2021 Medicare-Medicaid Plan Performance Data Technical Notes

Updated – February 2021

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Introduction

Under the Medicare-Medicaid Financial Alignment Initiative (FAI) capitated model, the Centers for Medicare & Medicaid Services (CMS) is collecting a variety of measures that examine plan performance and the quality of care provided to enrollees. The Medicare-Medicaid Plan (MMP) performance data published here represent currently available data on MMP performance on certain Medicare Parts C and D quality measures as well as select CMS core measures that MMPs are required to report. The data show MMP performance on quality measures during 2019 and the results of surveys of MMP enrollees conducted in 2019; however, data are limited due to the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) (see further details below). The measures are organized into five domains that largely track the potential domains under a future MMP star ratings system described in the Medicare-Medicaid Plan Quality Ratings Strategy published in November 2015.

The scope of the measures displayed here is limited, particularly in the area of long term services and supports. Our longer term intent is to add measures and use performance data in future years to help consumers select an MMP. For now, however, we urge caution in using any of these data for comparative or MMP selection purposes.

In addition, we note that the differences in MMP eligibility across states participating in the FAI, and the differences in the characteristics of enrollees in particular MMPs, may limit the ability to compare MMP performance across demonstrations. For example, enrollment in MMPs in Massachusetts is limited to individuals under the age of 65 at the time of enrollment, while in South Carolina, only individuals aged 65 or older living in the community can enroll. In the New York Fully Integrated Duals Advantage (FIDA) demonstration, only individuals who meet state criteria for requiring institutional or community-based long term care can enroll, and in the New York FIDA-IDD demonstration, only individuals with intellectual and developmental disabilities (IDD) can enroll.[1]

Questions about the MMP performance data should be sent to: mmcocapsmodel@cms.hhs.gov.

State Weighted Averages

Within the MMP Performance Data File, state weighted averages are provided for each measure. Depending on the measure type, the averages are weighted by the enrollment of each MMP with valid data for the measure or by the eligible population for the measure as reported for each MMP. More specifically, averages for measures from the Health Outcomes Survey (HOS) are weighted using the total number of members enrolled in February 2019 to align with the timeframe during which the survey's sampling frame was drawn. Averages for the Call Center Foreign Language Interpreter and TTY Availability measures are weighted using the total number of members enrolled in February 2020 to align with the timeframe during which call center monitoring commenced. Averages for all other measures are weighted using each MMP's eligible population for the measure (e.g., the denominator for each MMP).

Differences between the 2020 and 2021 MMP Performance Data File and Technical Notes

There were a few changes between the 2020 and 2021 versions of the MMP Performance Data File and Technical Notes. This section provides a summary of the notable differences.

Revisions:

- Where applicable, measure numbers, measure specifications, and related attachments were updated to comport with the Medicare 2021 Part C & D Star Ratings Technical Notes.
- The Plan All-Cause Readmissions measure was renumbered to DMC23 to align with the measure's temporary transition to the display page for the 2021 and 2022 Star Ratings.
- The Controlling Blood Pressure measure was renumbered to DMC16.

Additions:

- No measures were added to the MMP Performance Data File and Technical Notes.

[1] The New York FIDA demonstration ended as scheduled on December 31, 2019. The data included for New York FIDA in the 2021 MMP Performance Data File represent the final year of measure reporting.

Removals:

- No measures were removed from the MMP Performance Data File and Technical Notes.

Additionally, due to the COVID-19 PHE, not all of the measures listed in the 2021 MMP Performance Data File and Technical Notes were reported for the applicable reporting period. As a result of the challenges and safety concerns regarding data collection for Healthcare Effectiveness Data and Information Set (HEDIS) measures and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey due to the PHE, HEDIS reporting was suspended for the 2019 measurement year and CAHPS survey administration was suspended for the 2020 survey year.[2] Within the technical notes, measure frameworks and details for HEDIS and CAHPS measures were updated to align with measure steward specifications for the data time frame noted, even though data were not actually reported for those time frames due to the PHE. These measures are denoted with an asterisk (*) by the measure name, and by the message "data not reported due to PHE" in the data time frame field.

Framework and Definitions for the Domain and Measure Details Section

This section contains the formatting framework and definition of each sub-section that is used to describe the domain and measure details on the following pages.

Domain: The name of the domain to which the measures following this heading belong

Measure: The measure ID and common name of the measure

Title	Description
Label for Data:	Optional – The label that provides a fuller title for the measure.
Description:	The English language description for the measure.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS/HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS are unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Case-mix Adjusted:	Indicates if the data are case-mix adjusted.
NQF #:	The National Quality Framework (NQF) number for the measure or "Not Applicable" if there is no equivalent measure with NQF endorsement.
Data Display:	The format used to the display the numeric data.

[2] Reporting for the HEDIS/HOS measures (Reducing the Risk of Falling, Improving Bladder Control, and Monitoring Physical Activity) was not impacted by the COVID-19 PHE for the data time frame included in the 2021 MMP Performance Data File and Technical Notes.

Domain 1: Coordination of Care and Long Term Services and Supports

Measure: M21 - Comprehensive Health Risk Assessment

Title	Description
Description:	Percent of members who received a health risk assessment within 90 days of enrollment in the MMP.
Metric:	This measure captures the total number of members with a health risk assessment completed within the first 90 days of enrollment. When calculating the completion rate, the members that were unreachable (after at least three contact attempts) and the members that refused the assessment are subtracted from the denominator.
Primary Data Source:	Measure Core 2.1 from the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements
Data Source Category:	Health and Drug Plans
Exclusions:	Members that were unreachable (after at least three contact attempts) and members that refused the assessment are subtracted from the denominator.
General Notes:	A full description of the measure specifications is available in the CY 2019 Core Reporting Requirements.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: M32 - Care Plan Completion

Title	Description
Description:	Percent of members who had a care plan completed within 90 days of enrollment in the MMP.
Metric:	This measure captures the total number of members with a care plan completed within the first 90 days of enrollment. When calculating the completion rate, the members that were unreachable (after at least three contact attempts) and the members that refused the care plan are subtracted from the denominator.
Primary Data Source:	Measure Core 3.2 from the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements
Data Source Category:	Health and Drug Plans
Exclusions:	Members that were unreachable (after at least three contact attempts) and members that refused the care plan are subtracted from the denominator.
General Notes:	A full description of the measure specifications is available in the CY 2019 Core Reporting Requirements.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C10 - Care for Older Adults – Functional Status Assessment*

