



Analysis of Calendar Year 2012 Medicare Part C Reporting Requirements Data

October 2014

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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 C benefit. One such data source is the Part C Reporting Requirements, which are data reported by Part C Medicare Advantage Organizations (MAOs) on various matters including the cost of operations, patterns of service utilization, availability and accessibility of services, and grievances lodged by beneficiaries. The submitted Reporting Requirements data aid CMS in better understanding the current functioning of the Part C 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 (PRA) requirements. CMS also releases technical guidance known as the Part C Reporting Requirements Technical Specifications to further assist Sponsors with the accurate and timely submission of required data. The Technical Specifications contain additional detail on how CMS expects data to be reported and which data checks and analyses will be performed on the submitted data. The goal of these documents is to ensure a common understanding of reporting requirements, outline the timeframes and methods through which data must be submitted, and explain how the data will be used to achieve monitoring and oversight goals. Current reporting requirements and related guidance documents can be found at: <http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.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 C reporting Requirements for each CY from 2010 through 2014.

Table 1.1: Summary of Part C Reporting Requirements by CY, 2010-2014

Reporting Section	CY 2010	CY2011	CY2012	CY2013	CY2014
Enrollment and Disenrollment			✓	✓	✓
Grievances	✓	✓	✓	✓	✓
Employer Group Plan Sponsors	✓	✓	✓	✓	✓
Plan Oversight of Agents ¹	✓	✓	✓		✓
Organization Determinations and Reconsiderations	✓	✓	✓	✓	✓
Special Needs Plan (SNP) Care Management	✓	✓	✓	✓	✓
Serious Reportable Adverse Events	✓	✓	✓	✓	
Provider Network Adequacy	✓	✓	✓		

¹ The Plan Oversight of Agents reporting section was suspended in CY 2013; however, sponsors resumed data collection with revised technical specifications in CY 2014.

Reporting Section	CY 2010	CY2011	CY2012	CY2013	CY2014
Benefit Utilization	✓				
Procedure Frequency	✓	✓	✓		
Private Fee-For-Service (PFFS) Plan Enrollment Verification Calls	✓	✓	✓	✓	✓
PFFS Provider Payment Dispute Resolution	✓	✓	✓	✓	✓

This report provides an analysis of the data submitted by MAOs in accordance with the Part C Reporting Requirements for CY 2012. Table 1.2 summarizes the reporting sections collected under the CY 2012 Part C Reporting Requirements and included in this report.

Table 1.2: CY 2012 Part C Reporting Sections

Reporting Section	Included in Report?
Employer Group Plan Sponsors	✓
Grievances	✓
Organization Determinations and Reconsiderations	✓
Plan Oversight of Agents	✓
Procedure Frequency	✓
Serious Reportable Adverse Events	✓
Provider Network Adequacy	✓
SNP Care Management	✓
PFFS Provider Payment Disputes	✓
PFFS Enrollment Verification	✓
Enrollment and Disenrollment	✓

For each of these reporting sections, this report presents program-wide averages and identifies trends between CY 2012 and CY 2011 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 1.3.

Table 1.3: Reporting Sections and Key Metrics

Reporting Section	Metric	Description
Grievances	Rate of grievances per 1,000 enrollees	The rate of grievances filed per 1,000 enrollees per month.
Organization Determinations and Reconsiderations	Percent of determinations with fully favorable outcomes	The percent of organization determinations for which the contract's decision was fully favorable for the beneficiary.
	Percent of determinations with partially favorable outcomes	The percent of organization determinations for which the contract's decision was partially favorable for the beneficiary.

Reporting Section	Metric	Description
	Percent of determinations with adverse outcomes	The percent of organization determinations for which the contract's decision was adverse for the beneficiary.
	Percent of adverse and partially favorable determinations appealed for reconsideration	The percent of organization determinations with adverse or partially favorable decisions for the beneficiary that were appealed for reconsideration.
	Percent of reconsiderations with fully favorable outcomes	The percent of reconsiderations for which the contract's decision was fully favorable for the beneficiary.
	Percent of reconsiderations with partially favorable outcomes	The percent of reconsiderations for which the contract's decision was partially favorable for the beneficiary.
	Percent of reconsiderations with adverse outcomes	The percent of reconsiderations for which the contract's decision was adverse for the beneficiary.
Plan Oversight of Agents	Rate of complaints per 1,000 enrollees	The rate of complaints per 1,000 enrollees.
Procedure Frequency	Rate of procedures per 1,000 enrollees	The rate of procedures (e.g., cancer-related surgeries, transplants) performed per 1,000 enrollees.
Serious Reportable Adverse Events (SRAEs)	Rate of non-surgical SRAEs per 100,000 enrollees	The rate of non-surgical SRAEs (e.g., dislocations, burns) per 100,000 enrollees.
Provider Network Adequacy	Percent of primary care providers (PCPs) continuously in network	The percent of PCPs enrolled in-network on the first day of the benefit year that remained continuously in the network throughout the benefit year.
	Percent of specialists continuously in network	The percent of specialists enrolled in-network on the first day of the benefit year that remained continuously in network throughout the benefit year.
	Rate of PCPs accepting new patients per 100 enrollees	The number of PCPs accepting new patients on the first day of the benefit year per 100 enrollees.
PFFS Enrollment Verification	Percent of plans that contacted less than 100% of new enrollees	The share of plans that failed to contact 100% of new enrollees to verify their enrollment and explain plan policies.
PFFS Provider Payment Disputes	Rate of provider payment appeals per 100 enrollees	The rate of provider payment appeals per 100 enrollees.
	Percent of payment appeals settled in the provider's favor	The percent of provider payment appeals settled with a favorable outcome for the provider.
	Percent of payment appeals resolved in over 60 days	The percent of provider payment appeals taking longer than 60 days to resolve.

Reporting Section	Metric	Description
SNP Care Management	Percent of new enrollees receiving an initial assessment	The percent of new enrollees in the SNP receiving an initial assessment of their medical, psychosocial, functional, and cognitive status.
	Percent of eligible enrollees receiving an annual reassessment	The percent of eligible enrollees in the SNP receiving a reassessment of their medical, psychosocial, functional, and cognitive status.
Employer Group Plan Sponsors	Number of employers	The number of reported employers.
Enrollment and Disenrollment	Percent of enrollment requests received by method	The share of enrollment requests received via method (e.g., paper, telephonic).
	Percent of requests complete at the time of initial receipt	The percent of enrollment or disenrollment requests that were complete at time of initial receipt.
	Percent of requests denied	The percent of enrollment or disenrollment requests that were denied by the sponsor.

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 is updated annually as part of CMS’s Display Measures.² 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.³

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 and exclusions applied to the data used in the analysis. Sections 3 through 13 present the main findings for each of the eleven reporting sections listed above.

² <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

³ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

2 DATA OVERVIEW

To improve reliability for analysis purposes, the Part C Reporting Requirements data undergo a series of integrity checks as part of the submission and validation processes. Additionally, exclusion criteria are applied over the course of this analysis in order to exclude data that have not passed these integrity checks and might otherwise skew results and findings.

2.1 Submission Process

Sponsors submit Reporting Requirements data via the Health Plan Management System (HPMS). Data can be uploaded or modified until the submission deadlines specified in CMS's Technical Specifications. If a Sponsor does not submit by the deadline, the Sponsor may request the opportunity to submit and HPMS would reopen the submission window for that Sponsor. Sponsors may also make requests for resubmission to HPMS, 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's outlier and placeholder notification process. The outlier and placeholder notices inform Sponsors if they have high or low (outlier) values relative to the rest of the Part C program or if they reported "0" (placeholder) values for all data elements in multiple reporting sections. When a resubmission occurs, the more recent data are utilized.

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 organizational 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 enhance assessment of their performance and to make improvements to their internal data, systems, and reporting processes.

The data validation process yields scores for each sponsor at the reporting section level, as well as element-specific pass or fail results for some reporting sections.⁴ For each reporting section, auditors record information for a total of seven standards to assess (i) proper documentation of source documents, (ii) proper calculation of data elements for each section, (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

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

changes (if applicable), and (vii) regular monitoring of the quality and timeliness of data collected by the delegated entity, if applicable.⁵ Scores at the reporting section level are assigned based on the share of applicable standards with which the contract complied.

