



Analysis of Calendar Year 2017 Medicare Part C Reporting Requirements Data

January 2019

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1 INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) utilizes many data sources to conduct oversight and monitor performance within the Medicare Part 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 enrollees.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 enrollees 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 2013 through 2017.

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

Reporting Section	2013	2014	2015	2016	2017
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	✓	✓	✓	✓	✓
Plan Oversight of Agents	–	✓	✓	✓	–
Rewards and Incentives Program	–	–	–	✓	✓

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>

Reporting Section	2013	2014	2015	2016	2017
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 2017. For each of these reporting sections,² this report presents program-wide averages and identifies trends between CY 2015, CY 2016, and CY 2017 data. The metrics evaluated in each section aim to provide information about enrollee 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 contracts reporting zero grievances	The number of contracts with at least 100 enrollees that reported zero grievances divided by the total number of contracts 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, weighted by Contract Year Average Enrollment.
	Share of grievances by category	The number of grievances by category (e.g., access, marketing) divided by the total number of grievances, weighted by Contract Year Average Enrollment.
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, weighted by Contract Year Average Enrollment.
	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, weighted by Contract Year Average Enrollment.
	Percentage of organization determinations by outcome	The number of organization determinations with specified outcome for the enrollee (i.e., fully favorable, partially favorable, or adverse) divided by the total number of organization determinations, weighted by Contract Year Average Enrollment.
	Percentage of reconsiderations by outcome	The number of reconsiderations with specified outcome for the enrollee (i.e., fully favorable, partially favorable, or adverse) divided by the total number of reconsiderations, weighted by Contract Year Average Enrollment.
	Rate of reopened decisions per 1,000 enrollees	The number of reopened decisions per 1,000 enrollees, weighted by Contract Year Average Enrollment.
	Rate of withdrawn and dismissed requests per 1,000 enrollees	The number of withdrawn and dismissed decisions per 1,000 enrollees, weighted by Contract Year Average Enrollment.

² The reporting section Plan Oversight of Agents was collected in CY 2015 and CY 2016, but was excluded from this analysis. The reporting section Mid-Year Network Changes was collected in CY 2016 and CY 2017, but was excluded from this analysis.

Reporting Section	Metric	Description
Organization Determinations and Reconsiderations (cont.)	Percentage of requests processed timely	The number of organization determinations or reconsiderations processed timely divided by the total number of organization determinations or reconsiderations, weighted by Contract Year Average Enrollment.
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, weighted 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, weighted by the total number of new 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, weighted by the total number of new 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.
	Percentage of enrollees not receiving an assessment	The number of enrollees (i.e., new, eligible, or new + eligible) that did not receive an assessment because enrollee refused or SNP could not reach enrollee divided by total number of SNPs, weighted by the total number of new enrollees, or by the total number of eligible enrollees in the SNP.
PFFS Provider Payment Dispute Resolution Process	Rate of provider payment appeals per 100 enrollees	The number of provider payment appeals per 100 enrollees, weighted by Contract Year Average Enrollment.
	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, weighted by Contract Year Average Enrollment.
	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, weighted by Contract Year Average Enrollment.
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.

Reporting Section	Metric	Description
Enrollment and Disenrollment	Enrollment requests by mechanism	The number of enrollment requests by mechanism (i.e., paper, telephone, internet, or Medicare Online Enrollment Center) divided by the total number of enrollment requests, weighted by Contract Year Average Enrollment.
	Requests completed at initial receipt	The number of enrollment or disenrollment requests completed at initial receipt divided by total number of enrollment or disenrollment requests, weighted by Contract Year Average Enrollment.
	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, weighted by Contract Year Average Enrollment.
	Involuntarily disenrolled individuals (for failure to pay plan premium) who submitted timely requests for reinstatement for good cause	The number of disenrolled individuals who submitted a timely request for reinstatement for good cause divided by the number of involuntary disenrollments for failure to pay plan premium in the specified time period, weighted by Contract Year Average Enrollment.
	Requests for reinstatement for good cause determinations that were favorable	The number of favorable good cause determinations divided by number of disenrolled individuals who submitted a timely request for reinstatement for good cause, weighted by Contract Year Average Enrollment.
	Individuals reinstated after receiving a favorable good cause determinations	The number of individuals reinstated divided by the number of favorable good cause determinations, weighted by Contract Year Average Enrollment.
Payments to Providers	Share of payments made by payment type	The value of payments made by payment type divided by total Medicare Advantage payments
	Share of providers paid by payment type	The number of providers paid by payment type divided by total number of Medicare Advantage providers
Rewards and Incentives	Number of beneficiaries per Rewards Program	The number of beneficiaries enrolled in a Rewards Program divided by the number of Rewards Programs
	Number of rewards per Rewards Program	The number of rewards awarded divided by the number of Rewards Programs
	Share of contracts offering a Rewards Program	The number of contracts with at least 1 Rewards Program divided by the total number of contracts
	Percentage of beneficiaries enrolled in a Rewards Program	The number of beneficiaries enrolled in a Rewards Program divided by the number of beneficiaries

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

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 10 present the main findings for each of the eight reporting sections listed above. Section 11 summarizes key results from the analysis. Appendix A details the data elements and formulas used to create each metric in this analysis.

³For information on CMS's Star Ratings and Display Measures, please visit the CMS website on Part C and D Performance Data, <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

⁴ For information on CMS's Public Use Files (PUFs), please visit the CMS website on Part C and D Data Validation, <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. Data that have not passed these integrity checks are excluded from the analyses. Section 2.1 discusses the process for MAOs to submit Reporting Requirements data via HPMS. Section 2.2 explains the data validation process that each MAO must undergo. Section 2.3 outlines the criteria for exclusion from this analysis and overviews the contract- and plan-level data validation results. Section 2.4 details which reporting sections are included in the PUF and the restrictions applied to each reporting section's data.

2.1 Submission Process

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 on compliance notices and enforcement actions in response to reporting requirement failures.

MAOs 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 values relative to the rest of the Part C program. Acumen's placeholder notices inform MAOs if they reported "0" 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 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. Starting in CY 2016, CMS began using a Likert scale for evaluating certain element-level data validation checks, in which contracts are assigned a value of 1 through 5 based on the percent of records found to have an error.⁶ In previous years, all element-level data validation checks were judged on a binary (Yes or No) scale. For the metrics in this report, if a contract scores a 1, 2 or 3 on the Likert scale or a “No” on the binary scale they are classified as failing the element-level data validation check.

As shown in Table 2.1, three of the eight reporting sections included in this report, Grievances, Organization Determinations and Reconsiderations, and SNP Care Management, underwent data validation for the CY 2015 through CY 2017 data. Data for the Employer Group Plan Sponsors, PFFS Provider Payment Disputes, and Enrollment and Disenrollment, Payments to Providers, and Rewards and Incentives Programs sections are collected for monitoring purposes only and did not undergo validation.

Table 2.1: Reporting Sections Undergoing Data Validation

Reporting Section	CY 2015 Data	CY 2016 Data	CY 2017 Data
Grievances	2016 DV	2017 DV	2018 DV
Organization Determinations and Reconsiderations	2016 DV	2017 DV	2018 DV
SNP Care Management	2016 DV	2017 DV	2018 DV
PFFS Provider Payment Disputes	–	–	–
Employer Group Plan Sponsors	–	–	–
Enrollment and Disenrollment	–	–	–
Payments to Providers	–	–	–
Rewards and Incentives Programs	–	–	–

2.3 Data Validation Exclusion Criteria

Contracts’ inclusion in this analysis is contingent on (i) the contract submitting the required data by the specified reporting deadline, and (ii) the submitted data meeting minimum data validation requirements. Prior to CY 2016, contracts that terminate on or before the applicable deadline to submit data validation results to CMS are excluded. For CY 2016 and CY 2017, contracts that submitted data but were not required to submit due to termination were included if all other inclusion criteria were met. For

⁵ For more information on the data validation methodology, please visit the CMS website on Part C and Part D Data Validation <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

⁶ For more information on the Likert scale, reference the Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual, available at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

the CY 2015 through CY 2017 reporting sections that underwent validation in the 2016, 2017, or 2018 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 Grievances, which increased in each year, from 90.8% and 59.6% in CY 2015 to 98.0% and 83.6% in CY 2017, respectively. Grievances had the highest percentage of contracts with a data validation score of 100% in CY 2017 with 83.6%. SNP Care Management exhibited a decrease in the percent of contracts achieving a score of 100%, lowering from 93.5% in CY 2015 to 76.4% in CY 2017. For SNP Care Management, the percent of contracts achieving a passing data validation score decreased from 99.0% in CY 2015 to 98.1% in CY 2016, then increasing to 99.5% in CY 2017. SNP Care Management saw the highest percentage of contracts achieving a passing data validation score in CY 2017. Organization Determinations and Reconsiderations saw increases in the percent of contracts with a passing data validation score and the percent of contracts with a data validation score of 100%, going from 92.6% and 63.6% in CY 2015 to 98.8% and 77.2% in CY 2017, respectively.

Table 2.2: Summary of Contract Data Validation Results by Reporting Section, 2015-2017⁷

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	2015	513	513	466	90.8%	306	59.6%
Grievances	2016	508	508	497	97.8%	410	80.7%
Grievances	2017	489	489	479	98.0%	409	83.6%
Organization Determinations and Reconsiderations	2015	511	511	473	92.6%	325	63.6%
Organization Determinations and Reconsiderations	2016	508	508	498	98.0%	374	73.6%
Organization Determinations and Reconsiderations	2017	487	487	481	98.8%	376	77.2%
SNP Care Management	2015	200	200	198	99.0%	187	93.5%
SNP Care Management	2016	208	208	204	98.1%	163	78.4%
SNP Care Management	2017	212	212	211	99.5%	162	76.4%

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). Sections that did not undergo DV are not included in the summary table (i.e., PFFS Provider Payment, Employer Group Plan Sponsors, Enrollment and Disenrollment, Payments to Providers, and Rewards and Incentives). In CY 2016 and CY 2017, contracts/plans that submitted data but were not required to submit due to termination were included in this table if all other inclusion criteria were met.

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 the only data validation section reported at the plan level. The percentage of plans with contracts achieving a passing data validation score for SNP Care Management increased overall, from 99.1% in CY 2015 to 99.8% CY 2017, with a small decrease to 98.8% in CY 2016. The percentage of plans with contracts achieving a data validation score of 100% has decreased each year, going from 95.5% in CY 2015 to 88.1% in CY 2016 and 81.8% in CY 2017.

Table 2.3: Summary of Data Validation Results by Reporting Section for Plans, 2015-2017⁸

Reporting Section	Year	Total Number Eligible for Inclusion	Number Included in Analysis and Underwent DV	# of Plans DV Score ≥ 95%	% of Plans DV Score ≥ 95%	# of Plans DV Score = 100%	% of Plans DV Score = 100%
SNP Care Management	2015	444	444	440	99.1%	424	95.5%
SNP Care Management	2016	513	513	507	98.8%	452	88.1%
SNP Care Management	2017	516	516	515	99.8%	422	81.8%

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.⁹ 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	✓

⁸ Total number eligible for inclusion represents contracts/plans required to report for all four quarters and that met termination requirements (i.e., does not reflect size exclusions). Number included in analysis and underwent DV represents contracts/plans that are excluded from analysis if they do not meet termination and/or minimum size requirements. Inclusion in DV Score = 100% must score exactly 100% (un-rounded). In CY 2016 and CY 2017, plans that submitted data but were not required to submit due to termination were included in this table if all other inclusion criteria were met.

⁹ For more information on CMS's Public Use Files (PUFs), please visit the CMS website on Parts C and D Data Validation, <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDDataValidation.html>

Reporting Section	Utilized for Public Use Files?
SNP Care Management	✓
PFFS Provider Payment Dispute Resolution Process	–
Employer Group Plan Sponsors	–
Enrollment and Disenrollment	✓
Payments to Providers	✓
Rewards and Incentives	✓

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.¹⁰

- Plan-level sections¹¹:
 - 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 sections¹²:
 - Contract required to submit
 - Contract had year average enrollment greater than or equal to 11
 - Contract active as of end of reporting year

¹⁰ 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.

¹¹ If all other inclusion criteria are met, data submitted by plans that were not required to submit due to termination were included in this report.

¹² If all other inclusion criteria are met, data submitted by contracts that were not required to submit due to termination were included in this report.

3 GRIEVANCES

The Part C regulations at 42 C.F.R. Part 422, Subpart M set forth the requirements related to grievances. To help CMS assess whether enrollees are satisfied with the provision of Medicare services and whether MAOs address enrollee complaints in a timely manner, CMS requires MAOs report the total number of grievances filed during the benefit year, as well as the number of grievances the plan resolved in a timely manner. 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.¹³ 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.¹⁴

The share of contracts with at least 100 enrollees reporting zero grievances was around 2.0% in all three years (Table 3.1). The majority of contracts reporting zero grievances were Local CCP organizations in all three years, which is because most contracts are Local CCP organizations.

