



Analysis of Calendar Year 2015 Medicare Part C Reporting Requirements Data

April 2017

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1 INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) utilizes many data sources to conduct oversight and monitor performance within the Medicare Part C benefit. One such data source is the Part C Reporting Requirements, which are data reported by Part C Medicare Advantage Organizations (MAOs), including Medicare Advantage Prescription Drug Plans (MA-PDs) and Medicare-Medicaid Plans (MMPs), to CMS on various matters including the cost of operations, patterns of service utilization, availability and accessibility of services, and grievances lodged by beneficiaries.¹ 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 MAOs 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 C Reporting Requirements Technical Specifications to further assist MAOs 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 CMS's monitoring and oversight goals. Current Part C 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 2016.

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

Reporting Section	2010	2011	2012	2013	2014	2015	2016
Grievances	✓	✓	✓	✓	✓	✓	✓
Organization Determinations and Reconsiderations	✓	✓	✓	✓	✓	✓	✓
Special Needs Plan (SNP) Care Management	✓	✓	✓	✓	✓	✓	✓
Serious Reportable Adverse Events (SRAEs)	✓	✓	✓	✓	–	–	–
Private Fee-For-Service (PFFS) Plan Enrollment Verification Calls	✓	✓	✓	✓	✓	✓	✓
PFFS Provider Payment Dispute Resolution Process	✓	✓	✓	✓	✓	✓	✓
Employer Group Plan Sponsors	✓	✓	✓	✓	✓	✓	✓
Enrollment and Disenrollment	–	–	✓	✓	✓	✓	✓
Provider Network Adequacy	✓	✓	✓	–	–	–	–

¹ Please refer to Part C Technical Specifications for additional information on reporting requirements for organization types: <https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html>

1 Introduction

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Reporting Section	2010	2011	2012	2013	2014	2015	2016
Benefit Utilization	✓	–	–	–	–	–	–
Procedure Frequency	✓	✓	✓	–	–	–	–
Plan Oversight of Agents	✓	✓	✓	–	✓	✓	✓
Rewards and Incentives Program	–	–	–	–	–	–	✓
Mid-Year Network Changes	–	–	–	–	–	–	✓
Payments to Providers	–	–	–	–	–	–	✓

This report provides an analysis of the data submitted by Part C MAOs in accordance with the Part C Reporting Requirements for CY 2015. For each of these reporting sections,² this report presents program-wide averages and identifies trends between CY 2013, CY 2014, and CY 2015 data. The metrics evaluated in each section aim to provide information about beneficiary experience, MAO performance, and overall program functioning. Table 1.2 presents the key metrics included in this report.

Table 1.2: Reporting Sections and Key Metrics

Reporting Section	Metric	Description
Grievances	Share of plans reporting zero grievances	The number of contracts/plans with at least 100 enrollees that reported zero grievances divided by the total number of contracts/plans with at least 100 enrollees.
	Rate of grievances per 1,000 enrollees per month	The rate of grievances filed per 1,000 enrollees per month.
	Share of grievances by category	The number of grievances by category (e.g., fraud, benefit package) divided by the total number of grievances.
Organization Determinations and Reconsiderations	Rate of organization determination requests per 1,000 enrollees	The number of organization determination requests (e.g., coverage, continuation of treatment) per 1,000 enrollees.
	Rate of reconsideration requests per 1,000 enrollees	The number of reconsideration requests (i.e., appeal of adverse or partially favorable determinations) per 1,000 enrollees.
	Percentage of organization determinations by outcome	The number of organization determinations with specified outcome for the beneficiary (i.e., fully favorable, partially favorable, or adverse) divided by the total number of organization determinations.
	Percentage of reconsiderations by outcome	The number of reconsiderations with specified outcome for the beneficiary (i.e., fully favorable, partially favorable, or adverse) divided by the total number of reconsiderations.
	Rate of reopened decisions per 1,000 enrollees	The number of reopened decisions per 1,000 enrollees.
	Percentage of requests processed timely	The number of organization determinations or reconsiderations processed timely divided by the total number of organization determinations or reconsiderations.

² The reporting section Plan Oversight of Agents was collected in CY 2014 and CY 2015 but excluded from this analysis.

2 Introduction

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Reporting Section	Metric	Description
SNP Care Management	Percentage of enrollees receiving an assessment	<ul style="list-style-type: none"> • New Enrollees: The number of new enrollees in the SNP receiving an initial assessment (i.e., of their medical, psychosocial, functional, and cognitive status) divided by the total number of new enrollees in the SNP. • Eligible Enrollees: The number of eligible enrollees in the SNP receiving a reassessment divided by the total number of eligible enrollees in the SNP. • New + Eligible Enrollees: The number of new or eligible enrollees in the SNP receiving an initial assessment or reassessment divided by the total number of new or eligible enrollees in the SNP.
	Percentage of SNPs assessing 100% of enrollees	The number of SNPs that assess all enrollees (i.e., new, eligible, or new + eligible) throughout the measurement year divided by the total number of SNPs.
PFFS Plan Enrollment Verification Calls	Number of Plans by PFFS Plan Enrollment Verification	<p>Documented (i) number of enrollments and (ii) attempts to contact new enrollees. Attempts to contact new enrollees include:</p> <ul style="list-style-type: none"> • Number of times the plan reached the prospective enrollee with the first call. • Number of follow-up educational letters sent.
PFFS Provider Payment Dispute Resolution Process	Rate of provider payment appeals per 100 enrollees	The number of provider payment appeals per 100 enrollees.
	Percentage of payment appeals settled in the provider's favor	The number of provider payment appeals denials overturned in favor of provider upon appeal divided by the total number of provider payment appeals.
	Percentage of payment appeals resolved in over 60 days	The number of provider payment appeals taking longer than 60 days to resolve divided by the total number of payment appeals.
Employer Group Plan Sponsors	Number of employers	The number of reported employers.
	Share of employers	The number of employers by type (i.e., group sponsor type, organization type) divided by the total number of employers.
	Share of enrollment	The number of enrollees by type (i.e., group, sponsor type, organization type) divided by the total number of enrollees.
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.
	Requests completed at initial receipt	The number of enrollment or disenrollment requests completed at initial receipt divided by total number of enrollment or disenrollment requests.
	Requests denied by MAO	The number of enrollment or disenrollment requests denied by the MAO divided by the total number of enrollment or disenrollment requests.

3 Introduction

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In addition to the analyses performed in this report, CMS has also taken additional steps to leverage the reporting requirements data to publicly report information on plan performance. For example, the rate of grievances filed per 1,000 enrollees and percentage of eligible Special Needs Plan (SNP) enrollees receiving an assessment are updated annually as part of CMS's Display Measures and Star Ratings Measures, respectively.³ CMS has also released public use files with data from some of these reporting sections in a continued effort to increase transparency and promote provider and plan accountability.⁴ Additional information on utilization of public use files data for these reporting sections can be found in Section 2.4 of this report.

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 9 present the main findings for each of the seven reporting sections listed above. Section 10 summarizes key results from the analysis.

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

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

4 Introduction

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2 DATA OVERVIEW

To improve reliability for analysis purposes, the Part C 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 the analyses.

2.1 Submission Process

MA Organizations (MAOs) submit Part C Reporting Requirements data via the Health Plan Management System (HPMS). 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 MAOs. Compliance requires that the data not only be submitted in a timely manner, but that they also are accurate. Only data that reflect a good faith effort by an MAO to provide accurate responses to Part C Reporting Requirements will count as data submitted in a timely manner. MAOs can expect CMS to rely more on compliance notices and enforcement actions in response to reporting requirement failures.

MA Organizations 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 MAOs discover an error or omission in previously reported data. Errors may be discovered by the MAO, or the MAO may be alerted to errors via CMS contractor's (Acumen) outlier, placeholder, and data integrity notification process. Acumen's outlier notices inform MAOs if they have high or low (i.e., outlier) values relative to the rest of the Part C program. Acumen's placeholder notices inform MAOs if they reported "0" (i.e., placeholder) values for all data elements in multiple reporting sections. Acumen's data integrity notices inform MAOs if their reported data has integrity issues, such as data that are internally inconsistent or do 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 resubmissions must be completed by March 31 of the subsequent year.

2.2 Validation Process

Beginning with CY 2010 data, CMS requires that MAOs 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 MAOs are reliable, complete, valid, comparable, and timely. CMS uses the validated data to assess MAO performance and to respond to inquiries from entities such as Congress, oversight agencies, and the public. Additionally, MAOs can take advantage of the data validation process to assess their performance and to make improvements to their internal data, systems, and reporting processes.

The data validation process yields scores for each MAO at the reporting section level, as well as element-specific pass or fail results for some reporting sections.⁵ For each reporting section, auditors record information for a total of seven standards to assess (i) proper source documentation, (ii) proper

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

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 MAO complied.