Title	Description
Label for Data:	Yearly Assessment of How Well MMP Members Are Able to Do Activities of Daily Living
Description:	Percent of members whose doctor has done a functional status assessment to see how well they are able to do Activities of Daily Living such as dressing, eating, and bathing.
HEDIS Label:	Care for Older Adults (COA) – Functional Status Assessment
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 121
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one functional status assessment (Functional Status Assessment Value Set) during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMPs whose enrollment was less than 30 as of the February 2019 Monthly Enrollment by Plan Report were excluded from this measure. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Domain 2: Managing Chronic (Long Term) Conditions/Health Outcomes

Measure: C09 - Care for Older Adults – Medication Review*

Title	Description
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 121
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMPs whose enrollment was less than 30 as of the February 2019 Monthly Enrollment by Plan Report were excluded from this measure. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
Case-mix adjusted:	No

Title	Description
NQF #:	0553
Data Display:	Percentage with no decimal place

Measure: C11 - Care for Older Adults – Pain Assessment*

Title	Description
Label for Data:	Yearly Pain Screening or Pain Management Plan
Description:	Percent of plan members who had a pain screening at least once during the year.
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 121
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMPs whose enrollment was less than 30 as of the February 2019 Monthly Enrollment by Plan Report were excluded from this measure. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C12 - Osteoporosis Management in Women who had a Fracture*

Title	Description
Label for Data:	Osteoporosis Management
Description:	Percent of female members who broke a bone and got screening or treatment for osteoporosis within 6 months.
HEDIS Label:	Osteoporosis Management in Women Who Had a Fracture (OMW)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 223
Metric:	The percentage of woman MMP enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the Episode Date. • Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the Episode Date. • Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the Episode Date.

Title	Description
	• Members who are enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. • Members living long-term in an institution any time during the intake period through the end of the measurement year. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 67 - 85 and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0053
Data Display:	Percentage with no decimal place

Measure: C13 - Diabetes Care – Eye Exam*

Title	Description
Label for Data:	Eye Exam to Check for Damage from Diabetes
Description:	Percent of members with diabetes who had an eye exam to check for damage from diabetes during the year.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 182
Metric:	The percentage of diabetic MMP enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0055

Title	Description
Data Display:	Percentage with no decimal place

Measure: C14 - Diabetes Care – Kidney Disease Monitoring*

Title	Description
Label for Data:	Kidney Function Testing for Members with Diabetes
Description:	Percent of members with diabetes who had a kidney function test during the year.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 182
Metric:	The percentage of diabetic MMP enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0062
Data Display:	Percentage with no decimal place

Measure: C15 - Diabetes Care – Blood Sugar Controlled*

Title	Description
Label for Data:	Members with Diabetes whose Blood Sugar is Under Control
Description:	Percent of members with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 182
Metric:	The percentage of diabetic MMP enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year

Title	Description
	(numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0059
Data Display:	Percentage with no decimal place

Measure: C16 - Rheumatoid Arthritis Management*

Title	Description
Label for Data:	Rheumatoid Arthritis Management
Description:	Percent of members with rheumatoid arthritis who got one or more prescriptions for an anti-rheumatic drug.
HEDIS Label:	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 218
Metric:	The percentage of MMP members who were diagnosed with rheumatoid arthritis during the measurement year (denominator), and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude from reporting members age 66 and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. – Use the run date of the file to determine if a member had an LTI flag during the measurement year.

Title	Description
	Exclude members age 81 and older as of December 31 of the measurement year with frailty. Exclude members age 66-80 years as of December 31 of the measurement year with advanced illness and frailty. Members must meet both the frailty and advanced illness criteria to be excluded. (optional) • A diagnosis of HIV (HIV Value Set; HIV Type 2 Value Set) any time during the member's history through December 31 of the measurement year. • Female members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0054
Data Display:	Percentage with no decimal place

Measure: C17 - Reducing the Risk of Falling

Title	Description
Label for Data:	Reducing the Risk of Falling
Description:	Percent of members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS 2019 Specifications for The Medicare Health Outcomes Survey Volume 6, page 39
Metric:	The percentage of members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).
Primary Data Source:	HEDIS / HOS
Data Source Description:	Cohort 20 Follow-up Data collection (2019) and Cohort 22 Baseline data collection (2019). HOS Survey Question 48: A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? HOS Survey Question 49: Did you fall in the past 12 months? HOS Survey Question 50: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 51: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.
Data Source Category:	Survey of Enrollees
Exclusions:	Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data

Title	Description
	available." Members with evidence from CMS administrative records of a hospice start date are excluded. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	04/01/2019 – 07/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C18 - Improving Bladder Control

Title	Description
Label for Data:	Improving Bladder Control
Description:	Percent of members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.
HEDIS Label:	Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS 2019 Specifications for The Medicare Health Outcomes Survey Volume 6, page 33
Metric:	The percentage of members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).
Primary Data Source:	HEDIS / HOS
Data Source Description:	Cohort 20 Follow-up Data collection (2019) and Cohort 22 Baseline data collection (2019). HOS Survey Question 42: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 45: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? Member choices must be as follows to be included in the denominator: • Q42 = "Yes." • Q45 = "Yes" or "No." The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider. Member choice must be as follows to be included in the numerator: • Q45 = "Yes."
Data Source Category:	Survey of Enrollees
Exclusions:	Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.

