lists the reporting section data utilized for public use files.

Table 2.4 Reporting Sections Utilized for Public Use Files

Reporting Section	Utilized for Public Use Files?
Grievances	✓
Coverage Determinations and Redeterminations	✓
MTM Programs	✓
Enrollment and Disenrollment	✓
Improving Drug Utilization Review Controls	✓

¹¹ 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 that 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). In CY 2017, plans that submitted data but were not required to submit due to termination were included in this table if all other inclusion criteria were met.

¹² <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

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.

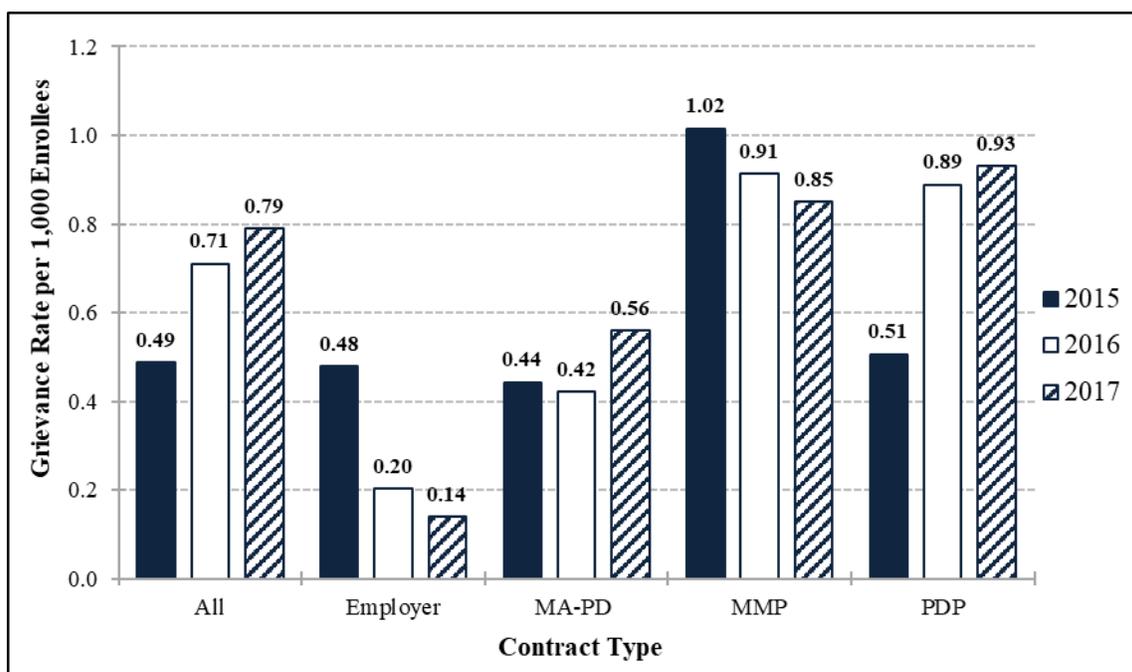
3 GRIEVANCES

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.¹³

The yearly grievance rate per 1,000 enrollees per month was higher in CY 2017 than in CY 2015 and CY 2016 (Figure 3.1). In CY 2017, the rate of Part D grievances increased to 0.79, an 11.3% increase from 0.71 in CY 2016, while in comparison, the yearly grievance rate increased 44.9%, from 0.49 to 0.71, from CY 2015 to CY 2016. This change is driven by a substantial increase in the grievance rate for PDP contracts, which increased from 0.51 in CY 2015 to 0.89 in CY 2016 and 0.93 in CY 2017. This increase in the grievance rate for PDP contracts in CY 2016 and 2017 was in turn driven by a large contract with an above average grievance rate being included for both years after having been excluded in CY 2015 due to DV issues.

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

Figure 3.1: Grievance Rates per 1,000 Enrollees per Month, 2015-2017¹⁴



Reported data classify grievances into several categories, including enrollment/disenrollment, plan benefit, pharmacy access, marketing, customer service, coverage determination and redetermination process, quality of care, or “other”. In all three years, plan benefit grievances represented the highest share of grievances, with 27.1% in CY 2015, 28.8% in CY 2016, and 28.9% in CY 2017 (Table 3.3). Customer service grievances had the second highest share in all three years, with 25.4%, 23.4%, and 27.1%, respectively, followed by other grievances, with 18.4%, 17.8%, and 15.3%, respectively.

Table 3.1: Part D Grievances by Category, 2015-2017¹⁵

Category	Year	Total Number of Contracts	Number of Contracts Reporting At Least One Grievance	Total Number of Grievances	Share of Grievances
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%

¹⁴ Measure values are weighted by Contract Year Average Enrollment. Grievances due to CMS issues are excluded when determining a contract’s reported grievance count.

¹⁵ Measure values are weighted by Contract Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

Category	Year	Total Number of Contracts	Number of Contracts Reporting At Least One Grievance	Total Number of Grievances	Share of Grievances
Total	2016	522	479	333,612	100.0%
Enrollment / Disenrollment	2016	522	196	56,307	10.1%
Plan Benefit	2016	522	425	115,205	28.8%
Pharmacy Access	2016	522	292	21,991	8.7%
Marketing	2016	522	225	11,955	3.1%
Customer Service	2016	522	392	83,242	23.4%
Coverage Determinations & Redeterminations Process	2016	522	312	10,592	4.7%
Quality of Care	2016	522	245	8,226	3.3%
Other	2016	522	340	26,094	17.8%
Total	2017	509	463	391,031	100.0%
Enrollment / Disenrollment	2017	509	188	56,898	9.2%
Plan Benefit	2017	509	420	121,637	28.9%
Pharmacy Access	2017	509	310	29,150	8.1%
Marketing	2017	509	227	16,010	3.7%
Customer Service	2017	509	399	105,188	27.1%
Coverage Determinations & Redeterminations Process	2017	509	323	13,796	4.5%
Quality of Care	2017	509	231	11,878	3.1%
Other	2017	509	337	36,474	15.3%

The percentage of all Part D grievances with a response within the required 30 day or 24-hour timeframe increased slightly from CY 2015 to CY 2017 (Table 3.4). From CY 2015 to CY 2016, the percent of grievances responded to on time fell for all grievance categories, although it remained above 98% for plan benefit, pharmacy access, customer service, and other grievances. From CY 2016 to CY 2017, the percentage of Part D grievances with a timely response increased for all categories, with the exception of expedited grievances. Differences in timely response rates across grievance categories were larger in CY 2016 than in CY 2015 or CY 2017, when there was little variation in the percentage of timely decisions among the grievance categories and expedited grievances were the only category with less than 98% of grievances with a timely response. Expedited grievances exhibited the largest decrease in the percent of grievances with a timely response from CY 2015 to CY 2017, decreasing by 6.7 percentage points, followed by marketing grievances, which decreased by 1.1 percentage points.

Table 3.2: Percentage of Part D Grievances the Contract Responded to On Time by Grievance Type, 2015-2017¹⁶

Grievance Type	2015	2016	2017
Total	98.3%	98.3%	99.1%
Enrollment / Disenrollment	98.9%	97.7%	98.9%
Plan Benefit	98.6%	98.4%	99.3%
Pharmacy Access	99.4%	98.3%	99.5%
Marketing	99.1%	97.6%	98.0%
Customer Service	98.4%	98.3%	99.2%
Coverage Determinations & Redeterminations Process	99.0%	97.6%	98.9%
Quality of Care	97.4%	95.4%	98.8%
Other	98.8%	98.6%	99.0%
Expedited	89.3%	75.3%	82.6%

¹⁶ Measure values are weighted by Contract Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

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 transactions, which are not generally 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 five reasons: non-formulary status, prior authorization requirements, step therapy requirements, quantity limit requirements, and high cost edits for non-compounds.

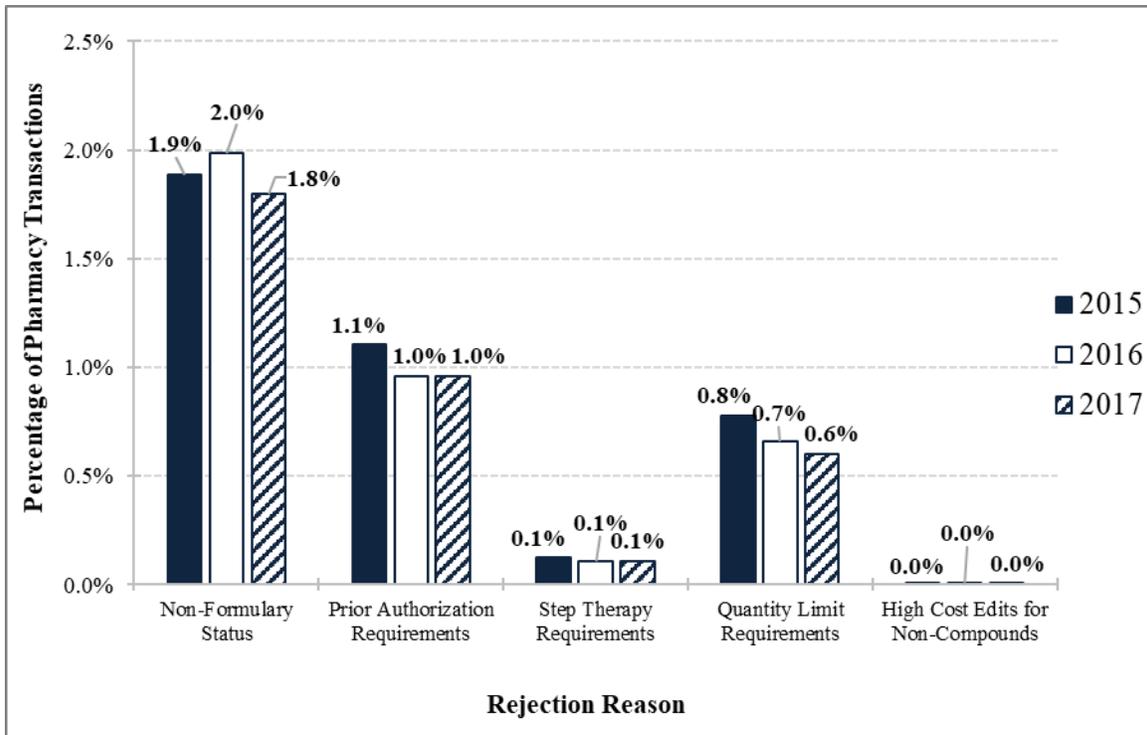
The requirements related to coverage determinations, including formulary and tiering exceptions, can be found in 42 CFR Part 423, Subpart M. A coverage determination is any decision made by or on behalf of a Part D plan sponsor, or its delegated entity, regarding payment or benefits to which an enrollee 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 effectuated 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.

A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. A reopening occurs after a decision has been made, generally to correct clerical error, in response to the receipt of information not available or known to exist at the time the request was initially processed or if evidence used in making the original determination clearly shows an obvious error was made at the time of the determination. All sponsors must report all fully favorable, partially favorable, adverse, or pending reopenings of coverage determinations and redeterminations.

The reported data include five reasons a pharmacy transaction may be rejected, including non-formulary status, prior authorization requirements, step therapy requirements, quantity limit requirements, or high cost edits for non-compounds. The most common rejection reason in CY 2015, CY 2016, and CY 2017 was non-formulary status, with 1.9%, 2.0%, and 1.8% of pharmacy transactions rejected for that reason, respectively (Figure 4.1). Prior authorization requirements were the second most common reason for rejection of pharmacy transactions, with 1.1%, 1.0%, and 1.0% of rejections, respectively.