As shown in Table 2.1, five of the eleven reporting sections included in this report underwent data validation for both the CY 2011 and CY 2012 data. CY 2011 data for the Employer Group Plan Sponsors and Provider Network Adequacy sections underwent validation, but the CY 2012 data did not. Data for the Procedure Frequency, PFFS Provider Payment Disputes, PFFS Enrollment Verification, and Enrollment and Disenrollment sections are collected for monitoring purposes only and did not undergo validation.

Table 2.1: Reporting Sections Undergoing Data Validation

Reporting Section	CY 2012 Data	CY 2011 Data
Employer Group Plan Sponsors	-	2012 DV
Grievances	2013 DV	2012 DV
Organization Determinations and Reconsiderations	2013 DV	2012 DV
Plan Oversight of Agents	2013 DV	2012 DV
Procedure Frequency	-	-
Serious Reportable Adverse Events	2014 DV	2013 DV
Provider Network Adequacy	-	2012 DV
SNP Care Management	2014 DV	2013 DV
PFFS Provider Payment Disputes	-	-
PFFS Enrollment Verification	-	-
Enrollment and Disenrollment	-	N/A

2.3 Exclusion Criteria

Contracts' inclusion in this analysis is contingent on (i) the contract submitting the required data by the specified reporting deadline, and (ii) the submitted data meeting minimum data validation requirements. Contracts that terminate on or before the applicable deadline to submit data validation results to CMS are excluded. For CY 2011 reporting sections that underwent validation in the 2012 data validation cycle, contracts must have a section-specific data validation score of at least 90% in order to be included. For CY 2011 and CY 2012 reporting sections that underwent validation in the 2013 or 2014 data validation cycles, contracts must have a section-specific data validation score of at least 95% to be included.

Table 2.2 displays data validation results by reporting section and CY of data. The CY 2012 reporting sections with the lowest percentage of contracts achieving a passing data validation score are SNP Care Management, with 75%, and Organization Determinations and

⁵ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

Reconsiderations, with 85%. The SRAE section had the highest percentage of contracts meeting the minimum data validation passing score for CY 2012 data, with 97%.

Table 2.2: Summary of Data Validation (DV) Results by Reporting Measure, 2011-2012

Reporting Measure	2012				2011				
	Number of Contracts that Underwent DV	Percent of Contracts Achieving Passing Score	Number of Contracts Achieving Minimum DV Score		Number of Contracts that Underwent DV	Percent of Contracts Achieving Passing Score	Number of Contracts Achieving Minimum DV Score		
			95%	100%			90%	95%	100%
Employer Group Plan Sponsors	<i>Not Validated</i>				213	100%	213	213	186
Grievances	521	88%	460	379	545	95%	516	496	469
Organization Determinations and Reconsiderations	528	85%	447	408	551	93%	514	488	449
Plan Oversight of Agents	522	89%	465	338	546	94%	515	467	416
Procedure Frequency	<i>Not Validated</i>				<i>Not Validated</i>				
SRAEs	479	97%	465	377	495	93%	-	462	358
Provider Network Adequacy	<i>Not Validated</i>				528	95%	500	475	377
SNP Care Management	216	75%	161	149	222	77%	-	171	166
PFFS Provider Payment	<i>Not Validated</i>				<i>Not Validated</i>				
PFFS Enrollment Verification	<i>Not Validated</i>				<i>Not Validated</i>				
Enrollment and Disenrollment	<i>Not Validated</i>				<i>Not Collected</i>				

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 calculation.

3 GRIEVANCES

To assess whether beneficiaries are satisfied with the provision of Medicare services, CMS requires Part C sponsors to report the number of grievances completed during the year. Grievances are defined as complaints filed by Medicare enrollees or their representatives regarding the timeliness, appropriateness, access to or setting of provided health services, procedures, or other items.⁶ A grievance becomes complete when the plan notifies the enrollee of its decision. Plans are expected to notify enrollees of their decision no later than 30 days after the date the grievance is filed with the health plan.⁷

In CY 2012, 4.3% of plans with at least 100 enrollees reported that no grievances were filed, compared to 4.1% in CY 2011 (Table 3.1). Non-SNPs had a lower share of plans reporting zero grievances relative to SNPs in both years. Within SNP plans, 6.7% of Local Coordinated Care Plans (CCPs) with at least 100 enrollees in CY 2012 reported zero grievances.

Table 3.1: Plans with at least 100 Enrollees Reporting Zero Grievances by Plan Type, 2011-2012

Plan Type	2012			2011		
	Number of Plans	Number of Plans Reporting Zero Grievances	Share of Plans Reporting Zero Grievances	Number of Plans	Number of Plans Reporting Zero Grievances	Share of Plans Reporting Zero Grievances
All	1,710	74	4.3%	2,029	83	4.1%
SNP	249	16	6.4%	310	14	4.5%
Local CCP	239	16	6.7%	299	14	4.7%
Regional CCP	10	0	0.0%	11	0	0.0%
Non-SNP	1,461	58	4.0%	1,719	69	4.0%
Local CCP	1,265	52	4.1%	1,420	45	3.2%
Regional CCP	11	0	0.0%	79	1	1.3%
PFFS/1876 Cost	184	6	3.3%	219	23	10.5%
Medical Savings Account (MSA)	1	0	0.0%	1	0	0.0%

In both years, the majority of plans with at least 100 enrollees that reported zero grievances have fewer than 1,000 enrollees (Table 3.2). Only 12% of plans that reported zero grievances had 1,000 or more enrollees.

⁶ <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf>

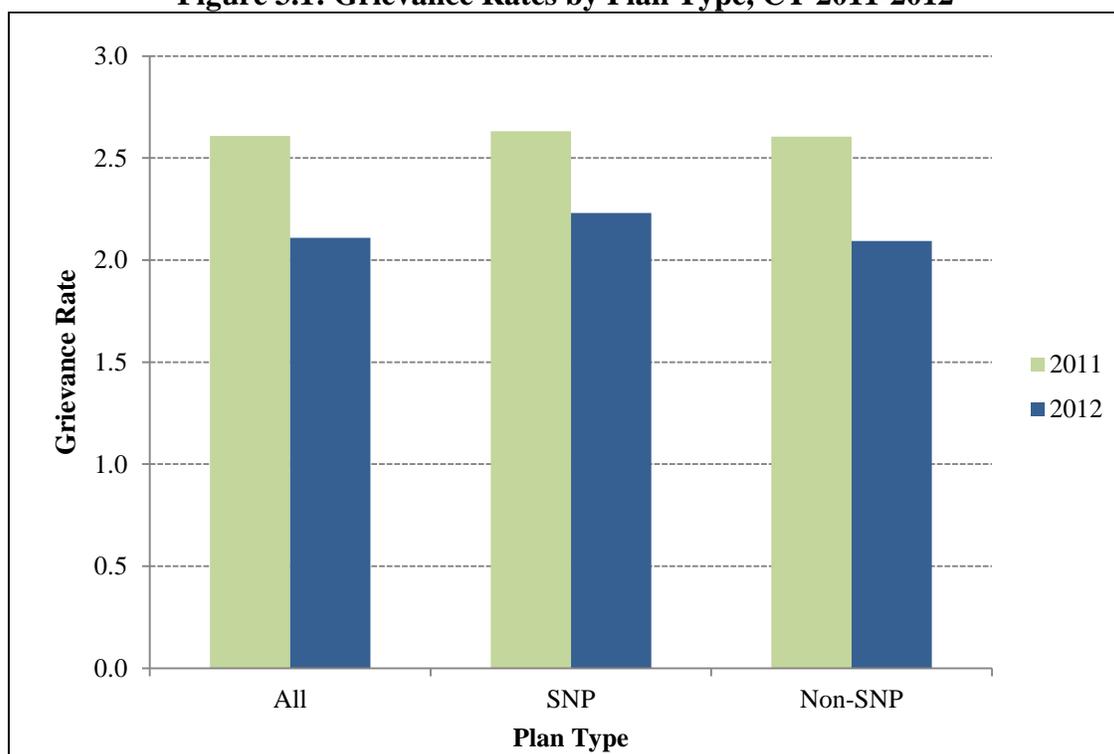
⁷ MAOs may choose to request an extension of up to 14 days but must promptly notify enrollees that they intend to do so.