Table 3.1: Contracts Reporting Zero Grievances by Organization Type, 2015-2017¹⁵

Organization Type	2015 Total Number of Contracts	2015 Number of Contracts Reporting Zero	2015 Share of Contracts that Reported Zero	2016 Total Number of Contracts	2016 Number of Contracts Reporting Zero	2016 Share of Contracts that Reported Zero	2017 Total Number of Contracts	2017 Number of Contracts Reporting Zero	2017 Share of Contracts that Reported Zero
All	323	7	2.2%	422	7	1.7%	440	11	2.5%
MMP	28	0	0.0%	39	0	0.0%	45	0	0.0%
Local CCP	272	4	1.5%	358	6	1.7%	365	9	2.5%
Regional CCP	6	0	0.0%	8	0	0.0%	10	0	0.0%
PFFS/1876 Cost	16	2	12.5%	14	1	7.1%	17	2	11.8%
MSA	1	1	100.0%	3	0	0.0%	3	0	0.0%

The share of contracts represented by each enrollment bucket was fairly consistent across years and smaller contracts were more likely to report zero grievances (Table 3.2). The smallest enrollment bucket of 100-499 enrollees had the highest share of contracts reporting zero grievances for all three years, with 17.2% of contracts within the category reporting zero grievances in CY 2015, 12.9% in CY 2016, and 17.1% in CY 2017.

¹³ For additional guidance on regulatory requirements for grievances, please see Chapter 13 of the Medicare Managed Care Manual, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf>

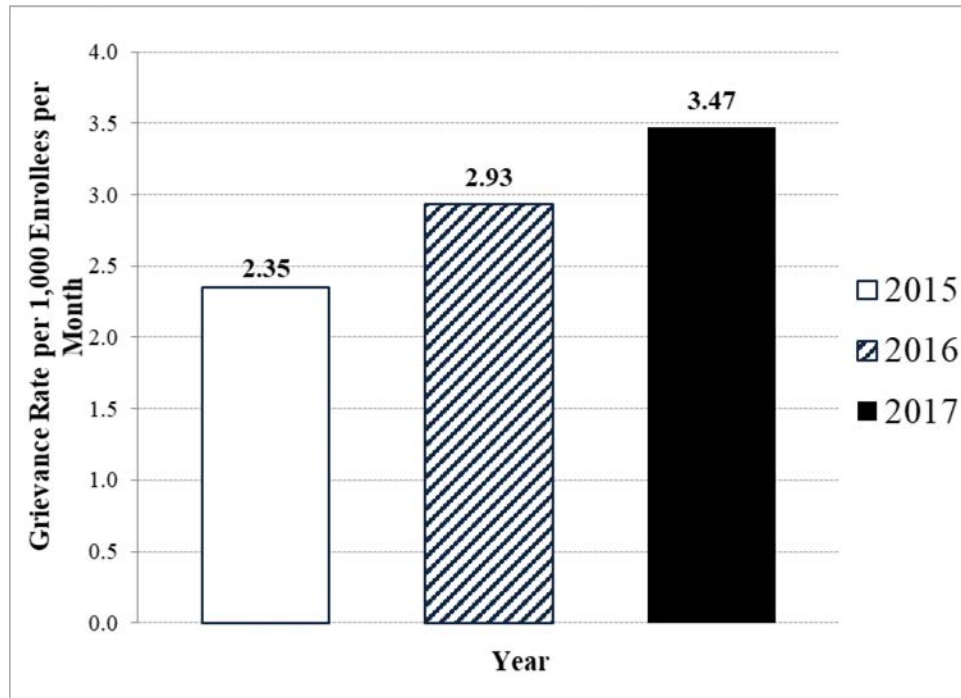
¹⁴ MAOs may extend the 30-day timeframe by up to 14 days but must promptly notify enrollees that they intend to do so. Also, expedited grievances related to the plan's refusal to process an enrollee's request for an expedited pre-service organization determination or reconsideration must be responded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

¹⁵ 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.

Table 3.2: Contracts Reporting Zero Grievances by Enrollment, 2015-2017¹⁶

Contract Enrollment	2015 Total Number of Contracts	2015 Number of Contracts Reporting Zero	2015 Share of Contracts that Reported Zero	2016 Total Number of Contracts	2016 Number of Contracts Reporting Zero	2016 Share of Contracts that Reported Zero	2017 Total Number of Contracts	2017 Number of Contracts Reporting Zero	2017 Share of Contracts that Reported Zero
All	323	7	2.2%	422	7	1.7%	440	11	2.5%
100 - 499	29	5	17.2%	31	4	12.9%	35	6	17.1%
500-999	24	1	4.2%	27	1	3.7%	27	3	11.1%
1,000 - 9,999	115	1	0.9%	157	2	1.3%	157	2	1.3%
10,000 - 99,999	139	0	0.0%	180	0	0.0%	181	0	0.0%
100,000+	16	0	0.0%	27	0	0.0%	40	0	0.0%

The yearly grievance rate per 1,000 enrollees per month has risen each year from CY 2015 to CY 2017(Figure 3.1). In CY 2016, the grievance rate increased to 2.93, a 24.4% increase over CY 2015. From CY 2016 to CY 2017, the grievance rate increased again by 18.4% to 3.47.

Figure 3.1: Grievance Rates per 1,000 Enrollees per Month, 2015-2017¹⁷

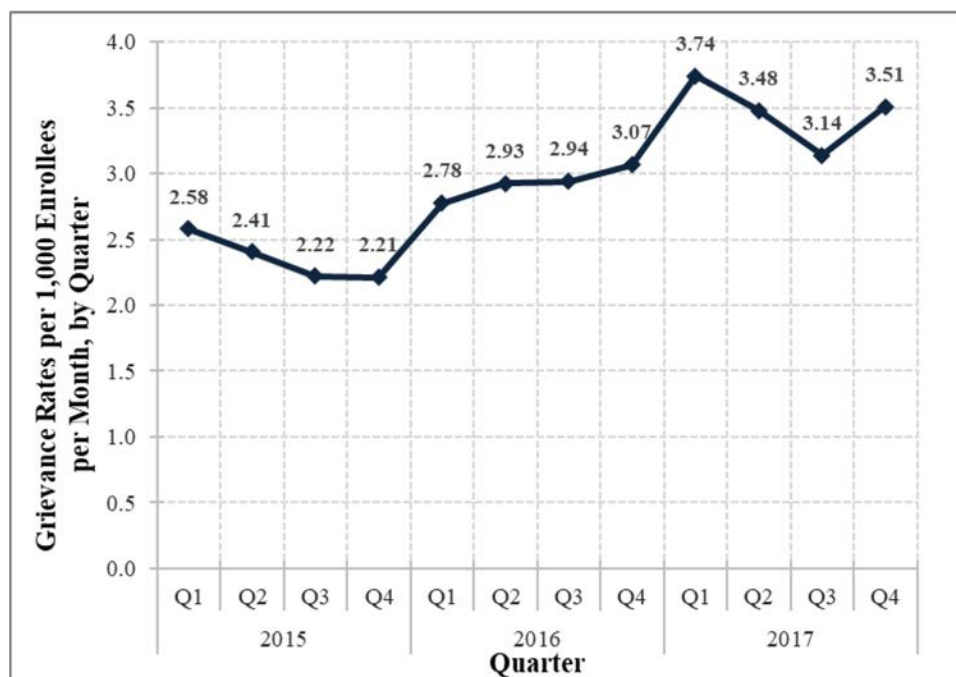
The quarterly grievance rate per 1,000 enrollees per month was generally highest in the later quarters for CY 2016, but for CY 2015, the grievance rate per 1,000 enrollees per month experienced decreases throughout the year, and for CY 2017 the grievance rate decreased from Quarter 1 through

¹⁶ 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.

¹⁷ Measure values are weighted by Contract Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

Quarter 3, and then had a slight peak for Quarter 4 (Figure 3.2). In CY 2015, the grievance rate per 1,000 enrollees per month decreased across all quarters, from 2.58 in Quarter 1 to 2.21 in Quarter 4. Then in CY 2016, this trend reversed and the grievance rate increased across all quarters, from 2.78 in Quarter 1 to 3.07 in Quarter 4. In CY 2017, the grievance rate decreased from 3.7 in Quarter 1 to 3.1 in Quarter 3, rebounding slightly to 3.5 in Quarter 4.

Figure 3.2: Grievance Rates per 1,000 Enrollees per Month, by Year and Quarter, 2015-2017¹⁸



Across all three years, MMP and Regional CCP organizations had the highest grievance rates per 1,000 enrollees per month (Table 3.3). In all three years, MMP organizations had the highest grievance rate of any type of organization, but that rate has decreased steadily from 5.92 in CY 2015 to 5.47 in CY 2016 to 5.37 in CY 2017. Regional CCP had the largest increase across the three years, going from 2.61 in CY 2015 to 4.09 in both CY 2016 and CY 2017.

Table 3.3: Grievance Rates per 1,000 Enrollees per Month by Organization Type, 2015-2017

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2015 Grievance Rate	2.35	5.92	2.28	2.61	1.94	0.00
2015 Number of Contracts	339	34	281	6	17	1
2016 Grievance Rate	2.93	5.47	2.89	4.09	1.69	0.75
2016 Number of Contracts	434	45	363	8	15	3
2017 Grievance Rate	3.47	5.37	3.43	4.09	2.28	0.95
2017 Number of Contracts	452	47	375	10	17	3

¹⁸ Measure values are weighted by Contract Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues.

Reported data enable CMS to identify the category a grievance was related to, including enrollment/disenrollment, plan benefits, access, marketing, customer service, organization determination and reconsideration process, quality of care, or “other”. Data are also reported regarding grievances that were expedited, and beginning in CY 2017, dismissed. Table 3.4 provides the rate per 1,000 enrollees per month for each grievance category. Grievances filed related to plan benefits, customer service, and “other” were most common in all three calendar years. The largest increase between years was for grievances filed for customer service, which increased by 0.32 grievances per 1,000 enrollees per month, from 0.84 grievances per 1,000 enrollees per month in CY 2015 to 1.16 in CY 2017. Other grievances exhibited the only decrease over the three years, decreasing by 0.05 grievances per 1,000 enrollees per month, from 0.49 in CY 2015 to 0.44 in CY 2017.

Table 3.4: Grievance Rates per 1,000 Enrollees per Month by Category, 2015-2017¹⁹

Category	2015	2016	2017
Total	2.35	2.93	3.47
Enrollment / Disenrollment	0.18	0.18	0.26
Plan Benefit ²⁰	0.31	0.46	0.52
Access	0.30	0.31	0.44
Marketing	0.13	0.13	0.26
Customer Service	0.84	0.81	1.16
Organization Determination and Reconsideration Process	0.05	0.06	0.08
Quality of Care	0.23	0.21	0.24
Other	0.49	0.44	0.44
Expedited	0.00	0.00	0.00
Dismissed	—	—	0.11

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 plan benefit grievances. Grievances related to customer service had the largest share in CY 2015, CY 2016, and CY 2017, with 26.3%, 29.1%, and 30.5% respectively.

Table 3.5: Percentage Share of Total Grievances by Category, 2015-2017²¹

Category	2015	2016	2017
Total	100.0%	100.0%	100.0%
Enrollment / Disenrollment	5.3%	6.8%	6.6%

¹⁹ Measure values are weighted by Contract Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues, expedited grievances, and dismissed grievances.

²⁰ Beginning in CY 2017, Benefit Package grievances were called Plan Benefit grievances.

²¹ Measure values are weighted by Contract Year Average Enrollment. Total grievances are defined as the sum of grievances by category, excluding grievances due to CMS issues, expedited grievances, and dismissed grievances.

Category	2015	2016	2017
Total	100.0%	100.0%	100.0%
Plan Benefit ²²	14.4%	15.8%	16.1%
Access	9.2%	10.0%	10.2%
Marketing	3.8%	5.3%	6.5%
Customer Service	26.3%	29.1%	30.5%
Organization Determination and Reconsideration Process	2.7%	2.4%	2.4%
Quality of Care	13.5%	10.8%	9.5%
Other	24.8%	20.0%	18.3%

²² This grievance category changed from Benefit Package to Plan Benefit in 2017.

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 MAOs report the total number of organization determinations, reconsiderations, number of organization determination and reconsideration requests resolved in a timely manner, reopenings, and whether the outcome of each is fully favorable, partially favorable, or adverse for the enrollee. 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 representatives or providers, 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 enrollee; 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. A withdrawn organization determination is a request that is removed from the plan's review process at the behest of the requestor. A dismissal is an action taken by a MAO when an organization determination request lacks required information or otherwise does not meet requirements to be considered a valid request.

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 decision to overturn or affirm the adverse decision is made by the MAO. An enrollee 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 enrollees, 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, the number of requests the plan resolved in a timely manner, and how many resulted in a fully favorable, partially favorable or adverse decision. Data on the number of withdrawn and dismissed reconsiderations is also collected from MAOs.

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 a clerical error, or in response to the receipt of information not available or known to exist at the time the request was initially processed or for other reasons. All MAOs must report all fully favorable, partially favorable, adverse or pending reopenings of organization determinations and reconsiderations.