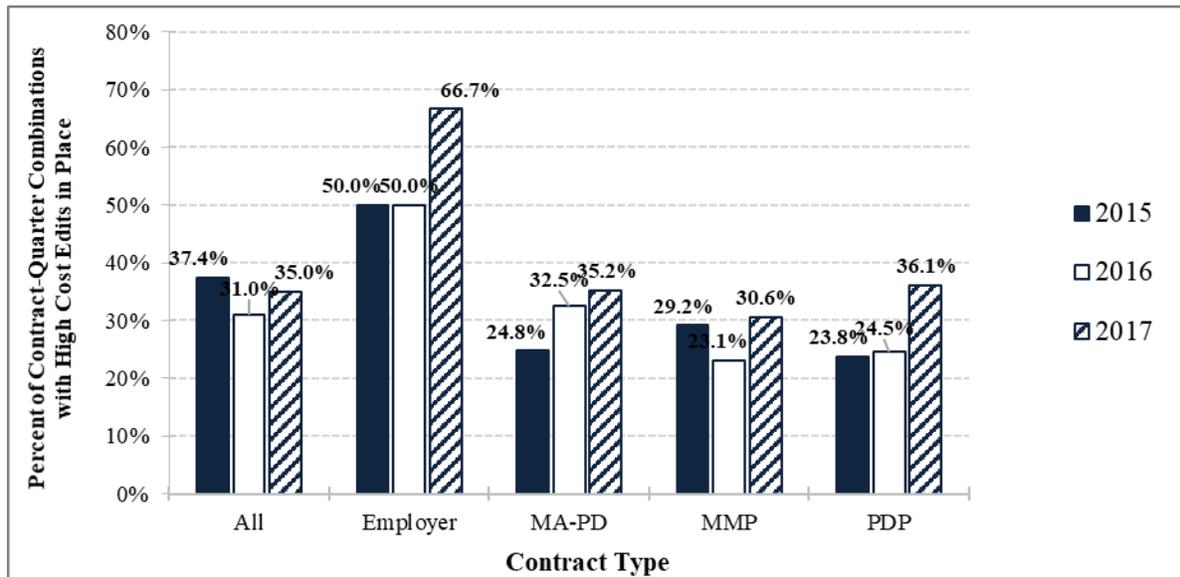
Figure 4.1: Percentage of Pharmacy Transactions Rejected, 2015-2017¹⁷



For all contracts, the percent of contract-quarters with high cost edits for non-compounds decreased from CY 2015 to CY 2017, from 37.4% in CY 2015 to 35.0% in CY 2017 (Figure 4.2). Of all contract types, Employer contracts had the highest percentage of contract-quarter combinations with high cost edits in place for non-compounds, with 50.0% in CY 2015 and CY 2016, and 66.7% in CY 2017. MA-PD, MMP, and PDP contracts had similar percentages of contract-quarter combinations with high cost edits in place for non-compounds, and the percentage of contract quarters increased from CY 2015 to CY 2017 for each contract type. The increase was most notable for PDP contracts, which increased by 12.3 percentage points from CY 2015 to CY 2017.

¹⁷ Measure values are weighted by Contract Year Average Enrollment.

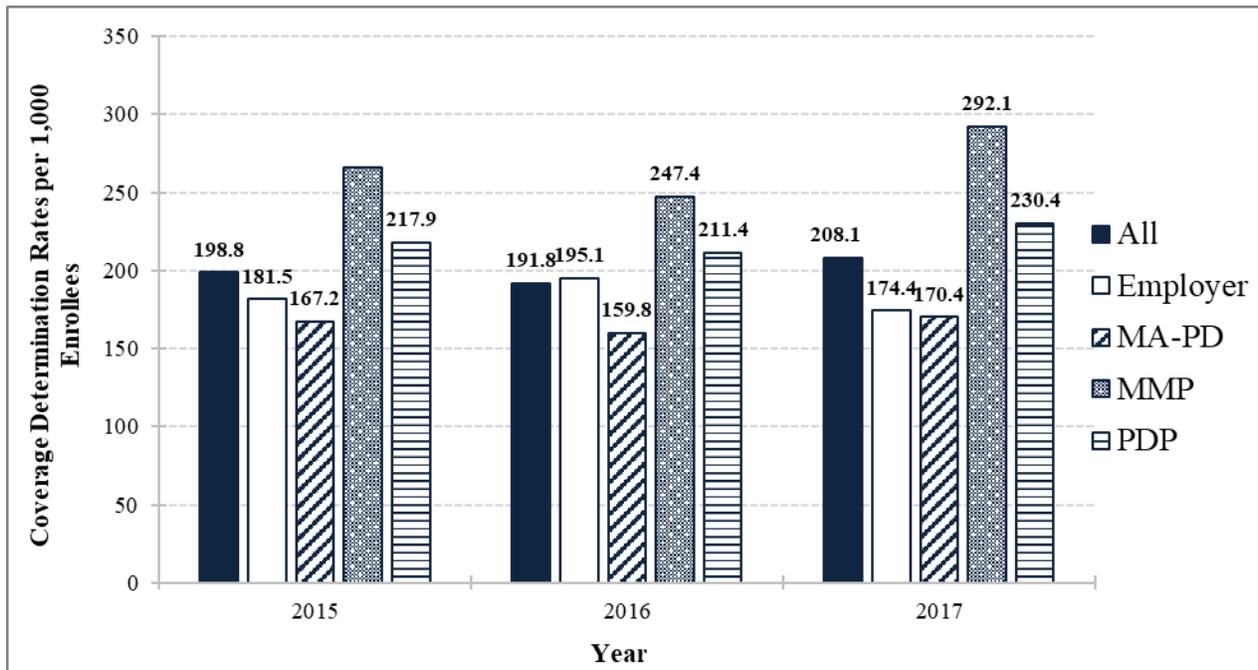
Figure 4.2: Percentage of Contract-Quarter Combinations with High Cost Edits in Place for Non-Compounds, 2015- 2017¹⁸



The overall rate of coverage determinations per 1,000 enrollees increased from 198.8 in CY 2015 to 208.1 in CY 2017, falling to 191.8 in CY 2016 (Figure 4.3). Rates followed a similar pattern across the years for PDP, MA-PD, and MMP contracts, while rates for Employer contracts decreased from CY 2015 to CY 2017. MMP contracts had the highest rates of coverage determinations in all three years, with the rate of coverage determinations per 1,000 enrollees falling from 266.3 in CY 2015 to 247.4 in CY 2016, then increasing to 292.1 in CY 2017.

¹⁸ Since a single contract can change its response across quarters, this figure presents the share of contract-quarter combinations with each response.

Figure 4.3: Coverage Determination Rates per 1,000 Enrollees, 2015-2017¹⁹



Coverage determination decisions may be classified as fully favorable and partially favorable, or adverse. In CY 2017, 61.5% of coverage determinations decisions were fully favorable, 0.5% were partially favorable, and 38.0% were adverse, with MA-PD and PDP contracts following a similar pattern (Table 4.1). The share of fully favorable outcomes was highest for MMPs (66.8%) and lowest for MA-PDs (61.0%); likewise, the share of adverse outcomes was highest for MA-PDs (38.4%) and lowest for MMPs (22.9%).

Table 4.1: Percentage of Coverage Determinations by Outcome and Contract Type, 2017²⁰

Contract Type	Percent Fully Favorable	Percent Partially Favorable	Percent Adverse
All	61.5%	0.5%	38.0%
Employer	65.4%	0.0%	34.6%
MA-PD	61.0%	0.6%	38.4%
MMP	66.8%	0.3%	22.9%
PDP	61.7%	0.4%	37.9%

Of contracts with at least 100 enrollees, the percent of contracts reporting zero redeterminations decreased from 1.9% in CY 2015 to 1.6% in CY 2017 (Table 4.2). From CY 2015 to CY 2017, the percentage of MA-PD contracts with at least 100 enrollees reporting zero redeterminations increased slightly, from 1.9% in CY 2015 to 2.0% in CY 2017. In comparison, the percentage of PDP contracts with zero redeterminations decreased from 1.7% in CY 2015 to 0.0% in CY 2016 and CY. In both CY 2015 and CY 2016, MMP contracts had the highest share of contracts reporting zero redeterminations,

¹⁹ Measure values are weighted by Contract Year Average Enrollment.

²⁰ Measure values are weighted by Contract Year Average Enrollment.

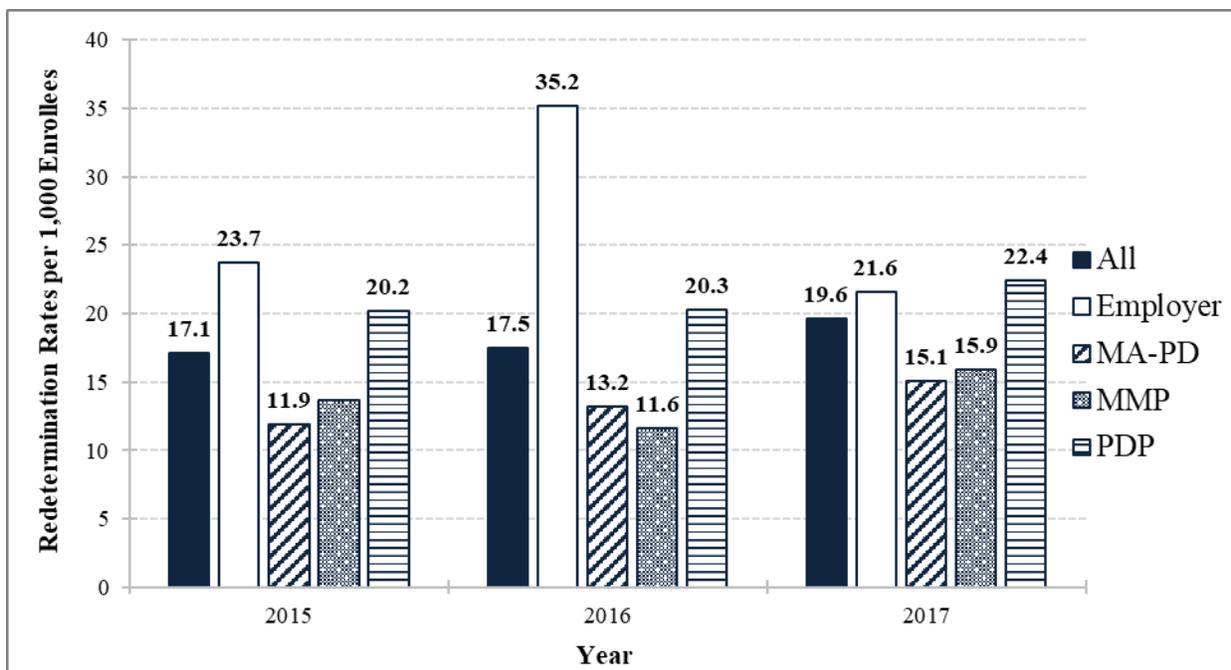
with 2.6% and 2.2%. In CY 2017, MA-PD contracts had the highest share of contracts reporting zero redeterminations.

Table 4.2: Contracts Reporting Zero Redeterminations by Contract Type, 2015-2017²¹

Contract Type	2015 Total Number of Contracts	2015 Number of Contracts Reporting Zero	2015 Share of Contracts Reporting Zero	2016 Total Number of Contracts	2016 Number of Contracts Reporting Zero	2016 Share of Contracts Reporting Zero	2017 Total Number of Contracts	2017 Number of Contracts Reporting Zero	2017 Share of Contracts Reporting Zero
All	531	10	1.9%	534	7	1.3%	506	8	1.6%
Employer	4	0	0.0%	5	0	0.0%	2	0	0.0%
MA-PD	430	8	1.9%	432	6	1.4%	406	8	2.0%
MMP	38	1	2.6%	46	1	2.2%	45	0	0.0%
PDP	59	1	1.7%	51	0	0.0%	53	0	0.0%

The redetermination rate per 1,000 enrollees increased in each year from CY 2015 to CY 2017, going from 17.1 in CY 2015 to 17.5 in CY 2016 to 19.6 in CY 2017 (Figure 4.4). In CY 2015 and CY 2016, Employer contracts had the highest redeterminations rates per 1,000 enrollees, at 23.7 and 35.2, respectively; in CY 2017, PDP contracts had the highest redetermination rate per 1,000 enrollees, at 22.4. In CY 2015 and CY 2017, MA-PDs had the lowest redetermination rates per 1,000 enrollees, decreasing from 11.9 in CY 2015 to 15.1 in CY 2017; in CY 2016, MMPs had the lowest rates, at 11.6 per 1,000 enrollees.

Figure 4.4: Redetermination Rates per 1,000 Enrollees by Year and Contract Type, 2015-2017²²



Across all contract types, the majority of enrollees were successful in obtaining a favorable redetermination decision in CY 2017 (Table 4.3). Of all contracts, 64.4% of redeterminations decisions

²¹ Restricted to contracts with a year average HPMS enrollment of at least 100.

²² Measure values are weighted by Contract Year Average Enrollment.