Title	Description
Data Time Frame:	04/01/2019 – 07/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C19 - Medication Reconciliation Post-Discharge*

Title	Description
Label for Data:	The MMP Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Description:	This shows the percent of members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.
HEDIS Label:	Medication Reconciliation Post-Discharge (MRP)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 300
Metric:	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2019 – 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0097
Data Display:	Percentage with no decimal place

Measure: C20 - Statin Therapy for Patients with Cardiovascular Disease*

Title	Description
Label for Data:	The MMP Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Description:	This rating is based on the percent of members with heart disease who get the right type of cholesterol-lowering drugs. MMPs can help make sure their members are prescribed medications that are more effective for them.
HEDIS Label:	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 173
Metric:	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria:

Title	Description
	• Female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. • In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year. • ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. – A dispensed dementia medication (Dementia Medications List).
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: D10 - Medication Adherence for Diabetes Medications

Title	Description
Label for Data:	Taking Diabetes Medication as Directed
Description:	Percent of members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The MMP, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug,* a *sulfonylurea drug,* a *thiazolidinedione drug*, a *DPP-IV inhibitor,* an *incretin mimetic drug,* a *meglitinide drug,* or an *SGLT2 inhibitor*. Members who take insulin are not included.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes

Title	Description
	medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to Medicare by June 30, 2020 with dates of service from January 1, 2019-December 31, 2019. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.

Title	Description
	The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment C: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0541
Data Display:	Percentage with no decimal place

Measure: D11 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	Percent of members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The MMP, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACE (angiotensin converting enzyme) inhibitor*, an *ARB (angiotensin receptor blocker),* or a *direct renin inhibitor* drug.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).

Title	Description
	See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to Medicare by June 30, 2020 with dates of service from January 1, 2019-December 31, 2019. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment C: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.

Title	Description
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0541
Data Display:	Percentage with no decimal place

Measure: D12 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Data:	Taking Cholesterol Medication as Directed
Description:	Percent of members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The MMP, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their statin medication occurs at least 91 days before the end of the enrollment period. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to Medicare by June 30, 2020 with dates of service from January 1, 2019-December 31, 2019. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available).

Title	Description
	• RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year)
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment C: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0541
Data Display:	Percentage with no decimal place

Measure: D13 - MTM Program Completion Rate for CMR

Title	Description
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the MMP. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.

Title	Description
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract. Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	Additional data sources used to calculate the measure: Medicare Enrollment Database (EDB) File. Data were reported by contracts to CMS per the Part D Reporting Requirements. Validation of these data was performed retrospectively during the 2020 Data Validation cycle.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts that terminated effective December 31, 2019 are excluded from the measure and listed as "Not reportable due to plan termination." Contracts that terminated after December 31, 2019 but before the deadline to submit data validation results to CMS (June 30, 2020) are excluded and listed as "No data available." The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation.

Title	Description
	MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any of the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation: • HICN (or MBI) or RRB Number (Element B) • Met the specified targeting criteria per CMS – Part D requirements (Element F) • Date of MTM program enrollment (Element I) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element K) • Received annual CMR with written summary in CMS standardized format (Element P) • Date(s) of CMR(s) (Element Q) MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as “CMS identified issues with this plan's data.” Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov. Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "Not enough data available.”
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: D14 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Data:	The MMP Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of members with diabetes who take the most effective cholesterol-lowering drugs. MMPs can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills during the measurement period (denominator). The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA).

Title	Description
	See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to Medicare for dates of service from January 1, 2019-December 31, 2019, and processed by June 30, 2020. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year)
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: DMC01 - Follow-up Visit after Hospital Stay for Mental Illness (within 30 days of discharge)*

Title	Description
Description:	The percent of members who were hospitalized for certain mental health disorders who received follow-up care within 30 days of leaving the hospital.
HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 245

Title	Description
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health illness or intentional self-harm diagnosis (denominator) and who had a follow-up visit with a mental health practitioner within 30 days after discharge (numerator).
Exclusions:	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. These discharges are excluded from the measure because re-hospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF#:	0576
Data Display:	Percentage with no decimal place

Measure: DMC02 - Antidepressant Medication Management (6 months)*

Title	Description
Description:	The percent of members with a diagnosis of major depression who received an antidepressant medication for at least 180 days.
HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 232
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (numerator).
Exclusions:	Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population: • An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. • An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set with Major Depression Value Set. • A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set with Major Depression Value Set. • An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Outpatient POS Value Set with Major Depression Value Set. • An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set with Major Depression Value Set.

Title	Description
	• An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with Major Depression Value Set. • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set with Major Depression Value Set. • A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with Major Depression Value Set. • Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set with Major Depression Value Set. • Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set with Major Depression Value Set. • A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Telehealth POS Value Set with Major Depression Value Set. • An observation visit (Observation Value Set) with any diagnosis of major depression (Major Depression Value Set). • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set). • An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with ED POS Value Set with Major Depression Value Set. • A telephone visit (Telephone Visits Value Set) with any diagnosis of major depression (Major Depression Value Set).
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF#:	0105
Data Display:	Percentage with no decimal place

Measure: DMC13 - Initiation of Alcohol or other Drug Treatment*

Title	Description
Description:	The percent of members with a new episode of alcohol or other drug (AOD) abuse or dependence who received treatment within 14 days of being diagnosed as needing treatment.
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 404
Metric:	The percentage of adolescent and adult members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case Mix Adjusted:	No

Title	Description
NQF #:	0004
Data Display:	Percentage with no decimal place

Measure: DMC14 - Engagement of Alcohol or other Drug Treatment*

Title	Description
Description:	The percent of members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and had two or more services for alcohol or drug treatment within 34 days of their first visit.
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 404
Metric:	The percentage of adolescent and adult members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.
Exclusions:	None listed.
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF#:	0004
Data Display:	Percentage with no decimal place

Measure: DMC16 - Controlling Blood Pressure*

Title	Description
Label for Data	Controlling High Blood Pressure
Description:	Percent of members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 158
Metric:	The percentage of MMP members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year (numerator).
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded:

Title	Description

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years).
   - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
   - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
   - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim.
   - A dispensed dementia medication (Dementia Medications List).