As shown in Table 2.1, three of the seven reporting sections included in this report underwent data validation for the CY 2013 through CY 2015 data, including the Grievances, Organization Determinations and Reconsiderations, and SNP Care Management sections. Data for the Employer Group Plan Sponsors, 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 2013 Data	CY 2014 Data	CY 2015 Data
Grievances	2014 DV	2015 DV	2016 DV
Organization Determinations and Reconsiderations	2014 DV	2015 DV	2016 DV
SNP Care Management	2014 DV	2015 DV	2016 DV
PFFS Provider Payment Disputes	–	–	–
PFFS Enrollment Verification	–	–	–
Employer Group Plan Sponsors	–	–	–
Enrollment and Disenrollment	–	–	–

2.3 Data Validation Exclusion Criteria

Contracts' inclusion in this analysis is contingent on (i) the contract submitting the required data by the specified reporting deadline, and (ii) the submitted data meeting minimum data validation requirements. Contracts that terminate on or before the applicable deadline to submit data validation results to CMS are excluded. For the CY 2013 through CY 2015 reporting sections that underwent validation in the 2014, 2015, or 2016 data validation cycles, contracts must have a section-specific data validation score of at least 95% to be included. If a contract passed validation for the reporting section, but failed an element-specific data validation check, the contract will be excluded from the calculations of any metrics that utilize the element(s) that failed. This may cause plan and contract counts to vary between metrics within a section.

Table 2.2 displays contract-level data validation results by reporting section and CY of data. The reporting section with the largest change in both the percentage of contracts achieving a passing data validation score and in the percent achieving a score of 100% was SNP Care Management, which increased in each year, from 75.0% and 68.0% in CY 2013 to 99.0% and 93.5% in CY 2015, respectively. Grievances exhibited an increase in both the percentage of contracts achieving a passing data validation score and percent achieving a score of 100%, rising from CY 2013 (88.3% and 62.8%, respectively) to CY 2014 (97.5% and 70.4%, respectively). Both percentages also then experienced a decrease in CY 2015, to 90.8% for those achieving a passing data validation score and to 59.6% for those

achieving a score of 100%. Organization Determinations and Reconsiderations had a relatively stable percentage of contracts achieving a passing data validation score, around 93.0% for all three years. This was not true for the percentage of contracts achieving a data validation score of 100% for Organization Determinations and Reconsiderations, which experienced much more variation in between years, decreasing between CY 2013 (87.3%) and CY 2014 (60.1%) and then increasing in CY 2015 (63.6%).

Table 2.2: Summary of Contract Data Validation (DV) Results by Reporting Section, 2013-2015⁶

Reporting Section	Year	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# of Contracts DV Score ≥ 95%	% of Contracts DV Score ≥ 95%	# of Contracts DV Score = 100%	% of Contracts DV Score = 100%
Grievances	2013	525	522	461	88.3%	328	62.8%
Grievances	2014	513	513	500	97.5%	361	70.4%
Grievances	2015	513	513	466	90.8%	306	59.6%
Organization Determinations and Reconsiderations	2013	530	529	492	93.0%	462	87.3%
Organization Determinations and Reconsiderations	2014	514	514	476	92.6%	309	60.1%
Organization Determinations and Reconsiderations	2015	511	511	473	92.6%	325	63.6%
SNPs Care Management	2013	230	228	171	75.0%	155	68.0%
SNPs Care Management	2014	219	219	209	95.4%	180	82.2%
SNPs Care Management	2015	200	200	198	99.0%	187	93.5%
PFFS Provider Payment	2013	—	—	—	—	—	—
PFFS Provider Payment	2014	—	—	—	—	—	—
PFFS Provider Payment	2015	—	—	—	—	—	—
PFFS Enrollment Verification	2013	—	—	—	—	—	—
PFFS Enrollment Verification	2014	—	—	—	—	—	—
PFFS Enrollment Verification	2015	—	—	—	—	—	—
Employer Group Plan Sponsors	2013	—	—	—	—	—	—
Employer Group Plan Sponsors	2014	—	—	—	—	—	—
Employer Group Plan Sponsors	2015	—	—	—	—	—	—
Enrollment and Disenrollment	2013	—	—	—	—	—	—
Enrollment and Disenrollment	2014	—	—	—	—	—	—
Enrollment and Disenrollment	2015	—	—	—	—	—	—

Data validation results are assigned at the contract level, however, some reporting requirement sections are submitted at the plan level. For reporting sections submitted at the plan level, all plans under a given contract are assigned the same data validation score. Table 2.3 displays corresponding plan counts for the SNP Care Management section, which was reported at the plan level. The percentage of

⁶ 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). Sections that did not undergo DV are represented with a placeholder value (i.e., PFFS Provider Payment, PFFS Enrollment Verification, Employer Group Plan Sponsors, and Enrollment and Disenrollment).

7 Data Overview

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plans with contracts achieving a passing data validation score for SNP Care Management increased to 99.1% of contracts in CY 2015, which was significantly higher than the percentage of contracts passing data validation in CY 2013 (82.5%). The percentage of plans with contracts achieving a data validation score of exactly 100% for SNP Care Management also increased between years, from 77.2% in CY 2013 to 95.5% in CY 2015.

Table 2.3: Summary of Data Validation Results by Reporting Section for Plans, 2013-2015⁷

Reporting Section	Year	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# of Contracts DV Score ≥ 95%	% of Contracts DV Score ≥ 95%	# of Contracts DV Score = 100%	% of Contracts DV Score = 100%
SNPs Care Management	2013	496	486	401	82.5%	375	77.2%
SNPs Care Management	2014	482	482	467	96.9%	419	86.9%
SNPs Care Management	2015	444	444	440	99.1%	424	95.5%

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. As a result, the number of plans included in different metrics for the same reporting section may vary based on exclusions 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.⁸ 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	✓
Organization Determinations and Reconsiderations	✓
SNP Care Management	✓
PFFS Plan Enrollment Verification	–
PFFS Provider Payment Dispute Resolution Process	–
Employer Group Plan Sponsors	–
Enrollment and Disenrollment	✓

⁷ 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).

⁸ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

8 Data Overview

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To be included in this analysis, requirements are applied to each reporting section's data. For sections that are represented in the public use files, the same restrictions/exclusions apply to those sections in this analysis. For sections that are not represented in the public use files, restrictions and exclusions are applied based on the section's level of reporting.⁹ Due to the limited number of Medicare-Medicaid Plans (MMPs) that were active for the full 2013 and 2014 reporting years, only 2015 data submitted to CMS by MMPs were included in this report.¹⁰

- Plan-level sections:
 - Plan required to submit for the reporting year
 - Plan not deleted before the end of the reporting year
 - Plan had year average enrollment greater than or equal to 11
 - Contract was active as of end of reporting year
- Contract-level sections:
 - Contract required to submit
 - Contract had year average enrollment greater than or equal to 11
 - Contract active as of end of reporting year

⁹ Additional criteria are applied to sections that underwent data validation, including that the contract must be active as of the data validation deadline and the contract must pass the section level data validation with a score of 95% or higher.

¹⁰ MMPs were required to report data for only the Grievances and Organization Determinations and Redeterminations sections for CY 2013, CY2014 or CY 2015.

3 GRIEVANCES

The Part C regulations at 42 C.F.R. Part 422, Subpart M set forth the requirements related to grievances. To assess whether beneficiaries are satisfied with the provision of Medicare services and whether MA Organizations (MAOs) address beneficiary complaints in a timely manner, CMS requires MAOs 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.¹¹ 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.¹²

In CY 2015, 2.2% of contracts with at least 100 enrollees reported that no grievances were filed (Table 3.1). Of the seven contracts reporting zero grievances, four were Local CCP organizations; as seen in Table 3.2, the majority of contracts with at least 100 enrollees were Local CCP organizations.

Table 3.1: Contracts Reporting Zero Grievances by Organization Type, 2015¹³

Organization Type	Total Number of Contracts	Number of Contracts Reporting Zero	Share of Contracts that Reported Zero
All	323	7	2.2%
MMP	28	0	0.0%
Local CCP	272	4	1.5%
Regional CCP	6	0	0.0%
PFFS/1876 Cost	16	2	12.5%
MSA	1	1	100.0%

All seven contracts with at least 100 enrollees that reported zero grievances had fewer than 10,000 enrollees (Table 3.2). Of those seven contracts, five contracts had fewer than 500 enrollees.

Table 3.2: Contracts Reporting Zero Grievances by Enrollment, 2015¹⁴

Contract Enrollment	Total Number of Contracts	Number of Contracts Reporting Zero	Share of Contracts that Reported Zero
All	323	7	2.2%
100 - 499	29	5	17.2%
500-999	24	1	4.2%
1,000 - 9,999	115	1	0.9%
10,000 - 99,999	139	0	0.0%
100,000+	16	0	0.0%

¹¹ <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf>

¹² MAOs may extend the 30-day timeframe by up to 14 days but must promptly notify enrollees that they intend to do so. Also, expedited grievances related to the plan's refusal to process an enrollee's request for an expedited pre-service organization determination or reconsideration must be responded to within 24 hours.

¹³ Restricted to contracts with a year average HPMS enrollment of at least 100. Grievances due to CMS issues were excluded when determining contracts reported grievance count.

