Analysis of Calendar Year 2016 Medicare Part C Reporting Requirements Data

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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 2012 through 2016.

Table 1.1: Summary of Part C Reporting Requirements by Calendar Year, 2012-2016

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

[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	2012	2013	2014	2015	2016
Plan Oversight of Agents	✓	-	✓	✓	✓
Rewards and Incentives Program	–	–	–	–	✓
Mid-Year Network Changes	–	–	–	–	✓
Payments to Providers	–	–	–	–	✓

This report provides an analysis of the data submitted by Part C MAOs in accordance with the Part C Reporting Requirements for CY 2016. For each of these reporting sections,[2] this report presents program-wide averages and identifies trends between CY 2014, CY 2015, and CY 2016 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., fraud, benefit package) 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.

[2] The reporting section Plan Oversight of Agents was collected in CY 2014, CY 2015, and CY 2016, but was excluded from this analysis. Rewards and Incentives Program, Mid-Year Network Changes, and Payments to Providers were collected in CY 2016, but were excluded from this analysis.

Reporting Section	Metric	Description
Organization Determinations and Reconsiderations (cont.)	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.
	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	• 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 Plan Enrollment Verification Calls	Number of Plans by PFFS Plan Enrollment Verification	Documented (i) number of enrollments and (ii) attempts to contact new enrollees. Attempts to contact new enrollees include: • Number of times the plan reached the prospective enrollee with the first call, weighted by Contract Year Average Enrollment. • Number of follow-up educational letters sent, weighted by Contract Year Average Enrollment.
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.

Reporting Section	Metric	Description
PFFS Provider Payment Dispute Resolution Process (cont.)	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.
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.

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

[3] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
[4] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.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 seven reporting sections included in this report, Grievances, Organization Determinations and Reconsiderations, and SNP Care Management, underwent data validation for the CY 2014 through CY 2016 data. Data for the Employer Group Plan Sponsors, PFFS Provider Payment Disputes, PFFS Enrollment Verification, and Enrollment and Disenrollment sections are collected for monitoring purposes only and did not undergo validation.

Table 2.1: Reporting Sections Undergoing Data Validation

Reporting Section	CY 2014 Data	CY 2015 Data	CY 2016 Data
Grievances	2015 DV	2016 DV	2017 DV
Organization Determinations and Reconsiderations	2015 DV	2016 DV	2017 DV
SNP Care Management	2015 DV	2016 DV	2017 DV
PFFS Provider Payment Disputes	–	–	–
PFFS Enrollment Verification	–	–	–
Employer Group Plan Sponsors	–	–	–
Enrollment and Disenrollment	–	–	–

2.3 Data Validation Exclusion Criteria

Contracts' inclusion in this analysis is contingent on (i) the contract submitting the required data by the specified reporting deadline, and (ii) the submitted data meeting minimum data validation requirements. 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, contracts that submitted data but were not required to submit due to termination were included if all other inclusion criteria were met. For the CY 2014 through CY 2016 reporting sections that underwent validation in the 2015, 2016, or 2017 data validation cycles, contracts must have a section-specific data validation score of at least 95% to be

[5] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.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/PartCDDataValidation.html

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 Organization Determinations and Reconsiderations, which increased in each year, from 92.6% and 60.1% in CY 2014 to 98.0% and 73.6% in CY 2016, respectively. Grievances exhibited a decrease in both the percentage of contracts achieving a passing data validation score and percent achieving a score of 100%, lowering from CY 2014 (97.5% and 70.4%, respectively) to CY 2015 (90.8% and 59.6%, respectively). Both percentages also then experienced an increase in CY 2016, to 97.8% for those achieving a passing data validation score and to 80.7% for those achieving a score of 100%. SNP Care Management was the only section to experience an overall decrease in the percentage of contracts achieving a score of 100%, from 82.2% in CY 2014 to 78.4% in CY 2016. During this same time, SNP Care Management exhibited an overall increase in the percentage of contracts achieving a passing data validation score, from 95.4% to 98.1%.

Table 2.2: Summary of Contract Data Validation Results by Reporting Section, 2014-2016[7]

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	2014	513	513	500	97.5%	361	70.4%
Grievances	2015	513	513	466	90.8%	306	59.6%
Grievances	2016	508	508	497	97.8%	410	80.7%
Organization Determinations and Reconsiderations	2014	514	514	476	92.6%	309	60.1%
Organization Determinations and Reconsiderations	2015	511	511	473	92.6%	325	63.6%
Organization Determinations and Reconsiderations	2016	508	508	498	98.0%	374	73.6%
SNP Care Management	2014	219	219	209	95.4%	180	82.2%
SNP Care Management	2015	200	200	198	99.0%	187	93.5%
SNP Care Management	2016	208	208	204	98.1%	163	78.4%
PFFS Provider Payment	2014	–	–	–	–	–	–
PFFS Provider Payment	2015	–	–	–	–	–	–
PFFS Provider Payment	2016	–	–	–	–	–	–
PFFS Enrollment Verification	2014	–	–	–	–	–	–
PFFS Enrollment Verification	2015	–	–	–	–	–	–
PFFS Enrollment Verification	2016	–	–	–	–	–	–

[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 represented with a placeholder value (i.e., PFFS Provider Payment, PFFS Enrollment Verification, Employer Group Plan Sponsors, and Enrollment and Disenrollment). In CY 2016, 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.

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%
Employer Group Plan Sponsors	2014	–	–	–	–	–	–
Employer Group Plan Sponsors	2015	–	–	–	–	–	–
Employer Group Plan Sponsors	2016	–	–	–	–	–	–
Enrollment and Disenrollment	2014	–	–	–	–	–	–
Enrollment and Disenrollment	2015	–	–	–	–	–	–
Enrollment and Disenrollment	2016	–	–	–	–	–	–

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 and a score of 100% for SNP Care Management both increased, from 96.9% and 86.9% in CY 2014 to 99.1% and 95.5% in CY 2015, and then decreased to 98.8% and 88.1% in CY 2016, respectively.

Table 2.3: Summary of Data Validation Results by Reporting Section for Plans, 2014-2016[8]

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	2014	482	482	467	96.9%	419	86.9%
SNP Care Management	2015	444	444	440	99.1%	424	95.5%
SNP Care Management	2016	513	513	507	98.8%	452	88.1%

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

[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, 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.

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	✓
SNP Care Management	✓
PFFS Plan Enrollment Verification	–
PFFS Provider Payment Dispute Resolution Process	–
Employer Group Plan Sponsors	–
Enrollment and Disenrollment	✓

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] Due to the limited number of Medicare-Medicaid Plans that were active for the full 2014 reporting year, only 2015 and 2016 data submitted to CMS by MMPs were included in this report.[11]

- Plan-level sections[12]:
  - Plan required to submit for the reporting year
  - Plan not deleted before the end of the reporting year
  - Plan had year average enrollment greater than or equal to 11
  - Contract was active as of end of reporting year
- Contract-level sections[13]:
  - Contract required to submit
  - Contract had year average enrollment greater than or equal to 11
  - Contract active as of end of reporting year

[9] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html
[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] MMPs were required to report data for the Grievances and Organization Determinations and Redeterminations sections for CY 2014, CY 2015, and CY 2016.
[12] 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.
[13] 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.[14] 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.[15]

The share of contracts with at least 100 enrollees reporting no 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, 2014-2016[16]

Organization Type	2014 Total Number of Contracts	2014 Number of Contracts Reporting Zero	2014 Share of Contracts that Reported Zero	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
All	**398**	**8**	**2.0%**	**323**	**7**	**2.2%**	**422**	**7**	**1.7%**
MMP	–	–	–	28	0	0.0%	39	0	0.0%
Local CCP	373	8	2.1%	272	4	1.5%	358	6	1.7%
Regional CCP	8	0	0.0%	6	0	0.0%	8	0	0.0%
PFFS/1876 Cost	14	0	0.0%	16	2	12.5%	14	1	7.1%
MSA	3	0	0.0%	1	1	100.0%	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 14.6% of contracts within the category reporting zero grievances in CY 2014, 17.2% in CY 2015, and 12.9% in CY 2016.