The overall rate of organization determination requests per 1,000 enrollees for services and claims decreased by 8.5% between CY 2015 and CY 2016, from 31,757.2 to 29,050.2, and then increased by nearly the same margin in CY 2017 to 31,454.4 (Table 4.1). The rate for PFFS/1876 Cost organizations experienced the most variation across years, decreasing by 22.3% from CY 2015 to CY 2016, then increasing by 3.6% from CY 2016 to CY 2017. From CY 2015 to CY 2017, MMP organizations had the highest request rates of all organization types by a large margin. Compared to all

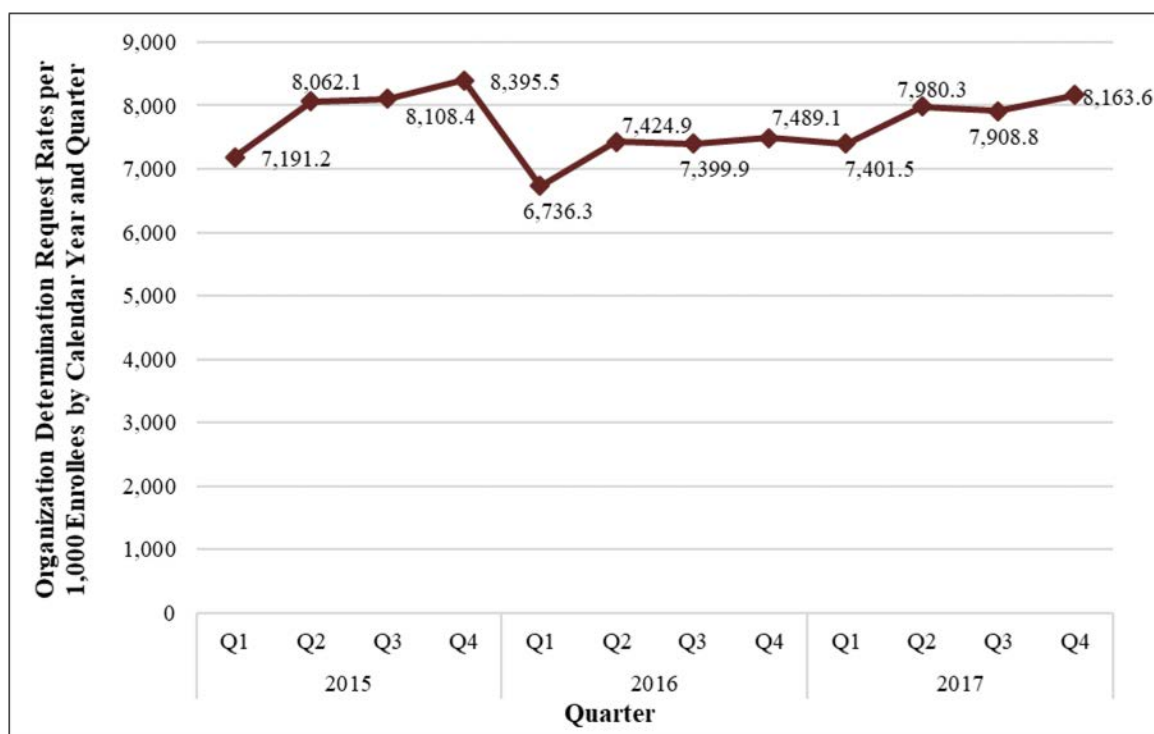
other organization types, MSA organizations had substantially lower rates in all three years, however, this may be attributed to small sample size due to there being few MSAs offered.

Table 4.1: Organization Determination Request Rates per 1,000 Enrollees, 2015-2017²³

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2015 Number of Contracts	438	39	369	10	19	1
2016 Number of Contracts	440	46	365	9	17	3
2017 Number of Contracts	432	44	357	10	18	3
2015 Total Number of Requests	441,612,602	11,190,117	366,227,417	38,841,363	25,334,973	18,732
2016 Total Number of Requests	464,848,464	12,952,372	407,204,563	28,543,116	16,095,908	52,505
2017 Total Number of Requests	499,304,613	13,876,691	421,379,201	42,416,761	21,526,039	105,921
2015 Request Rate	31,757.2	38,077.9	31,509.3	31,228.8	34,032.1	19,004.4
2016 Request Rate	29,050.2	39,219.8	28,862.6	30,019.7	26,428.0	17,214.8
2017 Request Rate	31,454.4	40,018.6	31,514.0	31,082.4	27,387.6	19,656.0

Figure 4.1 shows organization determination request rates per 1,000 enrollees by calendar year and quarter for CY 2015, CY 2016, and CY 2017. In all three years, organization determination request rates per 1,000 enrollees increased between the first quarter and fourth quarter.

Figure 4.1: Organization Determination Request Rates per 1,000 Enrollees, by Year and Quarter, 2015-2017²⁴



²³ Organization determination requests are defined as the sum of organization determination requests by outcome. Averages are weighted by Contract Year Average Enrollment.

²⁴ Organization determination requests are defined as the sum of organization determination requests by outcome. Averages are weighted by Contract Year Average Enrollment.

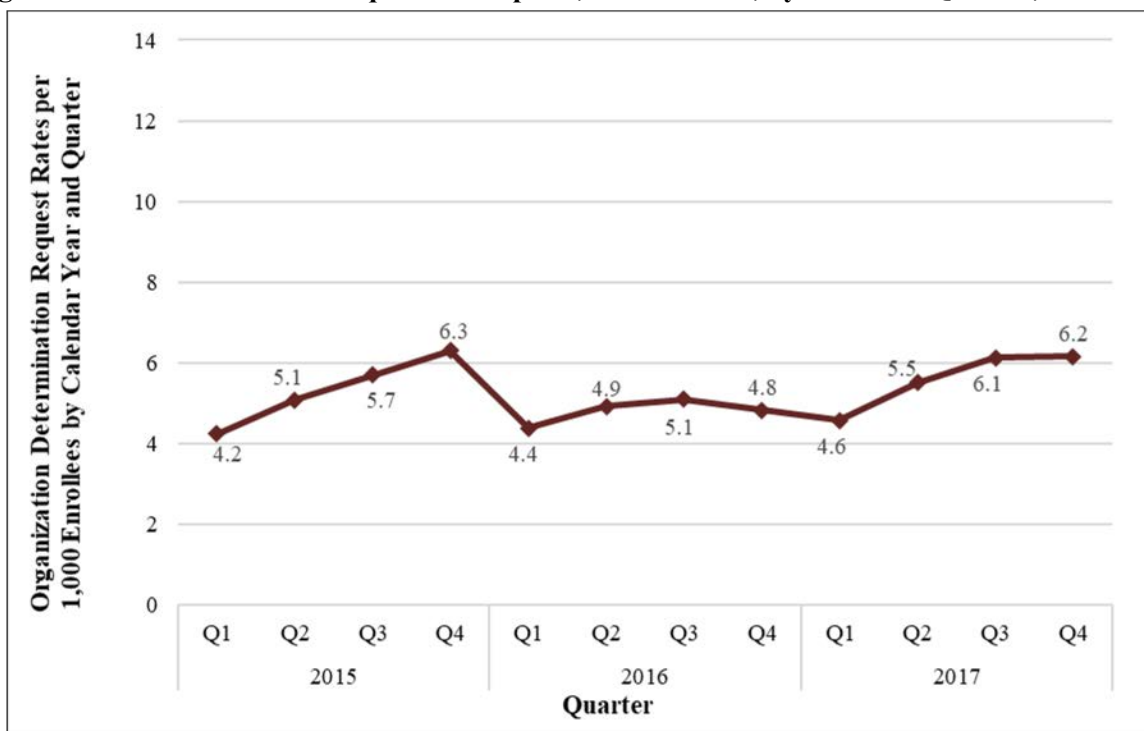
The percentage of organization determinations with fully favorable outcomes decreased slightly from CY 2015 to CY 2017, from 91.6% to 90.6% (Table 4.2). The percentage of organization determinations with partially favorable or adverse outcomes remained low, about 5% for each category for each year, with an increase in partially favorable outcomes from 4.6% CY 2015 to 5.3% in CY 2017 with a slight decrease to 4.5% CY 2016. During the same time period, the percentage of adverse outcomes increased from 3.8% in CY 2015 to 4.1% in CY 2017.

Table 4.2: Percentage of Organization Determinations by Outcome, 2015-2017²⁵

Organization Determination Outcome	2015 Number of Contracts	2015 Measure Value	2016 Number of Contracts	2016 Measure Value	2017 Number of Contracts	2017 Measure Value
Fully Favorable	437	91.6%	439	91.3%	431	90.6%
Partially Favorable	437	4.6%	439	4.5%	431	5.3%
Adverse	437	3.8%	439	4.3%	431	4.1%

Figure 4.2 shows reconsideration request rates per 1,000 enrollees by calendar year and quarter for CY 2015, CY 2016, and CY 2017. In all three years, reconsideration request rates per 1,000 enrollees increased between the first quarter and fourth quarter. In CY 2016, reconsideration request rates increased from Quarter 1 to Quarter 3 and then decreased in Quarter 4. In comparison, rates steadily increased from quarter to quarter in CY 2015 and CY 2017.

Figure 4.2: Reconsideration Request Rates per 1,000 Enrollees, by Year and Quarter, 2015-2017²⁶



²⁵ Organization determination requests are defined as the sum of organization determination requests by outcome. Averages are weighted by Contract Year Average Enrollment.

²⁶ Reconsideration requests are defined as the sum of reconsideration requests by outcome. Averages are weighted by Contract Year Average Enrollment.

The overall rate of reconsideration requests per 1,000 enrollees increased from 21.3 in CY 2015 to 22.4 in CY 2017, with a slight decrease to 19.3 in CY 2016 (Table 4.3). For each of the three years, MMP organizations had the highest reconsideration request rates, with 30.8 in CY 2015, 43.5 in CY 2016, and 40.2 reconsideration requests per 1,000 enrollees in CY 2017, respectively.

Table 4.3: Reconsideration Request Rates per 1,000 Enrollees, 2015-2017²⁷

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2015 Number of Contracts	444	43	369	10	21	1
2016 Number of Contracts	468	49	389	9	18	3
2017 Number of Contracts	467	45	391	10	18	3
2015 Total Number of Requests	298,467	9,059	256,242	26,230	6,931	5
2016 Total Number of Requests	318,117	15,268	267,308	28,946	6,578	17
2017 Total Number of Requests	403,016	14,009	338,973	43,173	6,823	38
2015 Request Rate	21.3	30.8	21.9	21.1	8.9	5.1
2016 Request Rate	19.3	43.5	18.6	30.4	8.2	5.6
2017 Request Rate	22.4	40.2	21.8	31.6	9.4	7.1

Reconsiderations with fully favorable outcomes represented the majority of reconsiderations, followed by adverse outcomes (Table 4.4). From CY 2015 to CY 2016, the percentage of fully favorable outcomes exhibited a 2.5 percentage point decrease, but from CY 2015 to CY 2017, the decrease was only 0.3 percentage points. From CY 2015 to CY 2017, the percentage of adverse outcomes increased by 0.5 percentage points. The percentage of reconsiderations with partially favorable outcomes remained small, decreasing slightly from 1.1% in CY 2015 to 0.9% in CY 2017.

Table 4.4: Percentage of Reconsiderations by Outcome, 2015-2017²⁸

Reconsideration Outcome	2015 Number of Contracts	2015 Number of Contracts	2016 Number of Contracts	2016 Number of Contracts	2017 Number of Contracts	2017 Number of Contracts
Fully Favorable	431	78.4%	458	75.9%	459	78.1%
Partially Favorable	431	1.1%	458	0.7%	459	0.9%
Adverse	431	20.5%	458	23.4%	459	21.0%

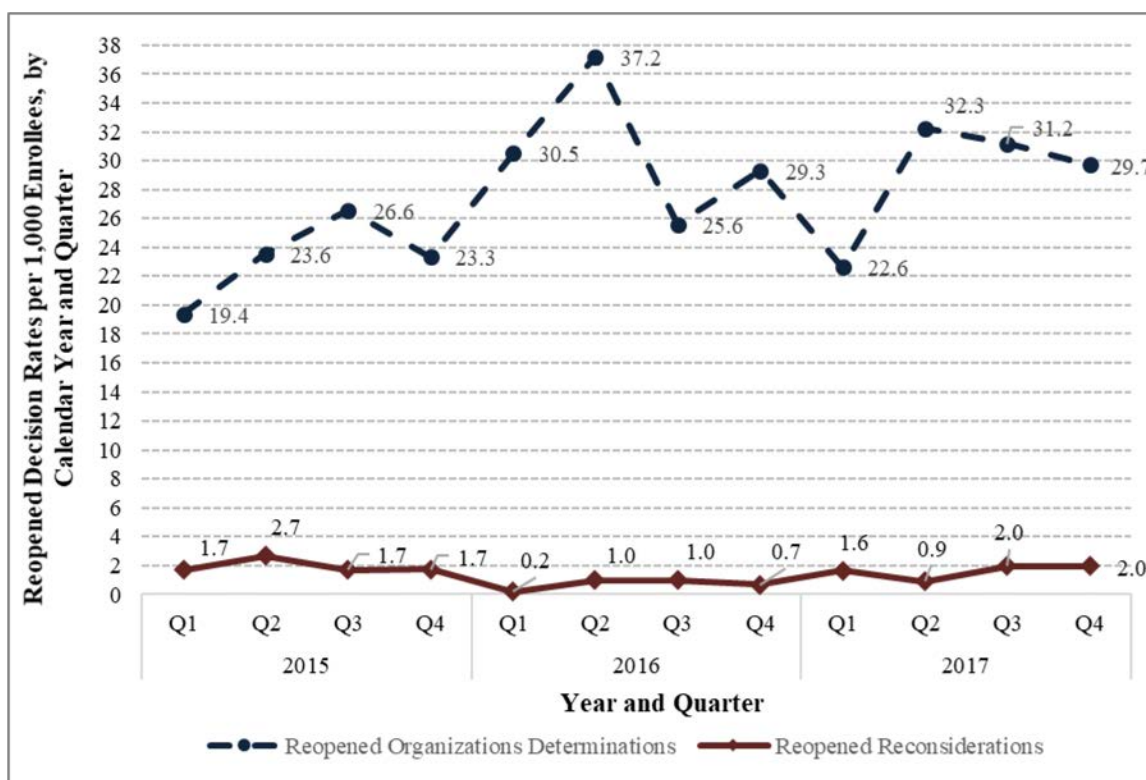
Figure 4.3 shows reopened decision rates per 1,000 enrollees by year and quarter for CY 2015, CY 2016, and CY 2017. In all quarters, the rates of reopened organization determinations were considerably higher than reopened reconsiderations. In CY 2015, the reopened organization determination rates increased 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. In CY 2016, reopened organization determination rates varied from quarter to quarter, increasing from 30.5 in Quarter 1 to 37.2 in Quarter 2, then decreasing to 25.6 in Quarter 3, and finally increasing to 29.3 in Quarter 4. Reopened reconsideration rates remained relatively small in each quarter, at 1.0 and below, increasing overall from 0.2 in Quarter 1 to 0.7 in Quarter 4. In CY

²⁷ Reconsideration requests are defined as the sum of reconsideration requests by outcome. Averages are weighted by Contract Year Average Enrollment.