Table 3.2: Plans with at least 100 Enrollees and Reporting Zero Grievances by Enrollment, 2011-2012

Plan Enrollment	2012		2011	
	Number of Plans	Share of Total	Number of Plans	Share of Total
All	74	100.0%	83	100.0%
100 - 999	65	87.8%	73	88.0%
1,000 - 9,999	9	12.2%	10	12.0%

The overall grievance rate per 1,000 enrollees per month decreased from 2.6 in CY 2011 to 2.1 in CY 2012 (Figure 3.1), showing that grievances were filed less often in CY 2012 than in the previous year.

Figure 3.1: Grievance Rates by Plan Type, CY 2011-2012⁸



Reported data enable CMS to identify the reason a grievance was filed, including reasons such as fraud and abuse, enrollment/disenrollment, access/benefit packages, marketing, confidentiality/privacy, quality of care, or other reasons. Grievances filed related to benefit packages and customer services were most common in CY 2012, with just over 0.5 grievances filed per 1,000 enrollees for each category (Table 3.3). Grievances due to other reasons were

⁸ Data are weighted by plan year average HPMS enrollment.

filed at a rate of 0.29 grievances per 1,000 enrollees, followed by grievances filed due to access at a rate of 0.26.

Table 3.3: Grievance Rates per 1,000 Enrollees by Plan Type and Grievance Category, 2012⁹

Plan Type	Grievance Category									
	Fraud and Abuse	Enrlmt/ Disenrlmt	Benefit Package	Access	Mktg	Cust. Service	Privacy	Quality of Care	Appeals	Other
All	0.02	0.15	0.52	0.26	0.14	0.51	0.01	0.19	0.02	0.29
SNP	0.04	0.17	0.29	0.32	0.12	0.64	0.01	0.25	0.01	0.38
Non-SNP	0.02	0.14	0.55	0.26	0.14	0.49	0.01	0.18	0.02	0.28

Looking solely at the number of reported grievances, independent of plan enrollment, grievances due to other reasons is the most frequently filed category in CY 2011 and second most frequent in CY 2012 (Table 3.4). Since there were no significant changes in the share of grievances for any category, it can be inferred that many of the grievances filed in the ‘other’ category in CY 2011 were related to customer service, which was reported in its own category in CY 2012 and comprised 22% of all grievances in this year.

Table 3.4: Share of Grievances by Category, 2011-2012

Grievance Type	2012	2011
All	100.0%	100.0%
Fraud/Abuse	1.3%	1.0%
Enrollment/Disenrollment/ Access/Benefit Package ¹⁰	36.8%	35.7%
Marketing	5.2%	4.7%
Customer Service	22.4%	-
Confidentiality/Privacy	0.6%	0.4%
Quality of Care	11.9%	11.9%
Appeals	1.1%	0.1%
Other Grievances	20.8%	46.1%

⁹ Data are weighted by plan year average HPMS enrollment.

¹⁰ In CY 2012, separate data elements were reported for Enrollment/Disenrollment, Benefit Package, and Access grievances, though these categories were all reported as one element in CY 2011. These numbers are therefore combined in the above table to provide a more accurate comparison between years. In CY 2012, 20.6% of all grievances were filed in the Benefit Package category, 9.3% in the Access category, and 6.9% in the Enrollment/Disenrollment category.

4 ORGANIZATION DETERMINATIONS AND RECONSIDERATIONS

To assess whether beneficiaries can successfully request and obtain payment for health services, CMS requires that MAOs report the number of organization determinations, reconsiderations, and whether the outcome of each is fully favorable, partially favorable, or adverse for the beneficiary. Organization determinations include plan responses to requests for coverage, including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. When enrollees, their providers, or their representatives request coverage for a service, the organization must make a determination stating the level of coverage it will provide, if any. If the MAO provides full coverage, then the outcome of the determination is fully favorable for the beneficiary; if the MAO provides some coverage but not the full amount, then the determination outcome is partially favorable; and if the MAO chooses not to cover the service, then the outcome is adverse. Beneficiaries can appeal adverse and partially favorable determinations through a process known as filing for reconsideration. MAOs then decide whether to uphold or overturn the adverse determination upon reconsideration, the latter indicating a favorable outcome for the beneficiary.

The percent of organization determinations with fully favorable outcomes decreased between years, from 97.6% in CY 2011 to 91.2% in CY 2012 (Table 4.1). The percentage of determinations with partially favorable or adverse outcomes increased, from 0.1% to 4.4% and 2.3% to 4.4%, respectively.

Table 4.1: Percent of Organization Determinations by Outcome, 2011-2012¹¹

Measure	2012		2011	
	Measure Value	Number of Contracts	Measure Value	Number of Contracts
Percent of Determinations with Fully Favorable Outcomes	91.2%	427	97.6%	483
Percent of Determinations with Partially Favorable Outcomes	4.4%	427	0.1%	483
Percent of Determinations with Adverse Outcomes	4.4%	427	2.3%	483

The percentage of adverse and partially favorable determinations appealed for reconsideration decreased between CY 2011 and CY 2012, from 4.5% to 1.7% (Table 4.2). The largest decrease for a single organization type is for PFFS/1876 Cost organizations, whose rate dropped from 8.1% in CY 2011 to 1.9% in CY 2012.

¹¹ Data are weighted by contract year average HPMS enrollment.

Table 4.2: Percent of Adverse and Partially Favorable Determinations Appealed for Reconsideration, 2011-2012¹²

Organization Type	2012		2011	
	Measure Value	Number of Contracts	Measure Value	Number of Contracts
All	1.7%	422	4.5%	460
Local CCP	1.7%	388	4.1%	415
Regional CCP	1.3%	11	5.2%	13
PFFS/1876 Cost	1.9%	21	8.1%	30
MSA	0.1%	2	0.1%	2

The percent of reconsiderations with fully favorable outcomes for the beneficiary increased from 72.1% in CY 2011 to 74.7% in CY 2012 (Table 4.3), indicating an increase in the number of beneficiary-favorable rulings at the reconsideration stage. The percentage of reconsiderations with adverse outcomes decreased from 27.1% in CY 2011 to 24.0% in CY 2012.

Table 4.3: Percent of Reconsiderations by Outcome, 2011-2012¹³

Measure	2012		2011	
	Measure Value	Number of Contracts	Measure Value	Number of Contracts
Percent of Reconsiderations with Fully Favorable Outcomes	74.7%	421	72.1%	462
Percent of Reconsiderations with Partially Favorable Outcomes	1.3%	421	0.9%	462
Percent of Reconsiderations with Adverse Outcomes	24.0%	421	27.1%	462

¹² Data are weighted by contract year average HPMS enrollment.

¹³ Data are weighted by contract year average HPMS enrollment.

5 PLAN OVERSIGHT OF AGENTS

To determine whether sponsors are monitoring their marketing agents and pursuing disciplinary actions as needed, CMS requires that MAOs report data on beneficiary complaints against marketing agents and MAOs' oversight efforts. MAOs report the number of complaints filed against agents in the HPMS Complaint Tracking Module (CTM) or filed directly with the MAO or Cost Contractor. Examples of actions that may result in complaints include enrolling beneficiaries in plans without their consent, steering beneficiaries into a particular plan, or making an appointment to tell a beneficiary about a plan without the beneficiary requesting such an appointment.¹⁴ MAOs also report their responses to these complaints, such as investigating agents or revoking agents' selling privileges.

As the CY 2011 and CY 2012 Part C Technical Specifications stated that the total number of agents reported under this section should reflect "the total number of unique individual agents who were licensed to sell on behalf of the Parent Organization,"¹⁵ metrics for this section are assessed at both the parent organization and contract levels. In the parent organization level analysis, the highest value reported for any contract under the parent organization is utilized as the parent organization's value.