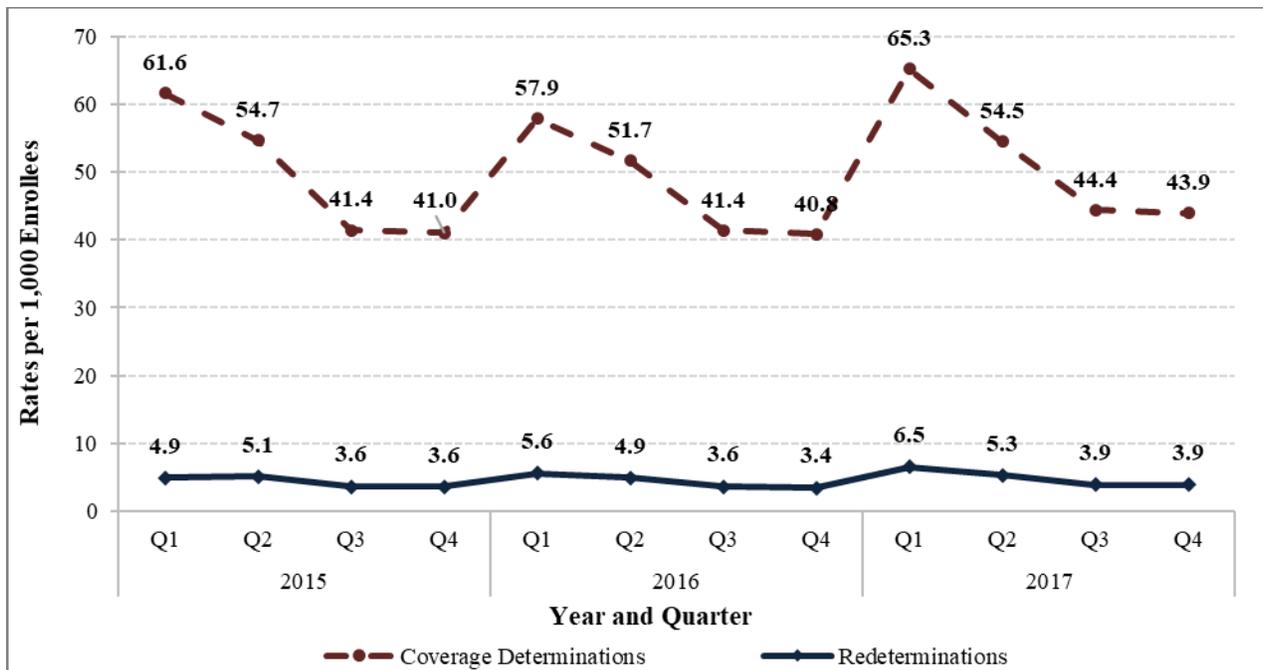
were fully favorable, while 0.6% were partially favorable, and 35.0% were adverse. Employer contracts had the highest percentage of redeterminations with fully favorable outcomes, with 79.5%, and the lowest percentage of partially favorable and adverse outcomes, with 0.2% and 20.3%, respectively. In comparison, MMP contracts had the lowest percentage of fully favorable outcomes, with 54.5%, and had the highest percent of adverse outcomes, with 45.2%. MA-PD contracts had the highest percentage of partially favorable outcomes, with 0.9%.

Table 4.3: Percentage of Redeterminations by Outcome and Contract Type, 2017²³

Contract Type	Percent Fully Favorable	Percent Partially Favorable	Percent Adverse
All	64.4%	0.6%	35.0%
Employer	79.5%	0.2%	20.3%
MA-PD	63.6%	0.9%	35.5%
MMP	54.5%	0.3%	45.2%
PDP	64.9%	0.4%	34.7%

As expected, the rates of coverage determinations and redeterminations per 1,000 enrollees fell during each year, decreasing from Quarter 1 to Quarter 4, and then rose 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, 2015-2017²⁴

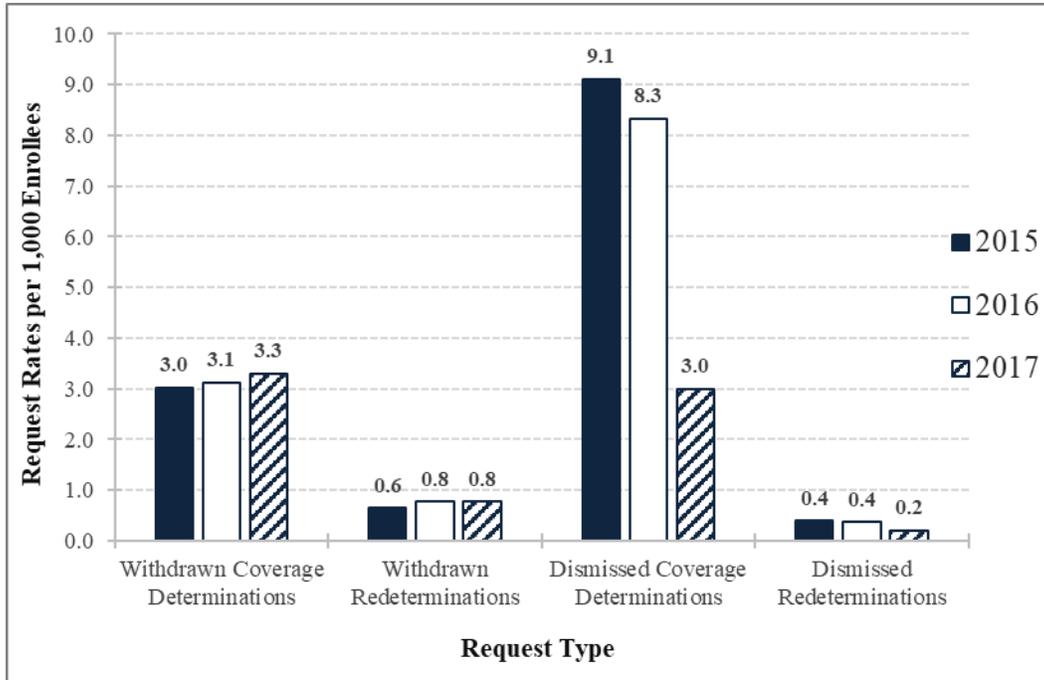


²³ Measure values are weighted by Contract Year Average Enrollment.

²⁴ Measure values are weighted by Contract Year Average Enrollment.

Withdrawn and dismissed coverage determinations rates were higher than withdrawn and dismissed redeterminations rates in all years (Figure 4.6). Rates of dismissed coverage determinations were high in CY 2015 and CY 2016, at 9.1 and 8.3 requests per 1,000 enrollees, respectively; the rate of dismissed coverage determinations fell sharply to 3.0 requests per 1,000 enrollees in CY 2017. Withdrawn coverage determination rates increased slightly in each year, going from 3.0 requests per 1,000 enrollees in CY 2015 to 3.1 and 3.3 in CY 2016 and CY 2017, respectively. Withdrawn and dismissed redeterminations rates were low, remaining below 1.0 in all three years.

Figure 4.6: Withdrawn and Dismissed Request Rates per 1,000 Enrollees, 2015-2017²⁵



In all three years, rates of reopened coverage determinations were higher than rates of reopened redeterminations (Table 4.4). The overall reopened coverage determination rate increased from 0.22 in CY 2015 to 0.52 in CY 2016 and 0.60 in CY 2017. In CY 2015 and CY 2016, Employer contracts had the highest rate, with 0.32 and 0.66, respectively, while in CY 2017, MMP contracts had the highest reopened coverage determination rate with 1.04. Additionally, the overall reopened redetermination rate increased in each year, from 0.10 in CY 2015 to 0.14 in CY 2016 to 0.18 in CY 2017. The rate of reopened determinations was highest for PDP contracts in all three years, with 0.12 in CY 2015, 0.18 in CY 2016, and 0.22 in CY 2017.

²⁵ Measure values are weighted by Contract Year Average Enrollment.

Table 4.4: Reopened Decision Rates per 1,000 Enrollees, by Year, 2015-2017

Contract Type	2015 Reopened Coverage Determinations	2016 Reopened Coverage Determinations	2017 Reopened Coverage Determinations	2015 Reopened Redeterminations	2016 Reopened Redeterminations	2017 Reopened Redeterminations
All	0.22	0.52	0.60	0.10	0.14	0.18
Employer	0.32	0.66	0.45	0.02	0.01	0.00
MA-PD	0.18	0.32	0.44	0.06	0.09	0.13
MMP	0.27	0.51	1.04	0.12	0.10	0.14
PDP	0.25	0.64	0.70	0.12	0.18	0.22

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.²⁶ CMS collects information on beneficiaries enrolled in MTM programs that meet either of these criteria. Beginning in CY 2017, CMS began offering the Part D Enhanced Medication Therapy Management (MTM) Model to allow Part D sponsors additional payment incentives and regulatory flexibility in administering MTM programs.²⁷

The total rate of beneficiaries eligible for an MTM program based on standard program criteria or other plan-specific expanded targeting criteria decreased in each year from 12.9% in CY 2015 to 9.4% in CY 2017 (Table 5.1). In each year, MMPs had the highest eligibility rate, with 24.6% in CY 2015, 24.7% in CY 2016, and 23.8% in CY 2017. In each year, Employer contracts had the lowest eligibility rate, with 9.0% in CY 2015, 8.6% in CY 2016, and 6.3% in CY 2017.

Table 5.1: Percentage of Beneficiaries Eligible for an MTM Program, 2015-2017²⁸

Contract Type	2015 Total Number of MTM-Eligible Beneficiaries	2015 Eligibility Rate	2015 Number of Contracts	2016 Total Number of MTM-Eligible Beneficiaries	2016 Eligibility Rate	2016 Number of Contracts	2017 Total Number of MTM-Eligible Beneficiaries	2017 Eligibility Rate	2017 Number of Contracts
All	4,801,887	12.9%	541	4,165,209	10.7%	542	3,717,449	9.4%	515
Employer	9,743	9.0%	5	9,879	8.6%	5	6,786	6.3%	3
MA-PD	1,940,782	14.1%	430	1,641,533	10.9%	434	1,471,956	9.3%	413
MMP	83,046	24.6%	47	92,804	24.7%	52	88,616	23.8%	46
PDP	2,768,316	12.0%	59	2,420,993	10.3%	51	2,150,091	9.2%	53

Both the percent of enrollees that were MTM-eligible based on the specified targeting criteria and the percent eligible based on expanded targeting criteria decreased in each year from CY 2015 to CY 2017 (Table 5.2). In CY 2016, the percent of enrollees that met specified targeting criteria decreased to

²⁶ In 2017, over 26% of MTM programs use expanded eligibility requirements beyond CMS' minimum requirements. 2017 MTM Program Fact Sheet. Accessed at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2017-MTM-Fact-Sheet.pdf>

²⁷ For more information on the Enhanced MTM Innovation Model, see the CMS Website on the Part D Enhanced Medication Therapy Management Model, <https://innovation.cms.gov/initiatives/enhancedmtm/>

²⁸ Eligibility rates utilize year average HPMS enrollment. Rates greater than 100% are capped at 100%. Enrollees in EMTM plans are excluded from the CY 2017 eligibility rate denominator.

10.5% from 12.1% in CY 2015, while the percent of enrollees that met other expanded targeting criteria fell to 0.1%, a 91.5% decrease over CY 2015. In CY 2017, the percent of enrollees that met specified targeting criteria decreased further to 9.0%, while the percent of enrollees that met other expanded targeting criteria remained stable at 0.1%.

Table 5.2: Percentage of Beneficiaries Eligible for an MTM Program by Criteria, 2015-2017^{29,30,31}

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	2015	4,506,475	12.1%	295,412	0.8%
Employer	2015	9,725	9.0%	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%
All	2016	4,095,017	10.5%	26,579	0.1%
Employer	2016	9,836	8.6%	43	0.0%
MA-PD	2016	1,625,607	10.8%	15,926	0.1%
MMP	2016	82,754	22.4%	10,050	2.5%
PDP	2016	2,376,820	10.1%	560	0.0%
All	2017	3,708,188	9.4%	9,261	0.0%
Employer	2017	6,786	6.3%	0	0.0%
MA-PD	2017	1,465,327	9.3%	6,629	0.0%
MMP	2017	86,003	23.3%	2,613	0.5%
PDP	2017	2,150,072	9.2%	19	0.0%

Among beneficiaries eligible for MTM under the specified targeting criteria, the share receiving a Comprehensive Medication Review (CMR) increased from 27.0% in CY 2015 to 36.2% in CY 2016, then continued to increase to 43.9% in CY 2017 (Table 5.3). While this increase occurred in all contract types, the rate rose fastest for MA-PDs, from 43.8% in CY 2015 to 71.4% in CY 2017. The CMR receipt rate for beneficiaries eligible for MTM under expanded targeting criteria has risen drastically, from 2.3% in CY 2015 to 50.6% in CY 2016 and 65.7% in CY 2017. In the three year period, there was a considerable increase for MA-PDs, PDPs, and MMP plans. However, the number of beneficiaries eligible for MTM under expanded targeting criteria is considerably smaller in CYs 2016 and 2017. The CMR receipt rate for beneficiaries eligible for MTM under expanded targeting criteria for MA-PDs rose from 1.7% to 75.6% in CY 2016, increasing to 78.3% in CY 2017. For PDPs, there was also a drastic increase in the CMR completion rate for beneficiaries eligible for MTM under expanded targeting criteria, from 5.3% in

²⁹ 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. Enrollees in EMTM plans are excluded from eligibility rate denominators.

³⁰ The Met Other Expanded Criteria Total Number of MTM-Eligible Beneficiaries and Eligibility Rate may not include the same contracts for the overall figures if there are contracts that failed data element level validation checks for the MTM field regarding whether or not a beneficiary “Met the specified targeting criteria per CMS – Part D requirements.”

³¹ The majority of the decrease in MTM enrollment from 2015 to 2016 was due to one sponsor.

CY 2015 to 91.5% in CY 2016, decreasing to 88.2% in CY 2017. The CMR receipt rate for beneficiaries eligible for MTM under expanded targeting criteria for MMP plans rose from 7.8% in CY 2015 to 8.3% in CY 2016 and 23.2% in CY 2017.