²⁸ Reconsideration requests are defined as the sum of reconsideration requests by outcome. Averages are weighted by Contract Year Average Enrollment.

2017, reopened organization determination rates increased drastically from 22.6 in Quarter 1 to 32.3 in Quarter 2, then decreased to 31.2 in Quarter 3 and 29.7 in Quarter 4. Reopened reconsideration rates remained relatively small, at 1.6 in Quarter 1, decreasing to 0.9 in Quarter 2, and then hovering at 2.0 for Quarter 3 and Quarter 4.

Figure 4.3: Reopened Decision Rates per 1,000 Enrollees, by Year and Quarter, 2015-2017²⁹



The percentage of organization determination requests processed in a timely manner has remained very high in the years from CY 2015 to CY 2017 (Table 4.5). In CY 2017, the percentage of organization determination requests processed timely was 98.1%, increasing slightly from CY 2016 when it was 97.2%, and remaining stable from CY 2015 when the rate was 98.0%. In CY 2017, every organization type had over 97% of their requests processed in a timely manner; this increase was most notable for MMP organizations, which processed 94.4% of organization determination requests in a timely manner in CY 2015, increasing that rate to 95.0% in CY 2016 and 97.7% in CY 2017. The rate of organization determination requests processed timely has decreased over the three years for PFFS/1876 Cost organizations, going from 98.6% in CY 2015 to 95.8% in CY 2016, then increasing slightly to 97.3% in CY 2017.

²⁹ Averages are weighted by Contract Year Average Enrollment.

Table 4.5: Percent of Organization Determination Requests Processed Timely, 2015-2017³⁰

Organization Type	2015 Number of Contracts	2015 Measure Value	2016 Number of Contracts	2016 Measure Value	2017 Number of Contracts	2017 Measure Value
All	449	98.0%	482	97.2%	462	98.1%
MMP	41	94.4%	52	95.0%	46	97.7%
Local CCP	380	98.0%	400	97.2%	384	98.0%
Regional CCP	10	98.7%	9	98.0%	10	99.3%
PFFS/1876 Cost	17	98.6%	18	95.8%	19	97.3%
MSA	1	96.6%	3	99.3%	3	98.4%

Between CY 2015 and CY 2016, there was a substantial increase in the percent of reconsideration requests processed timely, increasing from 79.8% to 92.5%, and then in CY 2017, the percentage of reconsideration requests processed timely increased further to 97.4% (Table 4.6). In all years, MSA organizations had the highest percentage of reconsiderations processed in a timely manner at 100.0%, but represented a very small share of the total number of contracts. Regional CCP and PFFS/1876 Cost organizations exhibited large increases in the percent of requests processed timely, from 63.9% and 79.8% in CY 2015 to 97.2% and 97.0% in CY 2017, respectively. Local CCP organizations also showed a substantial increase in the three year period in the percent of reconsideration requests processed timely, going from 81.3% in CY 2015 to 97.7% in CY 2017.

Table 4.6: Percent of Reconsideration Requests Processed Timely, 2015-2017³¹

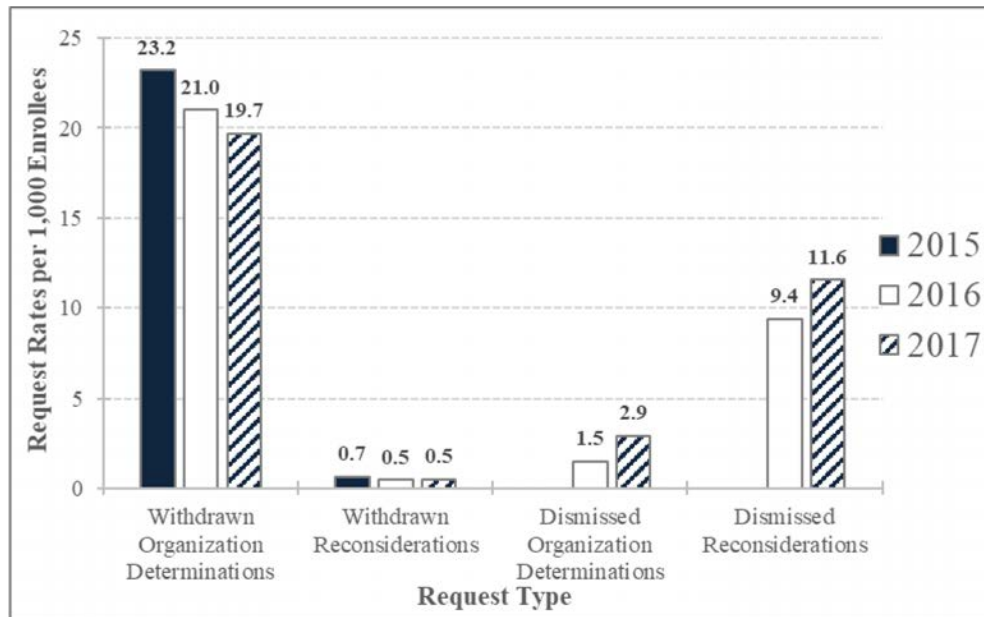
Organization Type	2015 Number of Contracts	2015 Measure Value	2016 Number of Contracts	2016 Measure Value	2017 Number of Contracts	2017 Measure Value
All	436	79.8%	468	92.5%	460	97.4%
MMP	38	86.6%	47	80.1%	43	89.5%
Local CCP	366	81.3%	390	92.9%	386	97.7%
Regional CCP	10	63.9%	9	86.7%	10	97.2%
PFFS/1876 Cost	21	79.8%	19	96.1%	18	97.0%
MSA	1	100.0%	3	100.0%	3	100.0%

From CY 2015 to CY 2017, the withdrawn organization determination request rate decreased significantly each year, from 23.2 in CY 2015 to 21.0 in CY 2016 to 19.7 in CY 2017. In comparison, withdrawn reconsideration request rates were noticeably smaller and decreased from 0.7 in CY 2015 to 0.5 in CY 2016 and remained stable in CY 2017. Starting in CY 2016, sponsors were required to submit data on dismissed organization determinations and reconsiderations. These rates increased from CY 2016 to CY 2017, from 1.5 to 2.9 and 9.4 to 11.6, respectively, for dismissed organization determinations and dismissed reconsiderations.

³⁰ Organization determination data are the reported totals, not the sums by outcome. Averages are weighted by Contract Year Average Enrollment.

³¹ Reconsideration data are the reported totals, not the sums by outcome. Averages are weighted by Contract Year Average Enrollment.

Figure 4.4: Withdrawn and Dismissed Request Rates per 1,000 Enrollees, 2015-2017³²



³² Dismissed organization determinations and reconsiderations were first reported in 2016. Averages are weighted by Contract Year Average Enrollment.

5 SPECIAL NEEDS PLAN CARE MANAGEMENT

Since SNPs provide coverage for vulnerable Medicare enrollees with specialized needs, CMS requires MAOs offering SNPs to perform initial assessments (within 90 days of enrollment) 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 enrollee's required care plan.³³ Under the Part C Reporting Requirements, CMS requires MAOs with SNPs to report information on new and eligible enrollees regarding the number of assessments performed and the number not performed if the enrollee refused or the SNP was unable to reach the enrollee.

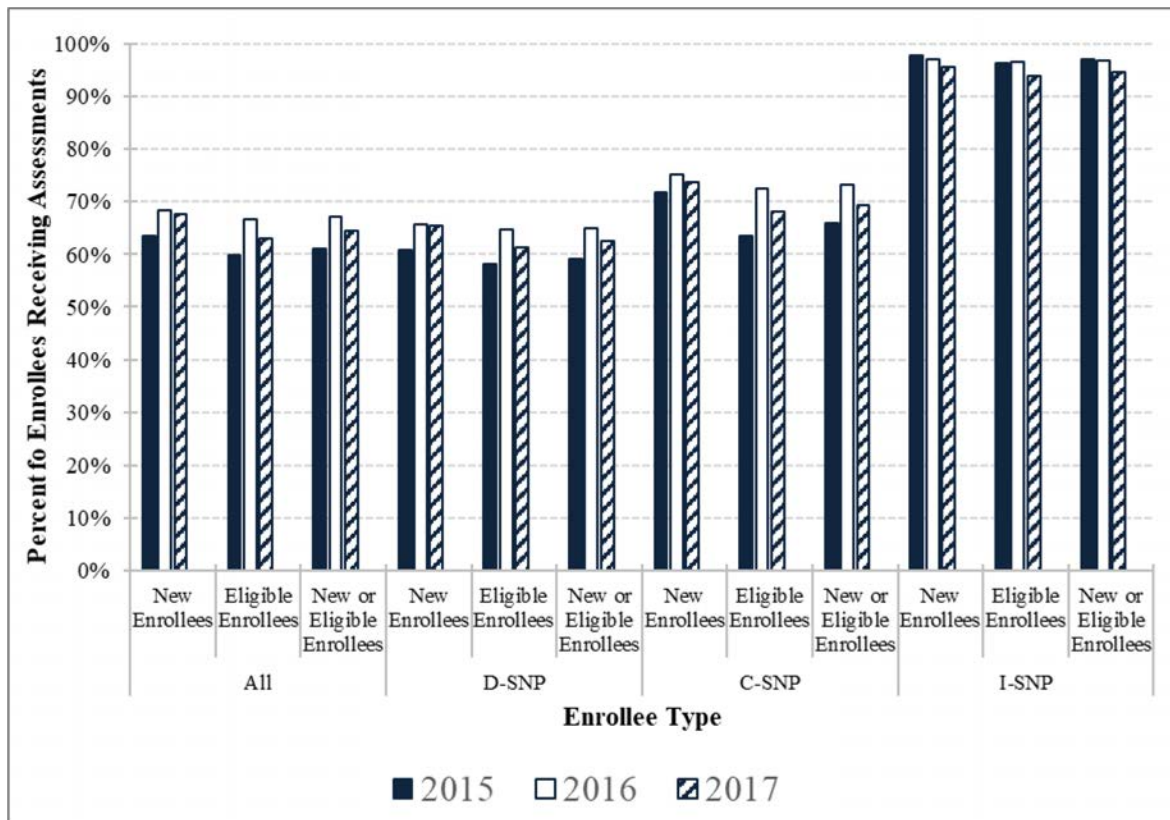
SNPs are separated into three categories: institutional SNPs (I-SNPs), dual eligible SNPs (D-SNPs), and chronic condition SNPs (C-SNPs). I-SNPs are defined as SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. D-SNPs are for individuals entitled to both Medicare and Medicaid, where states will cover some Medicare costs, depending on the state and the individual's eligibility. C-SNPs are SNPs that restrict enrollment to special needs individuals with a plan-specific combination of up to 15 severe or disabling chronic conditions, defined in 42 CFR 422.2.³⁴

The percent of new enrollees, eligible enrollees, or new or eligible enrollees receiving assessments for all SNP types was highest in CY 2016 and I-SNPs had the highest percent of enrollees receiving assessments in all three years (Figure 5.1). The overall percentage of enrollees receiving an assessment increased across all plan types, increasing by 3.3 percentage points for eligible enrollees and 4.3 percentage points for new enrollees from CY 2015 to CY 2017. The percentage of new enrollees, eligible enrollees, and new or eligible enrollees receiving assessments increased for each enrollee type for D-SNPs and C-SNPs from CY 2015 to CY 2017. The percentages for I-SNPs decreased slightly from CY 2015 to CY 2017. While I-SNPs exhibited very little change between CY 2015 and CY 2017, they had substantially higher percentages of enrollees receiving assessments than the other SNP types, with over 94% of all enrollee types receiving an assessment in all years.

³³ For more information about the assessments required for MAOs offering SNPs, see Chapter 5 of the Medicare Managed Care Manual, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf>

³⁴ For more information on the types of SNPs offered, see Chapter 16-B of the Medicare Managed Care Manual, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf>

Figure 5.1: Percentage of Enrollees Receiving Assessments, 2015-2017³⁵



The percentage of SNPs assessing 100% of new enrollees increased from 1.9% in CY 2015 to 3.4% in CY 2016, then to 6.9% in CY 2017 (Table 5.1). The percentage of SNPs assessing 100% of new enrollees was highest in I-SNPs for all three years, which is expected given the institutional level of care assessments needed to enroll in I-SNPs. Compared to I-SNPs, the percent of SNPs assessing 100% of new enrollees in D-SNPs and C-SNPs were much lower and exhibited slightly different trends across the three years, since the percentages for I-SNPs increased over the three years with a slight dip in CY 2016. The percentage of D-SNPs assessing 100% of new enrollees increased between CY 2015 and CY 2016, from 0.4% to 1.6%, and then increased further to 2.7% in CY 2017. The percentage of C-SNPs assessing 100% of new enrollees also increased drastically, going from 0.8% in CY 2015, 1.5% in CY 2016, and then increasing to 7.5% in CY 2017.