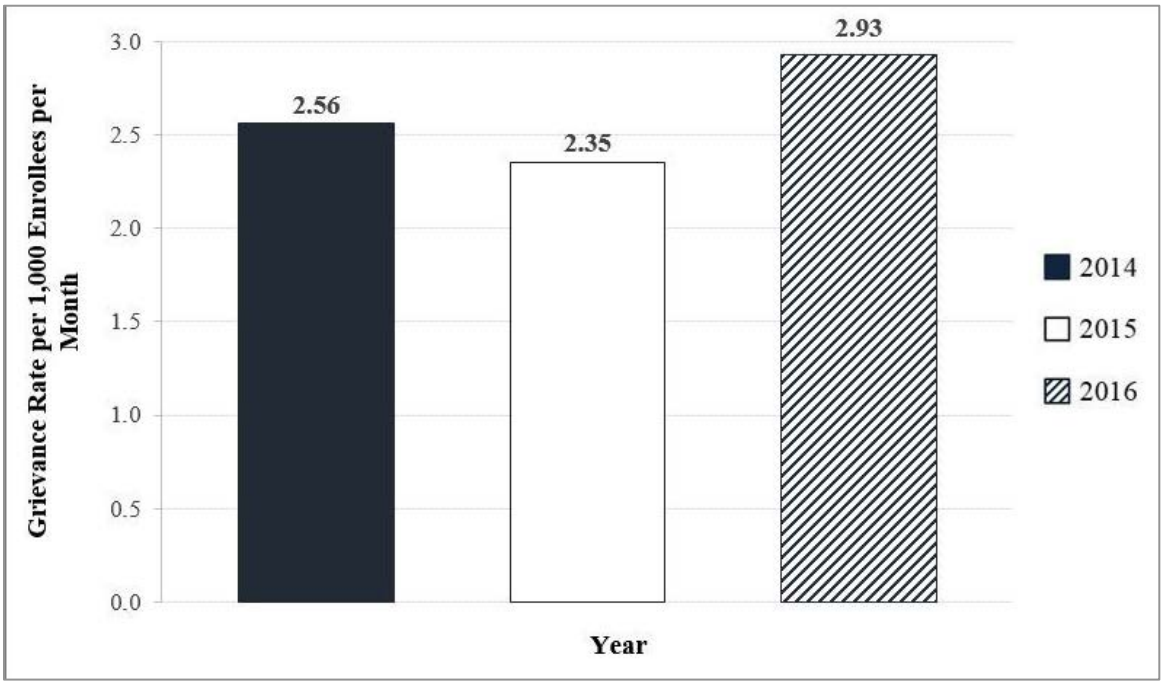
[14] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf
[15] MAOs may extend the 30-day timeframe by up to 14 days but must promptly notify enrollees that they intend to do so. Also, expedited grievances related to the plan's refusal to process an enrollee's request for an expedited pre-service organization determination or reconsideration must be responded to within 24 hours.
[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.

Table 3.2: Contracts Reporting Zero Grievances by Enrollment, 2014-2016[17]

Contract Enrollment	2014 Total Number of Contracts	2014 Number of Contracts Reporting Zero	2014 Share of Contracts that Reported Zero	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
All	**398**	**8**	**2.0%**	**323**	**7**	**2.2%**	**422**	**7**	**1.7%**
100 - 499	41	6	14.6%	29	5	17.2%	31	4	12.9%
500-999	24	1	4.2%	24	1	4.2%	27	1	3.7%
1,000 - 9,999	139	1	0.7%	115	1	0.9%	157	2	1.3%
10,000 - 99,999	175	0	0.0%	139	0	0.0%	180	0	0.0%
100,000+	19	0	0.0%	16	0	0.0%	27	0	0.0%

The yearly grievance rate per 1,000 enrollees per month was higher in CY 2016 than in CY 2014 and CY 2015 (Figure 3.1). Between CY 2014 and CY 2015, the yearly rate of grievances filed per 1,000 enrollees per month decreased by 8.1%, from 2.56 to 2.35. In CY 2016, the grievance rate increased to 2.93, a 24.4% increase over CY 2015.

Figure 3.1: Grievance Rates per 1,000 Enrollees per Month, 2014-2016[18]

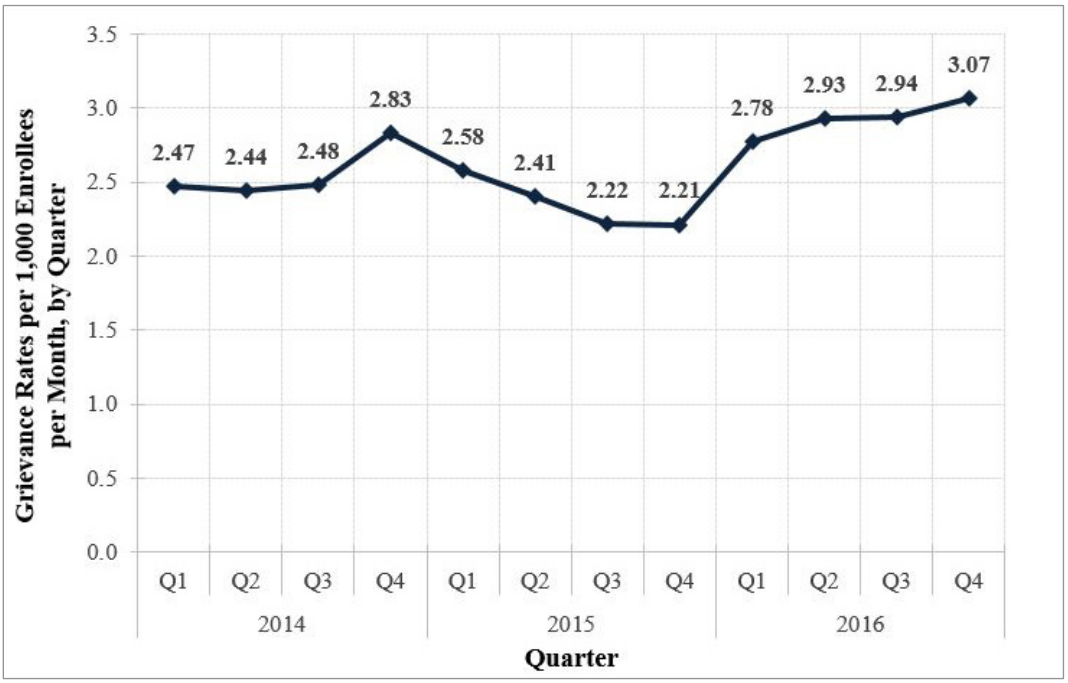


The quarterly grievance rate per 1,000 enrollees per month was generally highest in the later quarters for CY 2014 and CY 2016, but for CY 2015, the grievance rate per 1,000 enrollees per month experienced decreases throughout the year (Figure 3.2). In CY 2014, the grievance rate per 1,000 enrollees per month decreased between Quarter 1 and Quarter 2, but then increased in Quarters 3 and 4,

[17] 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.
[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.

for an overall increase from 2.47 in Quarter 1 to 2.83 in Quarter 4. In CY 2015, the rate exhibited a different trend, decreasing 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.

Figure 3.2: Grievance Rates per 1,000 Enrollees per Month, by Year and Quarter, 2014-2016[19]



Across all three years, MMP and Regional CCP organizations had the highest grievance rates per 1,000 enrollees per month (Table 3.3). In CY 2016, MMP organizations had the highest grievance rate, at 5.47, and Regional CCP organizations exhibited a large increase from CY 2015, from 2.61 to 4.09. In CY 2015, MMP organizations had a grievance rate of 5.92, more than double the rate of any of the other organization types, while in CY 2014, when data for MMP organizations was excluded, Regional CCP organizations had the highest grievance rate per 1,000 enrollees per month, with 3.55.

Table 3.3: Grievance Rates per 1,000 Enrollees per Month by Organization Type, 2014-2016

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2014 Grievance Rate	2.56	–	2.51	3.55	2.13	1.93
2014 Number of Contracts	406	–	381	8	14	3
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

Reported data enable CMS to identify the category a grievance was related to, including enrollment/disenrollment, benefit packages, access, marketing, customer service, organization

[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.

determination and reconsideration process, quality of care, or "other". Data are also reported regarding grievances that were expedited. Table 3.4 provides the rate per 1,000 enrollees per month for each grievance category. Grievances filed related to benefit packages, 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 0.21 grievances per 1,000 enrollees per month, from 0.60 grievances per 1,000 enrollees per month in CY 2014 to 0.81 in CY 2016. Benefit package grievances exhibited the largest decrease over the three years, decreasing by 0.08 grievances per 1,000 enrollees per month, from 0.54 in CY 2014 to 0.46 in CY 2016.

Table 3.4: Grievance Rates per 1,000 Enrollees per Month by Category, 2014-2016[20]

Category	2014	2015	2016
Total	**2.56**	**2.35**	**2.93**
Enrollment / Disenrollment	0.23	0.18	0.18
Benefit Package	0.54	0.31	0.46
Access	0.31	0.30	0.31
Marketing	0.09	0.13	0.13
Customer Service	0.60	0.84	0.81
Organization Determination and Reconsideration Process	0.03	0.05	0.06
Quality of Care	0.22	0.23	0.21
Other	0.49	0.49	0.44
Expedited	0.00	0.00	0.00

Table 3.5 provides the share that each grievance category comprises of all grievances for the specified year. Grievances filed related to customer service and "other" were the two most frequently filed categories in the three calendar years, followed by benefit package and quality of care. Grievances classified as "other" had the largest share in CY 2014, with 23.1%, while grievances related to customer service had the largest share in CY 2015 and CY 2016, with 26.3% and 29.1%, respectively.

[20] 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 and expedited grievances.

Table 3.5: Percentage Share of Total Grievances by Category, 2014-2016[21]

Category	2014	2015	2016
Total	**100.0%**	**100.0%**	**100.0%**
Enrollment / Disenrollment	7.3%	5.3%	6.8%
Benefit Package	21.0%	14.4%	15.8%
Access	9.3%	9.2%	10.0%
Marketing	3.5%	3.8%	5.3%
Customer Service	21.0%	26.3%	29.1%
Organization Determination and Reconsideration Process	1.7%	2.7%	2.4%
Quality of Care	13.2%	13.5%	10.8%
Other	23.1%	24.8%	20.0%

[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.

