CMS Is Eyeing Part D Performance Measures

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WASHINGTON — Medicare intends to use performance measures to monitor cost, quality, and access issues related to the new prescription drug benefit, a research analyst said during a meeting of the Medicare Payment Advisory Commission.

But Medicare has not yet "determined what those measures will be and how they will be used," said MedPAC analyst Cristina Boccuti. The Centers for Medicare and Medicaid Services will be collecting a large amount of data on the new drug benefit—or Medicare Part D—including drug utilization and plan benefit information, to construct these performance measures, Ms. Boccuti said. In addition to the agency's need for the data, "congressional agencies will need Part D data to report to the Congress on the impact of the drug benefit on cost, quality, and access," she added.

MedPAC commissioners recommended that the Health and Human Services department establish a process for the timely delivery of these data to interested parties. Individuals, employers, and government agencies currently use performance measures to evaluate how well health plans and pharmacy benefit managers manage drug benefits, Ms. Boccuti said.

To identify how policy makers could use these measures to monitor the Part D program, MedPAC convened a panel of 11 experts representing health plans, pharmacy benefits managers (PBMs), employers, pharmacies, consumers, quality assurance organizations, and researchers. The panel analyzed measures such as cost control, access and quality assurance, benefit administration and management, and enrollee satisfaction.

Based on the panel's findings, CMS plans to collect data on the following:

- Dispensing fees, generic dispensing rates, aggregate rebates, drug claims, and drug spending by plans and beneficiaries.
- Pharmacy networks, formularies (including prior authorization and exceptions), appeals rates, and drug utilization.
- Claims processing, including plans' out-of-pocket calculations.
- Beneficiary satisfaction, grievances, call center operations, and disenrollment rates.

Measures to track beneficiary satisfaction—such as member satisfaction surveys and performance of customer service call centers—are common types of performance guarantees that health plans and PBMs offer to their clients, she said. CMS plans to conduct its own consumer satisfaction surveys to provide comparative plan information to beneficiaries for making enrollment decisions. Also, plans will submit data on grievances filed, and call center performance measures such as abandonment rates and hold times.

Health plans will submit data on grievances filed and call center performance measures, such as hold times.

MedPAC commissioner Nancy-Ann DeParle, a health care consultant in Washington and former head of CMS' predecessor agency (the Health Care Financing Administration), asked whether CMS would be looking at these data at a physician level, in terms of who did the prescribing. "In our pay-for-performance discussions around physicians, [MedPAC indicated that] it would be useful to have this." Ms. Boccuti noted that there is a prescriber code associated with each drug.

On the issue of collecting cost data, Ms. DeParle said that she wondered whether CMS would be able to assess whether particular plans were getting a "good deal" on the drugs they purchased. "Will they know by drug?" she asked. The agency will be collecting data on actual drugs and the spending associated with those drugs, "so there will be the ability to track how much was paid at the point of sale," she said. ■