Table 5.1: Percentage of SNPs Assessing 100% of New Enrollees, 2015-2017

SNP Type	2015 Percentage of SNPs Assessing 100% of New Enrollees	2015 Number of Plans Assessing 100%	2016 Percentage of SNPs Assessing 100% of New Enrollees	2016 Number of Plans Assessing 100%	2017 Percentage of SNPs Assessing 100% of New Enrollees	2017 Number of Plans Assessing 100%
All	1.9%	8	3.4%	17	6.9%	35
D-SNP	0.4%	1	1.6%	5	2.7%	9
C-SNP	0.8%	1	1.5%	2	7.5%	8
I-SNP	19.4%	6	16.9%	10	28.1%	18

³⁵ Measure values are weighted by metrics' denominators.

The percentage of SNPs assessing 100% of eligible enrollees decreased for all SNP types from CY 2015 to CY 2016 and then increased slightly in CY 2017, with all SNP types exhibiting an overall decrease in CY 2017 over CY 2015 (Table 5.2). I-SNPs exhibited the largest decrease across all three years, decreasing from 21.2% in CY 2015 to 12.5% in CY 2017, for an overall 8.7 percentage point decrease across the three years. C-SNPs also experienced a decrease in the three year period, decreasing from 10.2% in CY 2015 to 1.6% in CY 2016, and then increasing to 3.0% in CY 2017. The percentage of D-SNPs assessing 100% of eligible enrollees stayed below the overall percentage of SNPs assessing 100% in CY 2015, CY 2016, and CY 2017, with 7.6%, 1.3%, and 2.2% respectively.

Table 5.2: Percentage of SNPs Assessing 100% of Eligible Enrollees, 2015-2017

SNP Type	2015 Percentage of SNPs Assessing 100% of Eligible Enrollees	2015 Number of Plans Assessing 100%	2016 Percentage of SNPs Assessing 100% of Eligible Enrollees	2016 Number of Plans Assessing 100%	2017 Percentage of SNPs Assessing 100% of Eligible Enrollees	2017 Number of Plans Assessing 100%
All	9.4%	39	3.1%	15	3.8%	18
D-SNP	7.6%	20	1.3%	4	2.2%	7
C-SNP	10.2%	12	1.6%	2	3.0%	3
I-SNP	21.2%	7	15.5%	9	12.5%	8

The overall percentage of plans assessing 100% of new or eligible enrollees increased from 0.9% in CY 2015 to 1.6% in CY 2016, and then to 2.6% in CY 2017 (Table 5.3). The percentage of D-SNPs assessing 100% of new or eligible enrollees increase steadily across the three years, from 0.0% in CY 2015 to 0.7% in CY 2016 and to 1.5% in CY 2017. The percentage of C-SNPs assessing 100% of new or eligible enrollees was 0.0% in both CY 2015 and CY 2016, and then increased to 1.0% in CY 2017. In contrast, I-SNPs decreased from 12.9% of plans assessing 100% of new or eligible enrollees in CY 2015 to 9.8% in CY 2016, and then increased slightly to 10.4% in CY 2017.

Table 5.3: Percentage of SNPs Assessing 100% of New or Eligible Enrollees, 2015-2017

SNP Type	2015 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2015 Number of Plans Assessing 100%	2016 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2016 Number of Plans Assessing 100%	2017 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2017 Number of Plans Assessing 100%
All	0.9%	4	1.6%	8	2.6%	13
D-SNP	0.0%	0	0.7%	2	1.5%	5
C-SNP	0.0%	0	0.0%	0	1.0%	1
I-SNP	12.9%	4	9.8%	6	10.4%	7

Starting in CY 2016, sponsors were required to report the number of assessments not performed because the enrollee refused or the SNP was unable to reach the enrollee. Overall, new enrollees had the highest percentage of enrollees not receiving assessments (Table 5.4). In CY 2016, 2.4% of new enrollees refused an initial HRA and 14.6% of new enrollees were unable to be reached by the SNP; in CY 2017, 1.8% of new enrollees refused an initial HRA and 20.1% of new enrollees were unable to be reached by the SNP. D-SNPs had the highest percent of enrollees not receiving assessments for all three enrollee type categories. In comparison, I-SNPs had 0.0% of enrollees not receiving an assessment due to enrollee refusal or inability to reach the enrollee in both CY 2016 and CY 2017.

Table 5.4: Percentage of Enrollees Not Receiving Assessments, 2016-2017

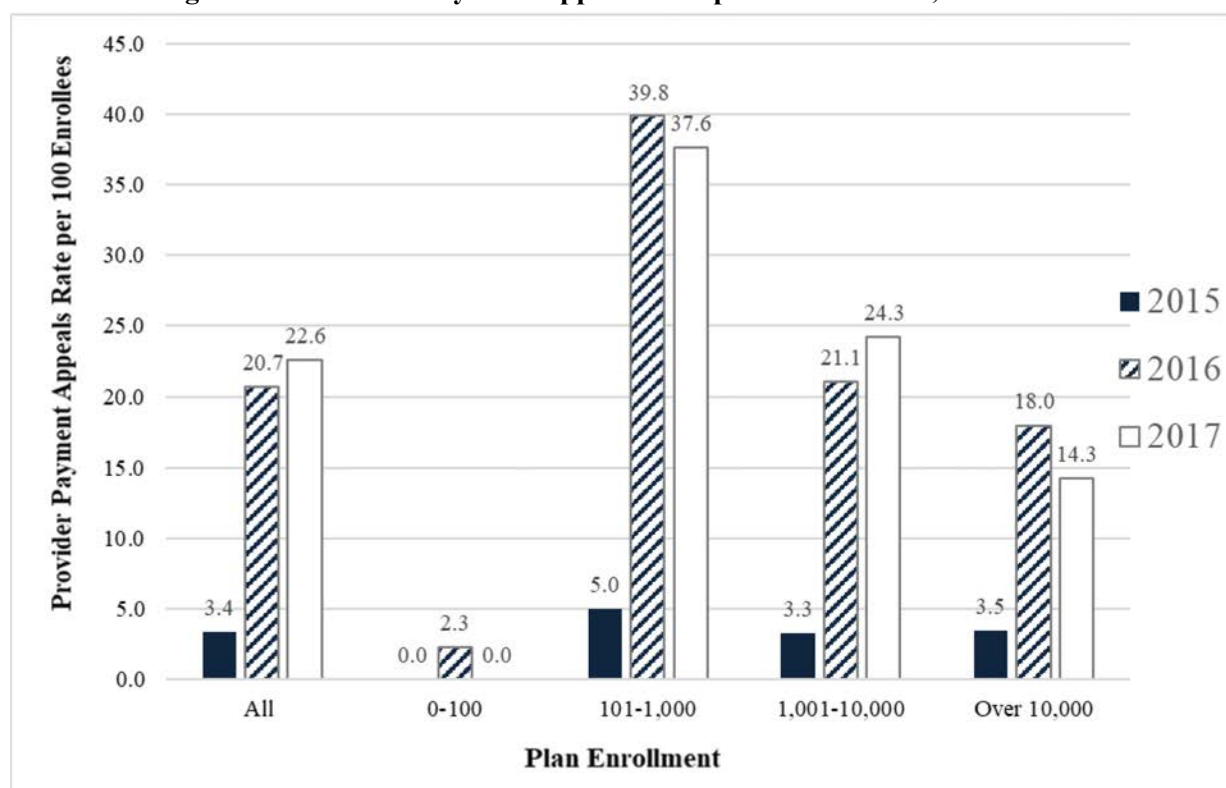
SNP Type - Year	New Enrollees - Enrollee Refused	New Enrollees - SNP Unable to Reach Enrollee	Eligible Enrollees - Enrollee Refused	Eligible Enrollees - SNP Unable to Reach Enrollee	New or Eligible Enrollees - Enrollee Refused	New or Eligible Enrollees - SNP Unable to Reach Enrollee
All - 2016	2.4%	14.6%	1.9%	11.3%	2.0%	12.1%
D-SNP - 2016	2.5%	15.9%	1.9%	12.1%	2.1%	13.1%
C-SNP - 2016	2.3%	11.9%	1.9%	9.0%	2.0%	9.7%
I-SNP - 2016	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
All - 2017	1.8%	20.1%	1.8%	12.5%	1.8%	14.6%
D-SNP - 2017	2.1%	21.6%	1.9%	13.2%	2.0%	15.6%
C-SNP - 2017	0.7%	17.4%	1.0%	10.3%	0.9%	12.1%
I-SNP - 2017	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

6 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 MAO PFFS plan's terms and conditions or original Medicare.

The overall rate of provider payment appeals per 100 enrollees increased substantially from 3.4 in CY 2015 to 20.7 in CY 2016, and then increased further to 22.6 in CY 2017 (Figure 6.1). The largest increase in provider payment appeals rates from CY 2016 to CY 2017 occurred for plans with 1,001 to 10,000 enrollees, going from 21.1 to 24.3. The large increase in the appeals rate from CY 2015 to CY 2016 is due to a substantial increase in the number of provider payment appeals reported by multiple contracts. However, due to the low number of contracts reporting data for this section, and the measure having a bimodal distribution with peaks at opposite ends of the distribution, these contracts were not classified as high outliers, and therefore, data for these contracts were not removed since they passed data validation. Data from CY 2017 was consistent with the data from CY 2016, with few contracts reporting data for this section, a bimodal distribution, and few high outliers.

Figure 6.1: Provider Payment Appeals Rate per 100 Enrollees, 2015-2017³⁶



³⁶ Measure values are weighted by Plan Year Average Enrollment.

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 27.3% in CY 2015 to 33.2% in CY 2017, peaking at 34.2% in CY 2016 (Table 6.1). The percentage followed a similar pattern for plans with enrollment from 101 to 1,000; the percentage of payment appeals settled in the provider's favor decreased from 33.2% in CY 2015 to 31.6% in CY 2017, peaking at 36.5%. The percentage of payment appeals settled in the provider's favor increased from CY 2015 to CY 2017 for plans with enrollment from 1,001 to 10,000, with a notable increase of 4.9 percentage points in CY 2016 over CY 2015. Trends for plans with enrollment over 10,000, were similar to overall trends, with the percentage of payment appeals settled in the provider's favor increasing from 28.8% in CY 2015 to 39.4% in CY 2017, peaking at 40.9% in CY 2016.

Table 6.1: Percentage of Payment Appeals Settled in Provider's Favor, 2015-2017³⁷

Plan Enrollment	2015 Measure Value	2015 Number of Provider Payment Denials Overturned in Favor of Provider	2015 Number of Plans	2016 Measure Value	2016 Number of Provider Payment Denials Overturned in Favor of Provider	2016 Number of Plans	2017 Measure Value	2017 Number of Provider Payment Denials Overturned in Favor of Provider	2017 Number of Plans
All	27.3%	2,594	60	34.2%	18,237	52	33.2%	12,920	47
0-100	—	—	—	0.0%	0	1	—	—	—
101-1,000	33.2%	166	15	36.5%	1,064	10	31.6%	806	11
1,001-10,000	26.0%	1,598	41	30.9%	12,573	38	31.4%	10,099	34
Over 10,000	28.8%	830	4	40.9%	4,600	3	39.4%	2,015	2

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 a slight increase in percentage of payment appeals resolved in over 60 days, going from 3.5% in CY 2015, dipping to 2.7% in CY 2016, and then increasing to 3.8% in CY 2017 (Table 6.2). Plans with 1,001 to 10,000 enrollees had an increase each year in the percentage of payment appeals resolved in over 60 days, going from 1.0% in CY 2015 to 2.2% in CY 2016, then increasing to 3.4% in CY 2017. Plans with over 10,000 enrollees was the only category to remain stable over the three years; the percentage of payment appeals resolved in over 60 days went from 1.6% in CY 2015, peaking at 2.6% in CY 2016, and then went back to CY 2015 levels, at 1.6%, in CY 2017.

Table 6.2: Percentage of Payment Appeals Resolved in Over 60 Days, 2015-2017³⁸

Plan Enrollment	2015 Measure Value	2015 Number of Provider Payment Appeals Resolved in Over 60 Days	2015 Number of Plans	2016 Measure Value	2016 Number of Provider Payment Appeals Resolved in Over 60 Days	2016 Number of Plans	2017 Measure Value	2017 Number of Provider Payment Appeals Resolved in Over 60 Days	2017 Number of Plans
All	1.3%	174	60	2.4%	1,470	52	3.0%	1,525	47
0-100	—	—	—	0.0%	0	1	—	—	—
101-1,000	3.5%	19	15	2.7%	81	10	3.8%	99	11

³⁷ Measure values are weighted by Plan Year Average Enrollment.

³⁸ Measure values are weighted by Plan Year Average Enrollment.