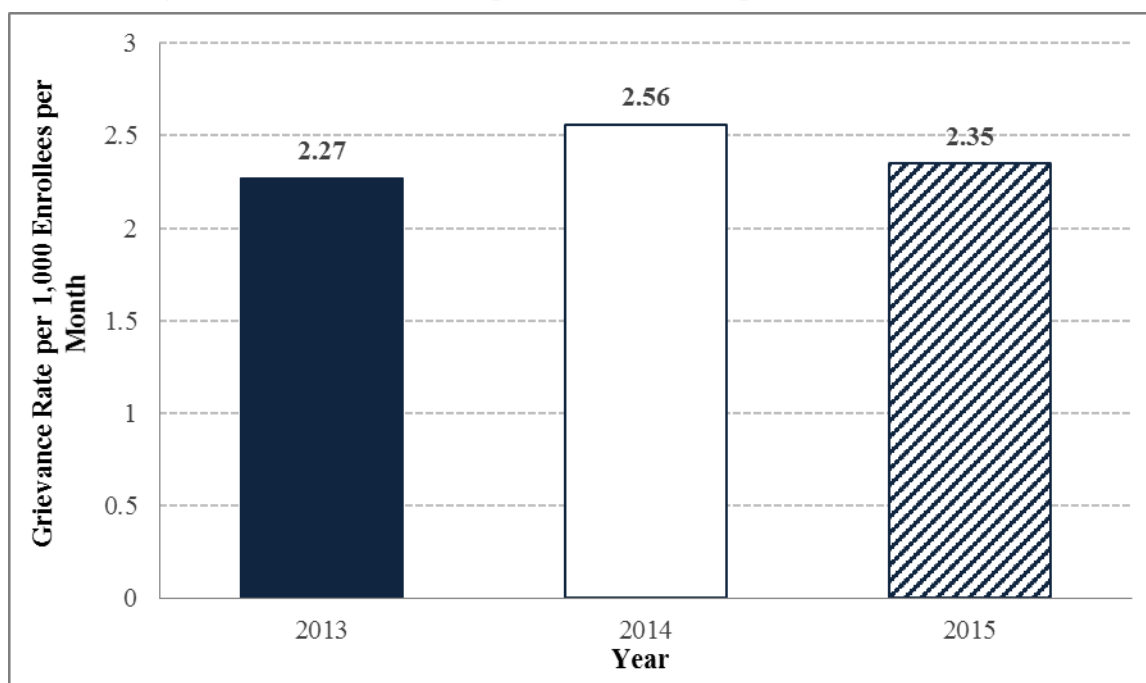
¹⁴ Restricted to contracts with a year average HPMS enrollment of at least 100. Grievances due to CMS issues were excluded when determining contracts reported grievance count.

10 Grievances

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The overall rate of grievances filed per 1,000 enrollees per month increased from 2.27 in CY 2013 to 2.56 in CY 2014, and then decreased to 2.35 in CY 2015 (Figure 3.1).

Figure 3.1: Grievance Rates per 1,000 Enrollees per Month, 2013-2015¹⁵



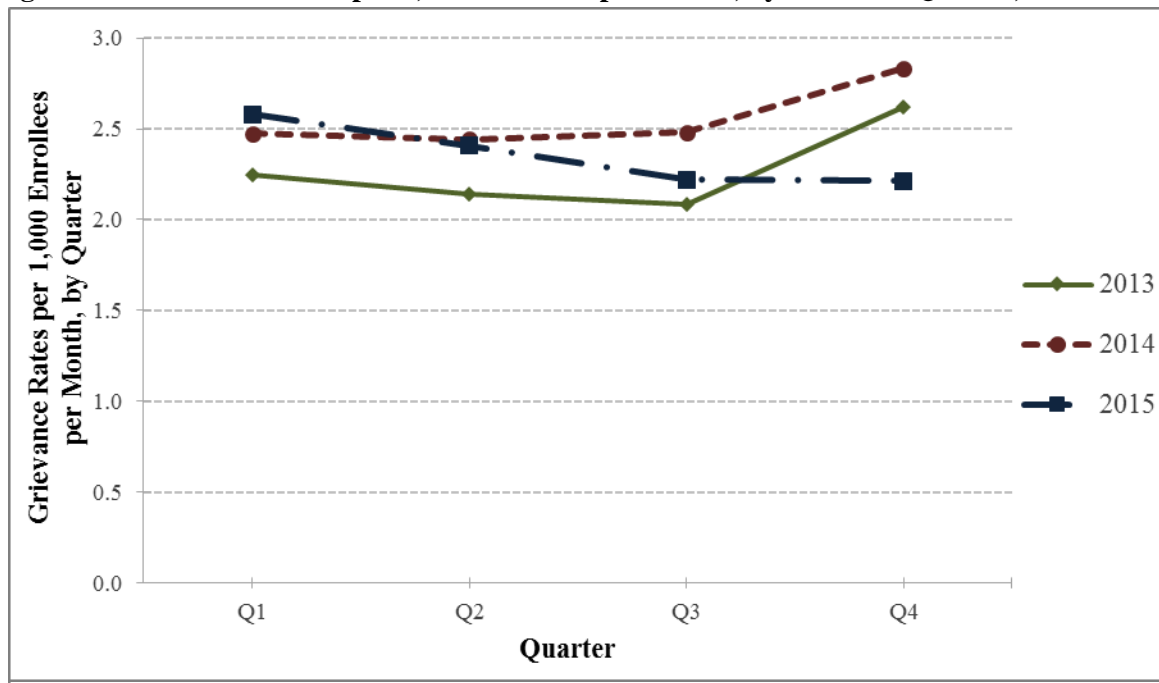
In CY 2013, the overall rate of grievances filed per 1,000 enrollees per month decreased from 2.24 in Quarter 1 to 2.08 in Quarter 3, but then increased to 2.62 in Quarter 4, exhibiting an overall increase over Quarter 1 (Figure 3.2). In CY 2014, the overall rate increased between the first quarter and the fourth quarter (from 2.47 in Quarter 1 to 2.83 in Quarter 4). The overall rate of grievances exhibited a different trend in CY 2015, with the overall rate of grievances per 1,000 enrollees per month decreasing across all quarters (2.58 in Quarter 1 to 2.21 in Quarter 4).

¹⁵ Measure values are weighted by Contract/Plan Year Average Enrollment. Total grievances are defined as the sum of grievances by category. In CY 2014 and CY 2015, total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

11 Grievances

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Figure 3.2: Grievance Rates per 1,000 Enrollees per Month, by Year and Quarter, 2013-2015¹⁶



In CY 2013 and CY 2014, Regional CCP organizations had the highest grievances rate per 1,000 enrollees per month. In CY 2015, MMP organizations had a grievance rate of 5.9, more than double the rate of the other individual organization types (Table 3.3).

Table 3.3: Grievance Rates per 1,000 Enrollees per Month by Organization Type, 2013-2015

Organization Type	Year	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2013 Grievance Rate	2013	2.3	—	2.2	4.1	1.9	0.9
2013 Number of Plans	2013	1,723	—	1,599	21	97	6
2014 Grievance Rate	2014	2.6	—	2.5	3.6	2.1	1.9
2014 Number of Contracts	2014	406	—	381	8	14	3
2015 Grievance Rate	2015	2.4	5.9	2.3	2.6	1.9	0
2015 Number of Contracts	2015	339	34	281	6	17	1

¹⁶ Measure values are weighted by Contract/Plan Year Average Enrollment. Total grievances are defined as the sum of grievances by category. In CY 2014 and CY 2015, total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

Reported data enable CMS to identify the category a grievance was related to, including enrollment/disenrollment, benefit packages, access, marketing, customer service, organization determination and reconsideration process, quality of care, or “other”. Data are also reported regarding grievances that were expedited. Table 3.4 provides the rate each grievance category was filed per 1,000 enrollees per month. Grievances filed related to benefit packages, access, customer service, and “other” were most common in all three calendar years. The largest increase between years was for grievances filed for customer service, with 0.53 grievances per 1,000 enrollees per month in CY 2013, increasing to 0.84 in CY 2015. Grievances filed as benefit package and as marketing were the only two categories to show an overall decrease between the three years, from 0.40 and 0.14 in CY 2013 to 0.31 and 0.13 in CY 2015, respectively.

Table 3.4: Grievance Rates per 1,000 Enrollees per Month by Category, 2013-2015^{17, 18}

Category	2013	2014	2015
Total	2.27	2.56	2.35
Fraud	0.02	–	–
Enrollment / Disenrollment	0.15	0.23	0.18
Benefit Package	0.40	0.54	0.31
Access	0.28	0.31	0.30
Marketing	0.14	0.09	0.13
Customer Service	0.53	0.60	0.84
Privacy Issues	0.01	–	–
Organization Determination and Reconsideration Process	–	0.03	0.05
Quality of Care	0.20	0.22	0.23
Appeals	0.02	–	–
Other	0.39	0.49	0.49
Expedited	–	0.00	0.00

¹⁷ Measure values are weighted by Contract/Plan Year Average Enrollment. Grievances due to CMS issues are excluded from the 2014 and 2015 rates; no such category was reported in 2013. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues and expedited grievances.