Parent Organization Level

The total number of agents reported per parent organization ranges from 0 to 49,091 for CY 2012. Six parent organizations reported that zero agents were licensed to sell on their behalf, and one reported more than 30,000 agents (Table 5.1). Just over half of the parent organizations included in the analysis (75 out of 144) reported between 1 and 100 agents. Across all parent organizations, a total of 146,995 agents were reported as licensed to sell.

Table 5.1: Distribution of Agents per Parent Organization, 2012

Number of Agents	Number of Parent Organizations
0	6
1-10	32
11-50	26
51-100	11
101-200	14
201-300	8
301-500	14
501-1,000	14
1,001-5,000	15
5,001-10,000	1

¹⁴ <http://www.medicare.gov/publications/pubs/pdf/10111.pdf>

¹⁵ http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/PartCTechSpecs_2012_011012.pdf

Number of Agents	Number of Parent Organizations
10,001-30,000	2
30,000 +	1

Contract Level

The rate of complaints against agents per 1,000 enrollees decreased from approximately 0.06 in CY 2011 to 0.02 in CY 2012 (Table 5.2). The largest decrease between years was for Regional CCP organizations, whose complaint rate per 1,000 enrollees decreased from approximately 0.15 to 0.02.

Table 5.2: Rate of Complaints against Agents per 1,000 Enrollees, 2011-2012¹⁶

Organization Type	2012		2011	
	Measure Value	Number of Contracts	Measure Value	Number of Contracts
All	0.02	464	0.06	514
Local CCP	0.02	424	0.05	469
Regional CCP	0.02	11	0.15	13
PFFS/1876 Cost	0.00	28	0.07	30
MSA	2.50	1	0.00	2

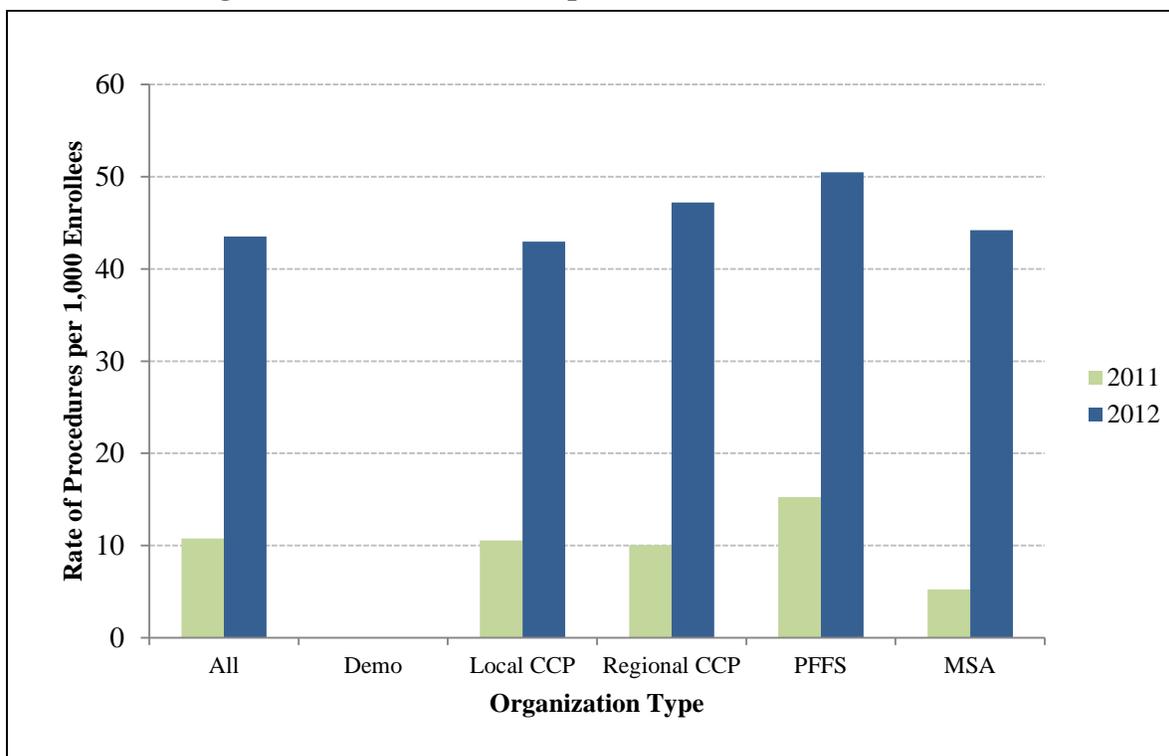
¹⁶ Data are weighted by contract year average HPMS enrollment.

6 PROCEDURE FREQUENCY

To monitor beneficiary access to medical procedures, CMS requires that sponsors report the number of enrollees that underwent certain procedures, including cardiac catheterization, open coronary angioplasty, hip or knee replacements, transplants, coronary artery bypass grafts, gastric bypass, and surgery to treat cancer.¹⁷

In CY 2011, certain measures that were reported through HEDIS were not required to be reported again via the Reporting Requirements. This reporting exclusion was lifted in CY 2012; therefore, as expected, the number of procedures per 1,000 enrollees significantly increased from 10.8 in CY 2011 to 43.5 in CY 2012 (Figure 6.1).

Figure 6.1: Procedure Rate per 1,000 Enrollees, 2011-2012¹⁸



¹⁷ http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/PartCTechSpecs_2012_011012.pdf

¹⁸ Data are weighted by contract year average HPMS enrollment.

7 SERIOUS REPORTABLE ADVERSE EVENTS

Part C beneficiaries may suffer from serious reportable adverse events, which are harmful events resulting from medical care that occurs in an acute hospital or within a specified period following discharge. MAOs are required to report data on SRAEs, and CMS uses this information to monitor the incidence of these events among Medicare beneficiaries. Data are reported by specific event, including occurrences such as blood incompatibility, air embolisms, burns, dislocations, and intracranial injuries.

The overall SRAE rate per 100,000 enrollees significantly decreased from 291.2 in CY 2011 to 73.5 in CY 2012 (Table 7.1).¹⁹ Notably, the rate of Stage III and IV Pressure Ulcers and Vascular Catheter-Associated Infections per 100,000 enrollees decreased from 47.9 and 50.08 in CY 2011 to 5.81 and 3.91 in CY 2012, respectively.

Table 7.1: SRAE Rates per 100,000 Enrollees, 2011-2012²⁰

Metric	2012		2011	
	Measure Value	Number of Contracts	Measure Value	Number of Contracts
Total Non-Surgical SRAE Rate per 100,000 Enrollees	50.07	448	221.07	488
Rate of Falls And Trauma per 100,000 Enrollees	28.56	455	71.00	488
Total SRAE Rate per 100,000 Enrollees	73.49	418	291.22	488
Rate of Surgeries on Wrong Body Part	0.02	465	0.02	488
Rate of Surgeries On Wrong Patient	0.00	465	0.00	488
Rate of Wrong Surgical Procedures	0.00	465	0.00	488
Rate of Surgeries With Post-Operative Death	0.18	463	1.44	488
Rate of Surgeries With Foreign Object Left	0.71	463	0.78	488
Rate of Air Embolism Events	0.07	464	2.02	488
Rate of Blood Incompatibility Events	0.02	465	1.94	488
Rate of Stage III and IV Pressure Ulcers	5.81	463	47.90	488
Rate of Fractures	21.55	458	30.72	488
Rate of Dislocations	0.87	464	4.28	488
Rate of Intracranial Injuries	2.74	462	28.58	488
Rate of Crushing Injuries	0.12	464	4.22	488
Rate of Burns	2.31	464	3.20	488
Rate of Vascular Catheter-Associated Infections	3.91	461	50.08	488
Rate of Catheter-Associated UTIs	9.81	463	10.86	488
Rate of Manifestations Of Poor Glycemic Control	2.35	464	37.27	488
Rate of SSI (Mediastinitis) after CABG	0.38	456	0.57	488
Rate of SSI after Orthopedic Procedures	13.63	452	27.83	488
Rate of SSI after Bariatric Surgery	0.68	448	1.81	488
Rate of DVT and Pulmonary Embolism after Orthopedic Procedures	6.04	459	37.69	488

¹⁹ Due to clarifications in the Technical Specifications, contracts were more likely to incorrectly report conditions present on admission in CY 2011 than in CY 2012.