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 increased by 9.9%, from 28,906.1 in CY 2014 to 31,757.2 in CY 2015, and then decreased by 8.5% to 29,050.2 in CY 2016 (Table 4.1). The rate for PFFS/1876 Cost organizations experienced the most variation across years, increasing by 12.8% between CY 2014 and CY 2015 and maintaining the second highest organization determination request rate. Then in CY 2016, the rate for PFFS/1876 Cost organizations decreased by 22.3%, making it the organization type with the second lowest request rate. In

CY 2015 and CY 2016, the only years where MMP data was evaluated, 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.

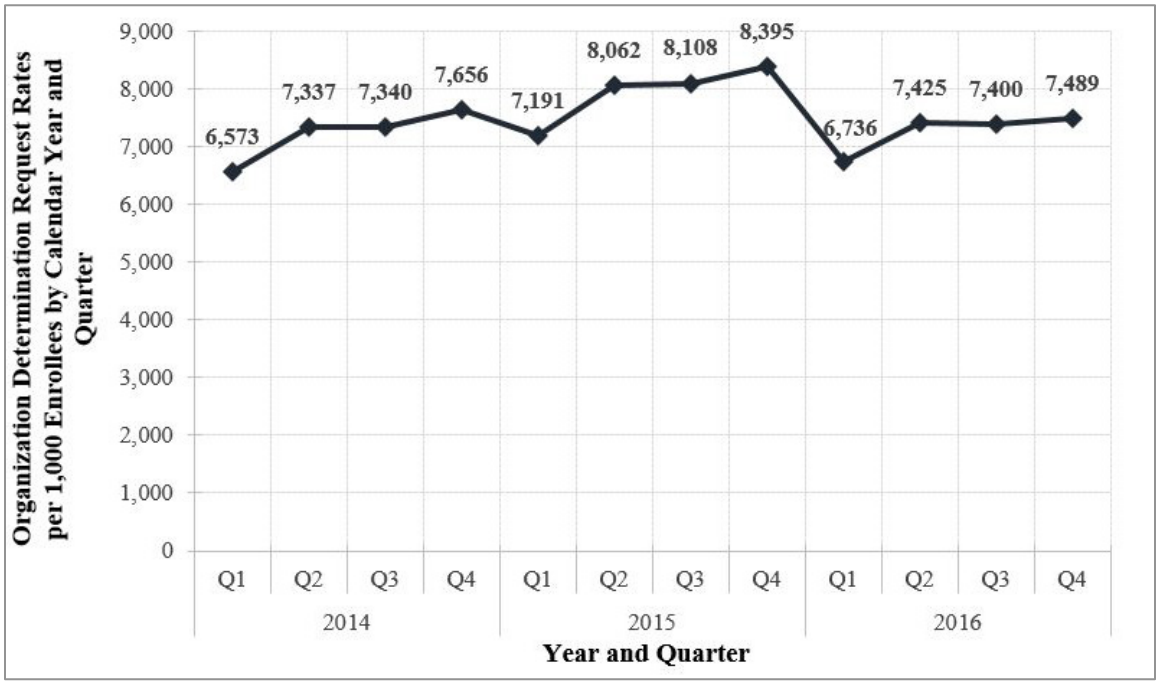
Table 4.1: Organization Determination Request Rates per 1,000 Enrollees, 2014-2016[22]

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2014 Number of Contracts	424	–	395	10	18	1
2015 Number of Contracts	438	39	369	10	19	1
2016 Number of Contracts	440	46	365	9	17	3
2014 Total Number of Requests	399,376,230	–	340,357,705	37,991,227	21,006,160	21,138
2015 Total Number of Requests	441,612,602	11,190,117	366,227,417	38,841,363	25,334,973	18,732
2016 Total Number of Requests	464,848,464	12,952,372	407,204,563	28,543,116	16,095,908	52,505
2014 Request Rate	28,906.1	–	28,591.6	31,272.6	30,176.5	16,881.1
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

Figure 4.1 shows organization determination request rates per 1,000 enrollees by calendar year and quarter for CY 2014, CY 2015, and CY 2016. In all three years, organization determination request rates per 1,000 enrollees increased between the first quarter and fourth quarter. In CY 2015, the request rates in each quarter increased over CY 2014 and then in CY 2016 returned to levels comparable to CY 2014.

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

Figure 4.1: Organization Determination Request Rates per 1,000 Enrollees, by Year and Quarter, 2014-2016[23]



The percentage of organization determinations with fully favorable outcomes decreased slightly from CY 2014 to CY 2016, from 91.9% to 91.3% (Table 4.2). The percentage of organization determinations with partially favorable or adverse outcomes remained low, below 5% for each category for each year, with an increase in partially favorable outcomes from 3.8% CY 2014 to 4.6% in CY 2015 and slight decrease to 4.5% CY 2016. During the same time period, the percentage of adverse outcomes decreased from 4.3% in CY 2014 to 3.8% in CY 2015, to then return to 4.3% in CY 2016.

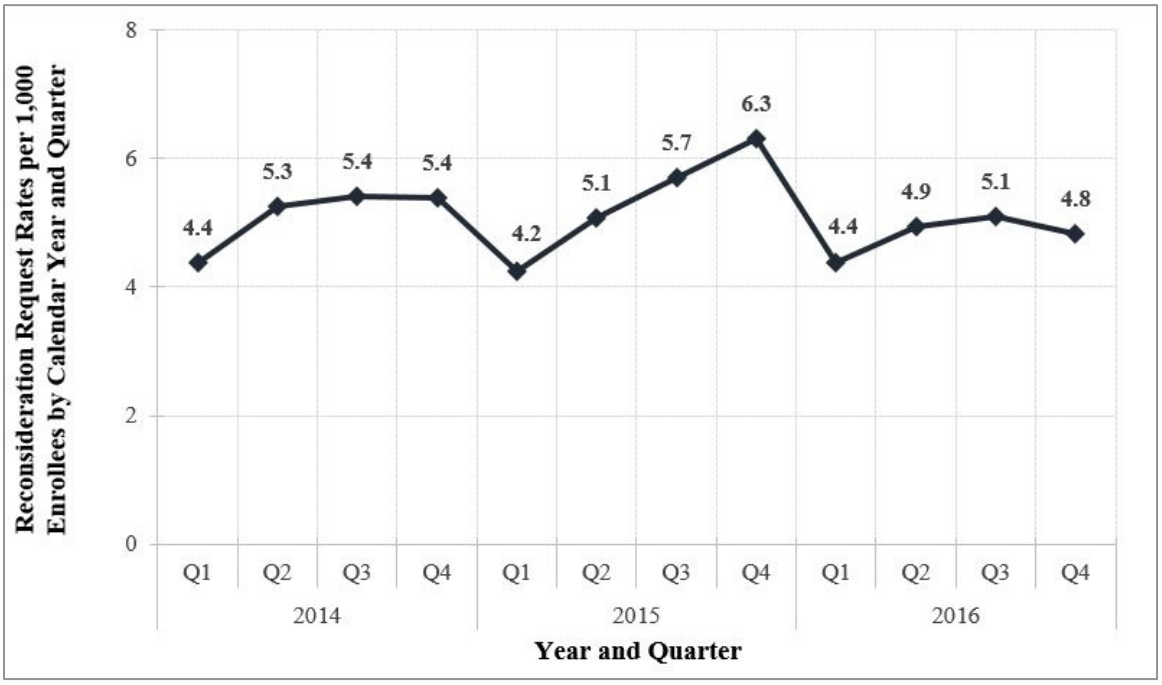
Table 4.2: Percentage of Organization Determinations by Outcome, 2014-2016[24]

Organization Determination Outcome	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value	2016 Number of Contracts	2016 Measure Value
Fully Favorable	423	91.9%	437	91.6%	439	91.3%
Partially Favorable	423	3.8%	437	4.6%	439	4.5%
Adverse	423	4.3%	437	3.8%	439	4.3%

Figure 4.2 shows reconsideration request rates per 1,000 enrollees by calendar year and quarter for CY 2014, CY 2015, and CY 2016. In all three years, reconsideration request rates per 1,000 enrollees increased between the first quarter and fourth quarter. Reconsideration request rates were similar in CY 2014 and CY 2016, increasing from Quarter 1 to Quarter 3 and then remaining the same or decreasing in Quarter 4. In comparison, rates steadily increased from quarter to quarter in CY 2015.

[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.

Figure 4.2: Reconsideration Request Rates per 1,000 Enrollees, by Year and Quarter, 2014-2016[25]



The overall rate of reconsideration requests per 1,000 enrollees increased from 20.4 in CY 2014 to 21.3 in CY 2015, and then decreased to 19.3 in CY 2016 (Table 4.3). In CY 2014, PFFS/1876 Cost had the highest request rate, at 46.0, but then decreased substantially in CY 2015 and CY 2016, to 8.9 and 8.2, respectively. In CY 2015 and CY 2016, MMP organizations had the highest reconsideration request rates, with 30.8 and 43.5 reconsideration requests per 1,000 enrollees, respectively.