Table 3.5 provides the share that each grievance category comprises of all grievances for the specified year. Grievances filed related to customer service and “other” were the two most frequently filed categories in the three calendar years, followed by benefit package and quality of care. Grievances related to customer service had the largest share in CY 2013 with 23.4%, while grievances filed as “other” had the largest share with 23.1% in CY 2014. In CY 2015, customer service once again represented the largest share with 26.3%, followed closely by “other” at 24.8%.

Table 3.5: Percentage Share of Total Grievances by Category, 2013-2015^{18,19}

Category	2013	2014	2015
Total	100%	100%	100%
Fraud	1.3%	–	–
Appeals	0.5%	–	–
Privacy Issues	0.5%	–	–
Enrollment / Disenrollment	6.3%	7.3%	5.3%
Benefit Package	19.1%	21.0%	14.4%
Access	9.8%	9.3%	9.2%
Marketing	5.1%	3.5%	3.8%
Customer Service	23.4%	21.0%	26.3%
Organization Determination and Reconsideration Process	–	1.7%	2.7%
Quality of Care	13.5%	13.2%	13.5%
Other	20.4%	23.1%	24.8%

¹⁸ Grievances were collected at the plan level in CY 2013, then at the contract level in CY 2014 and CY 2015. Measure values are weighted by Contract/Plan Year Average Enrollment. Grievances due to CMS issues are excluded from the CY 2014 and 2015 metrics; no such category was reported in CY 2013. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

¹⁹ Grievances filed for Fraud, Appeals, and Privacy Issues are only applicable to CY 2013. Grievances filed for Organization Determination and Reconsideration Process are only applicable to CY 2014 and CY 2015.

14 Grievances

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4 ORGANIZATION DETERMINATIONS AND RECONSIDERATIONS

The Part C regulations at 42 C.F.R. Part 422, Subpart M set forth the requirements related to organization determinations, reconsiderations, and reopenings. CMS requires that MA Organizations (MAOs) report the total number of organization determinations, reconsiderations, and reopenings, 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 MAO must make a determination stating the level of coverage it will provide, if any. If the MAO covers an item or service in whole, the outcome of the organization determination is fully favorable for the beneficiary; if the MAO partially covers an item or service, the organization determination outcome is partially favorable; and if the MAO chooses not to cover the item or service, then the outcome is adverse.

As defined in §422.580 of 42 C.F.R. Part 422, Subpart M, a reconsideration is the review of an adverse organization determination made by the plan. A reconsideration is the first of five levels of appeal in the Part C appeals process, and the reconsideration is made by the MAO. A beneficiary who has received an adverse or partially favorable organization determination has the right to request a reconsideration. The plans must issue a decision pursuant to the timeframes, notice and other requirements at §422.590. The reported reconsiderations data indicate how many adverse or partially favorable determinations are appealed by beneficiaries, and how successful enrollees are in obtaining a favorable outcome at this stage of the appeals process. MAOs are required to submit data on the total number of reconsiderations requested and how many resulted in a fully favorable, partially favorable or adverse decision.

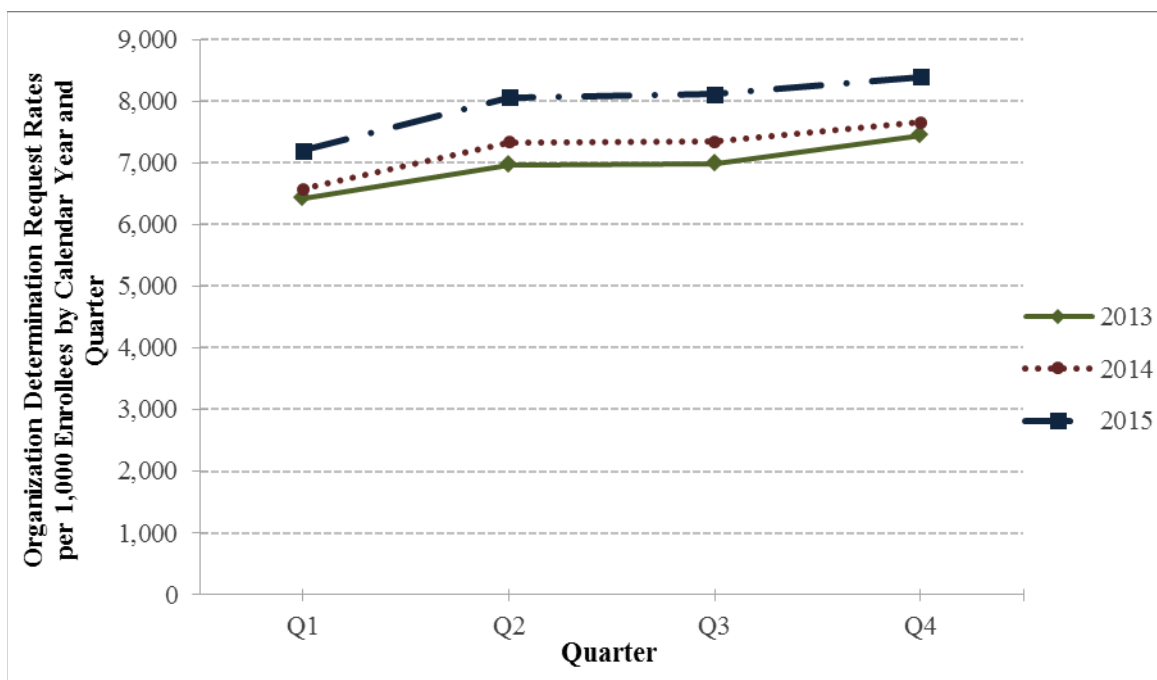
A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. A reopening occurs after a decision has been made, generally to correct an error, in response to suspected fraud or similar fault, or in response to the receipt of information not available or known to exist at the time the request was initially processed. All MAOs must report all fully favorable, partially favorable, adverse or pending reopenings of organization determinations and reconsiderations.

The total number of organization determination requests and the request rate continually increased from CY 2013 to CY 2015 (Table 4.1). The overall rate of organization determination requests per 1,000 enrollees for services and claims was 31,757.2 in CY 2015, a 14.1% increase from CY 2013 when the rate was 27,831.2 requests per 1,000 enrollees. Regional CCP organizations had the highest request rate in CY 2013 and CY 2014, with more than 31,000 requests per 1,000 enrollees in each year. However, in CY 2015, Regional CCP organizations had the second lowest request rate; lower than MMP, PFFS/1876 Cost, and Local CCP organizations.

Table 4.1: Organization Determination Request Rates per 1,000 Enrollees, 2013-2015²⁰

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2013 Number of Contracts	482	–	448	11	20	3
2014 Number of Contracts	424	–	395	10	18	1
2015 Number of Contracts	438	39	369	10	19	1
2013 Total Number of Requests	381,367,039	–	331,290,315	34,378,142	15,553,204	145,378
2014 Total Number of Requests	399,376,230	–	340,357,705	37,991,227	21,006,160	21,138
2015 Total Number of Requests	441,612,602	11,190,117	366,227,417	38,841,363	25,334,973	18,732
2013 Request Rate	27,831.2	–	27,450.8	31,385.1	29,175.2	24,805.0
2014 Request Rate	28,906.1	–	28,591.6	31,272.7	30,176.6	16,881.1
2015 Request Rate	31,757.2	38,077.9	31,509.3	31,228.8	34,032.1	19,004.4

Figure 4.1 shows organization determination request rates per 1,000 enrollees by calendar year and quarter for CY 2013, CY 2014, and CY 2015. In all three years, organization determination request rates per 1,000 enrollees increased between the first quarter and fourth quarter. In CY 2014, the request rates in each quarter increased over CY 2013 and continued to increase in CY 2015.

Figure 4.1: Organization Determination Request Rates per 1,000 Enrollees, by Year and Quarter, 2013-2015²¹

²⁰ Organization determination requests are defined as the sum of organization determination requests by outcome. Averages are weighted by Contract Year Average Enrollment. Organization determination requests for services and claims in CY 2014 and CY 2015 are comparable to total organization determination requests in CY 2013.

²¹ Organization determination requests are defined as the sum of organization determination requests by outcome. Averages are weighted by Contract Year Average Enrollment.