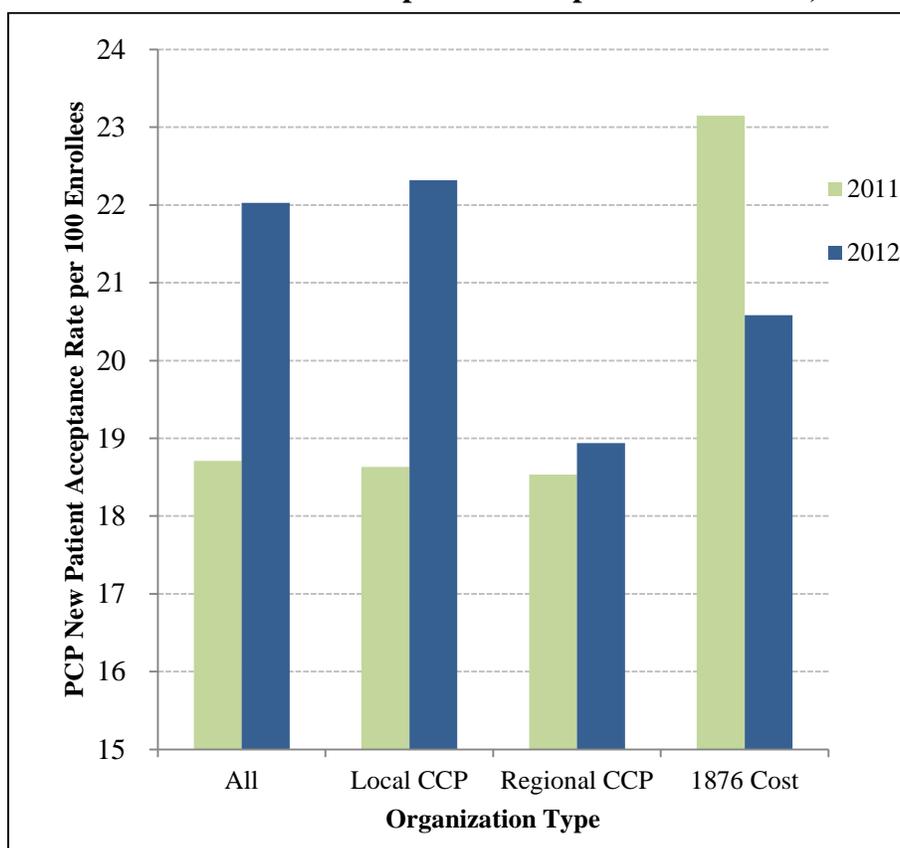
²⁰ Data are weighted by contract year average HPMS enrollment.

8 PROVIDER NETWORK ADEQUACY

To assess whether beneficiaries have sufficient access to primary care providers (PCPs) and specialists, CMS requires that sponsors report the number of providers in their network at the beginning and end of the benefit year, as well as the number of providers continuously enrolled in the network during the year. Sponsors also report the number of PCPs accepting new patients.

The PCP new patient acceptance rate per 100 enrollees measures new enrollees' access to providers by evaluating the number of PCPs accepting new patients on the first day of the reporting period. This rate increased from 18.7 in CY 2011 to 22.0 in CY 2012 (Figure 8.1). The largest difference between years was for Local CCP organizations, whose new patient acceptance rate increased from 18.6 in CY 2011 to 22.3 in CY 2012.

Figure 8.1: PCP New Patient Acceptance Rate per 100 Enrollees, 2011-2012²¹

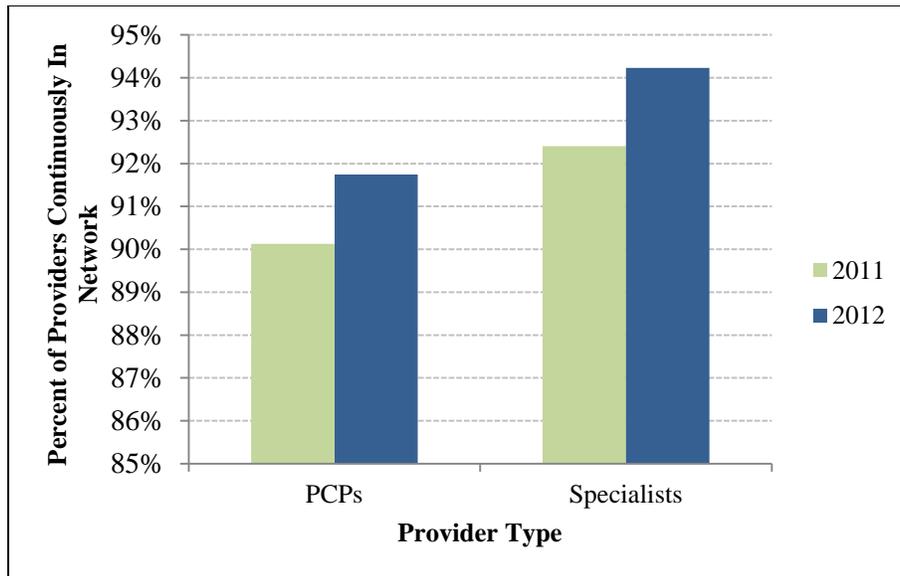


The percentages of PCPs and specialists continuously in network assess the share of providers enrolled on the first day of the benefit year that stayed enrolled in the provider network

²¹ Data are weighted by contract year average HPMS enrollment.

throughout the entire year. From the beneficiary perspective, this represents the probability that the provider chosen by the beneficiary at the beginning of the year will remain available throughout the year. The overall percentages of PCPs and specialists continuously in network both increased from CY 2011 to CY 2012 (Figure 8.2).

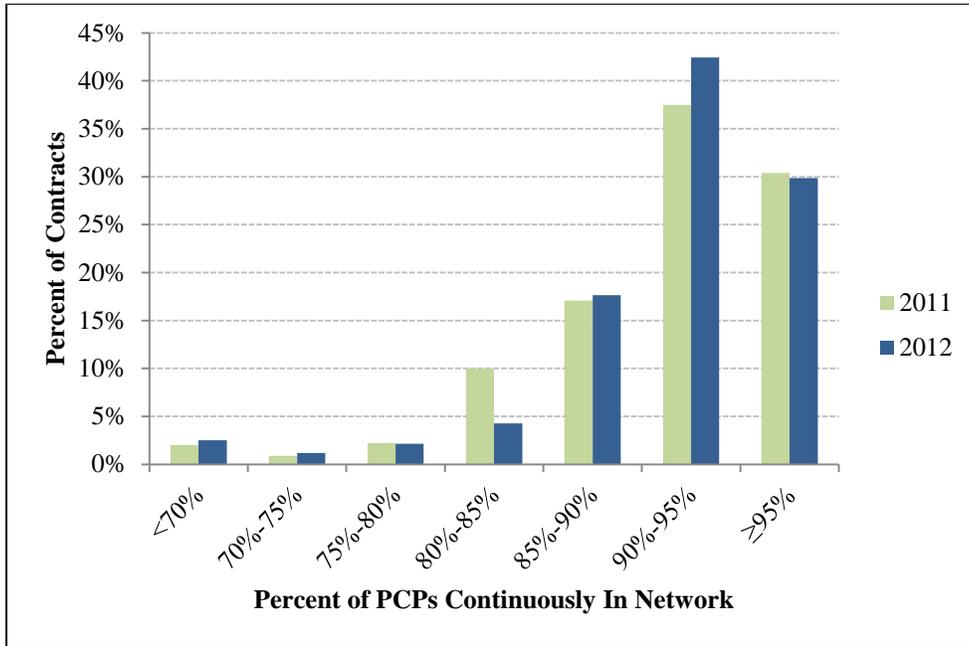
Figure 8.2: Percent of Providers Continuously In Network, 2011-2012²²



Only 2.5% of contracts in CY 2012 had less than 70% of PCPs continuously in network (Figure 8.3). The share of contracts with 95% or more of PCPs continuously in network decreased slightly from 30.4% in CY 2011 to 29.8% in CY 2012.