Table 4.3: Reconsideration Request Rates per 1,000 Enrollees, 2014-2016[26]

Organization Type	All	MMP	Local CCP	Regional CCP	PFFS/1876 Cost	MSA
2014 Number of Contracts	454	–	420	10	21	3
2015 Number of Contracts	444	43	369	10	21	1
2016 Number of Contracts	468	49	389	9	18	3
2014 Total Number of Requests	285,318	–	230,973	20,217	33,984	144
2015 Total Number of Requests	298,467	9,059	256,242	26,230	6,931	5
2016 Total Number of Requests	318,117	15,268	267,308	28,946	6,578	17
2014 Request Rate	20.4	–	19.3	16.6	46.0	12.7
2015 Request Rate	21.3	30.8	21.9	21.1	8.9	5.1
2016 Request Rate	19.3	43.5	18.6	30.4	8.2	5.6

Reconsiderations with fully favorable outcomes represented the majority of reconsiderations, followed by adverse outcomes (Table 4.4). From CY 2014 to CY 2015, the percentage of fully favorable outcomes exhibited a 1.3 percentage point increase, while the percentage of adverse outcomes showed a

[25] Reconsideration requests are defined as the sum of reconsideration 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.

1.0 percentage point decrease. Then from CY 2015 to CY 2016, the percentage of fully favorable outcomes decreased by 2.5 percentage points while the percentage of adverse outcomes increased by 2.9 percentage points. The percentage of reconsiderations with partially favorable outcomes remained small, decreasing gradually from 1.4% in CY 2014 to 0.7% in CY 2016.

Table 4.4: Percentage of Reconsiderations by Outcome, 2014-2016[27]

Reconsideration Outcome	2014 Number of Contracts	2014 Number of Contracts	2015 Number of Contracts	2015 Number of Contracts	2016 Number of Contracts	2016 Number of Contracts
Fully Favorable	446	77.1%	431	78.4%	458	75.9%
Partially Favorable	446	1.4%	431	1.1%	458	0.7%
Adverse	446	21.5%	431	20.5%	458	23.4%

Figure 4.3 shows reopened decision rates per 1,000 enrollees by year and quarter for CY 2014, CY 2015, and CY 2016. In all quarters, the rates of reopened organization determinations were considerably higher than reopened reconsiderations. In CY 2014, the reopened organization determination decision rates declined in each quarter (21.2 in Quarter 1 to 14.9 in Quarter 4), while reopened reconsideration decision rates increased in each quarter (0.2 in Quarter 1 to 0.4 in Quarter 4). In CY 2015, the reopened organization determination rates increased from 19.4 in Quarter 1 to 26.6 in Quarter 3 and then decreased to 23.3 in Quarter 4. Reopened reconsideration decisions rates were relatively constant in CY 2015, hovering around 1.7, with a slight spike to 2.7 in Quarter 2. 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.

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

Figure 4.3: Reopened Decision Rates per 1,000 Enrollees, by Year and Quarter, 2014-2016[28]

In CY 2014 and in CY 2015, 98.0% of all organization determination requests were processed in a timely manner, while in CY 2016, this percentage decreased to 97.2% (Table 4.5). In CY 2014, each organization type had over 97% of their organization determination requests processed timely, while in CY 2015, the percent of requests processed timely for MMP and MSA organizations dropped down to 94.4% and 96.6%, respectively. In CY 2016, the percent of requests processed timely for PFFS/1876 Cost organizations decreased from 98.6% of organization determination requests processed timely in CY 2015 to 95.8% of requests, while the percent increased for MSA organizations, rising from 96.6% in CY 2015 to 99.3%.

Table 4.5: Percent of Organization Determination Requests Processed Timely, 2014-2016[29]

Organization Type	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value	2016 Number of Contracts	2016 Measure Value
All	**452**	**98.0%**	**449**	**98.0%**	**482**	**97.2%**
MMP	–	–	41	94.4%	52	95.0%
Local CCP	418	97.9%	380	98.0%	400	97.2%
Regional CCP	10	98.4%	10	98.7%	9	98.0%
PFFS/1876 Cost	21	98.8%	17	98.6%	18	95.8%
MSA	3	97.8%	1	96.6%	3	99.3%

Between CY 2014 and CY 2015, there was a substantial drop in the percent of reconsideration requests processed timely, decreasing from 94.5% to 79.8%, and then in CY 2016, the percentage returned to near CY 2014 levels, increasing to 92.5% (Table 4.6). In all years, MSA organizations had the

[28] Averages are weighted by Contract Year Average Enrollment.
[29] Organization determination data are the reported totals, not the sums by outcome. Averages are weighted by Contract Year Average Enrollment.

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 decreases in the percent of requests processed timely, from 94.1% and 96.9% in CY 2014 to 63.9% and 79.8% in CY 2015, respectively; however in CY 2016, both Regional CCP and PFFS/1876 Cost organizations increased, to 86.7% and 96.1%, respectively. Local CCP organizations also showed a decrease in the percent of requests processed timely from CY 2014 to CY 2015, dropping from 94.4% to 81.3%, and then increased to 92.9% in CY 2016.

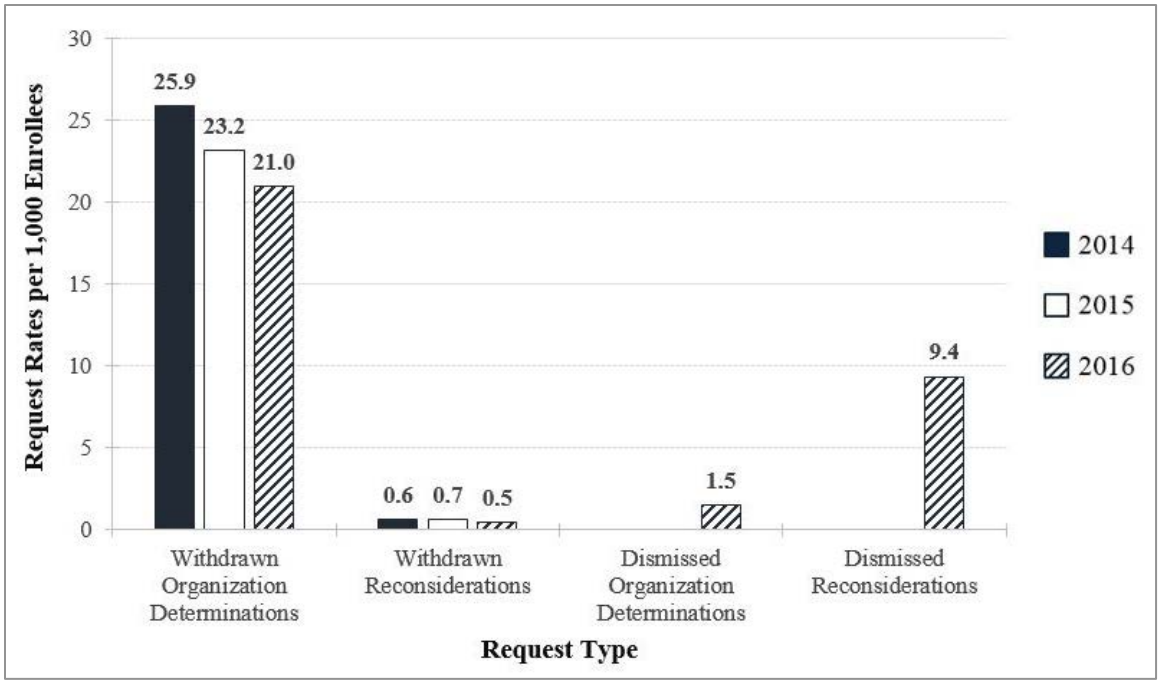
Table 4.6: Percent of Reconsideration Requests Processed Timely, 2014-2016[30]

Organization Type	2014 Number of Contracts	2014 Measure Value	2015 Number of Contracts	2015 Measure Value	2016 Number of Contracts	2016 Measure Value
All	**455**	**94.5%**	**436**	**79.8%**	**468**	**92.5%**
MMP	–	–	38	86.6%	47	80.1%
Local CCP	421	94.4%	366	81.3%	390	92.9%
Regional CCP	10	94.1%	10	63.9%	9	86.7%
PFFS/1876 Cost	21	96.9%	21	79.8%	19	96.1%
MSA	3	100.0%	1	100.0%	3	100.0%

From CY 2014 to CY 2016, the withdrawn organization determination request rate decreased by 10-11% in each year, from 25.9 in CY 2014 to 23.2 CY 2015 to 21.0 CY 2016. In comparison, withdrawn reconsideration request rates were noticeably smaller and increased from 0.6 in CY 2014 to 0.7 in CY 2015 and then decreased to 0.5 in CY 2016. Starting in CY 2016, sponsors were required to submit data on dismissed organization determinations and reconsiderations. In contrast to withdrawn request rates, dismissed organization determination request rates were lower than dismissed reconsideration request rates, 1.5 compared to 9.4, respectively.

[30] 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, 2014-2016[31]



[31] Dismissed organization determinations and reconsiderations were first reported in 2016.