Plan Enrollment	2015 Measure Value	2015 Number of Provider Payment Appeals Resolved in Over 60 Days	2015 Number of Plans	2016 Measure Value	2016 Number of Provider Payment Appeals Resolved in Over 60 Days	2016 Number of Plans	2017 Measure Value	2017 Number of Provider Payment Appeals Resolved in Over 60 Days	2017 Number of Plans
1,001-10,000	1.0%	83	41	2.2%	1,014	38	3.4%	1,293	34
Over 10,000	1.6%	72	4	2.6%	375	3	1.6%	133	2

7 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, group sponsor type, organization type, contract type, and current enrollment. Group sponsor type includes three categories: employers, labor organizations (union), and trustees of a fund established by one or more employers or labor organizations, or combination thereof (trustee). Employer organization type is based on how plan sponsors file their taxes and include the following categories: state government, local government, publicly traded organization, privately held corporation, non-profit, church group, and other. Contract type is broken down into three categories: insured, administrative services only (ASO), and other.

By far 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 7.1).

Table 7.1: Employers and Enrollment by Group Sponsor Type, 2015-2017³⁹

Group Sponsor Type	2015 Share of Employers	2015 Share of Enrollment	2016 Share of Employers	2016 Share of Enrollment	2017 Share of Employers	2017 Share of Enrollment
Union	3.3%	2.9%	3.4%	3.2%	3.3%	4.0%
Trustee	4.5%	21.0%	5.2%	21.6%	5.0%	17.2%
Employer	92.2%	76.1%	91.4%	75.2%	91.7%	78.8%

In all three years, privately held corporations and other organizations represented the largest share of employers (Table 7.2). Privately held corporations represented the highest share of employers in all years, although decreasing slightly from 36.5% in CY 2015 to 36.0% in CY 2017. Other organizations were the second highest share of employers in each year, decreasing from 34.2% in CY 2015 to 30.2% in CY 2016 and 30.3% in CY 2017.

Table 7.2: Share of Employers by Organization Type, 2015-2017

Year	Total Employers	State Government	Local Government	Publicly Traded Org	Privately Held Corp	Non-Profit	Church Group	Other
2015	19,153	1.6%	10.8%	7.9%	36.5%	7.7%	1.4%	34.2%
2016	15,505	3.2%	12.8%	8.6%	35.1%	8.6%	1.5%	30.2%
2017	15,076	3.2%	12.3%	8.1%	36.0%	8.7%	1.4%	30.3%

State governments, other organizations, and publicly traded organizations had the largest share of employer enrollment in all three years (Table 7.3), with all three types exhibiting different trends across years. State governments comprised the largest share in all three years, decreasing steadily from 42.3% in CY 2015 to 39.7% in CY 2016, and then to 36.1% in CY 2017. Other organizations had the second highest share, increasing slightly from 25.8% in CY 2015 to 26.0% in CY 2016, then decreasing to 24.0% in CY 2017. Lastly, publicly traded organizations represented the third highest share and increased in all three years, from 16.5% in CY 2015 to 17.6% in CY 2016 to 22.0% in CY 2017.

³⁹ Records with placeholder Federal Tax ID values (e.g., 000000000, 999999999) are excluded.

Table 7.3: Share of Employer Enrollment by Organization Type, 2015-2017

Organization Type	2015	2016	2017
State Government	42.3%	39.7%	36.1%
Local Government	8.7%	10.1%	10.0%
Publicly Traded Organization	16.5%	17.6%	22.0%
Privately Held Corporation	2.6%	2.1%	2.1%
Non-Profit	3.8%	4.2%	5.5%
Church Group	0.3%	0.3%	0.3%
Other	25.8%	26.0%	24.0%

Most employers were reported under the Insured contract type for CY 2015, CY 2016, and CY 2017, with over 99% in each year (Table 7.4). Administrative Services Organizations (ASOs) and Other contract types were negligible in comparison, at or below 0.7% in all years.

Table 7.4: Employers by Contract Type, 2015-2017

Contract Type	2015 Share of Total Employers	2015 Number of Employers	2015 Enrollment	2016 Share of Total Employers	2016 Number of Employers	2016 Enrollment	2017 Share of Total Employers	2017 Number of Employers	2017 Enrollment
All	100%	19,106	3,152,527	100%	15,468	3,187,577	100%	15,040	3,296,470
Insured	99.5%	19,003	2,950,528	99.3%	15,360	2,996,747	99.1%	14,911	3,104,229
ASOs	0.1%	12	173,968	0.1%	18	178,425	0.2%	29	178,418
Other	0.5%	91	28,031	0.6%	90	12,405	0.7%	100	13,823

8 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 MAO 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.⁴⁰

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

Except as provided for in 42 CFR 422.74, an MAO may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. An MAO may contact members to determine the reason for disenrollment, but they must not discourage members from disenrolling after they indicate their desire to do so. A member may request disenrollment from an MA plan only during one of the election periods specified by CMS. The member may disenroll by one of four methods: (1) enrolling in another plan (during a valid enrollment period); (2) giving or faxing a signed written notice to the MAO; (3) submitting a request via the Internet to the MAO, if applicable; or (4) Calling 1-800-MEDICARE.⁴¹

Most enrollment requests were received via paper followed by telephonic in CY 2015, CY 2016, and CY 2017 (Table 8.1). Requests via internet and OEC remained negligible all years, and requests via paper remained relatively stable, totaling greater than 99% in all years.

Table 8.1: Share of Enrollment Requests by Request Mechanism, 2015-2017

Request Mechanism	2015	2016	2017
Paper	99.5%	99.7%	99.2%
Telephonic	0.5%	0.3%	0.8%
Internet	0.0%	0.0%	0.0%
OEC	0.0%	0.0%	0.0%

In CY 2015, the percentage of enrollment requests completed at initial receipt was 89.5%, while the percentage for disenrollment requests was much higher at 99.1% (Table 8.2). In CY 2016, the percentage of enrollment requests completed at initial receipt decreased to 87.9%, and the percentage for disenrollment requests also decreased to 96.8%. However, in CY 2017, the percentage of enrollment

⁴⁰ Measure values are weighted by Contract Year Average Enrollment.

⁴¹ For more information on MAOs requirements surrounding disenrollment, see Chapter 2 of the Medicare Managed Care Manual, https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf

requests completed at initial receipt increased drastically to 100.0%, while the percentage for disenrollment requests remained similar to previous years at 97.5%.

Table 8.2: Enrollment and Disenrollment Requests Completed at Initial Receipt, 2015-2017

Request	2015	2016	2017
Enrollment	89.5%	87.9%	100.0%
Disenrollment	99.1%	96.8%	97.5%

In CY 2015, the percentage of enrollment requests denied was 1.1%, while the percentage of disenrollment requests was at 0.0% (Table 8.3). In CY 2016, the percentage of enrollment requests denied increased substantially, to 60.5%, while the percentage of disenrollments denied only increased slightly, to 0.2%. In CY 2017, the share of enrollment and disenrollment requests denied by the MAO returned to levels similar to CY 2015, at 0.1% and 0.0% respectively. The volatility in the percentage of enrollment requests denied is partially driven by there being so few contracts required to report enrollment data under the Part C requirements. Most organizations submit their enrollment data under the Part D requirements.

Table 8.3: Enrollment and Disenrollment Requests Denied by the MAO, 2015-2017

Request	2015	2016	2017
Enrollment	1.1%	60.5%	0.1%
Disenrollment	0.0%	0.2%	0.0%

Starting in CY 2016, sponsors were required to report information on the number of involuntary disenrollments for failure to pay plan premium and of these enrollees, the number of that requested to be reinstated for Good Cause and were reinstated. Of enrollees that were involuntarily disenrolled for failure to pay plan premium, 13.7% submitted a timely request for reinstatement due to good cause in CY 2016, and that number remained fairly stable, at 13.5% in CY 2017. Of these requests for reinstatement, 41.7%, resulted in a favorable good cause determination in CY 2016, and that number increased drastically to 79.7% in CY 2017. Of those receiving a favorable good cause determination, 87.7% were reinstated in CY 2016, increasing substantially to 100.0% in CY 2017.

Table 8.4: Involuntary Disenrollment Reinstatement Requests for Good Cause, 2016-2017

Request	2016	2017
Involuntarily Disenrolled Individuals (for Failure to Pay Plan Premium) who Submitted Timely Request for Reinstatement for Good Cause	13.7%	13.5%
Requests for Reinstatement for Good Cause Determinations that were Favorable	41.7%	79.7%
Favorable Good Cause Determinations were Individuals were Reinstated	87.7%	100.0%

9 PAYMENTS TO PROVIDERS

Beginning in CY 2016, MAOs were required to report information about value-based payment in order to maintain consistency with HHS goals of increasing the proportion of payment made based on quality and value. CMS is interested in understanding the extent and use of alternative payment models used by MAOs. In particular, CMS wants to explore how financial incentives can be constructed with APMs in order to reward providers that deliver high-quality, affordable care.

At their core, alternative payment models (APMs) are intended to achieve person-centered care and shift U.S. healthcare spending toward population-based, person-focused payment mechanisms. The APM framework that CMS uses has 4 categories, as summarized below:

Table 9.1: CMS APM Framework Summary⁴²

Category	Subcategories
Category 1: Fee for Service - No Link to Quality & Value	-
Category 2: Fee for Service - Link to Quality & Value	A: Foundational Payments for Infrastructure & Operations
	B: Pay for Reporting
	C: Pay-for-Performance
Category 3: APMs Built on Fee-for-Service Architecture	A: APMs with Shared Savings
	B: APMs with Shared Savings and Downside Risk
	3N: Risk Based Payments NOT Linked to Quality
Category 4: Population-Based Payment	A: Condition-Specific Population-Based Payment
	B: Comprehensive Population-Based Payment
	C: Integrated Finance & Delivery System
	4N: Capitated Payments NOT Linked to Quality

Category 1, Fee for Service – No Link to Quality & Value includes all arrangements where payments are made based on volume of services and not linked to quality or efficiency. Category 2, Fee for Service – Link to Quality & Value includes all arrangements where at least a portion of payments vary based on the quality or efficiency of healthcare delivery, which includes value-based purchasing and physician value-based modifiers. Category 3, APMs built on fee-for-service architecture, includes all arrangements where payment is linked to the effective management of a population or an episode of care, but payments are still triggered by delivery of services and include opportunities for shared savings or risk. Category 4, Population-Based Payment, includes arrangements where payment is not triggered by

⁴² For more information on CMS's APM Framework, see the HCP LAN Alternative Payment Model APM Framework, <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

service delivery, so volume of services is not directly linked to payment. Payments in Category 4 are to clinicians and organizations where they are responsible for the care of a beneficiary for a long period.

In order to more accurately capture existing Medicare Advantage payments, CMS added categories for Risk-Based Payments not Linked to Quality and Capitation Payment not Linked to Quality beginning with CY 2017 Reporting Requirements data.

Overall Medicare Advantage payments increased considerably from CY 2016 to CY 2017 (Table 9.2). While overall payments increased, the proportion of these payments made on a fee-for-service basis with no link to quality decreased from 64.3% in CY 2016 to 61.1% in CY 2017. The proportion of payments made on a fee-for-service basis with a link to quality increased by one percentage point from 3.7% in CY 2016 to 4.7% in CY 2017. The proportion of payments made as population-based payment decreased considerably from 23.2% in CY 2016 to 11.9% in CY 2017. For both years, Local CCP organizations made up the bulk of contracts and also the vast majority of payments. For both years, Regional CCP and PFFS 1876/Cost organizations had over 98% of their payments made on a fee-for-service basis with no link to quality; however, the percentage of payments made on a fee-for-service basis with no link to quality decreased from CY 2016 to CY 2017 for both MMPs and Local CCPs, from 78.5% to 62.6% and 61.4% to 57.2%, respectively.

Table 9.2: Payments by Category Summary, 2016-2017^{43,44}

Contract Type - Year	Number of Contracts	Total Medicare Advantage Payments	Fee-For-Service Basis with no Link to Quality	Fee-For-Service Basis with a Link to Quality	Alternative Payment Models Built on Fee-for-Service Architecture	Population-Based Payment	Risk-Based Payments not Linked to Quality	Capitation Payment not Linked to Quality
All-2016	485	\$109,971,380,712.79	64.3%	3.7%	6.6%	23.2%	-	-
MMP-2016	56	\$3,706,398,424.98	78.5%	2.0%	5.1%	14.2%	-	-
Local CCP-2016	415	\$99,656,279,029.24	61.4%	4.0%	7.1%	25.0%	-	-
Regional CCP-2016	9	\$5,020,242,729.88	98.7%	0.3%	0.0%	1.0%	-	-
PFFS/1876 Cost-2016	5	\$1,588,460,528.69	99.2%	0.6%	0.0%	0.4%	-	-
All-2017	467	\$139,926,403,116.26	61.1%	4.7%	4.2%	11.9%	2.6%	19.3%
MMP-2017	47	\$5,196,255,048.22	62.6%	5.6%	2.4%	15.8%	2.5%	13.7%
Local CCP-2017	405	\$122,531,689,737.80	57.2%	5.2%	4.7%	12.9%	2.8%	21.5%
Regional CCP-2017	10	\$10,702,250,880.64	99.1%	0.1%	0.1%	0.4%	0.0%	0.3%
PFFS/1876 Cost-2017	5	\$1,496,207,449.60	98.8%	0.3%	0.7%	0.0%	0.0%	0.2%

⁴³ Contracts that submitted data where the payment amount for any category was higher than the total Medicare Advantage payment, or where the number of providers for any category was higher than the total number of Medicare Advantage contracted providers, were excluded. For data submissions for CY 2018 and beyond, contracts where this is the case will be notified as having data integrity issues and will be expected to submit corrected data.

⁴⁴ Medicare-Medicaid Plans (MMPs) report payments to all APMS, not just Medicare APMs.