Table 5.3: Percentage of Eligible MTM Beneficiaries that Received a CMR, 2015-2017^{32,33}

Contract Type	2015 CMR Rate, All	2015 CMR Rate, Met Specified Targeting Criteria	2015 CMR Rate, Met Other Expanded Targeting Criteria	2016 CMR Rate, All	2016 CMR Rate, Met Specified Targeting Criteria	2016 CMR Rate, Met Other Expanded Targeting Criteria	2017 CMR Rate, All	2017 CMR Rate, Met Specified Targeting Criteria	2017 CMR Rate, Met Other Expanded Targeting Criteria
All	25.4%	27.0%	2.3%	36.1%	36.2%	50.6%	43.9%	43.9%	65.7%
Employer	26.1%	26.0%	100.0%	28.6%	28.3%	100.0%	46.6%	46.6%	-
MA-PD	38.0%	43.8%	1.7%	61.6%	61.5%	75.6%	71.5%	71.4%	78.3%
MMP	24.3%	29.8%	7.8%	32.4%	35.4%	8.3%	39.9%	40.3%	23.2%
PDP	16.5%	16.6%	5.3%	19.1%	19.1%	91.5%	25.5%	25.5%	88.2%

In all three years, the most common method for conducting CMRs was by telephone, with the percent of CMRs conducted via telephone increasing from 84.5% in CY 2015 to 87.3% in CY 2016 to 91.5% in CY 2017 (Table 5.4). CMRs performed face-to-face were the second most common method, and decreased in all three years, from 15.5% to 12.6% to 8.5%. Telehealth consultation and other methods were virtually non-existent in comparison, each comprising less than 0.1% of all CMRs conducted. In all three years, Employer contracts had the highest percentage of CMRs performed via telephone, with 100% in CY 2015 and CY 2016 and 98.9% in CY 2017, followed by MMPs in CY 2015 (87.7%), and MA-PDs in CY 2016 (89.4%) and CY 2017 (91.9%). In CY 2015 and CY 2016, PDP organizations had the highest percentage of face-to-face CMRs across all contract types. In CY 2017, MMP organizations had the highest percentage of face-to-face CMS across all contract types. Moreover, the percent of CMRs performed face-to-face has remained relatively stable for MMP organizations (going from 12.3% in CY 2015 to 12.4% in CY 2016 to 13.5% in CY 2017), even while the percent of CMRs performed face-to-face has fallen significantly for MA-PDs (going from 15.5% in CY 2015 to 10.6% in CY 2016 and 8.1% in CY 2017) and PDPs (going from 15.8% in CY 2015 to 17.0% in CY 2016 to 9.1% in CY 2017).

Table 5.4: Percentage of CMRs by Method and Contract Type, 2015-2017

Method	Year	All Organizations	Employer Organizations	MA-PD Organizations	MMP Organizations	PDP Organizations
Face-to-Face	2015	15.5%	0.0%	15.5%	12.3%	15.8%
Face-to-Face	2016	12.6%	0.0%	10.6%	12.4%	17.0%

³² CY 2015-2017 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.

³³ The CMR rate for beneficiaries who met other expanded criteria may not include the same contracts for the overall figures if there are contracts that failed data element level validation checks for the MTM field regarding whether or not a beneficiary “Met the specified targeting criteria per CMS – Part D requirements.”

Method	Year	All Organizations	Employer Organizations	MA-PD Organizations	MMP Organizations	PDP Organizations
Face-to-Face	2017	8.5%	1.1%	8.1%	13.5%	9.1%
Telephone	2015	84.5%	100.0%	84.5%	87.7%	84.2%
Telephone	2016	87.3%	100.0%	89.4%	86.8%	82.8%
Telephone	2017	91.5%	98.9%	91.9%	86.3%	90.9%
Telehealth Consultation	2015	0.0%	0.0%	0.0%	0.0%	0.0%
Telehealth Consultation	2016	0.1%	0.0%	0.0%	0.9%	0.1%
Telehealth Consultation	2017	0.0%	0.0%	0.0%	0.3%	0.0%
Other	2015	0.0%	0.0%	0.0%	0.0%	0.0%
Other	2016	0.0%	0.0%	0.0%	0.0%	0.0%
Other	2017	0.0%	0.0%	0.0%	0.0%	0.0%

Overall, in CY 2017, the largest percentage of CMRs were performed by MTM Vendor In-House Pharmacists (51.0%), followed by MTM Vendor Local Pharmacists (14.4%) and Plan Sponsor Pharmacists (11.7%) (Table 5.5). While MA-PDs and PDPs followed trends similar to the overall averages, MMP contracts had a higher percentage of MTM Vendor Local Pharmacists (24.5%) and PBM Pharmacist (18.0%) and lower percentage of MTM Vendor In-House Pharmacists (36.8%). PBM Pharmacist providers comprised 85.3% of CMRs performed for Employer plans in CY 2017, however, this category of provider was significantly smaller for MA-PDs, MMPs, and PDPs, comprising just 18.0% of CMRs or less for each organization type.

Table 5.5: Percentage of CMRs by Qualified Provider that Performed the CMR, 2017

Provider	All	Employer	MA-PD	MMP	PDP
Physician	0.2%	0.0%	0.3%	0.0%	0.0%
Registered Nurse	2.8%	0.0%	2.9%	0.0%	2.8%
Licensed Practical Nurse	0.5%	0.0%	0.7%	0.0%	0.0%
Nurse Practitioner	2.2%	0.0%	3.5%	0.3%	0.0%
Physician's Assistant	0.0%	0.0%	0.0%	0.0%	0.0%
Local Pharmacist	8.1%	3.0%	3.0%	4.3%	17.9%
LTC Consultant Pharmacist	0.2%	1.4%	0.0%	1.2%	0.5%
Plan Sponsor Pharmacist	11.7%	0.0%	17.5%	14.0%	0.5%
PBM Pharmacist	4.7%	85.3%	3.3%	18.0%	6.0%
MTM Vendor Local Pharmacist	14.4%	0.0%	14.0%	24.5%	14.7%
MTM Vendor In-House Pharmacist	51.0%	10.2%	48.8%	36.8%	56.2%
Hospital Pharmacist	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist - Other	3.7%	0.0%	5.5%	0.4%	0.4%
Supervised Pharmacy Intern	0.5%	0.0%	0.4%	0.4%	0.7%
Other	0.0%	0.0%	0.0%	0.0%	0.1%

The most common recipient of a CMR was the beneficiary, with 87.4% in CY 2015, 85.2% in CY 2016, and 84.1% in CY 2017, followed by caregiver, other authorized individual, then the beneficiary's prescriber (Table 5.6). Among cognitively impaired beneficiaries receiving a CMR, the most common recipient was a caregiver, with 71.6% in CY 2015, 73.6% in CY 2016, and 65.5% in CY 2017. The share of CMRs performed directly with cognitively impaired beneficiaries decreased by 6.9

percentage points from CY 2015 to CY 2017, while the share of CMRs performed with the beneficiary's prescriber has increased by 10.8 percentage points during that same period.

Table 5.6: Percentage of CMRs by Recipient, 2015-2017

Recipient	2015 All Beneficiaries	2015 Cognitively Impaired Beneficiaries	2016 All Beneficiaries	2016 Cognitively Impaired Beneficiaries	2017 All Beneficiaries	2017 Cognitively Impaired Beneficiaries
Beneficiary	87.4%	15.9%	85.2%	10.0%	84.1%	9.0%
Beneficiary's Prescriber	0.6%	3.7%	1.4%	8.9%	1.9%	14.5%
Caregiver	10.4%	71.6%	11.6%	73.6%	11.8%	65.5%
Other Authorized Individual	1.6%	8.7%	1.8%	7.5%	2.2%	11.0%

6 ENROLLMENT AND DISENROLLMENT

Part D 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. MAOs and 1876 Cost plans report enrollment and disenrollment activity that does not involve a Part D benefit under the Part C requirements; all enrollment and disenrollment activity involving a Part D benefit (e.g. standalone prescription drug plan, MA prescription drug plan, cost plan with Part D optional supplemental benefit) is reported via the Part D requirements.³⁴

As outlined in 42 CFR 423.32 and 422.66, a PDP sponsor or MAO must process all enrollment requests received, regardless of whether they are received in a face-to-face interview, by mail, by telephone, or through the Online Enrollment Center (OEC). An individual or an individual's authorized representative must complete an enrollment request mechanism to enroll in a PDP or MA plan and submit the enrollment request to the PDP or MAO during a valid enrollment period. Upon receiving an enrollment request, a PDP sponsor or MAO must provide within 10 calendar days, one of the following: acknowledgement notice, request for additional information, or a notice of denial.

As provided for in 42 CFR 423.44 and 422.74, a PDP sponsor or MAO may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. A PDP sponsor or MAO may contact members to determine the reason for disenrollment, but they must not discourage members from disenrolling after they indicate their desire to do so. A member may request disenrollment from a PDP or MAO only during one of the election periods specified by CMS. The member may disenroll by one of four methods: (1) enrolling in another plan (during a valid enrollment period); (2) giving or faxing a signed written notice to the PDP sponsor or MAO; (3) submitting a request via the Internet to the PDP sponsor or MAO (if offered); or (4) Calling 1-800-MEDICARE.^{35,36}

Enrollment requests can be completed via paper, telephone, internet, or the Medicare Online Enrollment Center (OEC). Most enrollment requests were received via paper with 28.1% in CY 2015, 29.1% in CY 2016, and 27.7% in CY 2017 (Table 6.1). In CY 2015, the percent of requests received via OEC was 22.2% and decreased to 20.7% in CY 2016 before increasing to 21.7% in CY 2017; OEC requests were the second most common type of request in CY 2015. The percentage of telephonic requests increased in the three year period, from 22.1% in CY 2015 to 23.3% in CY 2016 to 25.2% in CY 2017; telephonic requests were the second most common type of request in CY 2016 and CY 2017. Internet requests had the smallest share in all years, going from 10.6% of requests in CY 2015 to 11.1% in CY 2016 and 10.2% in CY 2017.

³⁴ Measure values are weighted by HPMS Contract Year Average Enrollment.

³⁵ https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY_2017_PDP_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf

³⁶ https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf

Table 6.1: Enrollment Requests by Request Mechanism, 2015-2017

Request Mechanism	2015 Percent Of Requests	2016 Percent Of Requests	2017 Percent Of Requests
Paper	28.1%	29.1%	27.7%
Telephonic	22.1%	23.3%	25.2%
Internet	10.6%	11.1%	10.2%
OEC	22.2%	20.7%	21.7%

The percentage of enrollment requests complete at the time of initial receipt slightly decreased in each year, from 95.4% in CY 2015 to 94.7% in CY 2016 to 93.4% in CY 2017 (Table 6.2). The percentage of disenrollment requests that were complete at the time of initial receipt increased overall, from 75.9% in CY 2015 to 80.9% in CY 2016, and then dipping to 78.9% in CY 2017.

Table 6.2: Enrollment and Disenrollment Requests Complete, 2015-2017

Request Type	2015 Percent Complete at Initial Receipt	2016 Percent Complete at Initial Receipt	2017 Percent Complete at Initial Receipt
Enrollment	95.4%	94.7%	93.4%
Disenrollment	75.9%	80.9%	78.9%

Less than 2% of enrollment requests were denied by the sponsor in each year (Table 6.3). The percentage of disenrollment requests denied by the sponsor decreased from 12.5% in CY 2015 to 9.9% in CY 2016, then decreased further to 7.5% in CY 2017.

Table 6.3: Enrollment and Disenrollment Requests Denied by the Sponsor, 2015-2017

Request Type	2015 Percent Denied by Sponsor	2016 Percent Denied by Sponsor	2017 Percent Denied by Sponsor
Enrollment	1.4%	1.6%	1.6%
Disenrollment	12.5%	9.9%	7.5%

Starting in CY 2016, sponsors were required to report information on the number of involuntary disenrollments for failure to pay plan premium and of these beneficiaries, the number of that requested to be reinstated for Good Cause and were reinstated. Of beneficiaries that were involuntarily disenrolled for failure to pay the plan premium, the percent that submitted a timely request for reinstatement due to good cause decreased from 12.6% in CY 2016 to 10.2% in CY 2017 (Table 6.4). Of these requests for reinstatement, 52.5% resulted in a favorable good cause determination in CY 2016; this percentage increased to 66.8% in CY 2017. Of the requests receiving favorable good cause determinations, 82.2% of individuals were reinstated in CY 2016, decreasing to 76.9% in CY 2017.