5 SPECIAL NEEDS PLAN CARE MANAGEMENT

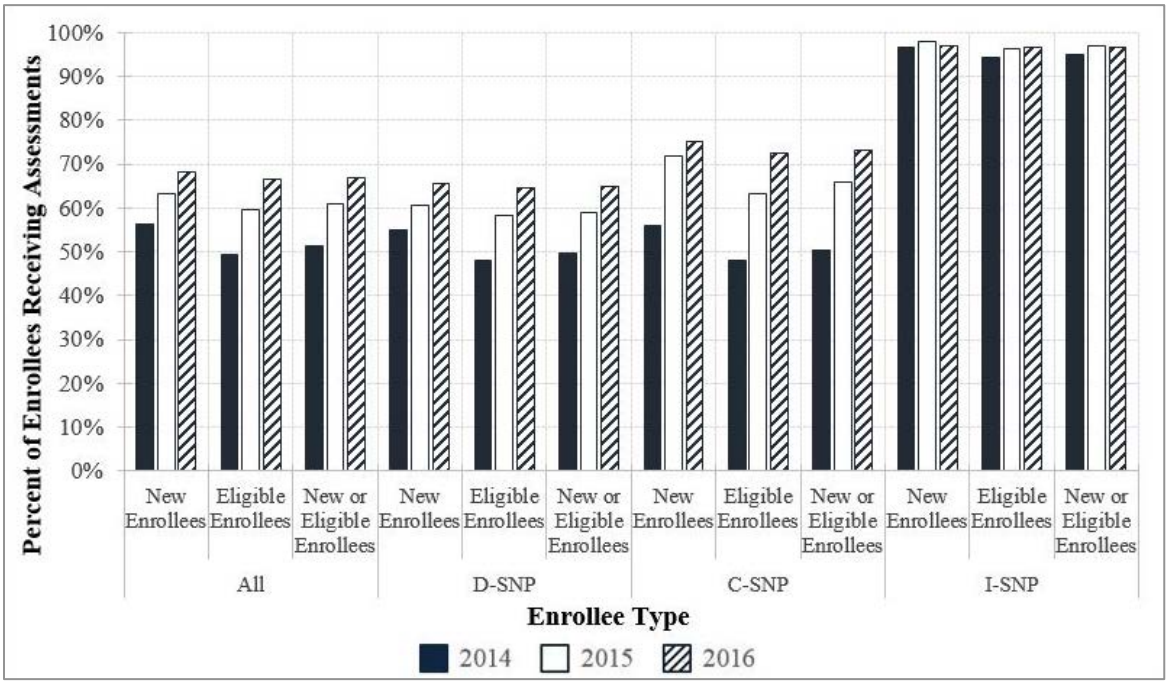
Since SNPs provide coverage for vulnerable Medicare enrollees with specialized needs, CMS requires MAOs offering SNPs to perform initial assessments (within 90 days of enrollment) of all enrollees' medical, psychosocial, functional, and cognitive status and to develop a specialized care plan for the 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.[32] 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.[33]

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 17.2 percentage points for eligible enrollees and 11.9 percentage points for new enrollees. 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 in each year from CY 2014 to CY 2016. C-SNPs had the largest increase from CY 2014 to CY 2016, increasing by 19.2 percentage points for new enrollees, 24.6 for eligible enrollees, and 22.8 for new or eligible enrollees. The percentages for I-SNPs increased from CY 2014 to CY 2016, despite a dip in CY 2015. While I-SNPs exhibited very little change between CY 2014 and CY 2016, 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.

[32] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf
[33] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf

Figure 5.1: Percentage of Enrollees Receiving Assessments, 2014-2016[34]



The percentage of SNPs assessing 100% of new enrollees decreased from 3.2% in CY 2014 to 1.9% in CY 2015, and then increased to 3.4% in CY 2016 (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 different trends across the three years. The percentage of D-SNPs assessing 100% of new enrollees decreased between CY 2014 and CY 2015, from 2.2% to 0.4%, but then increased to 1.6% in CY 2016. In comparison, the percentage of C-SNPs assessing 100% of new enrollees did not change between CY 2014 and CY 2015, staying at 0.8%, and then increasing to 1.5% in CY 2016.

Table 5.1: Percentage of SNPs Assessing 100% of New Enrollees, 2014-2016

SNP Type	2014 Percentage of SNPs Assessing 100% of New Enrollees	2014 Number of Plans Assessing 100%	2015 Percentage of SNPs Assessing 100% of New Enrollees	2015 Number of Plans Assessing 100%	2016 Percentage of SNPs Assessing 100% of New Enrollees	2016 Number of Plans Assessing 100%
All	**3.2%**	**14**	**1.9%**	**8**	**3.4%**	**17**
D-SNP	2.2%	6	0.4%	1	1.6%	5
C-SNP	0.8%	1	0.8%	1	1.5%	2
I-SNP	15.6%	7	19.4%	6	16.9%	10

The percentage of SNPs assessing 100% of eligible enrollees increased for all SNP types from CY 2014 to CY 2015 and then decreased in CY 2016, with all SNP types exhibiting an overall decrease in CY 2016 over CY 2014 (Table 5.2). C-SNPs exhibited the largest decrease across all three years, increasing from 8.2% in CY 2014 to 10.2% in CY 2015 and then decreasing to 1.6% in CY 2016, for an

[34] Measure values are weighted by metrics' denominators.

overall 6.6 percentage point decrease from CY 2014 to CY 2016. I-SNPs again had the highest percentage of SNPs assessing 100% of eligible enrollees, increasing from 16.3% in CY 2014 to 21.2% in CY 2015 and then decreasing to 15.5% in CY 2016. The percentage of D-SNPs assessing 100% of eligible enrollees stayed below the overall percentage of SNPs assessing 100% in CY 2014, CY 2015, and CY 2016, with 4.3%, 7.6%, and 1.3%, respectively.

Table 5.2: Percentage of SNPs Assessing 100% of Eligible Enrollees, 2014-2016

SNP Type	2014 Percentage of SNPs Assessing 100% of Eligible Enrollees	2014 Number of Plans Assessing 100%	2015 Percentage of SNPs Assessing 100% of Eligible Enrollees	2015 Number of Plans Assessing 100%	2016 Percentage of SNPs Assessing 100% of Eligible Enrollees	2016 Number of Plans Assessing 100%
All	**6.6%**	**28**	**9.4%**	**39**	**3.1%**	**15**
D-SNP	4.3%	11	7.6%	20	1.3%	4
C-SNP	8.2%	10	10.2%	12	1.6%	2
I-SNP	16.3%	7	21.2%	7	15.5%	9

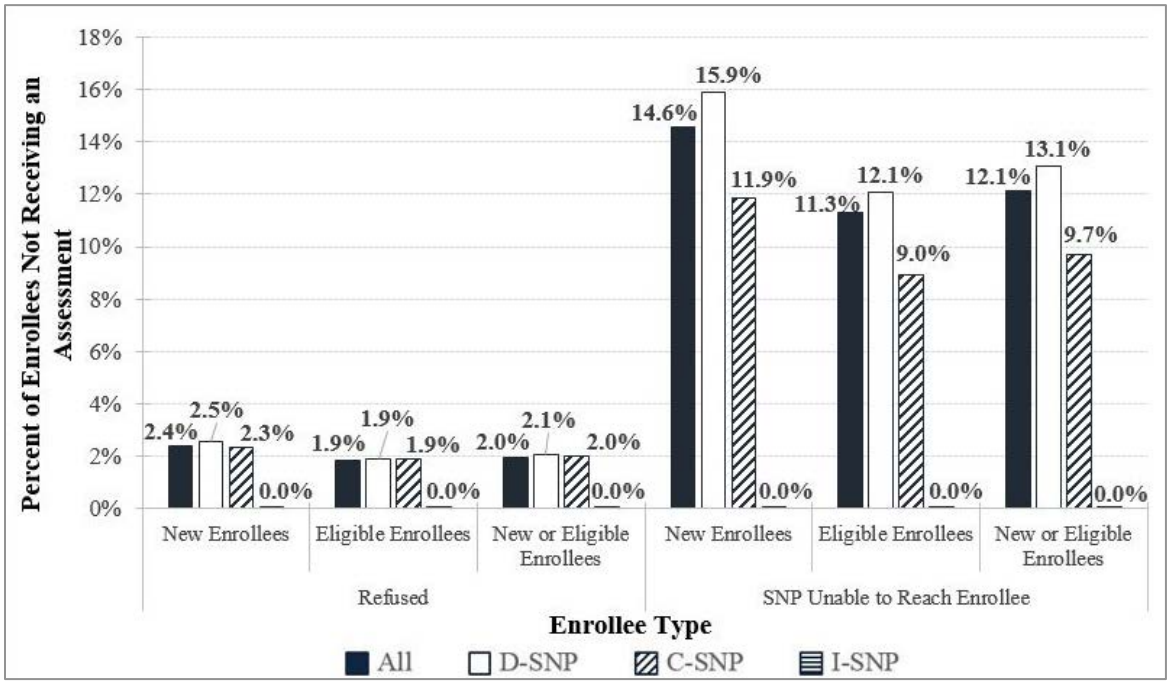
The overall percentage of plans assessing 100% of new or eligible enrollees decreased from 2.1% in CY 2014 to 0.9% in CY 2015, and then increased to 1.6% in CY 2016 (Table 5.3). The percentage of D-SNPs and C-SNPs assessing 100% of new or eligible enrollees decreased to zero in CY 2015, from 2.0% and 0.8% in CY 2014 to 0.0% in CY 2015, respectively. Then in CY 2016, the percentage of D-SNPs increased to 0.7%, while the percentage of C-SNPs remained at 0.0%. In contrast, I-SNPs increased from 6.7% of plans assessing 100% of new or eligible enrollees in CY 2014 to 12.9% in CY 2015, and then decreased to 9.8% in CY 2016.