While the number of Medicare Advantage contracted providers increased overall, the percent of providers paid on a fee-for-service basis with no link to quality decreased from 79.7% in CY 2016 to 65.9% in CY 2017 (Table 9.3). The percent of providers paid based on population-based payment also decreased from 10.5% in CY 2016 to 6.6% in CY 2017; in CY 2017, 0.0% of providers were paid based on population-based payment for both Regional CCP and PFFS/1876 Cost organizations. The proportion of providers paid on a fee-for-service basis with a link to quality increased by 1.1 percentage points, from 4.3% in CY 2016 to 5.4% in CY 2017. In both years, Regional CCP organizations had the highest percentage of Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality, but that proportion decreased from 92.9% in CY 2016 to 89.4% in CY 2017.

Table 9.3: Providers by Payment Category Summary, 2016-2017⁴⁵

Contract Type - Year	Number of Contracts	Number of Medicare Advantage Contracted Providers	Fee-For-Service Basis with no Link to Quality	Fee-For-Service Basis with a Link to Quality	Alternative Payment Models Built on Fee-for-Service Architecture	Population-Based Payment	Risk-Based Payments not Linked to Quality	Capitation Payment not Linked to Quality
All-2016	485	5,822,024	79.7%	4.3%	3.6%	10.5%	-	-
MMP-2016	56	372,509	75.1%	1.1%	2.4%	7.6%	-	-
Local CCP-2016	415	4,832,074	78.6%	4.8%	4.1%	11.2%	-	-
Regional CCP-2016	9	417,771	92.9%	1.1%	0.0%	6.0%	-	-
PFFS/1876 Cost-2016	5	199,670	85.9%	4.8%	0.0%	8.2%	-	-
All-2017	467	6,745,640	65.9%	5.4%	3.2%	6.6%	1.6%	3.6%
MMP-2017	47	374,484	65.7%	3.3%	1.0%	4.6%	1.5%	2.8%
Local CCP-2017	405	5,854,805	64.2%	5.4%	3.5%	7.3%	1.7%	3.3%
Regional CCP-2017	10	366,886	89.4%	2.7%	1.1%	0.0%	0.0%	6.8%
PFFS/1876 Cost-2017	5	149,465	74.9%	14.3%	1.4%	0.0%	0.0%	9.4%

⁴⁵ Providers can be included as Medicare Advantage contracted providers for more than one contract. Providers can also be paid based on different payment mechanisms depending on the contract for which they are included as Medicare Advantage contracted providers.

10 REWARDS AND INCENTIVES PROGRAMS

In CY 2015, CMS added a new regulation at 42 CFR §422.134 that allows MAOs to offer one or more Rewards and Incentives Programs to current enrollees. Plans are not required to offer rewards and incentives programs, but if they do offer them, they must comply with CMS regulations and report data to CMS about the structure and enrollment of these programs.

The goal of these programs is to improve the health outcomes of enrollees and prevent future illnesses or injuries. In Rewards and Incentives Programs, enrollees receive a reward in exchange for participating in a plan-designated activity or service designed to improve their health. An individual reward may not exceed the value of the health-related service or activity, but there is no aggregate maximum for beneficiaries.

Rewards and Incentives Programs must not discriminate against enrollees based on race, national origin, including limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty, health status or other prohibited basis. Programs must also be designed so that all enrollees are eligible to earn rewards. Rewards and Incentives may not be in the form of cash and may not be used to target potential enrollees.

From CY 2016 to CY 2017, the share of contracts with at least one rewards program increased from 49.9% to 54.8% (Table 10.1). The total number of beneficiaries enrolled in a rewards program increased by 8.4% from 6,359,811 in CY 2016 to 6,919,355 in CY 2017. Among organization types, however, there was significant variation for the percent of beneficiaries enrolled in a rewards program. In CY 2016, 87.8% of beneficiaries in MMP plans were enrolled in rewards programs, and only 51.4% of beneficiaries in Local CCP plans were enrolled in rewards programs. In CY 2017, 92.4% of MMP beneficiaries were enrolled in rewards programs and 48.3% of Local CCP beneficiaries were enrolled in rewards programs. In CY 2016, the total number of rewards was 11,142,546, and this number decreased by 24.5% to 8,410,167. The percent of contracts offering at least one rewards program also increased from 49.9% in CY 2016 to 54.8% in CY 2017, along with the overall number of rewards programs (from 345 in CY 2016 to 372 in CY 2017). From CY 2016 to CY 2017, the number of rewards per rewards program decreased by 30.0%, from 32,297 to 22,608. The number of beneficiaries per rewards program remained fairly stable, going from 18,434 in CY 2016 to 18,600 in CY 2017.

Table 10.1: Rewards and Incentives Program Summary, 2016-2017

Contract Type - Year	Number of Contracts	Number of Rewards Programs	Total Number of Rewards	Total Number of Beneficiaries Enrolled in a Rewards Program	Percent of Contracts with at least 1 Rewards Program	Percent of Beneficiaries Enrolled in a Rewards Program	Number of Beneficiaries per Rewards Program	Number of Rewards per Rewards Program
All-2016	495	345	11,142,546	6,359,811	49.9%	54.3%	18,434	32,297
MMP-2016	57	32	45,358	111,356	22.8%	87.8%	3,480	1,417
Local CCP-2016	421	298	10,399,968	5,353,054	52.5%	51.4%	17,963	34,899

Contract Type - Year	Number of Contracts	Number of Rewards Programs	Total Number of Rewards	Total Number of Beneficiaries Enrolled in a Rewards Program	Percent of Contracts with at least 1 Rewards Program	Percent of Beneficiaries Enrolled in a Rewards Program	Number of Beneficiaries per Rewards Program	Number of Rewards per Rewards Program
Regional CCP-2016	9	10	611,166	729,804	88.9%	76.9%	72,980	61,117
PFFS/1876 Cost-2016	5	4	85,832	165,573	80.0%	77.6%	41,393	21,458
MSA-2016	3	1	222	24	33.3%	1.4%	24	222
All-2017	476	372	8,410,167	6,919,355	54.8%	50.8%	18,600	22,608
MMP-2017	49	40	84,427	162,034	38.8%	92.4%	4,051	2,111
Local CCP-2017	409	318	7,216,486	5,760,035	56.0%	48.3%	18,113	22,693
Regional CCP-2017	10	10	976,332	876,794	90.0%	64.5%	87,679	97,633
PFFS/1876 Cost-2017	5	4	132,922	120,492	80.0%	70.9%	30,123	33,231
MSA-2017	3	0	0	0	-	-	-	-

11 SUMMARY OF RESULTS

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

Grievances

The percentage of contracts reporting zero Part C grievances decreased slightly between CY 2015 and CY 2016 and then increased in CY 2017. In all three years, contracts with less than 500 enrollees had the highest share of contracts reporting zero Part C grievances. The grievance rate per 1,000 enrollees per month increased from CY 2015 through CY 2017. For CY 2016, 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. For CY 2017, this rate was less consistent, but decreased from the first quarter to the fourth quarter. However, the grievance rate has consistently increased when comparing grievances rates for the same quarter across years. Grievances related to plan benefits, customer service, and “other” were the three most frequently filed categories in all three years.

Organization Determinations and Reconsiderations

Organization determination and reconsideration request rates per 1,000 enrollees decreased from CY 2015 to CY 2016, then increased from CY 2016 to CY 2017. The percentage of organization determinations with fully favorable, partially, or adverse outcomes for the enrollee stayed relatively constant during the three years. The percentage of reconsiderations with fully favorable outcomes experienced more variation across years, slightly decreasing between CY 2015 and CY 2016, then increasing in CY 2017. The percentage of reconsiderations with adverse outcomes exhibited the opposite trend, slightly increasing between CY 2015 and CY 2016, then decreasing in CY 2017, while the change in the percentage of reconsiderations with partially favorable outcomes was negligible in all years. In CY 2015, CY 2016, and CY 2017, reopened organization determination and reconsideration decision rates exhibited variation from quarter to quarter, for an overall increase from Quarter 1 to Quarter 4. From CY 2015 to CY 2017, 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, but has increased significantly from CY 2015 to CY 2017. Withdrawn organization determinations request rates decreased in each year, while withdrawn reconsiderations request rates were stable over time. In CY 2016 and CY 2017, withdrawn organization determinations were considerably higher than withdrawn reconsiderations, while dismissed reconsiderations were much higher than dismissed organization determinations.

SNP Care Management

The percentage of enrollees receiving assessments increased from CY 2015 to CY 2017, with a slight dip in CY 2016. This increase was most pronounced for C-SNPs. The percentage of SNPs assessing 100% of new enrollees and new or eligible enrollees also increased in each year from CY 2015 to CY 2017. The percentage of SNPs assessing 100% of eligible enrollees had a less pronounced trend, decreasing from CY 2015 to CY 2016, and then increasing slightly in CY 2017. Among the three types

of SNPs, I-SNPs had the highest percentage of SNPs assessing 100% of enrollees, across all enrollee types. New enrollees had the highest percentage of enrollees not receiving an assessment, for both enrollees who refused and enrollees where the SNP was unable to reach the enrollee. D-SNPs had the highest percentage of enrollees not receiving an assessment for all three enrollee types, while I-SNPs had the lowest percentage by a noticeable amount.

PFFS Provider Payment Dispute Resolution Process

The rate of provider payment appeals per 100 enrollees increased substantially from CY 2015 to CY 2016, then increased slightly in CY 2017. The large increase in the appeals rate is due to high outlier data for multiple contracts that was not removed due to a low number of contracts reporting data for this section. The percentage of payment appeals settled in the provider's favor increased from CY 2015 to CY 2016, then decreased slightly in CY 2017. The percentage of payment appeals resolved in over 60 days had another trend, increasing in each year from CY 2015 to CY 2017.

Employer Group Plan Sponsors

Between CY 2015, CY 2016, and CY 2017, 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 years, followed by "other" organizations and publicly traded organizations.

Enrollment and Disenrollment

Almost all enrollment requests were received via paper, with some requests submitted via telephone. From CY 2015 to CY 2017, greater than 99% of enrollment requests were submitted via paper. Nearly all enrollment and disenrollment requests were complete at the time of initial receipt from CY 2015 to CY 2017; 100% of enrollment requests were complete at the time of initial receipt in CY 2017, and the percent of disenrollment requests complete at the time of initial receipt was greater than 96% for each year. In CY 2016, the percent of enrollment and disenrollment requests complete at the time of initial receipt both decreased, and then both rates increased in CY 2017. Nearly all enrollment and disenrollment requests were accepted by MAOs in CY 2015, while in CY 2016, the percent of enrollment requests denied increased considerably. In CY 2016, data related to the number of involuntary disenrollments for failure to pay plan premium was first reported. The percent of individuals involuntarily disenrolled for failure to pay plan premium who submitted a timely request for reinstatement for good cause remained stable from CY 2016 to CY 2017, but the percent of those requests that received favorable good cause determinations nearly doubled. The percent of favorable good cause determinations that resulted in the individual being reinstated also increased from CY 2016 to CY 2017, reaching 100% in CY 2017.

Payments to Providers

Between CY 2016 and CY 2017, the share of payments made on a fee-for-service basis with no link to quality decreased slightly. The share of providers paid on a fee-for-service basis with no link to

quality also decreased slightly. The share of payments made as population-based payments also decreased dramatically over the two years. Likewise, the share of providers paid based on population-based payments decreased between CY 2016 and CY 2017. Changes to the reporting section from CY 2016 to CY 2017 have been maintained for CY 2018, which will allow for a more fruitful analysis of trends in payments with CY 2018 data.

Rewards and Incentives Programs

Between CY 2016 and CY 2017, the number of beneficiaries enrolled in a rewards program increased, but the number of rewards given and the number of rewards per rewards program both decreased. The number of beneficiaries per rewards program remained stable over the two years, and the percent of beneficiaries enrolled in a rewards program decreased slightly from CY 2016 to CY 2017. Additionally, the number of rewards programs and percent of contracts offering rewards programs increased from CY 2016 to CY 2017.