16 Organization Determinations and Reconsiderations

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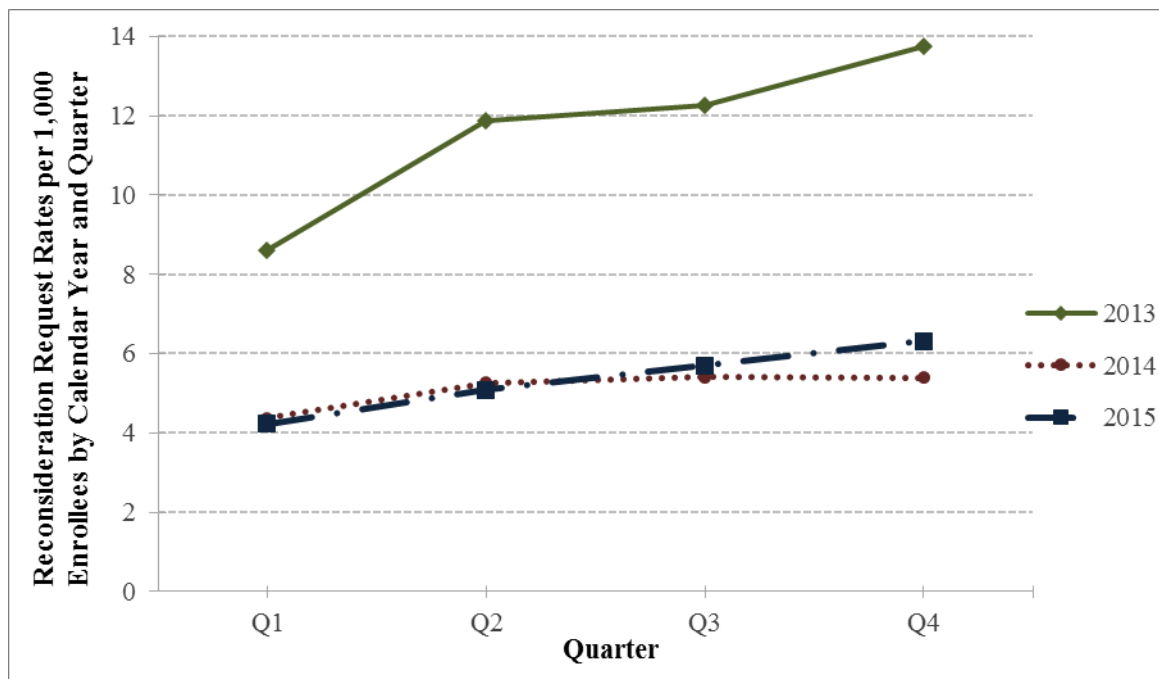
The percentage of organization determinations with fully favorable outcomes stayed relatively stable from CY 2013 to CY 2015, staying around 91% in all years (Table 4.2). The percentage of organization determinations with partially favorable or adverse outcomes remained low, below 5% for each category for each year, with a decrease in adverse outcomes from 4.3% CY 2013 to 3.8% CY 2015. During the same time period, the percentage of partially favorable outcomes increased from 3.9% to 4.6%.

Table 4.2: Percentage of Organization Determinations by Outcome, 2013-2015²²

Organization Determination Outcome	2013 Number of Contracts	2013 Measure Value	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value
Fully Favorable	481	91.8%	423	91.9%	437	91.6%
Partially Favorable	481	3.9%	423	3.8%	437	4.6%
Adverse	481	4.3%	423	4.3%	437	3.8%

Figure 4.2 shows reconsideration request rates per 1,000 enrollees by calendar year and quarter for CY 2013, CY 2014, and CY 2015. In all three years, reconsideration request rates per 1,000 enrollees increased between the first quarter and fourth quarter. While reconsideration request rates per 1,000 enrollees were similar between quarters in CY 2014 and CY 2015, they were nearly double in the four quarters of CY 2013.

Figure 4.2: Reconsideration Request Rates per 1,000 Enrollees, by Year and Quarter, 2013-2015²³



²² Organization determination requests are defined as the sum of organization determination requests by outcome. Averages are weighted by Contract Year Average Enrollment.

²³ Reconsideration requests are defined as the sum of reconsideration requests by outcome. Averages are weighted by Contract Year Average Enrollment.

17 Organization Determinations and Reconsiderations

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The overall rate of reconsideration requests per 1,000 enrollees decreased by more than half from CY 2013 (46.5) to CY 2015 (21.3) (Table 4.3). In CY 2013, Local CCPs had the highest request rate, at 50.9, and then decreased significantly to 19.3 in CY 2014, and maintained the lower rate into CY 2015, at 21.9; however, this was still a high request rate relative to the other organization types. The request rate for PFFS/1876 Cost plans increased significantly from CY 2013 (14.6) to CY 2014 (46.0), then significantly decreased in CY 2015 to 8.9. MMPs, which were excluded from this analysis in previous years, showed the highest request rate in CY 2015 at 30.8 reconsideration requests per 1,000 enrollees.

Table 4.3: Reconsideration Request Rates per 1,000 Enrollees, 2013-2015²⁴

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2013 Number of Contracts	484	–	448	11	22	3
2014 Number of Contracts	454	–	420	10	21	3
2015 Number of Contracts	444	43	369	10	21	1
2013 Total Number of Requests	635,325	–	610,776	16,079	8,450	20
2014 Total Number of Requests	285,318	–	230,973	20,217	33,984	144
2015 Total Number of Requests	298,467	9,059	256,242	26,320	6,931	5
2013 Request Rate	46.5	–	50.9	14.7	14.6	3.4
2014 Request Rate	20.4	–	19.3	16.6	46.0	12.7
2015 Request Rate	21.3	30.8	21.9	21.1	8.9	5.1

The percentage of reconsiderations with fully favorable outcomes for the beneficiary increased between all three years, while the percentage of adverse outcomes decreased over the same time period (Table 4.4). From CY 2013 to CY 2014, fully favorable outcomes exhibited a 2.3 percentage point increase, while adverse outcomes showed a 1.9 percentage point decrease. From CY 2014 to CY 2015, these changes in favorable and adverse outcomes between years were smaller (1.3 percentage point increase and 1 percentage point decrease, respectively). The percentage of reconsiderations with partially favorable outcomes remained relatively stable below 2% in all three years, decreasing only slightly by 0.3 percentage points in each year.

Table 4.4: Percentage of Reconsiderations by Outcome, 2013-2015²⁵

Reconsideration Outcome	2013 Number of Contracts	2013 Measure Value	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value
Fully Favorable	464	74.8%	446	77.1%	431	78.4%
Partially Favorable	464	1.7%	446	1.4%	431	1.1%
Adverse	464	23.4%	446	21.5%	431	20.5%

²⁴ Reconsideration requests are defined as the sum of reconsideration requests by outcome. Averages are weighted by Contract Year Average Enrollment. Reconsideration requests for services and claims in CY 2014 and CY 2015 are comparable to total reconsideration requests in CY 2013.

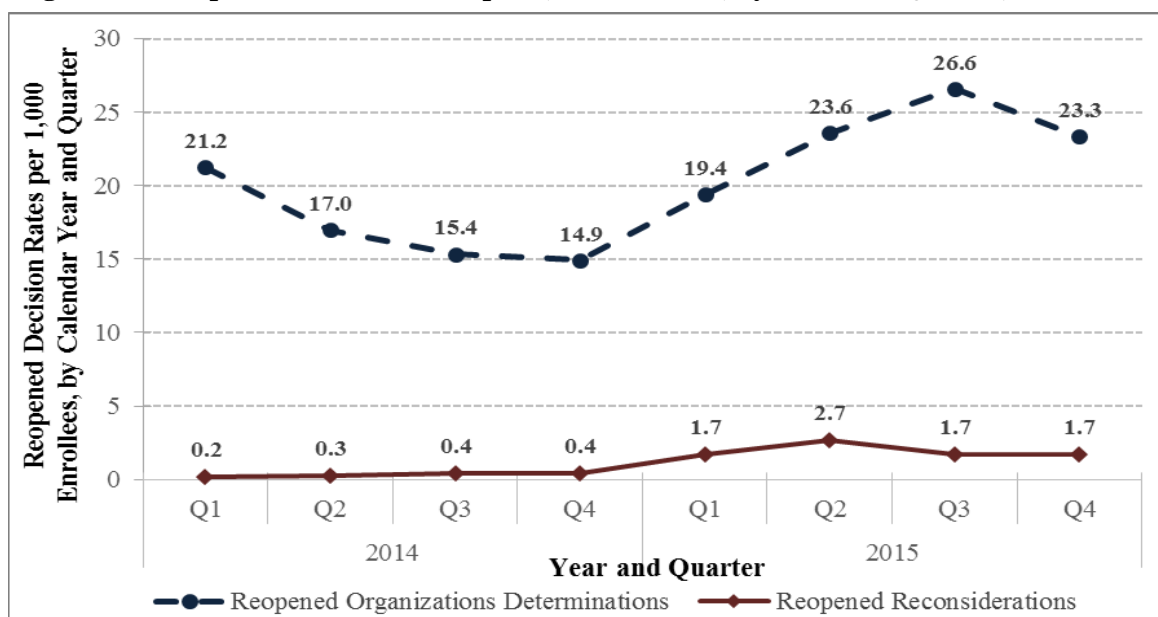
²⁵ Reconsideration requests are defined as the sum of reconsideration requests by outcome. Averages are weighted by Contract Year Average Enrollment.

18 Organization Determinations and Reconsiderations

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Figure 4.3 shows reopened decision rates per 1,000 enrollees by year and quarter for CY 2014 and CY 2015. In all quarters, the rates of reopened organization determinations were significantly higher than reopened reconsiderations. In CY 2014, the reopened organization determination decision rates declined in each quarter (21.2 in Quarter 1 to 14.9 in Quarter 4), while reopened reconsideration decision rates increased in each quarter (0.2 in Quarter 1 to 0.4 in Quarter 4). In CY 2015, the reopened organization determination rates increased from 19.4 in Quarter 1 to 26.6 in Quarter 3 and then decreased to 23.3 in Quarter 4. Reopened reconsideration decisions rates were relatively constant in CY 2015, hovering around 1.7, with a slight spike to 2.7 in Quarter 2.