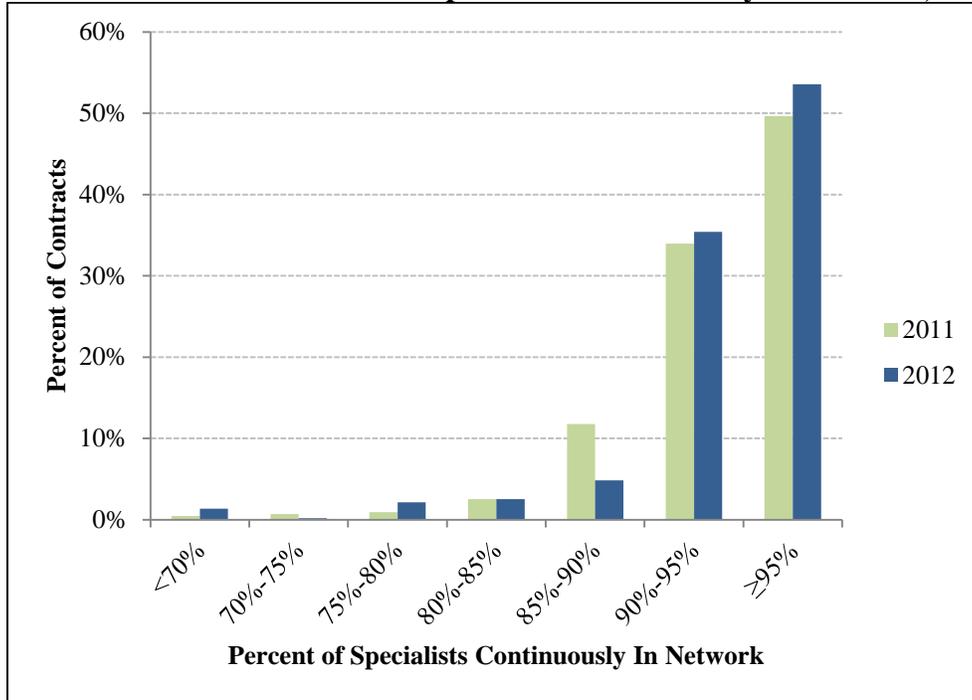
²² Data are weighted by contract year average HPMS enrollment.

Figure 8.3: Distribution of Percent of PCPs Continuously In Network, 2011-2012



In CY 2012, 53.6% of contracts had more than 95% of specialists continually in network, compared to 49.7% in CY 2011 (Figure 8.4).

Figure 8.4: Distribution of Percent of Specialists Continuously In Network, 2011-2012



9 PRIVATE FEE-FOR-SERVICE ENROLLMENT VERIFICATION

Failure to understand plan coverage policies could result in beneficiaries being unprepared for the amount they must pay for needed services. CMS therefore requires that PFFS plans contact new enrollees to ensure that these beneficiaries understand plan coverage policies. Plans must make three documented attempts to contact new enrollees. If the plan does not reach new enrollees with the first call, they must follow up by sending an enrollment verification letter. To monitor plans' adherence to this requirement, CMS requires that plans report the number of new enrollees contacted via phone and letter.

The percent of PFFS plans that contacted less than 100% of their new enrollees decreased from 10.3% in CY 2011 to 0.6% in CY 2012 (Table 9.1), indicating that almost all plans in CY 2012 contacted all of their new enrollees. This improvement may help a larger amount of new enrollees to understand plan coverage policies in CY 2012.

Table 9.1: PFFS Plans that Contacted Less than 100% of New Enrollees, 2011-2012

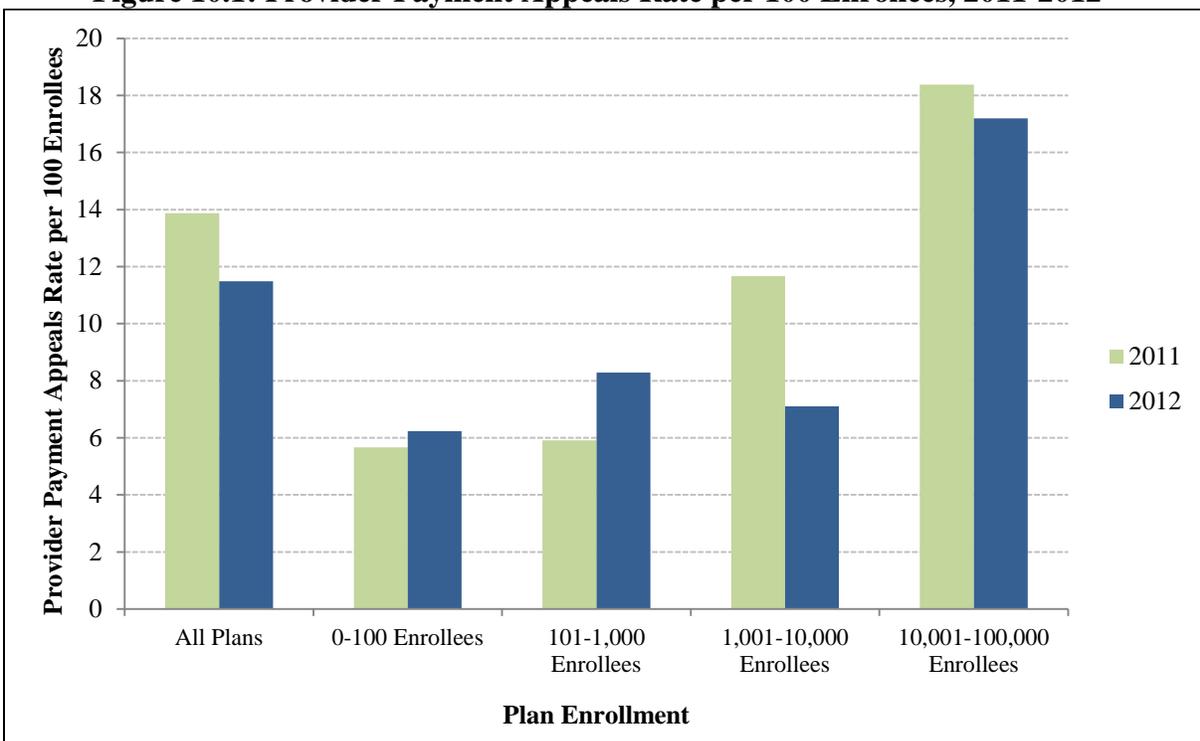
Plan Enrollment	2012		2011	
	Measure Value	Number of Plans	Measure Value	Number of Plans
All	0.6%	1	10.3%	19
0-100 Enrollees	0.0%	0	8.3%	1
101-1,000 Enrollees	0.0%	0	14.9%	10
1,001-10,000 Enrollees	1.3%	1	7.5%	7
Over 10,000 Enrollees	0.0%	0	7.7%	1

10 PRIVATE FEE-FOR-SERVICE PROVIDER PAYMENT DISPUTES

To ensure that payments to providers are accurate and timely, CMS requires PFFS plans to report the outcome of payment appeals made by providers contesting the payment amount they received. Plans only report disputes in cases when the payment to the provider is less than what would have been paid under the MAO PFFS plan's terms and conditions or original Medicare.

The overall rate of provider payment appeals per 100 enrollees decreased from CY 2011 to CY 2012, from 13.9 to 11.5 (Figure 10.1). The largest decrease in appeals rates was for plans with greater than 1,001 and less than 10,000 enrollees, decreasing from 11.7 to 7.1 between years.