Table 5.3: Percentage of SNPs Assessing 100% of New or Eligible Enrollees, 2014-2016

SNP Type	2014 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2014 Number of Plans Assessing 100%	2015 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2015 Number of Plans Assessing 100%	2016 Percentage of SNPs Assessing 100% of New or Eligible Enrollees	2016 Number of Plans Assessing 100%
All	**2.1%**	**9**	**0.9%**	**4**	**1.6%**	**8**
D-SNP	2.0%	5	0.0%	0	0.7%	2
C-SNP	0.8%	1	0.0%	0	0.0%	0
I-SNP	6.7%	3	12.9%	4	9.8%	6

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, with 2.4% of new enrollees refusing an initial HRA and 14.6% of new enrollees 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.

Figure 5.2: Percentage of Enrollees Not Receiving Assessments, 2016



6 PRIVATE FEE-FOR-SERVICE ENROLLMENT VERIFICATION CALLS

Failure to understand plan coverage policies could leave enrollees unprepared for the amount they must pay for needed services. CMS therefore requires that PFFS plans contact new enrollees to ensure that these enrollees understand plan coverage policies. Plans must make three documented attempts to contact new enrollees. If the plan does not reach new enrollees with the first call, they must follow up by sending an enrollment verification letter. To monitor plans' adherence to this requirement, CMS requires that plans report the number of new enrollees contacted via phone and letter. For CY 2015, this requirement was updated in Section 70.7 of the Medicare Marketing Guidelines which provides guidance that specifies that plans have the option to complete the enrollment verification process by telephone, email (if the enrollee opted-in for email), or direct mail. If the plan chooses to utilize a telephonic contact but is unable to speak with the individual or his or her appointed/authorized representative directly, the plan must either continue call attempts or follow up with a written communication.

In CY 2015 and CY 2016, all plans submitted zero values for the number of times the plan reached the prospective enrollee with the first call, due to a change in policy that allowed sponsors to reach out by email or direct mail instead. This change caused the number of times the plan reached the prospective enrollee with the first call to decrease considerably from CY 2014 to CY 2016, from 834 to zero (Table 6.1). The number of follow-up education letters sent and the number of enrollments both increased from CY 2014 to CY 2015, and then both decreased in CY 2016.

Table 6.1: Summary of PFFS Plan Enrollment Verification, 2014-2016[35]

Measure	2014 Number of Plans	2014 Measure Value	2015 Number of Plans	2015 Measure Value	2016 Number of Plans	2016 Measure Value
Number of Times the Plan Reached the Prospective Enrollee with the First Call	87	834	51	0	44	0
Number of Follow-Up Educational Letters Sent	87	891	51	1,591	44	1,108
Number of Enrollments	87	1,549	51	1,663	44	1,160

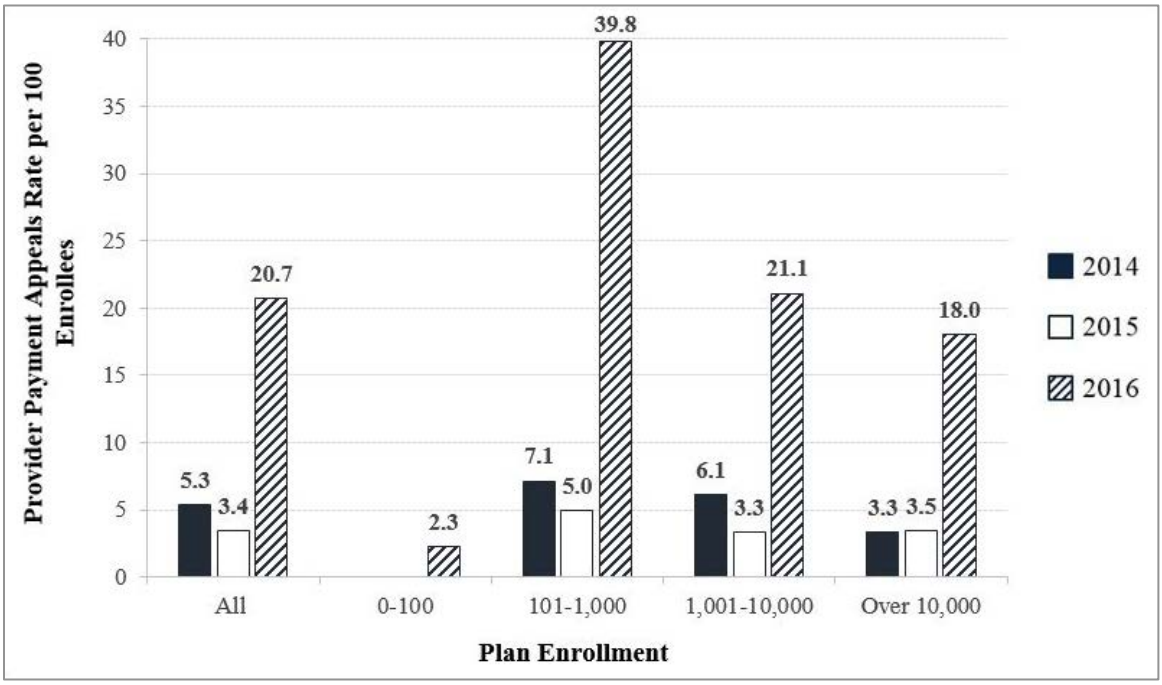
[35] Measure values are weighted by Plan Year Average Enrollment.

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

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

The overall rate of provider payment appeals per 100 enrollees decreased from 5.3 in CY 2014 to 3.4 in CY 2015, and then increased substantially to 20.7 in CY 2016 (Figure 7.1). The largest increase in provider payment appeals rates occurred for plans with 101 to 1,000 enrollees, increasing from 7.1 in CY 2014 to 39.8 in CY 2016. This large increase in the appeals rate 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.

Figure 7.1: Provider Payment Appeals Rate per 100 Enrollees, 2014-2016[36]



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 decreased sharply from 36.9% in CY 2014 to 27.3% in CY 2015, and then increased to previous levels to 34.2% in CY 2016 (Table 7.1). The percentage followed a similar pattern for plans with enrollment from (i) 101 to 1,000, and (ii) 1,001 to 10,000; the percentage of payment appeals settled in the provider's favor decreased for both groups from CY 2014 to CY 2015 and then increased from CY

[36] Measure values are weighted by Plan Year Average Enrollment.

2015 to CY 2016. The percentage of payment appeals settled in the provider's favor increased steadily from CY 2014 to CY 2016 for plans with enrollment over 10,000, with a notable increase of 12.1 percentage points in CY 2016 over CY 2015.

Table 7.1: Percentage of Payment Appeals Settled in Provider's Favor, 2014-2016[37]

Plan Enrollment	2014 Measure Value	2014 Number of Provider Payment Denials Overturned in Favor of Provider	2014 Number of Plans	2015 Measure Value	2015 Number of Provider Payment Denials Overturned in Favor of Provider	2015 Number of Plans	2016 Measure Value	2016 Number of Provider Payment Denials Overturned in Favor of Provider	2016 Number of Plans
All	**36.9%**	**5,708**	**82**	**27.3%**	**2,594**	**60**	**34.2%**	**18,237**	**52**
0-100	–	–	–	–	–	–	0.0%	0	1
101-1,000	40.0%	453	27	33.2%	166	15	36.5%	1,064	10
1,001-10,000	41.0%	4,464	51	26.0%	1,598	41	30.9%	12,573	38
Over 10,000	27.6%	791	4	28.8%	830	4	40.9%	4,600	3

The time taken to resolve payment appeals reflects whether plans are processing appeals in a timely manner. Plans with 101 to 1,000 enrollees experienced the largest decrease in the percentage of payment appeals resolved in over 60 days with 10.2% in CY 2014 to 3.5% in CY 2015 to 2.7% in CY 2016 (Table 7.2). Plans with 1,001 to 10,000 enrollees had an overall decrease in the percentage of payment appeals resolved in over 60 days decreasing from 6.7% in CY 2014 to 1.0% in CY 2015, and then slightly increasing to 2.2% in CY 2016. Plans with over 10,000 enrollees was the only category to exhibit an overall increase, albeit very small, in percentage of payment appeals resolved in over 60 days from CY 2014 to CY 2016, increasing from 2.5% to 2.6%.