Table 6.4: Involuntary Disenrollment Reinstatement Requests for Good Cause, 2016-2017

Request	2016	2017
Involuntarily Disenrolled Individuals (for Failure to Pay Plan Premium) who Submitted Timely Request for Reinstatement for Good Cause	12.6%	10.2%
Requests for Reinstatement for Good Cause Determinations that were Favorable	52.5%	66.8%
Favorable Good Cause Determinations were Individuals were Reinstated	82.2%	76.9%

7 IMPROVING DRUG UTILIZATION REVIEW CONTROLS

Sponsors are expected to comply with drug utilization management (DUM) requirements, as outlined in 42 C.F.R §423.153 et seq., to prevent the overutilization of opioids. As described in the 2017 Call Letter issued April 4, 2016, sponsors are expected to implement either soft and/or hard formulary-level cumulative morphine equivalent dose (MED) edit at point of sale (POS), while excluding from the edit(s) beneficiaries with known exemptions. POS soft edit claim rejections can be overridden at the pharmacy level by the pharmacist submitting the appropriate NCPDP codes or contacting the plan; hard edit claim rejections generally cannot be overridden in the absence of an action by the plan, such as a favorable coverage determination or appeal.³⁷ CMS expects sponsors' Pharmacy and Therapeutics (P&T) committees to develop the specifications for the formulary-level MED POS edit(s) based on the observed opioid overutilization in their Part D plans, as well as the reasonableness of the number of targeted beneficiaries for plan oversight.

For CY 2017, CMS recommended that soft opioid edit thresholds be set no lower than 90 mg MED, and hard opioid edit thresholds be set no lower than 200 mg MED. If sponsors included a prescriber count criterion, CMS recommended a limit no lower than two prescribers. Sponsors may also have included a pharmacy count criterion. Sponsors were expected to apply specifications to minimize false positive claim rejections by adding known exceptions to the edit criteria, such as hospice enrollment, certain cancer diagnoses, and high-dose opioid use previously deemed medically necessary through case management or the coverage determination and appeals process. Collection of Improving Drug Utilization Review Controls data enables CMS to monitor sponsors' implementation of the cumulative MED POS edits and the impact and outcome of the edits aggregated at the contract and unique beneficiary levels. CMS also uses plan reported DUR information to identify and communicate with outlier contracts to encourage ongoing process improvements that appropriately balance patient safety and access.

Part D plans submitted their soft and hard edit criteria to CMS prior to their Reporting Requirement submissions. Plans designated whether they were implementing a soft edit, hard edit, or both. All plans within the same contract reported implementing the same soft or hard edit criteria; therefore, all values are reported at the contract-level. Table 7.1 summarizes the number of Part D contracts, with a soft or hard edit, and the numbers and percent of Part D enrollees and opioid users by contract type. Table 7.2 details the number and percent of beneficiaries and opioid users by edit criteria. Tables 7.3-7.4 provide key metrics for the Drug Utilization Review (DUR) reporting requirements by edit criteria as well as by contract type, separately for soft and hard edits. The MED threshold, optional opioid prescriber and optional opioid dispensing pharmacy counts respectively are reported as three numbers in the summary tables (e.g. 100/4/4). Appendix B provides additional contract type-level details.

For 2017, a total of 44 million³⁸ beneficiaries were enrolled into 709 Part D contracts (4,243 individual plans). Of these, 3,182 Part D plans submitted DUR reporting requirements data to CMS (not shown) representing 37.3 million Medicare enrollees, or 85% of the total Medicare Part D enrollment. The data validation phase identified 524 (16.5%) plans as reporting inaccurate data. The remaining 2,658

³⁷ <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>

³⁸ Brief Summaries Of Medicare & Medicaid: Title XVIII and Title XIX of The Social Security Act as of October 15, 2018 (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2018.pdf>)

plans or 475 contracts (Table 7.1) include about 30 million beneficiaries, or 68% of all Part D enrollees. The data reported in Tables 7.1-7.4 are limited to this population that passed validation.

Nearly 70% (N=329) of contracts, representing 56% of the validated population (Table 7.1), implemented a soft edit. Fewer contracts, 56.2% (N=267) of contracts, representing 52.2% of the validated population, implemented a hard edit. The percent of opioid users enrolled in these contracts were similar, 55.5% for soft edits and 51.9% for hard edits.

Table 7.1 reports additional contract counts and enrollment by soft and hard edit implementation, and four contract types: Employer, MA-PD, MMP and PDP. The majority of enrollees in contracts implementing a soft edit (N≈ 16.8 million) were enrolled in either a PDP or MA-PD contract, 55.4% and 42.2%, respectively, or 97.6%. MMP and Employer contracts implementing soft edits represent a small proportion of enrollees, 2.4% (MMP: 1.9%, Employer: 0.5%). The proportion of opioid users enrolled in contracts implementing a soft edit compared to all enrollees was slightly higher for MMPs and PDPs and lower for employer and MA-PD plans. This suggests that proportionally, the percent of opioid users is higher in MMPs and PDPs than Employer and MA-PDs contracts implementing a soft edit.

MA-PDs (N=214) had the highest number of contracts implementing a hard edit while Employer contracts had the fewest (N=3). The number of Employer contracts implementing hard and soft edits was consistent at 3 contracts. The majority of beneficiaries enrolled in contracts with hard edits were in PDP and MA-PD contracts, 47.1% and 51.4%, respectively, or 98.5%. MMP and employer plans represent a small proportion of this enrollment, 1.4% (MMP: 0.9%, Employer: 0.5%). The proportion of opioid users enrolled in contracts implementing a hard edit compared to all enrollees was similar across contract types.

Fewer MMP, MA-PD and PDP contracts implemented a hard edit reducing the total enrollment population by more than million enrollees (N ≈15.6 million). The greatest difference in the number of contracts implementing a hard edit compared with a soft edit was among MMPs, a decrease from 34 to 20 contracts. Despite fewer contracts implementing a hard edit, the proportion of MA-PD enrollees in a contract with a hard edit increased from 42.2% to 51.4%, but decreased among PDPs from 55.4% to 47.1% and MMPs from 1.9% to 0.9%. Similar proportions were observed among contract type opioid users.

Table 7.1: Number and Percent of Part D Contracts Implementing Opioid MED Point-of-Sale Edits by Enrollment and Opioid Users, 2017³⁹

Contract Type	Total Number of Contracts	Percent of Total Contracts	Total Enrollment ⁴⁰	Percent of Total Enrollment	Total Number of Enrolled Opioid Users	Percent of Total Enrolled Opioid Users
Total ⁴¹	475	-	29,941,074	-	8,682,655	-
Soft Edit Contracts		69.3%		56.0%		55.5%
All (Total) ⁴²	329		16,775,797		4,816,565	
Employer	3	0.9%	79,570	0.5%	17,468	0.4%
MA-PD	259	78.7%	7,078,262	42.2%	1,852,821	38.5%
MMP	34	10.3%	316,255	1.9%	97,648	2.0%
PDP	33	10.0%	9,301,710	55.4%	2,848,628	59.1%
Hard Edit Contracts		56.2%		52.2%		51.9%
All (Total) ⁴³	267		15,629,692		4,503,423	
Employer	3	1.1%	79,570	0.5%	17,468	0.4%
MA-PD	214	80.1%	8,040,867	51.4%	2,293,484	50.9%
MMP	20	7.5%	148,306	0.9%	44,268	1.0%
PDP	30	11.2%	7,360,949	47.1%	2,148,203	47.7%

The soft edit criteria ranged from 90 to 250 MED, 0 to 4 opioid prescribers and 0 to 3 opioid dispensing pharmacies. The most common edit combination for contracts with a soft edit was an MED threshold of 120, a provider count of 4, and a pharmacy count of 0 (28.6% of soft edit contracts), which also included the greatest number of enrollees (49.8%) and opioid users (51.0%) of any soft edit combination, (Table 7.2). The hard edit criteria ranged from 200 to 500 MED, 0 to 4 opioid prescribers and 0 to 3 opioid dispensing pharmacies. The greatest percentage of contracts (40.4%) that implemented a hard edit had an MED Threshold of 200, a provider count of 0, and a pharmacy count of 0. The largest percentage of enrollees (53.0%) and opioid users (56.0%), however, were in contracts with a hard edit that had an MED threshold of 360, a provider count of 0, and a pharmacy count of 0.

³⁹ Individuals with cancer or enrolled in hospice are excluded from the beneficiary and opioid user counts. Total number of contracts required to report POS edit data and passing data validation checks. Denominators for contracts implementing either a opioid soft or hard MED POS edit percent calculations. The All (Total) row is the denominator for contract-type percent calculations.

⁴⁰ Individuals with cancer or enrolled in hospice are excluded from the enrollment and opioid user counts.

⁴¹ Total number of contracts required to report MED POS edit data that passed data validation checks. Denominators for contracts implementing either a opioid soft or hard MED POS edit percent calculations.

⁴² Denominator for contract-type percent calculations.

⁴³ Denominator for contract-type percent calculations

Table 7.2: Number and Percent of Part D Contracts Implementing Opioid MED Point-of-Sale Edits by Criteria Combinations, Enrollment and Opioid Users, 2017⁴⁴

Criteria Combinations	Percent of Contracts	Percent of Enrollment	Percent of Enrolled Opioid Users
Soft Edit Contracts	N=329	N= 16,775,797	N=4,816,565
90/0/0	2.7%	0.7%	0.5%
90/2/0	0.6%	0.5%	0.5%
100/0/0	6.1%	10.2%	8.5%
100/2/0	0.3%	2.2%	2.1%
100/3/3	10.0%	6.5%	6.7%
120/0/0	20.4%	7.1%	6.9%
120/0/3	0.6%	0.1%	0.1%
120/2/0	15.8%	4.1%	3.7%
120/2/2	5.2%	0.7%	0.7%
120/3/0	8.8%	17.8%	18.9%
120/3/3	0.3%	0.1%	0.1%
120/4/0	28.6%	49.8%	51.0%
250/0/0	0.6%	0.2%	0.2%
Hard Edit Contracts	N=267	N=15,629,692	N=4,503,423
200/0/0	40.4%	31.3%	29.4%
200/2/0	31.1%	11.3%	11.0%
200/3/0	0.7%	0.1%	0.0%
200/3/3	0.4%	0.1%	0.1%
200/4/0	0.4%	1.4%	0.8%
240/0/0	0.4%	0.2%	0.1%
240/3/3	0.4%	0.1%	0.1%
240/4/0	0.4%	0.1%	0.1%
250/0/0	1.1%	1.3%	1.3%
300/0/0	1.9%	0.6%	0.4%
360/0/0	18.7%	53.0%	56.0%
400/0/0	0.7%	0.1%	0.1%
400/2/2	2.6%	0.2%	0.2%
500/0/0	0.7%	0.2%	0.2%

The average number of soft edit rejected claims per beneficiary with at least one claim rejection was 4.5 for all contracts and ranged from 1.0 for 120/3/3 to 5.6 for 100/0/0 edit contracts and from 3.0 for PDPs to 5.7 for MMPs (Table 7.3). The percentage of beneficiaries with at least one soft edit claim rejection whose edit was overridden ranged from 0.0% for both 120/0/3 and 120/3/3 edit contracts⁴⁵ to 81.2% for 100/3/3 contracts, with 70.3% overall. The percentage of beneficiaries with a rejected claim whose edit was overridden was the lowest for Employer contracts (61.8%) and PDPs 62.3% and higher for MA-PDs (72.2%) and for MMPs (80.9%). The percentage of soft edit claim rejections that were

⁴⁴ Criteria Combination is the MED Threshold / Provider Count / Pharmacy Count

⁴⁵ The two contracts with 120/0/3 and 120/3/3 edit combinations represent 0.2% of beneficiaries enrolled in contracts with soft edits (Table 7.2).

overridden was lowest at 0.0% for both 120/0/3 and 120/3/3 edit contracts⁴⁶ and was the highest at 71.5% for 100/0/0 edit contracts, with 65.5% overall. The percentage was highest for MMPs at 72.8% and lowest for PDPs at 52.8% while the percentage was 60.5% for Employer contracts and 67.6% for MA-PDs.