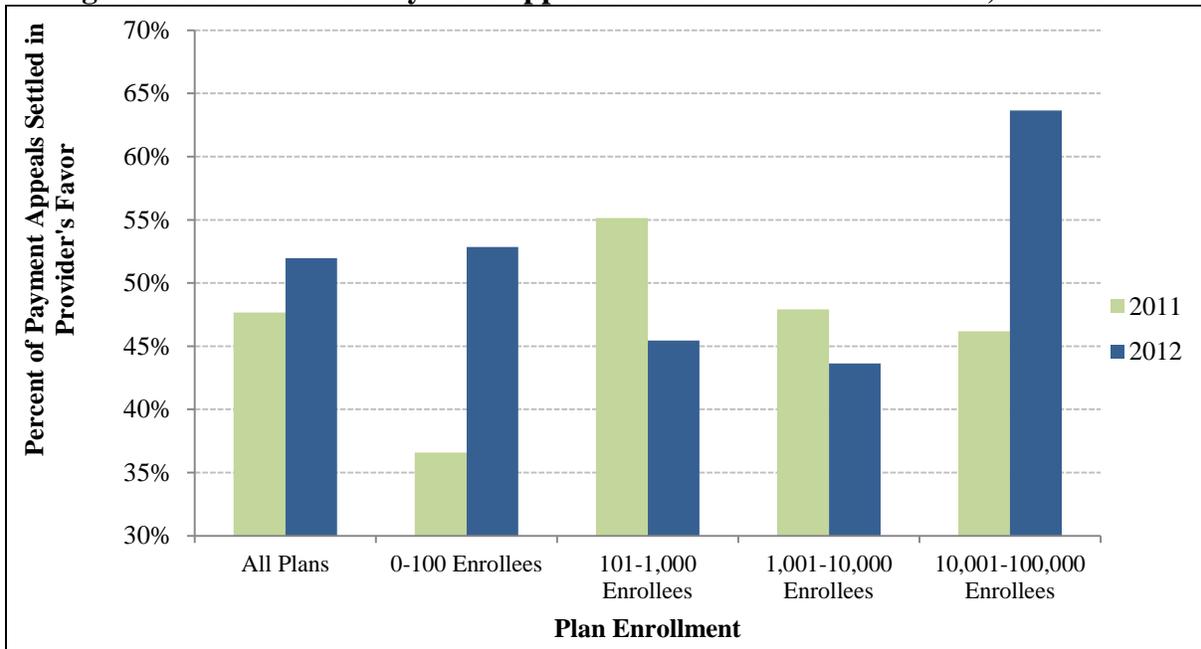
Figure 10.1: Provider Payment Appeals Rate per 100 Enrollees, 2011-2012²³



Appeals are considered to be settled in the provider's favor if the previously denied provider payment is overturned and the provider receives payment. Overall, the percentage of payment appeals settled in the provider's favor increased from 47.7% in CY 2011 to 52.0% in CY 2012 (Figure 10.2). The largest increase was for plans over 10,000 enrollees, increasing 46.2% to 63.7% between years. This difference was closely followed by plans with less than 100 enrollees, increasing from 36.6% to 52.8% between years.

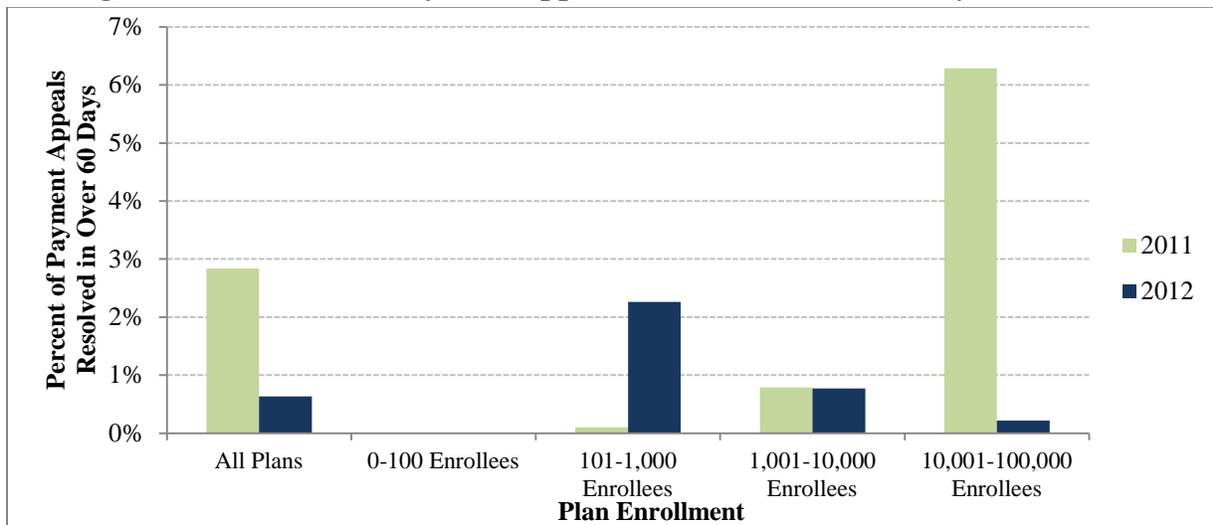
²³ Data are weighted by plan year average HPMS enrollment.

Figure 10.2: Percent of Payment Appeals Settled in Provider's Favor, 2011-2012²⁴



The time taken to resolve payment appeals reflects whether plans are processing appeals in a timely manner. The percentage of payment appeals resolved in over 60 days decreased from 2.8% in CY 2011 to 0.6% in CY 2012 (Figure 10.3), showing that most plans are resolving almost all of their appeals within 60 days. Plans with over 10,000 enrollees experienced a rather significant decrease in the percentage of payment appeals resolved in over 60 days, dropping from 6.3% in CY 2011 to 0.2% in CY 2012.

Figure 10.3: Percent of Payment Appeals Resolved in Over 60 Days, 2011-2012²⁵



²⁴ Data are weighted by plan year average HPMS enrollment.

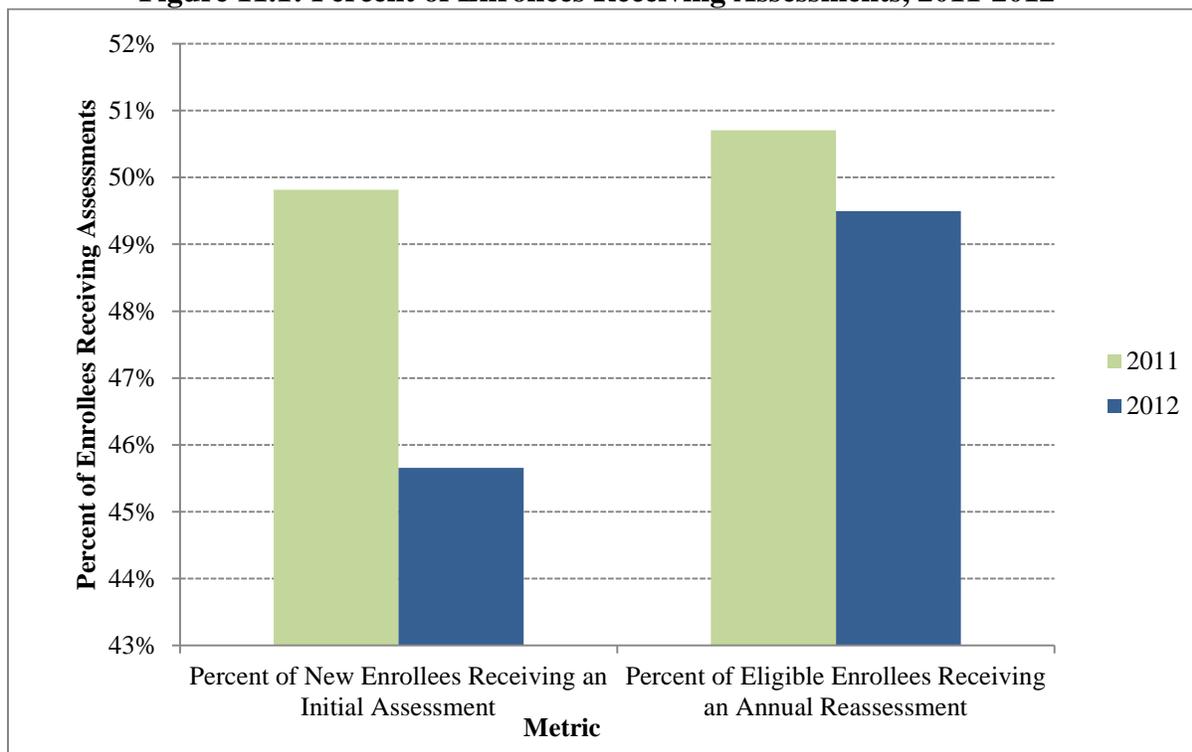
²⁵ Data are weighted by plan year average HPMS enrollment.