Table 7.2: Percentage of Payment Appeals Resolved in Over 60 Days, 2014-2016[38]

Plan Enrollment	2014 Measure Value	2014 Number of Provider Payment Appeals Resolved in Over 60 Days	2014 Number of Plans	2015 Measure Value	2015 Number of Provider Payment Appeals Resolved in Over 60 Days	2015 Number of Plans	2016 Measure Value	2016 Number of Provider Payment Appeals Resolved in Over 60 Days	2016 Number of Plans
All	**5.6%**	**1,102**	**82**	**1.3%**	**174**	**60**	**2.4%**	**1,470**	**52**
0-100	–	–	–	–	–	–	0.0%	0	1
101-1,000	10.2%	117	27	3.5%	19	15	2.7%	81	10
1,001-10,000	6.7%	859	51	1.0%	83	41	2.2%	1,014	38
Over 10,000	2.5%	126	4	1.6%	72	4	2.6%	375	3

[37] Measure values are weighted by Plan Year Average Enrollment.
[38] Measure values are weighted by Plan Year Average Enrollment.

8 EMPLOYER GROUP PLAN SPONSORS

CMS requires plans to report data on employer groups who have an arrangement in place with the Part C organization, including the employer name, address, 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 8.1).

Table 8.1: Employers and Enrollment by Group Sponsor Type, 2014-2016[39]

Group Sponsor Type	2014 Share of Employers	2014 Share of Enrollment	2015 Share of Employers	2015 Share of Enrollment	2016 Share of Employers	2016 Share of Enrollment
Union	3.1%	2.8%	3.3%	2.9%	3.4%	3.2%
Trustee	4.5%	18.3%	4.5%	21.0%	5.2%	21.6%
Employer	92.4%	78.9%	92.2%	76.1%	91.4%	75.2%

In all three years, privately held corporations and other organizations represented the largest share of employers (Table 8.2). In CY 2014, other organizations had the highest share of employers, with 35.3% of employers; however in CY 2015 and CY 2016, the share of employers decreased to 34.2% and 30.1%, respectively, and represented the second highest share. In contrast, the share of employers represented by privately held corporations increased from 35.1% in CY 2014 to 36.5% in CY 2015, and then decreased back to 35.1% in CY 2016; however, despite this decrease, privately held corporations still represented the highest share of employers.

Table 8.2: Share of Employers by Organization Type, 2014-2016

Year	Total Employers	State Government	Local Government	Publicly Traded Org	Privately Held Corp	Non-Profit	Church Group	Other
2014	19,118	1.7%	10.3%	8.7%	35.1%	7.5%	1.4%	35.3%
2015	19,153	1.6%	10.8%	7.9%	36.5%	7.7%	1.4%	34.2%
2016	15,505	3.2%	12.8%	8.6%	35.1%	8.6%	1.5%	30.2%

State governments, other organizations, and publicly traded organizations had the largest share of employer enrollment in all three years (Table 8.3), with all three types exhibiting different trends across years. State governments comprised the largest share in all three years, increasing from 37.5% in CY 2014 to 42.3% in CY 2015, and then decreasing to 39.7% in CY 2016. Other organizations had the second highest share, decreasing from 28.0% in CY 2014 to 25.8% in CY 2015 and then increasing

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

slightly to 26.0% in CY 2016. Lastly, publicly traded organizations represented the third highest share and increased in all three years, from 15.1% in CY 2014 to 16.5% in CY 2015 to 17.6% in CY 2016.

Table 8.3: Share of Employer Enrollment by Organization Type, 2014-2016

Organization Type	2014	2015	2016
State Government	37.5%	42.3%	39.7%
Local Government	12.2%	8.7%	10.1%
Publicly Traded Organization	15.1%	16.5%	17.6%
Privately Held Corporation	2.8%	2.6%	2.1%
Non-Profit	4.2%	3.8%	4.2%
Church Group	0.2%	0.3%	0.3%
Other	28.0%	25.8%	26.0%

Most employers were reported under the Insured contract type for CY 2014, CY 2015, and CY 2016, with about 99.5% in each year (Table 8.4). Administrative Services Organizations (ASOs) and Other contract types were negligible in comparison, at or below 0.6% in all years.

Table 8.4: Employers by Contract Type, 2014-2016

Contract Type	2014 Share of Total Employers	2014 Number of Employers	2014 Enrollment	2015 Share of Total Employers	2015 Number of Employers	2015 Enrollment	2016 Share of Total Employers	2016 Number of Employers	2016 Enrollment
All	**100%**	**19,091**	**3,391,320**	**100%**	**19,106**	**3,152,527**	**100%**	**15,468**	**3,187,577**
Insured	99.5%	18,995	3,195,194	99.5%	19,003	2,950,528	99.3%	15,360	2,996,747
ASOs	0.0%	9	170,362	0.1%	12	173,968	0.1%	18	178,425
Other	0.5%	87	25,764	0.5%	91	28,031	0.6%	90	12,405

9 ENROLLMENT AND DISENROLLMENT

Beginning in CY 2012, MAOs are required to report data to CMS on their processing of enrollment and disenrollment requests, enabling CMS to evaluate whether the procedures followed by the 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 in CY 2014, CY 2015, and CY 2016, followed by internet in CY 2014 and telephonic in CY 2015 and CY 2016 (Table 9.1). While requests via telephone and OEC remained negligible all years, requests via internet decreased from 9.3% in CY 2014 to 0.0% in CY 2015 and CY 2016. At the same time, requests via paper increased from 89.5% in CY 2014 to 99.5% in CY 2015 to 99.7% in CY 2016.

Table 9.1: Share of Enrollment Requests by Request Mechanism, 2014-2016

Request Mechanism	2014	2015	2016
Paper	89.5%	99.5%	99.7%
Telephonic	0.0%	0.5%	0.3%
Internet	9.3%	0.0%	0.0%
OEC	1.2%	0.0%	0.0%

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

[40] Measure values are weighted by Contract Year Average Enrollment.
[41] https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2016_MA_Enrollment_and_Disenrollment_Guidance_12-30-2015.pdf

percentage for disenrollment requests only decreased slightly to 99.1%. In CY 2016, both percentages decreased, to 87.9% and 96.8%, respectively.

Table 9.2: Enrollment and Disenrollment Requests Completed at Initial Receipt, 2014-2016

Request	2014	2015	2016
Enrollment	97.8%	89.5%	87.9%
Disenrollment	99.7%	99.1%	96.8%

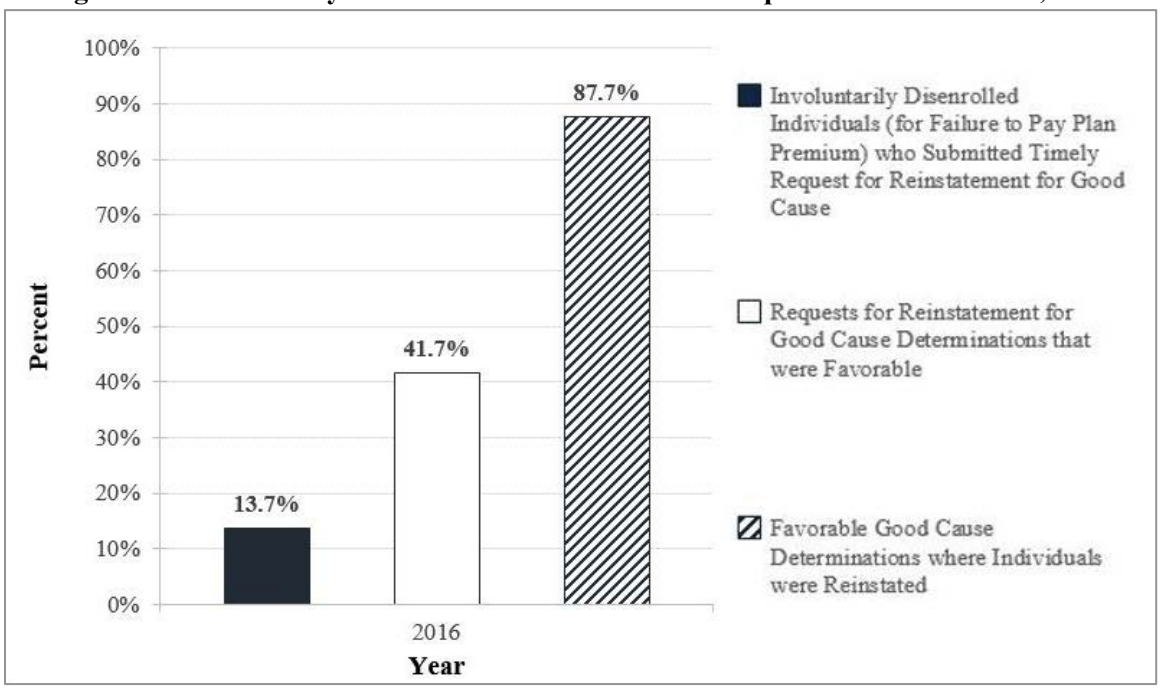
Less than 1% of enrollment and disenrollment requests were denied by MAOs in CY 2014 (Table 9.3). In CY 2015, the percentage of enrollment requests denied increased to over 1%, while the percentage of disenrollment requests decreased to 0%. In CY 2016, the percentage of enrollment requests denied increased substantially, to 60.5%, while the percentage of disenrollments denied only increased slightly, to 0.2%. 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 9.3: Enrollment and Disenrollment Requests Denied by the MAO, 2014-2016

Request	2014	2015	2016
Enrollment	0.6%	1.1%	60.5%
Disenrollment	0.1%	0.0%	0.2%

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. Of these requests for reinstatement, 41.7%, resulted in a favorable good cause determination and then 87.7% of individuals receiving a favorable good cause determination were reinstated.