Table 7.3: Soft Opioid MED Point-of-Sale Claim Rejection and Override Rates by Criteria Combinations and Contract Type, 2017^{47,48}

Soft-POS Edit:	Percent of Enrollment	Number of Rejected Claims per Beneficiary with a Rejected Claim		Beneficiaries with a Rejected Claim whose Edit was Overridden		Soft Edit Claim Rejections that are Overridden	
		Contracts (N)	Average	Contracts (N)	Percent	Contracts (N)	Percent
Total	N=16,775,797	264	4.5	264	70.3%	255	65.5%
Combinations							
90/0/0	0.7%	9	4.4	9	46.5%	9	54.9%
90/2/0	0.5%	2	2.4	2	68.0%	2	64.4%
100/0/0	10.2%	19	5.6	19	78.5%	19	71.5%
100/2/0	2.2%	1	2.1	1	54.8%	1	44.5%
100/3/3	6.5%	30	3.8	30	81.2%	30	65.6%
120/0/0	7.1%	67	4.6	66	63.7%	57	57.7%
120/0/3	0.1%	1	2	1	0.0%	1	0.0%
120/2/0	4.1%	48	2.4	48	67.1%	48	62.1%
120/2/2	0.7%	11	1.8	11	70.1%	12	58.7%
120/3/0	17.8%	28	1.9	28	75.3%	28	64.8%
120/3/3	0.1%	1	1	1	0.0%	1	0.0%
120/4/0	49.8%	45	1.7	46	60.3%	45	48.5%
250/0/0	0.2%	2	2.5	2	71.1%	2	62.6%
Contract Type							
Employer	0.5%	3	4.5	3	61.8%	3	60.5%
MA-PDs	42.2%	206	4.9	206	72.2%	201	67.6%
MMPs	1.9%	28	5.7	28	80.9%	24	72.8%
PDP	55.4%	27	3	27	62.3%	27	52.8%

The average number of hard edit rejected claims per beneficiary was 3.8 for all contracts with hard edit, ranging from 3.0 for Employer contracts to 4.0 for PDPs. The average number of hard edit rejected claims per beneficiary ranged from 1.0 for 200/3/3 and 240/3/3 edit contracts⁴⁹ to 4.2 for 360/0/0 edit contracts. The percent of beneficiaries with at least one hard edit rejected claim that requested a coverage determination for an opioid subject to a hard edit was 51.4% for all contracts and ranged from 49.0% for MA-PDs to 57.0% for Employer contracts. The percentage ranged from 0.0% for 200/3/3 and 240/3/3 edit contracts to 68.9% for 500/0/0 contracts. The percent of coverage determinations requested resulting in the coverage of an opioid drug was generally high in CY 2017, with 83.7% for all contracts.

⁴⁶ The two contracts with 120/0/3 and 120/3/3 edit combinations represent 0.2% of beneficiaries enrolled in contracts with soft edits (Table 7.2).

⁴⁷ Criteria Combination is the MED Threshold / Provider Count / Pharmacy Count

⁴⁸ The number of contracts presented in the table varies from the number of contracts with soft edits because of element-level data validation failures for elements used to calculate measures

⁴⁹ The two contracts with 200/3/3 and 240/3/3 edit combinations represent 0.2% of beneficiaries enrolled in contracts with hard edits (Table 7.2)

The percent ranged from 79.4% for MA-PDs and MMPs to 86.4% for PDPs and from 0.0% for 400/2/2 edit contracts to 100.0% for the 240/0/0 contract.

Table 7.4: Hard Opioid MED Point-of-Sale Opioid Claim Rejection and Coverage Rates by Criteria Combinations and Contract Type, 2017^{50,51}

Hard-POS Edit:	Percent of Enrollment	Number of Rejected Claims per Beneficiary with a Rejected Claim		Beneficiaries with a Rejected Claim that Requested a Coverage Determination		Beneficiaries with a Coverage Determination Request Resulting in Successfully Processed (paid) Opioid Claim	
		Contracts (N)	Average	Contracts (N)	Percent	Contracts (N)	Percent
Total	15,629,692	248	3.8	247	51.4%	223	83.7%
Combinations							
200/0/0	31.3%	101	3.5	100	48.7%	87	87.1%
200/2/0	11.3%	77	3.2	77	50.0%	72	86.8%
200/3/0	0.1%	2	3.0	2	66.7%	1	50.0%
200/3/3	0.1%	1	1.0	1	0.0%	0	.
240/0/0	0.2%	1	3.0	1	46.5%	1	100.0%
240/3/3	0.1%	1	1.0	1	0.0%	0	.
250/0/0	1.3%	3	2.8	3	42.6%	3	83.6%
300/0/0	0.6%	5	3.2	5	62.1%	5	81.9%
360/0/0	53.0%	50	4.2	50	54.4%	50	80.3%
400/0/0	0.1%	2	2.9	2	37.5%	1	93.3%
400/2/2	0.2%	3	3.3	3	11.1%	1	0.0%
500/0/0	0.2%	2	3.1	2	68.9%	2	95.7%
Contract-Type							
Employer	0.5%	3	3.0	3	57.0%	3	82.2%
MA-PDs	51.4%	203	3.6	202	49.0%	181	79.4%
MMPs	0.9%	14	4.0	14	51.2%	13	79.4%
PDP	47.1%	28	3.9	28	53.0%	26	86.4%

⁵⁰ Criteria Combination is the MED Threshold / Provider Count / Pharmacy Count

⁵¹ The number of contracts presented in the table varies from the number of contracts with hard edits because of element-level data validation failures for elements used to calculate measures

8 SUMMARY OF RESULTS

The results of this analysis reveal that there have been improvements in several reporting areas from CY 2015 to CY 2017, while other areas have potential for improvement in future years.

Grievances

The percentage of contracts reporting zero Part D grievances decreased slightly between CY 2015 and CY 2016 and then increased slightly in CY 2017. In all three years, contracts with less than 500 enrollees had the highest share of contracts reporting zero Part D grievances. The share of contracts with more than 10,000 enrollees reporting zero Part D grievances was marginal in comparison.

The Part D grievances rate increased considerably from CY 2015 to CY 2016 and then increased slightly in CY 2017; the increase in CY 2016 was primarily due to a substantial increase in the grievance rate for PDP contracts between CY 2015 and CY 2016. This increase in the grievance rate for PDP contracts in CY 2016 was driven by a large contract with an above average grievance rate being included in CY 2016 after having been excluded in CY 2015 due to DV issues. 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 and years, with the exception of expedited grievances.

Coverage Determinations and Redeterminations

The percent of contracts reporting zero redeterminations decreased from CY 2015 to CY 2016, and then increased slightly in CY 2017. The overall rate of coverage determinations per 1,000 enrollees decreased from CY 2015 to CY 2016 and then increased in CY 2017. In contrast, the rate of redeterminations per 1,000 enrollees increased slightly in each year from CY 2015 to CY 2017. Additionally, from CY 2015 to 2017, 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 determinations and redeterminations had fully favorable outcomes. Reopened coverage determinations and redeterminations remained low in all years, with reopened coverage determinations slightly higher than reopened redeterminations.

The most common reason for the rejection of pharmacy transactions in CY 2015, CY 2016, and CY 2017 was non-formulary status, followed by prior authorization requirements and quantity limit requirements. The percentage of contract quarter combinations with high cost edits in place for non-compounds decreased from CY 2015 to CY 2016, then increased in CY 2017. Employer contracts had a significant increase in the percentage of contract-quarter combinations with high cost edits in place for non-compounds in CY 2017.

MTM Programs

The overall rate of beneficiaries eligible for an MTM program based on specified targeting criteria per CMS Part D requirements or other expanded plan-specific targeting criteria decreased in each year from CY 2015 to CY 2017. The eligibility rate for beneficiaries that met other expanded targeting

criteria fell considerably between CY 2015 and CY 2016, and then remained stable in CY 2017, which was driven by several large contracts no longer offering MTM to beneficiaries using expanded criteria beginning in CY 2016.

The overall percent of eligible MTM beneficiaries that received a Comprehensive Medication Review (CMR) increased from CY 2015 to CY 2016, and then again increased in CY 2017. That means that compared to 2016, almost 130,000 more CMRs were performed in 2017. 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 2017, 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 2015, CY 2016, and CY 2017. In CY 2016 and CY 2017, telephonic requests were the second most common type of request, followed closely by OEC requests. In CY 2015, OEC requests were the second most common, followed closely by telephonic requests. Almost all enrollment requests were complete at the time of initial receipt in all three years, but the percentage decreased slightly from CY 2015 to CY 2016 and then decreased again in CY 2017. The percentage of disenrollment requests that were complete at the time of initial receipt increased from CY 2015 to CY 2016 and then decreased in CY 2017. This percentage of disenrollment requests complete at the time of initial receipt was considerably lower than the corresponding percentage of enrollment requests complete at the time of initial receipt 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 by the sponsor was much higher. In CY 2016, data related to the number of involuntary disenrollments for failure to pay plan premium was first reported. From CY 2016 to CY 2017, the percent of individuals involuntarily disenrolled for failure to pay the plan premium who submitted a timely request for reinstatement for good cause decreased, and of these individuals, the percent of requests for reinstatement that received favorable good cause determinations increased from CY 2016 to CY 2017. The majority of favorable good cause determinations resulted in the individual being reinstated, although the percentage decreased from CY 2016 to CY 2017.

Improving Drug Utilization Review Controls

About 30 million or 68% of all Part D beneficiaries were enrolled in a Part D plan that reported implementing either an opioid MED POS soft or hard edit with valid data in CY 2017, including 8.7 million opioid users. About half of the beneficiaries (~16.8 million) and opioid users (~4.8 million) were enrolled in contracts that implemented soft edits, and about half were in contracts with hard edits (~15.6 million and 4.5 million respectively). A larger proportion of MA-PD enrollees and opioid users were enrolled in contracts implementing a hard edit compared to a soft edit, which was the opposite for PDP and MMP plans. The percentage of soft edit claim rejections that were overridden varied based on contract type and soft edit combination. The average number of soft edit rejected claims per beneficiary

with at least one rejected claim and the number of overrides per beneficiary with at least one soft edit rejected claim also varied. PDPs tended to have lower rejection rates and override rates for soft edit rejected claims, while MMPs had higher rejection rates and override rates for soft edit rejected claims, however, these differences may be related to the specific criteria implemented rather than the contract type. Hard edit measures showed less variation based on contract type and hard edit criteria than soft edit measures. The metrics in this reporting section added in CY 2017 were maintained for CY 2018, which will allow for a more fruitful analysis of trends in Drug Utilization Review Controls with CY 2018 data.

9 APPENDIX A: ADDITIONAL COVERAGE DETERMINATIONS AND REDETERMINATIONS DATA

The following tables provide additional information regarding coverage determinations and redeterminations data reported by contracts participating in Medicare Part D from CY 2015 to CY 2017.

Table 9.1: Redeterminations Data, 2015-2017^{52,53}

Year	Number of Contracts	Number of Redeterminations	Number Fully Favorable	Number Partially Favorable	Percent Fully or Partially Favorable
2015	574	638,386	472,107	2,835	74.4%
2016	555	681,526	504,501	3,158	74.5%
2017	530	806,259	550,447	4,627	68.8%

Table 9.2: Coverage Determinations Data for Pharmacy Rejections, 2015-2017⁵⁴

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
2015	574	40,762,226	23,637,266	2,665,274	15,800,725
2016	555	47,427,649	22,702,862	2,511,536	14,896,473
2017	530	43,525,763	24,480,040	2,422,199	14,699,373

Table 9.3: Coverage Determinations Data, 2015-2017⁵⁵

Year	Number of Contracts	Number of Coverage Determinations	Number Fully Favorable	Percent Fully Favorable	Number Partially Favorable	Percent Partially Favorable	Number Adverse	Percent Adverse
2015	574	7,446,084	4,784,961	64.3%	33,314	0.4%	2,627,809	35.3%
2016	555	7,458,787	4,909,722	65.8%	16,291	0.2%	2,532,774	34.0%
2017	530	8,556,036	5,406,830	63.2%	27,927	0.3%	2,859,940	33.4%

⁵² Includes standard and expedited requests for redetermination and excludes requests subsequently withdrawn.

⁵³ 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.

⁵⁴ 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.

⁵⁵ 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.