(optional)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2019 - 12/31/2019 (data not reported due to PHE)

General Trend: Higher is better

Case Mix Adjusted: No

NQF#: 0018

Data Display: Percentage with no decimal place

Measure: DMC23 - Plan All-Cause Readmissions*

Title	Description
Label for Data:	Readmission to a Hospital within 30 Days of Being Discharged (lower ratios are better because it means fewer members are being readmitted than would be expected for the MMP's population)
Description:	The ratio of the MMP's observed readmission rate to the MMP's expected readmission rate. The readmission rate is based on the percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the

Title	Description
	hospital the first time. This "risk-adjustment" helps make the comparisons between MMPs fair and meaningful.)
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 507
Metric:	The MMP's observed readmission rate (i.e., the percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days), as compared to the readmission rate that the MMP is expected to have given its case mix. This analysis is referred to as the observed-to-expected (O/E) ratio. The O/E ratio is calculated as the observed readmission rate divided by the expected readmission rate. To calculate the observed readmission rate and expected readmission rate, the following formulas were used: 1. The observed readmission rate equals the sum of the count of 30-day readmissions across all age bands divided by the sum of the count of index stays across all age bands. 2. The expected readmission rate equals the sum of the expected readmissions rates across all age bands, weighted by the percentage of index stays in each age band. See Attachment B: Calculating Measure DMC23: Plan All-Cause Readmissions for the complete formula.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. As listed in the HEDIS Technical Specifications. Additionally, CMS has excluded contracts whose denominator (i.e., number of index stays) was 150 or less.
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Lower is better
Case-mix adjusted:	Yes
NQF #:	1768
Data Display:	Numeric with two decimal places

Domain 3: Member Experience with Integrated Plan and Care Providers

Measure: C21 - Getting Needed Care*

Title	Description
Label for Data:	Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how easy it is for members to get needed care, including care from specialists.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Title	Description
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal place

Measure: C22 - Getting Appointments and Care Quickly*

Title	Description
Label for Data:	Getting Appointments and Care Quickly (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how quickly members get appointments and care.
Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better

Title	Description
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal place

Measure: C23 - Customer Service*

Title	Description
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how easy it is for members to get information and help from the MMP when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal place

Measure: C24 - Rating of Health Care Quality*

Title	Description
Label for Data:	Member's Rating of Health Care Quality (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned from members who rated the quality of the health care they received.
Metric:	This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS

Title	Description
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal place

Measure: C25 - Rating of Health Plan*

Title	Description
Label for Data:	Member's Rating of Health Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned from members who rated the health plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal place

Measure: C26 - Care Coordination*

Title	Description
Label for Data:	Coordination of Members' Health Care Services (on a scale from 0 to 100)

Title	Description
Description:	Percent of the best possible score the MMP earned on how well the MMP coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Data Source Category:	Survey of Enrollees
Exclusions	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	Not Applicable
Data Display:	Numeric with no decimal place

Measure: OHP5 - Satisfaction with Care Coordination*

Title	Description
Description:	Percent of members who are very satisfied with the help they received coordinating the care from different doctors and health providers.
Metric:	The percentage of survey respondents who answered "Very satisfied" to the measure question on how satisfied the respondent was with the care coordination services they received in the last 6 months. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • How satisfied are you with the help you received to coordinate your care in the last 6 months?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure.

Title	Description
	Only MMPs with at least 11 “Yes” answers to the screening question (In the last 6 months, did anyone from your health plan, doctor’s office, or clinic help coordinate your care among these doctors or other health providers?) and have at least 11 “Very satisfied” responses on the measure question have a rate displayed.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: CC10 - Access to Medical Equipment*

Title	Description
Description:	Percent of members who said it was always easy to get or replace medical equipment that they needed.
Metric:	The percentage of survey respondents who answered “Always” to the measure question on how easy it was to get or replace medical equipment. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • In the last 6 months, how often was it easy to get or replace the medical equipment you needed through your health plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. Only MMPs with at least 11 “Yes” answers to the screening question (In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, wheelchair or oxygen equipment?) and at least 11 “Always” responses on the measure question have a rate displayed.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: CC14 - Access to Personal Care*

Title	Description
Description:	Percent of members who said it was always easy to get personal care at home.
Metric:	The percentage of survey respondents who answered “Always” to the measure question on how often it was easy to obtain access to personal care or aide assistance at home. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often was it easy to get personal care or aide assistance at home through your care plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure.

Title	Description
	Only MMPs with at least 11 “Yes” answers to the screening question (Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?) and 11 “Always” responses on the measure question have a rate displayed.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: MH3 - Access to Mental Health Treatment*

Title	Description
Description:	Percent of members who said it was always easy to get treatment or counseling for a personal or family problem.
Metric:	The percentage of survey respondents who answered “Always” to the measure question on how often it was easy to get the treatment or counseling they needed. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure.
	Only MMPs with at least 11 “Yes” answers to the screening question (In the last 6 months, did you need any treatment or counseling for a personal or family problem?) and at least 11 “Always” responses on the measure question have a rate displayed.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: D07 - Rating of Drug Plan*

Title	Description
Label for Data:	Members’ Rating of Drug Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned from members who rated the prescription drug plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS

Title	Description
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	Not Applicable
Data Display:	Numeric with no decimal place

Measure: D08 - Getting Needed Prescription Drugs*

Title	Description
Label for Data:	Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how easy it is for members to get the prescription drugs they need using the MMP.
Metric:	This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
Data Source Category:	Survey of Enrollees
Exclusions	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	Not Applicable

Title	Description
Data Display:	Numeric with no decimal place

Domain 4: Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening*

Title	Description
Label for Data:	Breast Cancer Screening
Description:	Percent of female members aged 52-74 who had a mammogram during the past two years.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 99
Metric:	The percentage of women MMP enrollees 50 to 74 years of age (denominator) who had a mammogram to screen for breast cancer (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set),nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. – A dispensed dementia medication (Dementia Medications List). (optional) Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: • Bilateral mastectomy (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set). • Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set) • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).