12 APPENDIX A: REPORT METRIC CALCULATIONS OVERVIEW

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

Grievances

Table or Figure Name	Metric	Data Elements
Table 3.1: Contracts Reporting Zero Grievances by Organization Type	Contracts Reporting Zero Grievances, by Organization Type	Sum of F, H, J, L, N, P, R, and V = 0
Table 3.2: Contracts Reporting Zero Grievances by Enrollment	Contracts Reporting Zero Grievances, by Enrollment Category	Sum of F, H, J, L, N, P, R, and V = 0
Table 3.3: Grievance Rates per 1,000 Enrollees per Month by Organization Type	Grievance Rate, by Organization Type	$[(\text{Sum of F, H, J, L, N, P, R, and V}) / \text{Year Average Enrollment} * 1,000] * 30 / \text{Number of days in the reporting year}$
Table 3.4: Grievance Rates per 1,000 Enrollees per Month by Category	Overall Grievance Rate	$[(\text{Sum of F, H, J, L, N, P, R, and V}) / \text{Year Average Enrollment} * 1,000] * 30 / \text{Number of days in the reporting year}$
	Enrollment / Disenrollment Grievance Rate	$(F / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Plan Benefit Grievance Rate	$(H / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Access Grievance Rate	$(J / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Marketing Grievance Rate	$(L / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Customer Service Grievance Rate	$(N / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Organization Determination and Reconsideration Process Grievance Rate	$(P / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Quality Of Care Grievance Rate	$(R / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	“Other” Grievance Rate	$(V / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Expedited Grievance Rate	$(C / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
	Dismissed Grievance Rate	$(E / \text{Year Average Enrollment} * 1,000) * 30 / \text{Number of days in the reporting year}$
Table 3.5: Percentage Share of Total Grievances by Category	Share of Grievances that were Enrollment / Disenrollment Grievances	$F / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Plan Benefit Grievances	$H / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Access Grievances	$J / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Marketing Grievances	$L / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Customer Service Grievances	$N / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were Organization Determination and Reconsideration Process Grievances	$P / (\text{Sum of F, H, J, L, N, P, R, and V})$

Table or Figure Name	Metric	Data Elements
Table 3.5: Percentage Share of Total Grievances by Category (cont.)	Share of Grievances that were Quality Of Care Grievances	$R / (\text{Sum of F, H, J, L, N, P, R, and V})$
	Share of Grievances that were “Other” Grievances	$V / (\text{Sum of F, H, J, L, N, P, R, and V})$
Figure 3.1: Grievance Rates per 1,000 Enrollees per Month	Grievance Rate	$[(\text{Sum of F, H, J, L, N, P, R, and V}) / \text{Year Average Enrollment} * 1,000] * 30 / \text{Number of days in the reporting year}$
Figure 3.2: Grievance Rates per 1,000 Enrollees per Month, by Year and Quarter	Grievance Rate	$[(\text{Sum of F, H, J, L, N, P, R, and V}) / \text{Year Average Enrollment} * 1,000] * 30 / \text{Total days in quarter in the reporting year}$

Organization Determinations and Reconsiderations

Table or Figure Name	Metric	Data Elements
Table 4.1: Organization Determination Request Rates per 1,000 Enrollees	Organization Determination Request Rate	$(\text{Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8}) / \text{Year Average Enrollment} * 1,000$
Table 4.2: Percentage of Organization Determinations by Outcome	Share of Organization Determinations Requests that were Fully Favorable	$(6.3 + 6.4) / (\text{Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8})$
	Share of Organization Determinations Requests that were Partially Favorable	$(6.5 + 6.6) / (\text{Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8})$
	Share of Organization Determinations Requests that were Adverse	$(6.7 + 6.8) / (\text{Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8})$
Table 4.3: Reconsideration Request Rates per 1,000 Enrollees	Reconsideration Request Rate	$(\text{Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18}) / \text{Year Average Enrollment} * 1,000$
Table 4.4: Percentage of Reconsiderations by Outcome	Share of Reconsideration Requests that were Fully Favorable	$(6.13 + 6.14) / (\text{Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18})$
	Share of Reconsideration Requests that were Partially Favorable	$(6.15 + 6.16) / (\text{Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18})$
	Share of Reconsideration Requests that were Adverse	$(6.17 + 6.18) / (\text{Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18})$
Table 4.5: Percent of Organization Determination Requests Processed Timely	Share of Organization Determination Requests Processed Timely	$6.2 / 6.1$
Table 4.6: Percent of Reconsideration Requests Processed Timely	Share of Reconsideration Requests Processed Timely	$6.12 / 6.11$
Figure 4.1: Organization Determination Request Rates per 1,000 Enrollees, by Year and Quarter	Organization Determination Request Rate	$(\text{Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8}) / \text{Year Average Enrollment} * 1,000$
Figure 4.2: Reconsideration Request Rates per 1,000 Enrollees, by Year and Quarter	Reconsideration Request Rate	$(\text{Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18}) / \text{Year Average Enrollment} * 1,000$
Figure 4.3: Reopened Decision Rates per 1,000 Enrollees, by Year and Quarter	Reopened Organization Determinations Request Rate	$(6.25 = \text{Organization Determination}) / \text{Year Average Enrollment} * 1,000$
	Reopened Reconsiderations Request Rate	$(6.25 = \text{Reconsideration}) / \text{Year Average Enrollment} * 1,000$
Figure 4.4: Withdrawn and Dismissed Request Rates per 1,000 Enrollees	Withdrawn Organization Determinations Rate	$6.9 / \text{Year Average Enrollment} * 1,000$

Table or Figure Name	Metric	Data Elements
Figure 4.4: Withdrawn and Dismissed Request Rates per 1,000 Enrollees (cont.)	Withdrawn Reconsiderations Rate	6.19 / Year Average Enrollment * 1,000
	Dismissed Organization Determinations Rate	6.10 / Year Average Enrollment * 1,000
	Dismissed Reconsiderations Rate	6.20 / Year Average Enrollment * 1,000

SNP Care Management

Table or Figure Name	Metric	Data Elements
Table 5.1: Percentage of SNPs Assessing 100% of New Enrollees	Share of SNPs Assessing 100% of New Enrollees	(Number of SNPs where 13.1 = 13.3 and with $13.1 \geq 1$) / (Total Number of SNPs with $13.1 \geq 1$)
Table 5.2: Percentage of SNPs Assessing 100% of Eligible Enrollees	Share of SNPs Assessing 100% of Eligible Enrollees	(Number of SNPs where 13.2 = 13.6 and $13.2 \geq 1$) / (Total Number of SNPs with $13.2 \geq 1$)
Table 5.3: Percentage of SNPs Assessing 100% of New or Eligible Enrollees	Share of SNPs Assessing 100% of New or Eligible Enrollees	[Number of SNPs where $(13.1 + 13.2) = (13.3 + 13.6)$ and $(13.1 + 13.2) \geq 1$] / (Total Number of SNPs with $(13.1 + 13.2) \geq 1$)
Table 5.4: Percentage of Enrollees Not Receiving Assessments	Share of New Enrollees Not Receiving Initial HRAs because Enrollee Refused	13.4 / 13.1
	Share of Eligible Enrollees Not Receiving Annual Reassessments because Enrollee Refused	13.7 / 13.2
	Share of New or Eligible Enrollees Not Receiving Assessment because Enrollee Refused	$(13.4 + 13.7) / (13.1 + 13.2)$
	Share of New Enrollees Not Receiving Initial HRAs because SNP is Unable to Reach Enrollee	13.5 / 13.1
	Share of Eligible Enrollees Not Receiving Annual HRAs because SNP is Unable to Reach Enrollee	13.8 / 13.2
	Share of New Or Eligible Enrollees Not Receiving Assessment because SNP is Unable to Reach Enrollee	$(13.5 + 13.8) / (13.1 + 13.2)$
Figure 5.1: Percentage of Enrollees Receiving Assessments	Share of New Enrollees Receiving Initial HRAs	13.3 / 13.1
	Share of Eligible Enrollees Receiving Annual Reassessments	13.6 / 13.2
	Share of New or Eligible Enrollees Receiving Assessment	$(13.3 + 13.6) / (13.1 + 13.2)$

PFFS Provider Payment Dispute

Table or Figure Name	Metric	Data Elements
Table 6.1: Percentage of Payment Appeals Settled in Provider's Favor	Share of Provider Payment Denials Overturned in Favor of Provider Upon Appeal	9.1 / 9.2
Table 6.2: Percentage of Payment Appeals Resolved in Over 60 Days	Share Of Provider Payment Appeals Resolved in Greater than 60 Days	9.3 / 9.2
Figure 6.1: Provider Payment Appeals Rate per 100 Enrollees	Provider Payment Appeals Rate	9.2 / Year Average Enrollment * 100

Employer Group Plan Sponsors

Table or Figure Name	Metric	Data Elements
Table 7.1: Employers and Enrollment by Group Sponsor Type	Share of Employers and Enrollment Represented by Employer Group Type	Number of employers with 7.5 = Employer / Total number of employers; 7.10 (when 7.5 = Employer) / 7.10 (for all types)
	Share of Employers and Enrollment Represented by Union Group Type	Number of employers with 7.5 = Union / Total number of employers; 7.10 (when 7.5 = Union) / 7.10 (for all types)
	Share of Employers and Enrollment Represented by Trustee Group Type	Number of employers with 7.5 = Trustee of a Fund / Total number of employers; 7.10 (when 7.5 = Trustees of a Fund) / 7.10 (for all types)
Table 7.2: Share of Employers by Organization Type	Share of Employers Represented by State Government Organization Type	Number of employers with 7.6 = State Government / Total number of employers
	Share of Employers Represented by Local Government Organization Type	Number of employers with 7.6 = Local Government / Total number of employers
	Share of Employers Represented by Publicly Traded Organization Type	Number of employers with 7.6 = Publicly Traded Organization / Total number of employers
	Share of Employers Represented by Privately Held Corporation Organization Type	Number of employers with 7.6 = Privately Held Corporation / Total number of employers
	Share of Employers Represented by Non-Profit Organization Type	Number of employers with 7.6 = Non-Profit / Total number of employers
	Share of Employers Represented by Church Group Organization Type	Number of employers with 7.6 = Church Group / Total number of employers
	Share of Employers Represented by Other Organization Type	Number of employers with 7.6 = Other / Total number of employers
Table 7.3: Share of Employer Enrollment by Organization Type	Share of Employer Enrollment Represented by State Government Organization Type	7.10 (when 7.6 = State Government) / 7.10 (for all types)
	Share of Employer Enrollment Represented by Local Government Organization Type	7.10 (when 7.6 = Local Government) / 7.10 (for all types)
	Share of Employer Enrollment Represented by Publicly Traded Organization Type	7.10 (when 7.6 = Publicly Traded Organization) / 7.10 (for all types)
	Share of Employer Enrollment Represented by Privately Held Corporation Organization Type	7.10 (when 7.6 = Privately Held Corporation) / 7.10 (for all types)

Table or Figure Name	Metric	Data Elements
Table 7.3: Share of Employer Enrollment by Organization Type (cont.)	Share of Employer Enrollment Represented by Non-Profit Organization Type	7.10 (when 7.6 = Non-Profit) / 7.10 (for all types)
	Share of Employer Enrollment Represented by Church Group Organization Type	7.10 (when 7.6 = Church Group) / 7.10 (for all types)
	Share of Employer Enrollment Represented by Other Organization Type	7.10 (when 7.6 = Other) / 7.10 (for all types)
Table 7.4: Employers by Contract Type	Share of Employers Represented by Insured Contract Type	Number of employers with 7.7 = Insured / Total number of employers
	Share of Employers Represented by ASO Contract Type	Number of employers with 7.7 = ASO / Total number of employers
	Share of Employers Represented by Other Contract Type	Number of employers with 7.7 = Other / Total number of employers

Enrollment and Disenrollment

Table or Figure Name	Metric	Data Elements
Table 8.1: Share of Enrollment Requests by Request Mechanism	Share of Requests Submitted via Paper	1.G / 1.A
	Share of Requests Submitted via Telephone	1.H / 1.A
	Share of Requests Submitted via Internet	1.I / 1.A
	Share of Requests Submitted via OEC	1.J / 1.A
Table 8.2: Enrollment and Disenrollment Requests Completed at Initial Receipt	Percent of Enrollment Requests Completed at Initial Receipt	1.B / 1.A
	Percent of Disenrollment Requests Completed at Initial Receipt	2.B / 2.A
Table 8.3: Enrollment and Disenrollment Requests Denied by the MAO	Percent of Enrollment Requests Denied for Any Reason	(1.D + 1.F) / 1.A
	Percent of Disenrollment Requests Denied for Any Reason	2.C / 2.A
Table 8.4: Involuntary Disenrollment Reinstatement Requests for Good Cause	Percent of Involuntarily Disenrolled Individuals (for Failure to Pay Plan Premium) who Submitted Timely Request for Reinstatement for Good Cause	2.E / 2.D
	Percent of Requests for Reinstatement for Good Cause Determinations that were Favorable	2.F / 2.E
	Percent of Favorable Good Cause Determinations where Individuals were Reinstated	2.G / 2.F

Payments to Providers

Table or Figure Name	Metric	Data Elements
Table 9.2: Payments by Category Summary	Percent of MA payments with Fee-for-Service Basis with no Link to Quality	17.2 / 17.1
	Percent of MA payments with Fee-for-Service Basis with a Link to Quality	17.3 / 17.1
	Percent of MA payments with Alternative Payment Models Built on Fee-for-Service Architecture	17.4a / 17.1
	Percent of MA payments with Population-Based Payment	17.5a / 17.1
	Percent of MA payments with Risk-Based Payments not Linked to Quality	17.4b / 17.1
	Percent of MA payments with Capitation Payment not Linked to Quality	17.5b / 17.1
Table 9.3: Providers by Payment Category Summary	Percent of MA contracted providers paid on a Fee-for-Service Basis with no Link to Quality	17.7 / 17.6
	Percent of MA contracted providers paid on a Fee-for-Service Basis with a Link to Quality	17.8 / 17.6
	Percent of MA contracted providers paid based on Alternative Payment Models Built on Fee-for-Service Architecture	17.9a / 17.6
	Percent of MA contracted providers paid based on Population-Based Payment	17.10a / 17.6
	Percent of MA contracted providers paid based on Risk-Based Payments not Linked to Quality	17.9b / 17.6
	Percent of MA contracted providers paid based on Capitation with no Link to Quality	17.10b / 17.6

Rewards and Incentives Programs

Table or Figure Name	Metric	Data Elements
Table 10.1: Rewards and Incentives Program Summary	Percent of Contracts with at least one Rewards Program	“Yes” from 15.1 / Number of Contracts
	Percent of Beneficiaries enrolled in a Rewards Program	15.6 / Year Average Enrollment
	Number of Beneficiaries per Rewards Program	15.6 / Number of Rewards Programs
	Number of Rewards per Rewards Program	15.7 / Number of Rewards Programs