10 APPENDIX B: ADDITIONAL IMPROVING DRUG UTILIZATION REVIEW CONTROLS DATA

Table 10.4: Extended Soft Opioid MED Point-of-Sale Edit Data by Contract Type and Criteria Combinations Criteria, 2017

Contract Type- Soft Edit Criteria Combination	Total Number of Contracts	Total Enrollment	Total Number of Enrolled Opioid Users	Percent of Enrollment	Percent of Enrolled Opioid Users
All	329	16,775,797	4,816,565	56.0%	28.7%
Employer	3	79,570	17,468	0.3%	22.0%
Employer - 120/0/0	2	74,674	16,069	0.3%	21.5%
Employer - 120/2/0	1	4,896	1,399	0.0%	28.6%
MA-PDs	259	7,078,262	1,852,821	23.6%	26.2%
MA-PD - 90/0/0	6	92,758	19,716	0.3%	21.3%
MA-PD - 90/2/0	2	82,619	22,371	0.3%	27.1%
MA-PD - 100/0/0	20	1,715,594	410,330	5.7%	23.9%
MA-PD - 100/3/3	26	623,213	182,407	2.1%	29.3%
MA-PD - 120/0/0	50	666,401	192,404	2.2%	28.9%
MA-PD - 120/0/3	2	18,552	6,080	0.1%	32.8%
MA-PD - 120/2/0	39	459,734	126,316	1.5%	27.5%
MA-PD - 120/2/2	14	51,661	15,788	0.2%	30.6%
MA-PD - 120/3/0	24	1,153,729	316,178	3.8%	27.4%
MA-PD - 120/3/3	1	20,984	6,688	0.1%	31.9%
MA-PD - 120/4/0	73	2,157,572	544,020	7.2%	25.2%
MA-PD - 250/0/0	2	35,445	10,523	0.1%	29.7%
MMPs	34	316,255	97648	1.1%	30.9%
MMP - 90/0/0	2	17,720	4,140	0.1%	23.4%
MMP - 100/3/3	1	18,869	5,336	0.1%	28.3%
MMP - 120/0/0	8	63,318	20,367	0.2%	32.2%
MMP - 120/2/0	7	31,926	7,312	0.1%	22.9%
MMP - 120/2/2	2	36,622	10,039	0.1%	27.4%
MMP - 120/3/0	3	34,841	13,189	0.1%	37.9%
MMP - 120/4/0	11	112,959	37,265	0.4%	33.0%
PDP	33	9,301,710	2848628	31.1%	30.6%
PDP - 90/0/0	1	2,577	548	0.0%	21.3%
PDP - 100/2/0	1	362,289	100,900	1.2%	27.9%
PDP - 100/3/3	6	452,510	134,953	1.5%	29.8%
PDP - 120/0/0	7	383,561	103,061	1.3%	26.9%
PDP - 120/2/0	5	187,378	42,788	0.6%	22.8%
PDP - 120/2/2	1	33,076	7,244	0.1%	21.9%
PDP - 120/3/0	2	1,792,276	582,574	6.0%	32.5%
PDP - 120/4/0	10	6,088,043	1,876,560	20.3%	30.8%

Table 10.5: Extended Soft Opioid MED Point-of-Sale Claim Rejection and Override Rates by Contract Type and Criteria Combinations, 2017

Contract Type- Soft Edit Criteria Combination	Percent of Enrollment	2017					
		Number of Rejected Claims per Beneficiary with a Rejected Claim		Beneficiaries with a Rejected Claim whose Edit was Overridden		Soft Edit Claim Rejections that are Overridden	
		Contracts (N)	Average	Contracts (N)	Percent	Contracts (N)	Percent
All	56.0%	264	4.5	264	70.3%	255	65.6%
Employer	0.3%	3	4.5	3	61.8%	3	60.5%
Employer - 120/0/0	0.3%	2	4.6	2	61.6%	2	60.4%
Employer - 120/2/0	0.0%	1	1.7	1	68.3%	1	68.6%
MA-PDs	23.6%	206	4.9	206	72.2%	201	67.6%
MA-PD - 90/0/0	0.3%	6	3.6	6	40.9%	6	42.2%
MA-PD - 90/2/0	0.3%	2	2.4	2	68.0%	2	64.4%
MA-PD - 100/0/0	5.7%	19	5.6	19	78.5%	19	71.5%
MA-PD - 100/3/3	2.1%	23	3.5	23	80.2%	23	68.4%
MA-PD - 120/0/0	2.2%	50	4.5	49	63.5%	44	60.1%
MA-PD - 120/0/3	0.1%	1	2.0	1	0.0%	1	0.0%
MA-PD - 120/2/0	1.5%	37	2.3	37	65.4%	37	60.6%
MA-PD - 120/2/2	0.2%	8	1.8	8	64.2%	9	45.9%
MA-PD - 120/3/0	3.9%	23	1.9	23	75.6%	23	66.0%
MA-PD - 120/3/3	0.1%	1	1.0	1	0.0%	1	0.0%
MA-PD - 120/4/0	7.2%	34	1.8	35	50.6%	34	36.4%
MA-PD - 250/0/0	0.1%	2	2.5	2	71.1%	2	62.6%
MMPs	1.1%	28	5.7	28	80.9%	24	72.8%
MMP - 90/0/0	0.1%	2	8.8	2	79.0%	2	84.7%
MMP - 100/3/3	0.1%	1	10.7	1	83.3%	1	60.2%
MMP - 120/0/0	0.2%	8	5.7	8	83.9%	4	65.0%
MMP - 120/2/0	0.1%	5	2.8	5	65.0%	5	49.5%
MMP - 120/2/2	0.1%	2	1.9	2	71.9%	2	64.3%
MMP - 120/3/0	0.1%	3	1.8	3	71.1%	3	59.5%
MMP - 120/4/0	0.4%	7	1.4	7	100.0%	7	81.8%
PDP	31.1%	27	3.0	27	62.3%	27	52.8%
PDP - 90/0/0	0.0%	1	2.8	1	33.9%	1	31.8%
PDP - 100/2/0	1.2%	1	2.1	1	54.8%	1	44.5%
PDP - 100/3/3	1.5%	6	3.8	6	82.3%	6	63.1%
PDP - 120/0/0	1.3%	7	4.5	7	58.5%	7	51.1%
PDP - 120/2/0	0.6%	5	2.8	5	72.2%	5	67.0%
PDP - 120/2/2	0.1%	1	1.7	1	74.0%	1	69.2%
PDP - 120/3/0	6.0%	2	1.9	2	75.4%	2	64.6%
PDP - 120/4/0	20.3%	4	1.7	4	61.1%	4	49.8%

Table 10.3: Extended Hard Opioid MED Point-of-Sale Edit Data by Contract Type and Criteria Combinations, 2017

Contract Type- Hard Edit Criteria Combination	Total Number of Contracts	Total Enrollment	Total Number of Enrolled Opioid Users	Percent of Enrollment	Percent of Enrolled Opioid Users
All	267	15,629,692	4,503,423	52.2%	28.8%
Employer	3	79,570	17,468	0.3%	22.0%
Employer - 200/2/0	1	4,896	1,399	0.0%	28.6%
Employer - 300/0/0	2	74,674	16,069	0.3%	21.5%
MA-PDs	214	8,040,867	2,293,484	26.9%	28.5%
MA-PD - 200/0/0	87	2,098,890	538,358	7.0%	25.7%
MA-PD - 200/2/0	66	1,059,847	297,893	3.5%	28.1%
MA-PD - 200/3/0	2	10,971	2,044	0.0%	18.6%
MA-PD - 200/3/3	1	11,180	2,570	0.0%	23.0%
MA-PD - 200/4/0	1	213,833	35,231	0.7%	16.5%
MA-PD - 240/0/0	1	26,595	6,285	0.1%	23.6%
MA-PD - 240/3/3	1	20,984	6,688	0.1%	31.9%
MA-PD - 250/0/0	2	169,210	49,186	0.6%	29.1%
MA-PD - 300/0/0	3	15,044	4,002	0.1%	26.6%
MA-PD - 360/0/0	44	4,368,167	1,337,500	14.6%	30.6%
MA-PD - 400/0/0	1	1,958	304	0.0%	15.5%
MA-PD - 400/2/2	3	8,743	2,900	0.0%	33.2%
MA-PD - 500/0/0	2	35,445	10,523	0.1%	29.7%
MMPs	20	148,306	44,268	0.5%	29.9%
MMP - 200/0/0	5	31,710	11,898	0.1%	37.5%
MMP - 200/2/0	8	49,205	12,403	0.2%	25.2%
MMP - 360/0/0	2	24,727	8,269	0.1%	33.4%
MMP - 400/0/0	1	17,507	4,117	0.1%	23.5%
MMP - 400/2/2	4	25,157	7,581	0.1%	30.1%
PDP	30	7,360,949	2,148,203	24.6%	29.2%
PDP - 200/0/0	16	2,767,549	774,323	9.2%	28.0%
PDP - 200/2/0	8	655,341	183,121	2.2%	27.9%
PDP - 240/4/0	1	15,407	4,818	0.1%	31.3%
PDP - 250/0/0	1	29,803	9,714	0.1%	32.6%
PDP - 360/0/0	4	3,892,849	1,176,227	13.0%	30.2%

Table 10.4: Extended Hard Opioid MED Point-of-Sale Claim Rejection and Coverage Rates by Contract Type and Criteria Combinations, 2017

Contract Type- Hard Edit Criteria Combination	Percent of Enrollment	2017					
		Number of Rejected Claims per Beneficiary with a Rejected Claim		Beneficiaries with a Rejected Claim that Requested a Coverage Determination		Beneficiaries with a Coverage Determination Request Resulting in Successfully Processed (paid) Opioid Claim	
		Contracts (N)	Average	Contracts (N)	Percent	Contracts (N)	Percent
All	52.2%	248	3.8	247	51.4%	223	83.7%
Employer	0.3%	3	3.0	3	57.0%	3	82.2%
Employer - 200/2/0	0.0%	1	2.2	1	41.7%	1	90.0%
Employer - 300/0/0	0.3%	2	3.1	2	59.0%	2	81.5%
MA-PDs	26.9%	203	3.6	202	49.0%	181	79.4%
MA-PD - 200/0/0	7.0%	83	3.3	82	46.1%	71	76.8%
MA-PD - 200/2/0	3.5%	62	3.1	62	47.0%	57	85.7%
MA-PD - 200/3/0	0.0%	2	3.0	2	66.7%	1	50.0%
MA-PD - 200/3/3	0.0%	1	1.0	1	0.0%	0	.
MA-PD - 200/4/0	0.7%	0	.	0	.	0	.
MA-PD - 240/0/0	0.1%	1	3.0	1	46.5%	1	100.0%
MA-PD - 240/3/3	0.1%	1	1.0	1	0.0%	0	.
MA-PD - 250/0/0	0.6%	2	2.8	2	45.3%	2	83.9%
MA-PD - 300/0/0	0.1%	3	3.8	3	73.5%	3	83.3%
MA-PD - 360/0/0	14.6%	44	4.0	44	52.1%	44	79.2%
MA-PD - 400/0/0	0.0%	1	1.0	1	0.0%	0	.
MA-PD - 400/2/2	0.0%	1	1.5	1	0.0%	0	.
MA-PD - 500/0/0	0.1%	2	3.1	2	68.9%	2	95.7%
MMPs	0.5%	14	4.0	14	51.2%	13	79.4%
MMP - 200/0/0	0.1%	3	4.2	3	65.0%	3	83.9%
MMP - 200/2/0	0.2%	6	4.4	6	38.0%	6	66.2%
MMP - 360/0/0	0.1%	2	3.1	2	33.6%	2	71.1%
MMP - 400/0/0	0.1%	1	2.9	1	38.5%	1	93.3%
MMP - 400/2/2	0.1%	2	4.8	2	20.0%	1	0.0%
PDP	24.6%	28	3.9	28	53.0%	26	86.5%
PDP - 200/0/0	9.2%	15	3.6	15	50.0%	13	92.6%
PDP - 200/2/0	2.2%	8	3.1	8	53.9%	8	88.4%
PDP - 240/4/0	0.1%	0	.	0	.	0	.
PDP - 250/0/0	0.1%	1	2.9	1	36.0%	1	82.6%
PDP - 360/0/0	13.0%	4	4.4	4	55.9%	4	81.0%

11 APPENDIX C: REPORT METRIC CALCULATIONS OVERVIEW

The following tables provide additional information on how the various metrics in this report are calculated and data elements involved in calculating these measures. Data element references are based on 2017 Part D Reporting Requirements and Technical Specifications.

Grievances

Table or Figure Name	Metric	Data Elements
Table 3.1: Contracts Reporting Zero Part D Grievances by Contract Type	Contracts Reporting Zero Grievances, by Organization Type	Sum of F, H, J, L, N, P, R, and V = 0
Table 3.2: Contracts Reporting Zero Part D Grievances by Enrollment	Contracts Reporting Zero Grievances, by Enrollment Category	Sum of F, H, J, L, N, P, R, and V = 0
Table 3.3: Part D Grievances by Category	Share of Grievances that were Enrollment/Disenrollment Grievances	$F / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Plan Benefit Grievances	$H / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Pharmacy Access Grievances	$J / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Marketing Grievances	$L / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Customer Service Grievances	$N / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Coverage Determination & Redetermination Process Grievances	$P / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Quality of Care Grievances	$R / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Other Grievances	$V / (\text{Sum of F, H, J, L, N, P, R, and V})$
Table 3.4: Percentage of Part D Grievances the Contract Responded to On Time by Grievance Type	Share of Grievances Responded to On Time	$(\text{Sum of G, I, K, M, O, Q, S, and W}) / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Enrollment/Disenrollment Grievances Responded to On Time	G / F
	Share of Plan Benefit Grievances Responded to On Time	I / H
	Share of Pharmacy Access Grievances Responded to On Time	K / J
	Share of Marketing Grievances Responded to On Time	M / L
	Share of Customer Service Grievances Responded to On Time	O / N
	Share of Coverage Determination & Redetermination Process Grievances Responded to On Time	Q / P
	Share of Quality of Care Grievances Responded to On Time	S / R
	Share of Other Grievances Responded to On Time	W / V
	Share of Expedited Grievances Responded to On Time	D / C

Table or Figure Name	Metric	Data Elements
Figure 3.1: Grievance Rates per 1,000 Enrollees per Month	Grievance Rate per 1,000 Enrollees per Month	$[(\text{Sum of F, H, J, L, N, P, R, and V}) / \text{Year Average Enrollment} * 1,000] * 30 / \text{Number of days in the reporting year}$