Title	Description
	• Any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service: 1. Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same procedure). 2. Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same procedure). 3. Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a left-side modifier (Clinical Left Modified Value Set) (same procedure) 4. Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a right-side modifier (Clinical Right Modified Value Set) (same procedure) 5. Absence of the left breast (Absence of Left Breast Value Set) 6. Absence of the right breast (Absence of Right Breast Value Set) 7. Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) 8. Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	2372
Data Display:	Percentage with no decimal place

Measure: C02 - Colorectal Cancer Screening*

Title	Description
Label for Data:	Colorectal Cancer Screening
Description:	Percent of members aged 50-75 who had appropriate screening for colon cancer.
HEDIS Label:	Colorectal Cancer Screening (COL)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 109
Metric:	The percentage of MMP enrollees aged 50 to 75 (denominator) who had appropriate screenings for colorectal cancer (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (the diagnosis must be on the discharge claim) on different dates of service, with an advanced

Title	Description
	illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. – A dispensed dementia medication (Dementia Medications List).
	(optional) Either of the following any time during the member's history through December 31 of the measurement year: - Colorectal cancer (Colorectal Cancer Value Set) - Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set)
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
NQF #:	0034
Data Display:	Percentage with no decimal place

Measure: C03 - Annual Flu Vaccine*

Title	Description
Label for Data:	Yearly Flu Vaccine
Description:	Percent of members who got a vaccine (flu shot).
Metric:	The percentage of sampled members (denominator) who received an influenza vaccination (numerator).
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question number varies depending on survey type): • Have you had a flu shot since July 1, 2019?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	This measure is not case-mix adjusted. CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2020 - 05/2020 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C06 - Monitoring Physical Activity

Title	Description
Label for Data:	Monitoring Physical Activity
Description:	Percent of members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
HEDIS Label:	Physical Activity in Older Adults (PAO)

Title	Description
Measure Reference:	NCQA HEDIS 2019 Specifications for The Medicare Health Outcomes Survey Volume 6, page 37
Metric:	The percentage of sampled members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase or maintain their level exercise or physical activity (numerator).
Primary Data Source:	HEDIS / HOS
Data Source Description:	Cohort 20 Follow-up Data collection (2019) and Cohort 22 Baseline data collection (2019). HOS Survey Question 46: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise for physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. HOS Survey Question 47: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 46 are excluded from results calculations for Question 47. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded. This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	04/01/2019 - 07/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C07 - Adult BMI Assessment*

Title	Description
Label for Data:	Checking to See if Members Are at a Healthy Weight
Description:	Percent of members with an outpatient visit who had their "Body Mass Index" (BMI) calculated from their height and weight and recorded in their medical record.
HEDIS Label:	Adult BMI Assessment (ABA)
Measure Reference:	NCQA HEDIS 2020 Technical Specifications Volume 2, page 72
Metric:	The percentage of MMP enrollees 18-74 years of age (denominator) who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Female members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

Title	Description
Data Time Frame:	01/01/2019 - 12/31/2019 (data not reported due to PHE)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Domain 5: Plan Performance on Administrative Measures

Measure: C27 - Complaints about the Health Plan

Title	Description
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of members filing complaints with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
Data Source Category:	CMS Administrative Data
Exclusions:	On March 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Lower is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Numeric with two decimal places

Measure: C28 - Members Choosing to Leave the Plan

Title	Description
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because it means fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2019–December 31, 2019 (numerator) divided by all members enrolled in the contract at any time during 2019 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled MMPs that terminated effective December 31, 2019 are not included in the measure. MMPs with less than 1,000 enrollees are also excluded from this measure.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2019 and 12/31/2019 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available".
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Lower is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C30 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	Percent of members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.
Metric:	Percent of appeals timely processed by the MMP (numerator) out of all the MMP's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and dismissed because the MMP agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed/MMP Agreed to Cover])) * 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is "Not enough data available." Dismissed for reasons other than the MMP agreed to cover and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed/MMP Agreed to Cover]) - [Late]
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C31 - Reviewing Appeals Decisions

Title	Description
Label for Data:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	This rating shows how often an **independent reviewer** thought the health plan's decision to deny an appeal was fair. This includes appeals made by members and out-of-network providers. (This rating is not based on how often the MMP denies appeals, but rather *how fair* the MMP is when they deny an appeal.)
Metric:	Percent of appeals where an MMP's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the MMP's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: ([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)

Title	Description
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2020, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2020 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: D02 - Appeals Auto–Forward

Title	Description
Label for Data:	Drug Plan Fails to Make Timely Decisions about Appeals (for every 10,000 members)
Description:	Rate of members who failed to get a timely response when they made an appeal request to the drug plan about a decision to refuse payment or coverage. If you would like more information about Medicare appeals, click on http://www.medicare.gov/claims-and-appeals/index.html
Metric:	This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because the MMP exceeded decision timeframes for coverage determinations or redeterminations. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000. There is no minimum number of cases required to receive a rating.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Rates are not calculated for contracts with average enrollment less than 800 enrollees during the measurement period. Cases the IRE remands back to the MMP are not included in these data.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Lower is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Numeric with 1 decimal place

Measure: D03 - Appeals Upheld

Title	Description
Label for Data:	Fairness of Drug Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	How often an **independent reviewer** thought the drug plan's decision to deny an appeal was fair. This includes appeals made by members and out-of-network providers. (This rating is not based on how often the MMP denies appeals, but rather *how fair* the MMP is when they deny an appeal.)
Metric:	This measure is defined as the percent of IRE confirmations of upholding the MMPs' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100. Total number of cases reviewed is defined as all cases received by the IRE during the timeframe and receiving a decision before May 1, 2020. The denominator is equal to the number of cases upheld, fully reversed, and partially reversed. Dismissed, remanded, and withdrawn cases are not included in the denominator. Auto-forwarded cases are included, as these are considered to be adverse decisions per Subpart M rules. If a Reopening occurs and is decided prior to May 1, 2020, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2020 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data. Contracts with no IRE cases reviewed will not receive a score in this measure.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part D reconsiderations. The appeals used in this measure are based on the date they were received by the IRE, not the date a decision was reached by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Contracts with fewer than 10 cases reviewed by the IRE.
Data Time Frame:	01/01/2019 - 12/31/2019
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: C32 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.
Metric:	The calculation of this measure is the number of successfully completed contacts with the interpreter and TTY divided by the number of attempted contacts. Successfully completed contact with an interpreter is defined as establishing contact with an interpreter and affirmatively answering the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successfully completed TTY contact is defined as establishing contact with and confirming that the

Title	Description
	customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes. An affirmative response to the introductory question must be received back from the customer service representative or TTY relay operator in order to confirm that the TTY device is working properly and a connection is made so that all parties can communicate.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were not collected from MMPs that did not have a phone number accessible to survey callers, MMPs under sanction, and MMPs that terminated effective December 31, 2019.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2020 - 06/2020
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of successfully completed contacts with the interpreter and TTY divided by the number of attempted contacts. Successfully completed contact with an interpreter is defined as establishing contact with an interpreter and affirmatively answering the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successfully completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within seven minutes. An affirmative response to the introductory question must be received back from the customer service representative or TTY relay operator in order to confirm that the TTY device is working properly and a connection is made so that all parties can communicate.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were not collected from MMPs that did not have a phone number accessible to survey callers, MMPs under sanction, and MMPs that terminated effective December 31, 2019.