Figure 4.3: Reopened Decision Rates per 1,000 Enrollees, by Year and Quarter, 2014-2015²⁶



In CY 2014 and in CY 2015, 98.0% of all organization determination requests were processed in a timely manner (Table 4.5). In CY 2014, each organization type had over 97% of their organization determination requests processed timely. In CY 2015, MSA organizations were below this threshold, dropping from 97.8% in CY 2014 to 96.6% in CY 2015. MMP organizations were also below this threshold, with only 94.4% of requests processed timely.

Table 4.5: Percent of Organization Determination Requests Processed Timely, 2014-2015²⁷

Organization Type	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value
All	452	98.0%	449	98.0%
MMP	—	—	41	94.4%
Local CCP	418	97.9%	380	98.0%
Regional CCP	10	98.4%	10	98.7%
PFFS/1876 Cost	21	98.8%	17	98.6%
MSA	3	97.8%	1	96.6%

²⁶ Averages are weighted by Contract Year Average Enrollment.

²⁷ Organization determination data are the reported totals, not the sums by outcome. Averages are weighted by Contract Year Average Enrollment.

19 Organization Determinations and Reconsiderations

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Between CY 2014 and CY 2015, there was a significant drop in the percent of reconsideration requests processed timely, decreasing from 94.5% to 79.8% (Table 4.6). In both years, MSA organizations had the highest percentage of reconsiderations processed in a timely manner at 100.0%, but represented a very small share of total number of contracts. Regional CCP and PFFS/1876 Cost organizations exhibited large decreases in the percent of requests processed timely, from 94.1% and 96.9% in CY 2014 to 63.9% and 79.8% in CY 2015, respectively. Local CCP organizations also showed a decrease in the percent of requests processed timely, dropping from 94.4% of requests to 81.3%. MMP organizations had the second highest percent of requests processed timely in CY 2015, with 86.6%.

Table 4.6: Percent of Reconsideration Requests Processed Timely, 2014-2015²⁸

Organization Type	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value
All	455	94.5%	436	79.8%
MMP	–	–	38	86.6%
Local CCP	421	94.4%	366	81.3%
Regional CCP	10	94.1%	10	63.9%
PFFS/1876 Cost	21	96.9%	21	79.8%
MSA	3	100.0%	1	100.0%

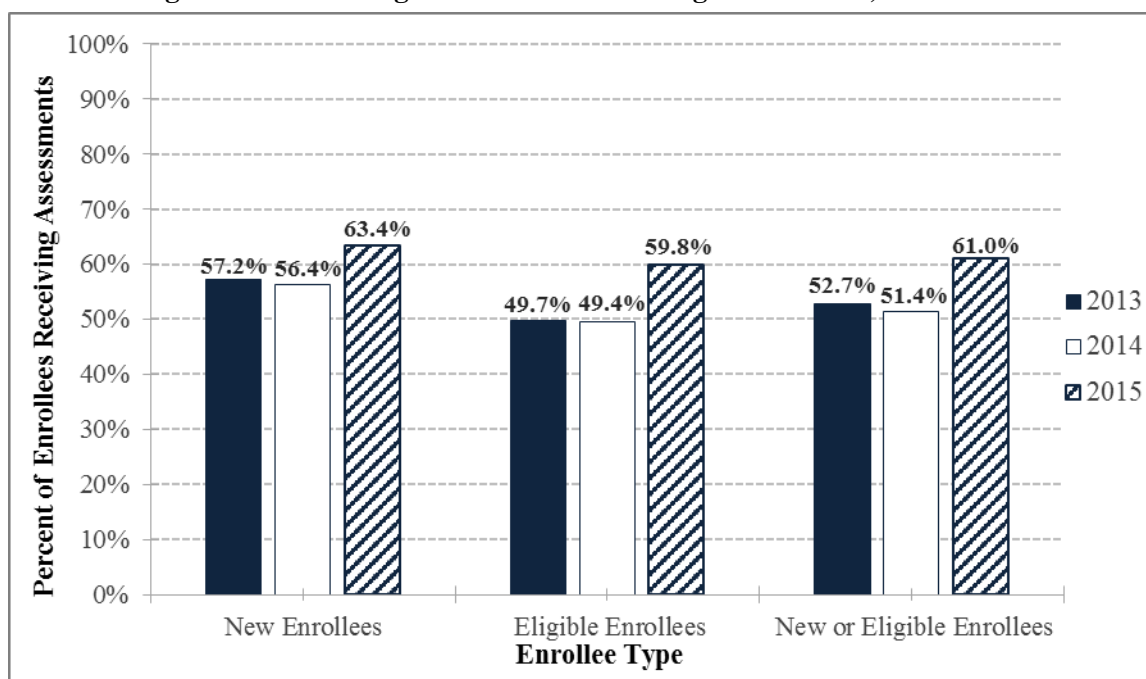
²⁸ Reconsideration data are the reported totals, not the sums by outcome. Averages are weighted by Contract Year Average Enrollment.

5 SPECIAL NEEDS PLAN CARE MANAGEMENT

Since SNPs provide coverage for vulnerable Medicare beneficiaries with specialized needs, CMS requires MA Organizations (MAOs) offering SNPs to perform initial assessments of all enrollees' medical, psychosocial, functional, and cognitive status and to develop a specialized care plan for the enrollees. MAOs are also required to perform reassessments within twelve months of the last risk assessment and use the assessment results to update the beneficiary's required care plan.²⁹

The percentage of new enrollees, eligible enrollees, and new or eligible enrollees receiving assessments slightly decreased for each category from CY 2013 to CY 2014, and then increased from CY 2014 to CY 2015 (Figure 5.1). The overall percentage of eligible enrollees receiving an initial assessment had the largest increase, by more than 10 percentage points, across years, from 49.7% in CY 2013 to 59.8% in CY 2015, followed by new or eligible enrollees and new enrollees, with 8.3 and 6.2 percentage point increases, respectively.

Figure 5.1: Percentage of Enrollees Receiving Assessments, 2013-2015³⁰



The percentage of SNPs assessing 100% of new enrollees increased slightly from 2.5% in CY 2013 to 3.2% in CY 2014, and then decreased to 1.9% in CY 2015 (Table 5.1). While the percentage of dual SNPs assessing 100% of new enrollees only decreased slightly from 2.6% to 2.2% between CY 2013 and CY 2014, and in CY 2015, it dropped to 0.4%. In contrast, the percentage of non-dual SNPs assessing 100% of new enrollees increased from 2.5% from CY 2013 to 4.8% CY 2014, and then slightly decreased to 4.6% in CY 2015. Moreover, the number of plans assessing 100% of new enrollees was minimal in all years, with 10 plans in CY 2013, 14 in CY 2014, and 8 in CY 2015.

²⁹ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf>

³⁰ Measure values are weighted by metrics' denominators.

Table 5.1: Percentage of SNPs Assessing 100% of New Enrollees, 2013-2015

SNP Type	2013 Percentage of SNPs Assessing 100% of New Enrollees	2013 Number of Plans Assessing 100%	2014 Percentage of SNPs Assessing 100% of New Enrollees	2014 Number of Plans Assessing 100%	2015 Percentage of SNPs Assessing 100% of New Enrollees	2015 Number of Plans Assessing 100%
All	2.5%	10	3.2%	14	1.9%	8
Dual	2.6%	6	2.2%	6	0.4%	1
Non-Dual	2.5%	4	4.8%	8	4.6%	7

The percentage of SNPs assessing 100% of eligible enrollees increased from 7.5% in CY 2013 to 9.4% in CY 2015 (Table 5.2). The percentage of SNPs assessing 100% of eligible enrollees decreased from CY 2013 to CY 2014 for dual SNPs, while the percentage increased for non-dual SNPs. In CY 2015, the percentage of SNPs assessing 100% of eligible enrollees increased for both dual and non-dual SNPs, with 3.3 and 2.3 percentage point increases over CY 2014, respectively. Between CY 2013 and CY 2014, the number of plans assessing 100% of eligible enrollees stayed constant at 28 plans, and then jumped to 39 plans in CY 2015.

Table 5.2: Percentage of SNPs Assessing 100% of Eligible Enrollees, 2013-2015

SNP Type	2013 Percentage of SNPs Assessing 100% of Eligible Enrollees	2013 Number of Plans Assessing 100%	2014 Percentage of SNPs Assessing 100% of Eligible Enrollees	2014 Number of Plans Assessing 100%	2015 Percentage of SNPs Assessing 100% of Eligible Enrollees	2015 Number of Plans Assessing 100%
All	7.5%	28	6.6%	28	9.4%	39
Dual	6.8%	15	4.3%	11	7.6%	20
Non-Dual	8.4%	13	10.3%	17	12.6%	19

The overall percentage of plans assessing 100% of new or eligible enrollees increased from 1.3% in CY 2013 to 2.1% in CY 2014, then decreased to 0.9% in CY 2015 (Table 5.3). The percentage of dual SNPs and non-dual SNPs assessing 100% of new or eligible enrollees had comparable trends from CY 2013 to CY 2014, and then diverged in CY 2015 with dual SNPs decreasing by 2 percentage points and non-dual increasing by 0.2 percentage points. There was a small number of plans assessing 100% in each year, with less than 10 plans in each year.