11 SPECIAL NEEDS PLAN CARE MANAGEMENT

Since SNPs provide coverage for vulnerable Medicare beneficiaries with specialized needs, CMS requires MAOs offering SNPs to perform initial assessments of all enrollees' medical, psychosocial, functional, and cognitive status and to develop a specialized care plan. MAOs are also required to perform reassessments within 12 months of the last risk assessment and use the assessment results to update the beneficiary's required care plan.²⁶

Both the percentage of new enrollees receiving an initial assessment and the percentage of eligible enrollees receiving an annual reassessment decreased from CY 2011 to CY 2012 (Figure 11.1). The overall percentage of new enrollees receiving an initial assessment decreased from 49.8% in CY 2011 to 45.7% in CY 2012, while the overall percentage of eligible enrollees receiving an annual reassessment decreased from 50.7% in CY 2011 to 49.5% in CY 2012.

Figure 11.1: Percent of Enrollees Receiving Assessments, 2011-2012²⁷



²⁶ <http://www.care1st.com/media/pdf/providers/SNP-Guidance-Model-of-Care.pdf>

²⁷ The percent of new enrollees receiving an initial assessment is weighted by the number of new enrollees. The percent of eligible enrollees receiving an annual reassessment is weighted by the number of enrollees eligible for a reassessment.

In CY 2012, only 7.1% of plans assessed 100% of new enrollees and 14.7% of plans reassessed 100% of eligible enrollees (Table 11.1). Plans that assessed 100% of new or eligible enrollees were more likely to be small plans with fewer than 100 enrollees.

Table 11.1: Percent of SNPs Assessing 100% of Enrollees by Enrollment, 2011-2012

Enrollment	2012				2011			
	Percent of SNPs Assessing 100% of New Enrollees		Percent of SNPs Reassessing 100% of Eligible Enrollees		Percent of SNPs Assessing 100% of New Enrollees		Percent of SNPs Reassessing 100% of Eligible Enrollees	
	Measure Value	Number of Plans	Measure Value	Number of Plans	Measure Value	Number of Plans	Measure Value	Number of Plans
All	7.1%	22	14.7%	40	4.2%	14	3.9%	13
0-100	25.0%	9	59.1%	13	25.0%	6	20.0%	5
101-1,000	11.2%	12	28.3%	26	6.0%	7	7.1%	8
1,001-10,000	0.7%	1	0.7%	1	0.6%	1	0.0%	0

12 EMPLOYER GROUP PLAN SPONSORS

CMS requires plans to report data on employer groups who have an arrangement in place with the Part C organization, including the employer name, address, sponsor type, organization type, contract type, and current enrollment.

The most common group sponsor type reported in both CY 2011 and CY 2012 was Employers, followed by Trustees, then Unions (Table 12.1).

Table 12.1: Share of Employers by Group Sponsor Type, 2011-2012

Group Sponsor Type	2012	2011
Union	2.8%	2.6%
Trustee	3.9%	3.3%
Employer	93.4%	94.1%

In CY 2012, the largest share of employers was reported under ‘other’ organizations, followed by privately held corporations, with 36.4% and 36.2%, respectively (Table 12.2).

Table 12.2: Share of Employers by Organization Type, 2011-2012

Organization Type	2012	2011
Church Group	1.2%	1.3%
State Government	1.7%	1.8%
Local Government	9.2%	8.7%
Non-Profit	6.3%	6.4%
Publicly Traded Organization	9.0%	9.8%
Privately Held Corporation	36.2%	31.8%
Other	36.4%	40.1%

Most employers were reported under the Insured contract type for both CY 2011 and CY 2012 with 99.5% and 99.4%, respectively (Table 12.3). Administrative Services Organizations (ASOs) and other contract types were negligible in comparison, at or below 0.5% in both years.

Table 12.3: Employers by Contract Type, 2011-2012

Contract Type	2012			2011		
	Number of Employers	Share of Employers	Enrollment	Number of Employers	Share of Employers	Enrollment
All	21,247	100.0%	2,077,665	22,759	100.0%	2,165,234
Insured	21,121	99.4%	1,902,092	22,638	99.5%	2,018,030
ASOs	23	0.1%	165,156	14	0.1%	136,897
Other	103	0.5%	10,417	107	0.5%	10,307

13 ENROLLMENT AND DISENROLLMENT

Beginning in CY 2012, MAOs are required to report data to CMS on their processing of enrollment and disenrollment requests, enabling CMS to evaluate whether the procedures followed by the sponsor fall in accordance with CMS requirements. Only stand-alone MAOs and 1876 cost plans without a prescription drug plan are to report these data under the Part C requirements; all other organizations report via the Part D requirements.

As shown in Table 13.1, most enrollment requests were received via paper (76.7%), followed by via the internet (22.7%), via telephone (0.9%), and via the Medicare Online Enrollment Center (OEC) (0.3%).

Table 13.1: Enrollment Requests by Request Mechanism, 2012

Percent of Requests by Request Mechanism			
Paper	Telephonic	Internet	OEC
76.7%	0.9%	22.7%	0.3%

The percentage of requests that were complete at the time of initial receipt in CY 2012 was the same for both enrollment and disenrollment requests, at approximately 98% (Table 13.2).

Table 13.2: Enrollment and Disenrollment Requests Completed, 2012

Percent of Requests Complete at Initial Receipt	
Enrollment	Disenrollment
97.9%	97.9%

Less than one percent of enrollment and disenrollment requests were denied by the sponsor (Table 13.3).

Table 13.3: Enrollment and Disenrollment Requests Denied by the Sponsor, 2012

Percent of Requests Denied	
Enrollment	Disenrollment
0.6%	0.3%

14 SUMMARY OF RESULTS

The results of this analysis reveal that there have been improvements in several reporting areas from CY 2011 to CY 2012, while other areas remain with the potential for growth in future years.

Grievances

The rate of grievances filed per 1,000 enrollees per month decreased between years, while the share of plans with at least 100 enrollees that reported zero grievances slightly increased. Most grievances were filed in the Benefit Package, Customer Service, and Other categories in CY 2012.

Organization Determinations and Reconsiderations

The percent of organization determinations with fully favorable outcomes for the beneficiary decreased from CY 2011 to CY 2012, showing that beneficiaries were slightly less successful at obtaining full coverage via the determinations process. While the percent of adverse or partially favorable determinations that were appealed for reconsideration decreased between years, the percent of reconsiderations with fully favorable outcomes for the beneficiary slightly increased, indicating beneficiaries' increased success at obtain positive outcomes during the reconsideration stage of the process.

Plan Oversight of Agents

The rate of complaints against agents per 1,000 enrollees remained low in both CY 2011 and CY 2012.

Procedure Frequency

Though changes in reporting specifications limit a direct comparison between years, the rate of procedures per 1,000 enrollees substantially increased between CY 2011 and CY 2012.

Serious Reportable Adverse Events

The overall rate of SRAEs per 100,000 enrollees significantly decreased between years, though this may again be due to clarifications in reporting specifications. The total non-surgical SRAE rate per 100,000 enrollees also significantly decreased between years.

Provider Network Adequacy

There was an increase between years in both the percent of PCPs and specialists continuously in-network, which benefits the beneficiary's experience related to a consistent provider network.

PFFS Enrollment Verification

Nearly all plans contacted 100% of new enrollees in CY 2012, which was not the case in CY 2011.

PFFS Provider Payment

While the rate of provider payment appeals per 100 enrollees decreased between years, the percent of payment appeals settled in the provider's favor increased.

SNP Care Management

The percent of new enrollees receiving an initial assessment and the percent of eligible enrollees receiving an annual reassessment decreased between CY 2011 and CY 2012. However, the share of plans that assessed 100% of their new enrollees or that reassessed 100% of their eligible enrollees increased.

Employer Group Plan Sponsors

The share of group sponsor, organization, and contract types remained consistent between CY 2011 and CY 2012, with employer group sponsors, other organizations, and insured contracts representing the largest shares.