Title	Description
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2020 - 06/2020
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Attachment A: CAHPS Case-Mix Adjustment

Due to the COVID-19 PHE, CAHPS survey administration was suspended for the 2020 survey year. As a result, CAHPS measure data are not available for the 2021 MMP Performance Data File. This attachment describes the CAHPS case-mix adjustment for previous years and is included for informational purposes only.

Most Part C and D CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include dual eligibility and education among other variables. The tables below include the case-mix variables and shows the case-mix coefficients for each of the Part C and D CAHPS measures included in the MMP Performance Data File. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to otherwise similar others with the baseline value for that characteristic, on the original scale of the item or composite, as presented in plan reports.

For example, for the measure "Getting Appointments and Care Quickly," the model coefficient for "age 75-79" is 0.0044, indicating that respondents in that age range tend to score their plans 0.0044 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligible beneficiaries tend to respond 0.0497 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are dual eligible beneficiaries will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. In the tables we report the average of the coefficients for these several items, for each of the categories (rows) of the table, as a summary of the adjustment for the composite. For more detailed information on the application of CAHPS case-mix adjustment, please review the materials at https://ma-pdpcahps.org/en/case-mix-adjustment/.

Note: The measures derived from the supplemental questions on the MMP CAHPS survey (OHP5: Satisfaction with Care Coordination, CC10: Access to Medical Equipment, CC14: Access to Personal Care, and MH3: Access to Mental Health Treatment) are not case-mix adjusted.

Table A-1: Coefficients of Part C CAHPS Measures

Predictor	C03: Annual Flu Vaccine	C21: Getting Needed Care (Comp)	C22: Getting Appointments and Care Quickly (Comp)	C23: Customer Service (Comp)	C24: Rating of Health Care Quality	C25: Rating of Health Plan	C26: Care Coordination (Comp)
Age: 64 or under	N/A	-0.0394	-0.0294	0.0114	-0.1532	-0.1642	-0.0163
Age: 65 - 69	N/A	-0.0310	-0.0102	0.0153	-0.0749	-0.1203	-0.0190
Age: 75 - 79	N/A	-0.0237	0.0044	0.0056	0.0002	0.0088	-0.0291
Age: 80 - 84	N/A	-0.0154	-0.0091	0.0114	-0.0219	0.0314	-0.0320
Age: 85 and older	N/A	-0.0018	0.0090	0.0003	0.0366	0.2146	-0.0569
Less than an 8th grade education	N/A	-0.0865	-0.0013	-0.0307	0.0135	0.0869	-0.0120
Some high school	N/A	-0.0655	-0.0076	-0.0272	-0.0649	0.0628	0.0045
Some college	N/A	-0.0444	-0.0424	-0.0321	-0.1096	-0.1717	-0.0316
College graduate	N/A	-0.0316	-0.0262	-0.0591	-0.1456	-0.2889	-0.0456
More than a bachelor's degree	N/A	-0.0618	-0.0282	-0.0636	-0.1893	-0.3502	-0.0641
General health rating: excellent	N/A	0.0600	0.1166	0.0503	0.3364	0.2991	0.0407
General health rating: very good	N/A	0.0684	0.0625	0.0187	0.2056	0.1753	0.0221
General health rating: fair	N/A	-0.0280	-0.0244	-0.0407	-0.1898	-0.1542	-0.0217
General health rating: poor	N/A	-0.0934	-0.0557	-0.0689	-0.4954	-0.2766	-0.0489
Mental health rating: excellent	N/A	0.1701	0.1119	0.0955	0.4429	0.3183	0.1246
Mental health rating: very good	N/A	0.0659	0.0506	0.0350	0.1938	0.1559	0.0507

Predictor	C03: Annual Flu Vaccine	C21: Getting Needed Care (Comp)	C22: Getting Appointments and Care Quickly (Comp)	C23: Customer Service (Comp)	C24: Rating of Health Care Quality	C25: Rating of Health Plan	C26: Care Coordination (Comp)
Mental health rating: fair	N/A	-0.0674	-0.0651	-0.0212	-0.2393	-0.1621	-0.0698
Mental health rating: poor	N/A	-0.1116	-0.1123	-0.0409	-0.5240	-0.3551	-0.1186
Proxy helped	N/A	-0.0041	-0.0671	-0.0230	-0.1473	-0.0677	0.0405
Proxy answered	N/A	0.0409	0.0158	-0.0427	0.0092	-0.0603	0.0452
Medicaid dual eligible	N/A	-0.0209	-0.0497	-0.0307	-0.0128	0.2140	-0.0260
Low-income subsidy (LIS)	N/A	-0.0424	-0.0460	0.0257	-0.2246	-0.0088	-0.0387
Asian Language	N/A	-0.2684	-0.1247	-0.2450	-0.3148	-0.0765	0.0077

Table A-2: Coefficients of Part D CAHPS Measures

Predictor	MA-PD D07: Rating of Drug Plan	MA-PD D08: Getting Needed Prescription Drugs (Comp)	PDP D07: Rating of Drug Plan	PDP D08: Getting Needed Prescription Drugs (Comp)
Age: 64 or under	-0.2170	-0.0524	-0.2681	-0.0344
Age: 65 - 69	-0.2073	-0.0331	-0.2419	-0.0198
Age: 75 - 79	0.0500	0.0146	0.1619	0.0344
Age: 80 - 84	0.2238	0.0328	0.2874	0.0427
Age: 85 and older	0.3212	0.0278	0.4664	0.0580
Less than an 8th grade education	0.0621	-0.0483	-0.1493	-0.0774
Some high school	0.0715	-0.0137	-0.0242	-0.0255
Some college	-0.2227	-0.0355	-0.2578	-0.0493
College graduate	-0.2863	-0.0474	-0.3389	-0.0547
More than a bachelor's degree	-0.4554	-0.0766	-0.4515	-0.0926
General health rating: excellent	0.3409	0.0251	0.2605	0.0070
General health rating: very good	0.1958	0.0426	0.3273	0.0434
General health rating: fair	-0.2001	-0.0483	-0.0777	-0.0482
General health rating: poor	-0.2592	-0.0978	-0.5140	-0.0834
Mental health rating: excellent	0.2526	0.0808	0.1632	0.0848
Mental health rating: very good	0.0763	0.0375	0.0399	0.0370
Mental health rating: fair	-0.1412	-0.0641	-0.0229	-0.0056
Mental health rating: poor	-0.3309	-0.0652	0.0381	-0.0078
Proxy helped	-0.1642	-0.0095	0.0632	-0.0425
Proxy answered	-0.1868	0.0015	0.1003	0.0567
Medicaid dual eligible	0.4990	0.0193	0.8698	0.0798
Low-income subsidy (LIS)	0.3071	-0.0027	0.7263	0.0471
Asian Language	-0.4894	-0.0757	0.0000	0.0000