Coverage Determinations and Redeterminations

Table or Figure Name	Metric	Data Elements
Table 4.1: Percentage of Coverage Determinations by Outcome and Contract Type	Percent of Fully Favorable Coverage Determinations	2.E / 2.A
	Percent of Partially Favorable Coverage Determinations	2.F / 2.A
	Percent of Adverse Coverage Determinations	2.G / 2.A
Table 4.2: Contracts Reporting Zero Redeterminations by Contract Type	Contracts Reporting Zero Redeterminations	3.A = 0
Table 4.3: Percentage of Redeterminations by Outcome and Contract Type	Percent of Fully Favorable Redeterminations	3.E / 3.A
	Percent of Partially Favorable Redeterminations	3.F / 3.A
	Percent of Adverse Redeterminations	3.G / 3.A
Table 4.4: Reopened Decision Rates per 1,000 Enrollees by Contract Type	Reopened Coverage Determination Rate	$(4.B.4 = \text{Coverage Determination}) / \text{Year Average Enrollment} * 1,000$
	Reopened Redetermination Rate	$(4.B.4 = \text{Redetermination}) / \text{Year Average Enrollment} * 1,000$
Figure 4.1: Percentage of Pharmacy Transactions Rejected	Percent of Pharmacy Transactions Rejected due to Non-Formulary Status	1.B / 1.A
	Percent of Pharmacy Transactions Rejected due to Prior Authorization Requirements	1.C / 1.A
	Percent of Pharmacy Transactions Rejected due to Step Therapy Requirements	1.D / 1.A
	Percent of Pharmacy Transactions Rejected due to Quantity Limit Requirements	1.E / 1.A
	Percent of Pharmacy Transactions Rejected due to High Cost Edits for Non-Compounds	1.G / 1.A
	Percentage of High Cost Edits for Non-Compounds	$(\text{Total number of contract-quarter combinations with } 1.F = Y) / (\text{Total number of contract-quarter combinations})$
	Figure 4.3: Coverage Determination Rates per 1,000 Enrollees by Year and Contract Type	Coverage Determination Rate
Figure 4.4: Redetermination Rates per 1,000 Enrollees by Year and Contract Type	Redetermination Rate	3.A / Year Average Enrollment * 1,000
Figure 4.5: Coverage Determination and	Coverage Determination Rate	2.A in Quarter / Year Average Enrollment * 1,000

Table or Figure Name	Metric	Data Elements
Redetermination Rates per 1,000 Enrollees by Quarter	Redetermination Rate	3.A in Quarter / Year Average Enrollment * 1,000
Figure 4.6: Withdrawn and Dismissed Rates per 1,000 Enrollees	Withdrawn Coverage Determination Rate	2.H / Year Average Enrollment * 1,000
	Dismissed Coverage Determination Rate	2.I / Year Average Enrollment * 1,000
	Withdrawn Redetermination Rate	3.H / Year Average Enrollment * 1,000
	Dismissed Redetermination Rate	3.I / Year Average Enrollment * 1,000

MTM Programs

Table or Figure Name	Metric	Data Elements
Table 5.1: Percentage of Beneficiaries Eligible for an MTM Program	Percent of Beneficiaries Eligible for MTM Program	Number of MTM eligible beneficiaries / Year Average Enrollment
Table 5.2: Percentage of Beneficiaries Eligible for an MTM Program by Criteria	Percent of Eligible Beneficiaries that Met Specified Targeting Criteria	Number of beneficiaries enrolled in the reporting year for MTM with G = Y / Year Average Enrollment
	Percent of Eligible Beneficiaries that Met Other Expanded Targeting Criteria	Number of beneficiaries enrolled in the reporting year for MTM with G = N / Year Average Enrollment
Table 5.3: Percentage of Eligible MTM Beneficiaries that Received a CMR	CMR Rate, All	Number of CMR eligible beneficiaries with O = Y / Number of CMR eligible beneficiaries
	CMR Rate, for Beneficiaries who Met Specified Targeting Criteria	Number of CMR eligible beneficiaries with O = Y (when G = Y) / Number of CMR eligible beneficiaries (when G = Y)
	CMR Rate, for Beneficiaries who Met Other Expanded Targeting Criteria	Number of CMR eligible beneficiaries with O = Y (when G = N) / Number of CMR eligible beneficiaries (when G = N)
Table 5.4: Percentage of CMRs by Method and Contract Type	Percent of CMRs Performed via Face-to-Face Method	Number of CMR eligible beneficiaries with O = Y (when R = Face-to-Face) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed via Telephone Method	Number of CMR eligible beneficiaries with O = Y (when R = Telephone) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed via Telehealth Consultation Method	Number of CMR eligible beneficiaries with O = Y (when R = Telehealth Consultation) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed via Other Method	Number of CMR eligible beneficiaries with O = Y (when R = Other) / Number of CMR eligible beneficiaries with O = Y
Table 5.5: Percentage of CMRs by Qualified Provider that Performed the CMR	Percent of CMRs Performed by Physician	Number of CMR eligible beneficiaries with O = Y (when S = Physician) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Registered Nurse	Number of CMR eligible beneficiaries with O = Y (when S = Registered Nurse) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Licensed Practical Nurse	Number of CMR eligible beneficiaries with O = Y (when S = Licensed Practical

Table or Figure Name	Metric	Data Elements
Table 5.5: Percentage of CMRs by Qualified Provider that Performed the CMR (cont.)		Nurse) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Nurse Practitioner	Number of CMR eligible beneficiaries with O = Y (when S = Nurse Practitioner) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Physician's Assistant	Number of CMR eligible beneficiaries with O = Y (when S = Physician's Assistant) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Local Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = Local Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by LTC Consultant Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = LTC Consultant Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Plan Sponsor Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = Plan Sponsor Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by PBM Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = PBM Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by MTM Vendor Local Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = MTM Vendor Local Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by MTM Vendor In-House Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = MTM Vendor In-House Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Hospital Pharmacist	Number of CMR eligible beneficiaries with O = Y (when S = Hospital Pharmacist) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Pharmacist – Other	Number of CMR eligible beneficiaries with O = Y (when S = Pharmacist – Other) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Performed by Supervised Pharmacy Intern	Number of CMR eligible beneficiaries with O = Y (when S = Supervised Pharmacy Intern) / Number of CMR eligible beneficiaries with O = Y
Percent of CMRs Performed by Other	Number of CMR eligible beneficiaries with O = Y (when S = Other) / Number of CMR eligible beneficiaries with O = Y	
Table 5.6: Percentage of CMRs by Recipient	Percent of CMRs Received by Beneficiary	Number of CMR eligible beneficiaries with O = Y (when T = Beneficiary) / Number of CMR eligible beneficiaries with O = Y

Table or Figure Name	Metric	Data Elements
Table 5.6: Percentage of CMRs by Recipient (cont)	Percent of CMRs Received by Beneficiary's Prescriber	Number of CMR eligible beneficiaries with O = Y (when T = Beneficiary's Prescriber) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Received by Caregiver	Number of CMR eligible beneficiaries with O = Y (when T = Caregiver) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Received by Other Authorized Individual	Number of CMR eligible beneficiaries with O = Y (when T = Other Authorized Individual) / Number of CMR eligible beneficiaries with O = Y
	Percent of CMRs Received by Beneficiary for Cognitively Impaired Beneficiaries	Number of CMR eligible beneficiaries with O = Y (when H = Y and T = Beneficiary) / Number of CMR eligible beneficiaries with O = Y (when H = Y)
	Percent of CMRs Received by Beneficiary's Prescriber for Cognitively Impaired Beneficiaries	Number of CMR eligible beneficiaries with O = Y (when H = Y and T = Beneficiary's Prescriber) / Number of CMR eligible beneficiaries with O = Y (when H = Y)
	Percent of CMRs Received by Caregiver for Cognitively Impaired Beneficiaries	Number of CMR eligible beneficiaries with O = Y (when H = Y and T = Caregiver) / Number of CMR eligible beneficiaries with O = Y (when H = Y)
	Percent of CMRs Received by Other Authorized Individual for Cognitively Impaired Beneficiaries	Number of CMR eligible beneficiaries with O = Y (when H = Y and T = Other Authorized Individual) / Number of CMR eligible beneficiaries with O = Y (when H = Y)

Enrollment and Disenrollment

Table or Figure Name	Metric	Data Elements
Table 6.1: Enrollment Requests by Request Mechanism	Share of Requests Submitted via Paper	1.G / 1.A
	Share of Requests Submitted via Telephone	1.H / 1.A
	Share of Requests Submitted via Internet	1.I / 1.A
	Share of Requests Submitted via OEC	1.J / 1.A
Table 6.2: Enrollment and Disenrollment Requests Complete	Percent of Enrollment Requests Completed at Initial Receipt	1.B / 1.A
	Percent of Disenrollment Requests Completed at Initial Receipt	2.B / 2.A
Table 6.3: Enrollment and Disenrollment Requests Denied by the Sponsor	Percent of Enrollment Requests Denied for Any Reason	(1.D + 1.F) / 1.A
	Percent of Disenrollment Requests Denied for Any Reason	2.C / 2.A
Figure 6.1: Involuntary Disenrollment Reinstatement Requests for Good Cause	Percent of Involuntarily Disenrolled Individuals (for Failure to Pay Plan Premium) who Submitted Timely Request for Reinstatement for Good Cause	2. E / 2.D

Table or Figure Name	Metric	Data Elements
	Percent of Requests for Reinstatement for Good Cause Determinations that were Favorable	2.F / 2.E
	Percent of Favorable Good Cause Determinations where Individuals were Reinstated	2.G / 2.F

Improving Drug Utilization Review Controls

Table or Figure Name	Metric	Data Elements
Table 7.3: Soft Opioid MED Point-of-Sale Claim Rejection and Override Rates by Criteria Combinations and Contract Type, 2017	Average Number of Soft Edit Rejected Claims per Beneficiary with at least one Claim Rejected	E / F
	Percentage of Beneficiaries with at least one Soft Edit Rejected Claim whose Edit was Overridden	H / F
	Percentage of Soft Edit Claim Rejections that are Overridden	G / E
Table 7.4: Hard Opioid MED Point-of-Sale Claim Rejection and Coverage Rates by Criteria Combinations and Contract Type, 2017	Average Number of Hard Edit Rejected Claims per Beneficiary with at least one Claim Rejected	M / N
	Percent of Beneficiaries with at least one Hard edit Rejected Claim that Requested a Coverage Determination	O / N
	Percent of Beneficiaries with at least one Hard Edit Rejected Claim that had a Favorable Review of a Coverage Determination Resulting in the Coverage of an Opioid Drug	P / N

Appendix A: Additional Coverage Determinations and Redeterminations Data

Table or Figure Name	Metric	Data Elements
Table 9.1: Redeterminations Data	Number of Redeterminations	Total reported in 3.A
	Number of Fully Favorable Redeterminations	Total reported in 3.E
	Number of Partially Favorable Redeterminations	Total reported in 3.F
	Percent of Redeterminations that were Fully or Partially Favorable	$(3.E + 3.F) / 3.A$
Table 9.2: Coverage Determinations Data for Pharmacy Rejections	Number of Pharmacy Rejections due to Non-Formulary Status	Total reported in 1.B
	Number of Pharmacy Rejections due to Prior Authorization Requirements	Total reported in 1.C
	Number of Pharmacy Rejections due to Step Therapy Requirements	Total reported in 1.D
	Number of Pharmacy Rejections due to Quantity Limit Requirements	Total reported in 1.E
Table 9.3: Coverage Determinations Data	Number of Coverage Determinations	Total reported in 2.A
	Number of Fully Favorable Coverage Determinations	Total reported in 2.E
	Percent of Coverage Determinations that were Fully Favorable	2.E / 2.A

Table or Figure Name	Metric	Data Elements
	Number of Partially Favorable Coverage Determinations	Total reported in 2.F
	Percent of Coverage Determinations that were Partially Favorable	2.F / 2.A
	Number of Adverse Coverage Determinations	Total reported in 2.G
	Percent of Coverage Determinations that were Adverse	2.G / 2.A

Appendix B: Additional Improving Drug Utilization Review Controls Data

Table or Figure Name	Metric	Data Elements
Table 10.2: Extended Soft Opioid MED Point-of-Sale Claim Rejection and Override Rates by Contract Type and Criteria Combinations, 2017	Average Number of Soft Edit Rejected Claims per Beneficiary with at least one Claim Rejected	E / F
	Percentage of Beneficiaries with at least one Soft Edit Rejected Claim whose Edit was Overridden	H / F
	Percentage of Soft Edit Claim Rejections that are Overridden	G / E
Table 10.4: Extended Hard Opioid MED Point-of-Sale Claim Rejection and Coverage Rates by Contract Type and Criteria Combinations, 2017	Average Number of Hard-Edit Rejected Claims per Beneficiary with at least one Claim Rejected	M / N
	Percent of Beneficiaries with at least one Hard-edit Rejected Claim that Requested a Coverage Determination	O / N
	Percent of Beneficiaries with at least one Hard-Edit Rejected Claim that had a Favorable Review of a Coverage Determination Resulting in the Coverage of an Opioid Drug	P / N