Table 5.3: Percentage of SNPs Assessing 100% of New or Eligible Enrollees, 2013-2015

SNP Type	2013 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2013 Number of Plans Assessing 100%	2014 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2014 Number of Plans Assessing 100%	2015 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2015 Number of Plans Assessing 100%
All	1.3%	5	2.1%	9	0.9%	4
Dual	1.3%	3	2.0%	5	0.0%	0
Non-Dual	1.3%	2	2.4%	4	2.6%	4

6 PRIVATE FEE-FOR-SERVICE ENROLLMENT VERIFICATION CALLS

Failure to understand plan coverage policies could leave beneficiaries 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. For CY 2015, this requirement was updated in Section 70.7 of the Medicare Marketing Guidelines which provide guidance that specifies that plans have the option to complete the enrollment verification process by telephone, email (if the beneficiary opted-in for email), or direct mail. If the plan chooses to utilize a telephonic contact but is unable to speak with the individual or his or her appointed/authorized representative directly, the plan must either continue call attempts or follow up with a written communication.

The number of times the plan reached the prospective enrollee with the first call decreased significantly year-to-year, with 1,915 in CY 2013 to 834 in CY 2014 to zero in CY 2015 (Table 6.1). In CY 2015, no data was available on the number of times the plan reached the prospective enrollee with the first call, due to sponsors being allowed to reach out by email or direct mail instead. The number of follow-up education letters sent and the number of enrollments both decreased from CY 2013 to CY 2014, and then both increased in CY 2015. At the same time, the number of plans included in the analysis continued to decrease across all three calendar years, from 126 in CY 2013 to 87 in CY 2014 to 51 in CY 2015.

Table 6.1: Summary of PFFS Plan Enrollment Verification, 2013-2015³¹

Measure	2013 Number of Plans	2013 Measure Value	2014 Number of Plans	2014 Measure Value	2015 Number of Plans	2015 Measure Value
Number of Times the Plan Reached the Prospective Enrollee with the First Call	126	1,915	87	834	51	0
Number of Follow-Up Educational Letters Sent	126	1,995	87	891	51	1,591
Number of Enrollments	126	3,028	87	1,549	51	1,663

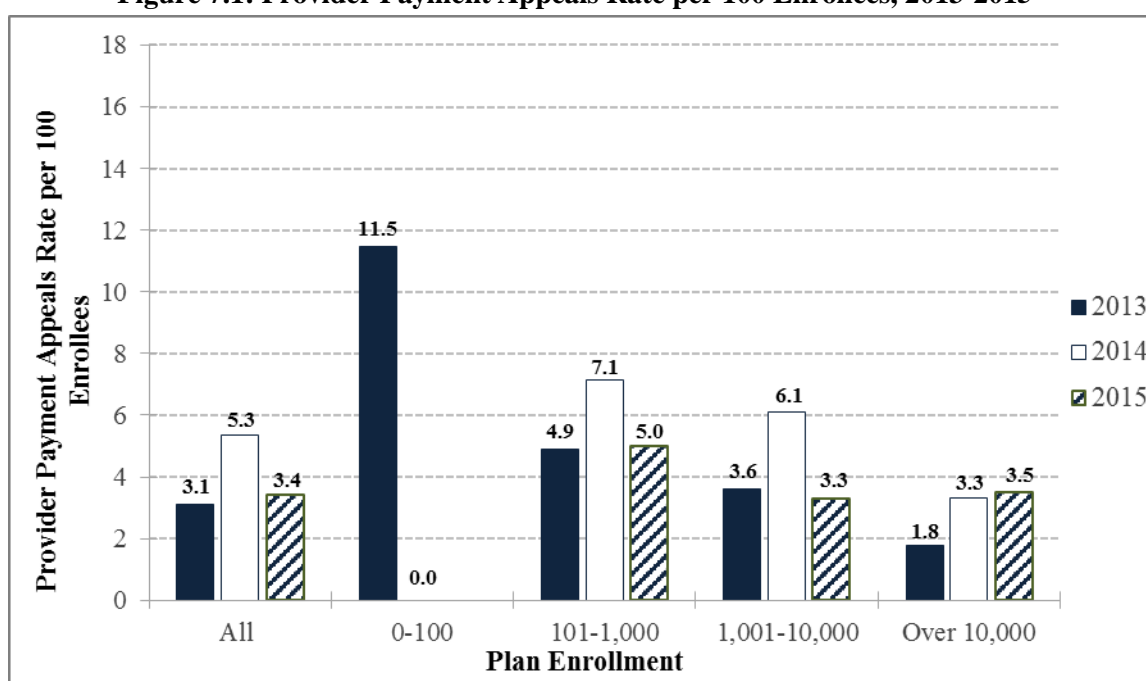
³¹ Measure values are weighted by Plan Year Average Enrollment.

7 PRIVATE FEE-FOR-SERVICE PROVIDER PAYMENT DISPUTE RESOLUTION PROCESS

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 MA Organization (MAO) PFFS plan's terms and conditions or original Medicare.

The overall rate of provider payment appeals per 100 enrollees increased from 3.1 in CY 2013 to 5.3 in CY 2014, and then decreased to 3.4 in CY 2015 (Figure 7.1). The largest decrease in provider payment appeals rates was for plans with zero to 100 enrollees, decreasing from 11.5 in CY 2013 to zero in CY 2014 and CY 2015.

Figure 7.1: Provider Payment Appeals Rate per 100 Enrollees, 2013-2015³²



Appeals are considered to be settled in the provider's favor if the previously denied provider payment is overturned and the provider receives payment. The percentage of payment appeals settled in the provider's favor increased slightly from 33.0% in CY 2013 to 36.9% in CY 2015, and then decreased to 27.3% in CY 2015 (Table 7.1). This was also observed for plans with enrollment from (i) 101 to 1,000, and (ii) 1,001 to 10,000; both categories experienced an increase in the percentage of payment appeals settled in the provider's favor from CY 2013 to CY 2014 and a decrease from CY 2014 to CY 2015. Conversely, plans with enrollment over 10,000 decreased from CY 2013 to CY 2014 and then increasing in CY 2015. However, both the decrease and increase were by less than 2 percentage points in magnitude.

³² Measure values are weighted by Plan Year Average Enrollment.

Table 7.1: Percentage of Payment Appeals Settled in Provider's Favor, 2013-2015³³

Plan Enrollment	2013 Measure Value	2013 Number of Provider Payment Denials Overturned in Favor of Provider	2013 Number of Plans	2014 Measure Value	2014 Number of Provider Payment Denials Overturned in Favor of Provider	2014 Number of Plans	2015 Measure Value	2015 Number of Provider Payment Denials Overturned in Favor of Provider	2015 Number of Plans
All	33.0%	3,911	120	36.9%	5,708	82	27.3%	2,594	60
0-100	36.2%	14	10	—	—	—	—	—	—
101-1,000	33.8%	325	37	40.0%	453	27	33.2%	166	15
1,001-10,000	34.8%	3,008	68	41.0%	4,464	51	26.0%	1,598	41
Over 10,000	29.2%	564	5	27.6%	791	4	28.8%	830	4

The time taken to resolve payment appeals reflects whether plans are processing appeals in a timely manner. Plans with 101 to 1,000 enrollees experienced the largest increase in the percentage of payment appeals resolved in over 60 days with 1.5% in CY 2013 to 10.2% in CY 2014 (Table 7.2). However, this category then decreased to 3.5% in CY 2015. Plans with 1,001 to 10,000 enrollees showed a similar pattern, albeit at a smaller magnitude, with the overall percentage of payment appeals resolved in over 60 days increasing from 1.7% in CY 2013 to 6.7% in CY 2014, and then decreasing to 1.3% in CY 2015. For the (i) 101 to 1,000 and (ii) 1,001 to 10,000 categories, the number of provider payment appeals resolved in over 60 days increased significantly from CY 2013 to CY 2014, only to exhibit a drop in CY 2015, returning to levels similar to those in CY 2013.

Table 7.2: Percentage of Payment Appeals Resolved in Over 60 Days, 2013-2015³⁴

Plan Enrollment	2013 Measure Value	2013 Number of Provider Payment Appeals Resolved in Over 60 Days	2013 Number of Plans	2014 Measure Value	2014 Number of Provider Payment Appeals Resolved in Over 60 Days	2014 Number of Plans	2015 Measure Value	2015 Number of Provider Payment Appeals Resolved in Over 60 Days	2015 Number of Plans
All	1.9%	168	120	5.6%	1,102	82	1.3%	174	60
0-100	1.2%	1	10	—	—	—	—	—	—
101-1,000	1.5%	11	37	10.2%	117	27	3.5%	19	15
1,001-10,000	1.7%	115	68	6.7%	859	51	1.0%	83	41
Over 10,000	2.2%	41	5	2.5%	126	4	1.6%	72	4

³³ Measure values are weighted by Plan Year Average Enrollment.