Attachment B: Calculating Measure DMC23: Plan All-Cause Readmissions

Due to the COVID-19 PHE, HEDIS reporting was suspended for the 2019 measurement year. As a result, HEDIS measure data are not available for the 2021 MMP Performance Data File. This attachment describes the Plan All-Cause Readmissions measure calculation for previous years and is included for informational purposes only.

All data come from the HEDIS 2019 M19_PCR and HEDIS 2019 M19_PCRb data files. The CMS SNP HEDIS Public Use File (PUF) data, which include MMPs, can be found on this page: Medicare Advantage/Part D Contract and Enrollment Data.

The following fields and formulas were used to calculate each MMP's performance rate for the Plan All-Cause Readmissions (PCR) measure. For MMPs in demonstrations that target populations either over or under age 65, the formulas were modified to use only the applicable age bands.

Formula Value	PCR Field	Field Description	PUF Field
A	is1844	Count of Index Stays (Denominator) Age 18-44	UOS524-0510
G	r1844	Count of 30-Day Readmissions (Numerator) Age 18-44	UOS524-0520
M	err1844	Expected Readmissions Rate (Expected Readmissions/Den) 18-44	UOS524-0530
B	is4554	Count of Index Stays (Denominator) Age 45-54	UOS524-0540
H	r4554	Count of 30-Day Readmissions (Numerator) Age 45-54	UOS524-0550
N	err4554	Expected Readmissions Rate (Expected Readmissions/Den) 45-54	UOS524-0560
C	is5564	Count of Index Stays (Denominator) Age 55-64	UOS524-0570
I	r5564	Count of 30-Day Readmissions (Numerator) Age 55-64	UOS524-0580
O	err5564	Expected Readmissions Rate (Expected Readmissions/Den) 55-64	UOS524-0590
Formula Value	**PCRb Field**	**Field Description**	**PUF Field**
D	is6574	Count of Index Stays (Denominator) Age 65-74	UOS524-0010
J	r6574	Count of 30-Day Readmissions (Numerator) Age 65-74	UOS524-0020
P	err6574	Expected Readmissions Rate (Expected Readmissions/Den) 65-74	UOS524-0030
E	is7584	Count of Index Stays (Denominator) Age 75-84	UOS524-0040
K	r7584	Count of 30-Day Readmissions (Numerator) Age 75-84	UOS524-0050
Q	err7584	Expected Readmissions Rate (Expected Readmission/Den) 75-84	UOS524-0060
F	is85	Count of Index Stays (Denominator) Age 85+	UOS524-0070
L	r85	Count of 30-Day readmissions (Numerator) Age 85+	UOS524-0080
R	err85	Expected Readmissions Rate (Expected Readmission/Den) 85+	UOS524-0090

$$\text{Observed} = \frac{G+H+I+J+K+L}{A+B+C+D+E+F}$$

$$\text{Expected} = \left(\frac{A}{A+B+C+D+E+F} \times M\right) + \left(\left(\frac{B}{A+B+C+D+E+F}\right) \times N\right) + \left(\left(\frac{C}{A+B+C+D+E+F}\right) \times O\right) + \left(\left(\frac{D}{A+B+C+D+E+F}\right) \times P\right) + \left(\left(\frac{E}{A+B+C+D+E+F}\right) \times Q\right) + \left(\left(\frac{F}{A+B+C+D+E+F}\right) \times R\right)$$

$$\text{Final Rate} = \frac{\text{Observed}}{\text{Expected}}$$

Attachment C: Medication Adherence Measure Calculations

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the measurement period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Days Covered Modification for Inpatient Stays and Skilled Nursing Facility Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

In this example, a beneficiary fills Benazepril and Captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the Captopril prescription after the days' supply for the Benazepril medication ended.

Table C-1: No Adjustment

Drug	January		February		March	
	1/1/2019	1/16/2019	2/1/2019	2/16/2019	3/1/2019	3/16/2019
Benazepril	15	16	15	13		
Captopril					15	16

PDC Calculation
Covered Days: 90
Measurement Period: 90
PDC: 90/90 = 100%

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same target generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing Lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted generic ingredient. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing Hydrochlorothiazide. However, Hydrochlorothiazide is not a RAS antagonist or targeted generic ingredient, so this overlap is not shifted.

Table C-2: Before Overlap Adjustment

Drug	January		February		March	
	1/1/2019	1/16/2019	2/1/2019	2/16/2019	3/1/2019	3/16/2019
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 59
Measurement Period: 90
PDC: 59/90 = 66%

Table C-3: After Overlap Adjustment

Drug	January		February		March	
	1/1/2019	1/16/2019	2/1/2019	2/16/2019	3/1/2019	3/16/2019
Lisinopril	15	16				
Lisinopril & HCTZ			15	13	3	
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 62
Measurement Period: 90
PDC: 62/90 = 69%

Example 3: Overlapping Fills of the Same and Different Target Drugs

In this example, a beneficiary is refilling both Lisinopril and Captopril. When a single and combination product both containing Lisinopril overlap, there is an adjustment to the PDC. When Lisinopril overlaps with Captopril, we do not make any adjustment to the days covered.