Figure 9.1: Involuntary Disenrollment Reinstatement Requests for Good Cause, 2016



10 SUMMARY OF RESULTS

The results of this analysis reveal that there have been improvements in several reporting areas from CY 2014 to CY 2016, while other areas have potential for improvement in future years.

Grievances

The percentage of contracts reporting zero Part D grievances increased slightly between CY 2014 and CY 2015 and then decreased in CY 2016. In all three years, contracts with less than 500 enrollees had the highest share of contracts reporting zero Part D grievances. The grievance rate per 1,000 enrollees per month slightly decreased from CY 2014 to CY 2015, and then increased in CY 2016. For CY 2014 and 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. Grievances related to benefit packages, customer service, quality of care, and "other" were the four most frequently filed categories in all three years.

Organization Determinations and Reconsiderations

Organization determination and reconsideration request rates per 1,000 enrollees increased from CY 2014 to CY 2015, and then decreased from CY 2015 to CY 2016. 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 increasing between CY 2014 and CY 2015 and then decreasing in CY 2016. The percentage of reconsiderations with adverse outcomes exhibited the opposite trend, decreasing from CY 2014 to CY 2015 and then increasing in CY 2016, while the change in the percentage of reconsiderations with partially favorable outcomes was negligible in all years. In CY 2014, reopened organization determination decision rates increased in each quarter, while reopened reconsideration decision rates decreased in each quarter. In CY 2015 and CY 2016, 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 2014 to CY 2016, almost all organization determination requests were processed in a timely manner. At the same time, the percent of reconsideration requests processed timely had much more variation among organization types, and exhibited a substantial drop from CY 2014 to CY 2015 and then increased in CY 2016 to levels slightly below CY 2014. Withdrawn organization determinations request rates decreased in each year, while withdrawn reconsiderations request rates were stable over time. In CY 2016, 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 in each year from CY 2014 to CY 2016. This increase was most pronounced for C-SNPs. The percentage of SNPs assessing 100% of new enrollees and new or eligible enrollees decreased from CY 2014 to CY 2015, but by CY 2016, these percentages had increased to around CY 2014 levels. The percentage of SNPs assessing 100% of eligible

enrollees exhibited the opposite trend, increasing from CY 2014 to CY 2015, and then decreasing below CY 2014 levels in CY 2016. 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 Plan Enrollment Verification

The number of times the plan reached the prospective enrollee with the first call decreased considerably from CY 2014 to CY 2016. The number of follow-up education letters sent and number of enrollments both increased from CY 2014 to CY 2015. In CY 2016, both measures decreased, with number of follow-up educational letters sent remaining above CY 2014 levels and number of enrollments falling below CY 2014 levels.

PFFS Provider Payment Dispute Resolution Process

The rate of provider payment appeals per 100 enrollees decreased from CY 2014 to CY 2015, and then increased substantially in CY 2016. 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 decreased from CY 2014 to CY 2015, and then increased in CY 2016 to slightly below CY 2014 levels. The percentage of payment appeals resolved in over 60 days followed a similar pattern, decreasing from CY 2014 to CY 2015, and then increasing in CY 2016.

Employer Group Plan Sponsors

Between CY 2014, CY 2015, and CY 2016, 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 the internet and telephone. From CY 2014 to CY 2016, the share of internet requests substantially decreased, while the share of paper and telephonic requests increased. Nearly all enrollment and disenrollment requests were complete at the time of initial receipt in CY 2014, however, in CY 2015, the percent of enrollment requests complete at the time of initial receipt decreased noticeably, while the percent of disenrollment requests complete at the time of initial receipt stayed relatively stable. In CY 2016, the percent of enrollment and disenrollment requests complete at the time of initial receipt both decreased. Nearly all enrollment and disenrollment requests were accepted by MAOs in CY 2014, and 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.

Around 14% of individuals involuntarily disenrolled for failure to pay plan premium submitted a timely request for reinstatement for good cause, and of these individuals, 42%, of these requests for reinstatement received favorable good cause determinations. The majority, over 88%, of favorable good cause determinations resulted in the individual being reinstated.

11 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 2016 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 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21 = 0
Table 3.2: Contracts Reporting Zero Grievances by Enrollment	Contracts Reporting Zero Grievances, by Enrollment Category	Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21 = 0
Table 3.3: Grievance Rates per 1,000 Enrollees per Month by Organization Type	Grievance Rate, by Organization Type	[(Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21) / Year Average Enrollment * 1,000] * 30 / Number of days in the reporting year
Table 3.4: Grievance Rates per 1,000 Enrollees per Month by Category	Overall Grievance Rate	[(Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21) / Year Average Enrollment * 1,000] * 30 / Number of days in the reporting year
	Enrollment / Disenrollment Grievance Rate	(5.5 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Benefit Package Grievance Rate	(5.7 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Access Grievance Rate	(5.9 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Marketing Grievance Rate	(5.11 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Customer Service Grievance Rate	(5.13 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Organization Determination and Reconsideration Process Grievance Rate	(5.15 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Quality Of Care Grievance Rate	(5.17 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	"Other" Grievance Rate	(5.21 / Year Average Enrollment * 1,000) * 30 / Number of days in the reporting year
	Expedited Grievance Rate	(5.3 / Year Average Enrollment * 1,000) * 30 / 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	5.5 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
	Share of Grievances that were Benefit Package Grievances	5.7 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
	Share of Grievances that were Access Grievances	5.9 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
	Share of Grievances that were Marketing Grievances	5.11 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
	Share of Grievances that were Customer Service Grievances	5.13 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
	Share of Grievances that were Organization Determination and Reconsideration Process Grievances	5.15 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)

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	5.17 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
	Share of Grievances that were "Other" Grievances	5.21 / (Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21)
Figure 3.1: Grievance Rates per 1,000 Enrollees per Month	Grievance Rate	[(Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21) / Year Average Enrollment * 1,000] * 30 / Number of days in the reporting year
Figure 3.2: Grievance Rates per 1,000 Enrollees per Month, by Year and Quarter	Grievance Rate	[(Sum of 5.5, 5.7, 5.9, 5.11, 5.13, 5.15, 5.17, and 5.21) / Year Average Enrollment * 1,000] * 30 / 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	(Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8) / 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) / (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) / (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) / (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	(Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18) / 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) / (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) / (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) / (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	(Sum of 6.3, 6.4, 6.5, 6.6, 6.7, and 6.8) / Year Average Enrollment * 1,000
Figure 4.2: Reconsideration Request Rates per 1,000 Enrollees, by Year and Quarter	Reconsideration Request Rate	(Sum of 6.13, 6.14, 6.15, 6.16, 6.17, and 6.18) / Year Average Enrollment * 1,000
Figure 4.3: Reopened Decision Rates per 1,000 Enrollees, by Year and Quarter	Reopened Organization Determinations Request Rate	(6.27 = Organization Determination) / Year Average Enrollment * 1,000
	Reopened Reconsiderations Request Rate	(6.27 = Reconsideration) / Year Average Enrollment * 1,000

Table or Figure Name	Metric	Data Elements
Figure 4.4: Withdrawn and Dismissed Request Rates per 1,000 Enrollees	Withdrawn Organization Determinations Rate	6.9 / Year Average Enrollment * 1,000
	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 ≥1) / (Total Number of SNPs with 13.1 ≥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 ≥ 1) / (Total Number of SNPs with 13.2 ≥ 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) ≥ 1] / (Total Number of SNPs with (13.1 + 13.2) ≥ 1)
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)
Figure 5.2: Percentage of Enrollees Not Receiving Assessments, 2016	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)

PFFS Enrollment Verification

Table or Figure Name	Metric	Data Elements
Table 6.1: Summary of PFFS Plan Enrollment Verification	Number of Times the Plan Reached the Prospective Enrollee with the First Call	8.1
	Number of Follow-Up Educational Letters Sent	8.2
	Number of Enrollments	8.3

PFFS Provider Payment Dispute

Table or Figure Name	Metric	Data Elements
Table 7.1: 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 7.2: 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 7.1: 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 8.1: 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 8.2: 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 or Figure Name	Metric	Data Elements
Table 8.3: 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)
	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 8.4: 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 9.1: 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 9.2: 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 9.3: 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
Figure 9.1: Involuntary Disenrollment Reinstatement Requests for Good Cause	Percent of Involuntarily Disenrolled Individuals (for Failure to Pay Plan Premium) who Submitted Timely Request for Reinstatement for Good Cause	2. E / 2.D
	Percent of Requests for Reinstatement for Good Cause Determinations that were Favorable	2.F / 2.E

Table or Figure Name	Metric	Data Elements
Figure 9.1: Involuntary Disenrollment Reinstatement Requests for Good Cause (cont.)	Percent of Favorable Good Cause Determinations where Individuals were Reinstated	2.G / 2.F