³⁴ Measure values are weighted by Plan Year Average Enrollment.

8 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 all three years was Employers, followed by Trustees, then Unions; this is true for both share of employers and share of enrollment (Table 8.1).

Table 8.1: Employers and Enrollment by Group Sponsor Type, 2013-2015³⁵

Group Sponsor Type	2013 Share of Employers	2013 Share of Enrollment	2014 Share of Employers	2014 Share of Enrollment	2015 Share of Employers	2015 Share of Enrollment
Union	2.8%	3.8%	3.1%	2.8%	3.3%	2.9%
Trustee	4.1%	20.4%	4.5%	18.3%	4.5%	21.0%
Employer	93.1%	75.8%	92.4%	78.9%	92.2%	76.1%

In CY 2015, the largest share of employers was reported under privately held corporations, closely followed by other organizations, with 36.5% and 34.2%, respectively (Table 8.2).

Table 8.2: Share of Employers by Organization Type, 2013-2015

Year	Total Employers	State Government	Local Government	Publicly Traded Org	Privately Held Corp	Non-Profit	Church Group	Other
2013	21,660	1.8%	9.1%	8.5%	32.6%	7.0%	1.2%	39.7%
2014	19,118	1.7%	10.3%	8.7%	35.1%	7.5%	1.4%	35.3%
2015	19,153	1.6%	10.8%	7.9%	36.5%	7.7%	1.4%	34.2%

State governments, other organizations, and publicly traded organizations had the largest share of employer enrollment in CY 2013, CY 2014, and CY 2015 (Table 8.3). State governments comprised the largest share all three years with 38.0% in CY 2013, 37.5% in CY 2014, and 42.3% in CY 2015.

Table 8.3: Share of Employer Enrollment by Organization Type, 2013-2015

Organization Type	2013	2014	2015
State Government	38.0%	37.5%	42.3%
Local Government	8.8%	12.2%	8.7%
Publicly Traded Org	17.5%	15.1%	16.5%
Privately Held Corp	3.1%	2.8%	2.6%
Non-Profit	4.1%	4.2%	3.8%
Church Group	0.3%	0.2%	0.3%
Other	28.1%	28.0%	25.8%

³⁵ Records with placeholder Federal Tax ID values (e.g., 000000000, 999999999) are excluded.

Most employers were reported under the Insured contract type for CY 2013, CY 2014, and CY 2015 with about 99.5% each year (Table 8.4). Administrative Services Organizations (ASOs) and other contract types were negligible in comparison, at or below 0.5% in all years.

Table 8.4: Employers by Contract Type, 2013-2015

Contract Type	2013 Share of Total Employers	2013 Number of Employers	2013 Enrollment	2014 Share of Total Employers	2014 Number of Employers	2014 Enrollment	2015 Share of Total Employers	2015 Number of Employers	2015 Enrollment
All	100%	21,640	2,741,013	100%	19,091	3,391,320	100%	19,106	3,152,527
Insured	99.4%	21,505	2,555,962	99.5%	18,995	3,195,194	99.5%	19,003	2,950,528
ASOs	0.2%	39	174,052	0.0%	9	170,362	0.1%	12	173,968
Other	0.4%	96	10,999	0.5%	87	25,764	0.5%	91	28,031

9 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 MA Organization 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.³⁶

Enrollment requests can be completed via paper, telephone, internet, or Medicare Online Enrollment Center (OEC). Most enrollment requests were received via paper in CY 2013, CY 2014, and CY 2015; the second most common form of request in all three years was via the internet (Table 9.1). While requests via telephone and OEC remained negligible for both years, requests via internet significantly decreased from 30.5% in CY 2013 to 9.3% in CY 2014 to 0.0% in CY 2015. At the same time, requests via paper significantly increased from 69.4% in CY 2013 to 89.5% in CY 2014 to 99.5% in CY 2015.

Table 9.1: Share of Enrollment Requests by Request Mechanism, 2013-2015

Request Mechanism	2013	2014	2015
Paper	69.4%	89.5%	99.5%
Telephonic	0.0%	0.0%	0.5%
Internet	30.5%	9.3%	0.0%
OEC	0.2%	1.2%	0.0%

In CY 2013 and CY 2014, the percentage of requests that were complete at the time of initial receipt was similar for both enrollment and disenrollment requests, 97.8% versus 98.8% in CY 2013, and 97.8% versus 99.7% in CY 2014, respectively. However, in CY 2015, the percentage of enrollment requests completed at initial receipt decreased significantly to 89.5%, while the percentage for disenrollment requests only decreased slightly to 99.1% (Table 9.2).

Table 9.2: Enrollment and Disenrollment Requests Completed at Initial Receipt, 2013-2015

Request	2013	2014	2015
Enrollment	97.8%	97.8%	89.5%
Disenrollment	98.8%	99.7%	99.1%

Less than one percent of enrollment and disenrollment requests were denied by MAOs in CY 2013 and CY 2014 (Table 9.3). However, in CY 2015, the percentage of enrollment request denied increased to over one percent, while the percentage of disenrollment requests decreased to zero percent.

Table 9.3: Enrollment and Disenrollment Requests Denied by the MA Organization, 2013-2015

Request	2013	2014	2015
Enrollment	0.7%	0.6%	1.1%
Disenrollment	0.1%	0.1%	0.0%

³⁶ Measure values are weighted by Contract Year Average Enrollment.

10 SUMMARY OF RESULTS

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

Grievances

The grievance rate per 1,000 enrollees per month slightly increased from CY 2013 to CY 2014, and then decreased in CY 2015. For CY 2013 and CY 2014, the grievance rate per 1,000 enrollees per month slightly increased from the first quarter to the fourth quarter. In contrast, this rate decreased in each quarter for CY 2015. Grievances filed related to benefit packages, access, customer service, and “other” were the four most frequently filed categories in all three years.

Organization Determinations and Reconsiderations

While the organization determination request rates per 1,000 enrollees continually increased from CY 2013 to CY 2015, the reconsideration request rates per 1,000 enrollees significantly decreased from CY 2013 to CY 2014, and then experienced a slight increase in CY 2015. The percentage of organization determinations with fully favorable outcomes for the beneficiary stayed relatively constant during the three years, while those with adverse outcomes decreased. In contrast, the percentage of reconsiderations with fully favorable outcomes experienced more variation across years, slightly increasing between years. In CY 2014, reopened organization determination decision rates increased in each quarter, while reopened reconsideration decision rates decreased in each quarter. In CY 2015, reopened organization determination decision rates exhibited an overall increase from Quarter 1 to Quarter 4, while reopened reconsideration rates remained relatively constant over the same period. In CY 2014 and CY 2015, almost all organization determination requests were processed in a timely manner. At the same time, the percent of reconsideration requests processed timely had much more variation among organization types, and exhibited a significant drop from CY 2014 to CY 2015.

SNP Care Management

The percentage of enrollees receiving assessments decreased from CY 2013 to CY 2014 and then increased from CY 2014 to CY 2015. This increase was most pronounced for eligible enrollees. The percentage of SNPs assessing 100% of new enrollees and new or eligible enrollees increased from CY 2013 to CY 2014, but by CY 2015, these percentages had decreased to below CY 2013 levels. The percentage of SNPs assessing 100% of eligible enrollees exhibited the opposite trend, decreasing from CY 2013 to CY 2014, and then increasing above CY 2013 levels in CY 2015.

PFFS Plan Enrollment Verification

The number of times the plan reached the prospective enrollee with the first call decreased significantly from CY 2013 to CY 2014 and again from CY 2014 to CY 2015. The number of follow-up education letters sent and number of enrollments also decreased significantly from CY 2013 to CY 2014. Both increased in CY 2015; however, the numbers remained below those in CY 2013, with the number of

enrollments in CY 2015 being nearly half that of the number in CY 2013. Additionally, the total number of plans decreased significantly in each year.

PFFS Provider Payment Dispute Resolution Process

The rate of provider payment appeals per 100 enrollees and the percentage of payment appeals settled in the provider's favor increased from CY 2013 to CY 2014 and then decreased in CY 2015. The percentage of payment appeals resolved in over 60 days followed a similar pattern from CY 2013 to CY 2015.

Employer Group Plan Sponsors

Between CY 2013, CY 2014, and CY 2015, employer group sponsors maintained the majority share of employers and of enrollment among all group sponsor types, while insured contracts maintained the majority shares among all contract types. Privately held corporations and "other" organizations held the largest share of employers by organization type. State government had the largest share of employer enrollment in all three years, followed by "other" organizations and publicly traded organizations.

Enrollment and Disenrollment

Most enrollment requests were received via paper, followed by the internet, in CY 2013, CY 2014, and CY 2015; however, the share of internet requests significantly decreased over all three years, while the share of paper request increased. Nearly all enrollment and disenrollment requests were complete at the time of initial receipt in CY 2013 and CY 2014, however, in CY 2015, the percent of enrollment requests decreased significantly, while the percent of disenrollment requests stayed relatively stable. Nearly all enrollment and disenrollment requests were accepted by MAOs in CY 2013, CY 2014, and CY 2015.