Table C-4: Before Overlap Adjustment

Drug	January		February		March		April	
	1/1/2019	1/16/2019	2/1/2019	2/16/2019	3/1/2019	3/16/2019	4/1/2019	4/16/2019
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 92
Measurement Period: 120
PDC: 92/120: 77%

Table C-5: After Overlap Adjustment

Drug	January		February		March		April	
	1/1/2019	1/16/2019	2/1/2019	2/16/2019	3/1/2019	3/16/2019	4/1/2019	4/16/2019
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105/120: 88%

PDC Adjustment for Inpatient, Hospice, and Skilled Nursing Facility Stays Examples

In response to Part D sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Star Ratings (using 2011 PDE data) to adjust for beneficiary stays in inpatient (IP) facilities, and with the 2015 Star Ratings (using 2013 PDE data) to also adjust for hospice enrollments and beneficiary stays in skilled nursing facilities (SNF). These adjustments account for periods that the Part D sponsor would not be responsible for providing prescription fills for targeted medications or more accurately reflect drugs covered under the hospice benefit or waived through the beneficiary's hospice election; thus, their medication fills during an IP or SNF stay or during hospice enrollment would not be included in the PDE claims used to calculate the Patient Safety adherence measures.

The PDC modification for IP stays, hospice enrollments, and SNF stays reflects this situation. Please note that while this modification will enhance the adherence measure calculation, extensive testing indicates that most Part D contracts will experience a negligible impact on their adherence rates. On average, the 2011 adherence rates increased 0.4 to 0.6 percentage points due to the inpatient stay adjustment, and the adjustment may impact the rates positively or negatively.

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. Hospice information from the Medicare Enrollment Database (EDB) and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs. SNF claims from the CWF have been used to adjust the SNF PDC adjustments for PDPs. Starting in the 2019 measurement year, when available for MA-PDs in the CWF, adjust the SNF PDC adjustments.

Note: Hospice enrollment is no longer a PDC adjustment but rather an exclusion starting with the 2020 Star Ratings (2019 YOS).

Calculating the PDC Adjustment for IP Stays and SNF Stays

The PDC modification for IP stays and SNF stays is based on two assumptions: 1) a beneficiary receives their medications through the facility during the IP or SNF stay, and 2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay or SNF stay, that supply can be used once he/she returns home. The modification is applied using the steps below:

1. Identify start and end dates of relevant types of stays for beneficiaries included in adherence measures. The discharge date is included in the PDC adjustment.
    - Use IP claims from the CWF to identify IP stays.
    - Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount with Medicare utilization days to identify Medicare Part A covered SNF dates. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 and/or a no payment reason code.
2. Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion of days covered calculation.
3. Shift days' supply from Part D prescription fills that overlap with the stay to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

If SNF and IP stays cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC.

Example 1: Gap in Coverage after IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage on days 1-8 and 12-15 and an IP stay on days 5 and 6, as illustrated in Table C-6.

Table C-6: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X	X	X	X	X	X	X	X				X	X	X	X
Inpatient Stay					+	+									

PDC Calculation:
Covered Days: 12
Measurement Period: 15
PDC: 12/15 = 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the measurement period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received his/her medication through the hospital on days 5 and 6, then he/she accumulated two extra days' supply during the IP stay. The two extra days' supply is used to cover the gaps in Part D drug coverage in days 9 and 10. This is illustrated in Table C-7.

Table C-7: After Adjustment

Day	1	2	3	4	7	8	9	10	11	12	13	14	15
Drug Coverage	X	X	X	X	X	X	+	+		X	X	X	X
Inpatient Stay													

PDC Calculation:
Covered Days: 12
Measurement Period: 13
PDC: 12/15 = 92%

Example 2: Gap in Coverage before IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and 13, as illustrated in Table C-8.

Table C-8: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X	X	X	X	X	X	X					X	X	X	X
Inpatient Stay												+	+		

PDC Calculation:
Covered Days: 11
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the measurement period. While there are two days' supply from the IP stay on days 12 and 13, there are no days without drug coverage after the IP stay. Thus, the extra days' supply are not shifted. This is illustrated in Table C-9.

Table C-9: After Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	14	15
Drug Coverage	X	X	X	X	X	X	X					X	X
Inpatient Stay													

PDC Calculation:
Covered Days: 9
Measurement Period: 13
PDC: 9/13 = 69%

Example 3: Gap in Coverage Before and After IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, and an IP stay on days 6-9, as illustrated in Table C-10.

Table C-10: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X	X	X			X	X	X	X			X	X	X	X
Inpatient Stay						+	+	+	+						

PDC Calculation:
Covered Days: 11
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 6-9 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay, based on the assumption that the beneficiary received his/her medication through the hospital on days 6-9. In this case, only days 10 and 11 do not have drug coverage and are after the IP stay, so two days' supply are shifted to days 10 and 11. This is illustrated in Table C-11.

Table C-11: After Adjustment

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X	X	X			+	+	X	X	X	X
Inpatient Stay											

PDC Calculation:
Covered Days: 9
Measurement Period: 11
PDC: 9/11 = 82%

Attachment D: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D13: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2019. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.

Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2019.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2020), or that were not required to participate in data validation. The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation.

Additionally, exclude contracts that did not score at least 95% on data validation for their MMP reporting of the MTM Program section and contracts that scored 95% or higher on data validation for the MTM Program section but that were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation.

- HICN or RRB Number (Element B)
- Met the specified targeting criteria per CMS – Part D requirements (Element G)
- Date of MTM program enrollment (Element I)
- Date met the specified targeting criteria per CMS – Part D requirements (Element J)
- Date of MTM program opt-out, if applicable (Element K)
- Received annual CMR with written summary in CMS standardized format (Element O)
- Date(s) of CMR(s) with written summary in CMS standardized format (Element Q)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

File DV failure: Contracts that failed to submit the CY 2019 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2019 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2019 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have fewer than 31 beneficiaries enrolled are listed as "Not enough data available."

Organizations can view their own MMP reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contracts using the following formula:

Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period / Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period, met the specified targeting criteria per CMS during the reporting period, weren't in hospice at any point during the reporting period, and who were enrolled in the MTM program for at least 60 days during the reporting period.

Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe.

Attachment E: Missing Data Messages

Due to the COVID-19 PHE, HEDIS reporting was suspended for the 2019 measurement year and CAHPS survey administration was suspended for the 2020 survey year. As a result, HEDIS and CAHPS measure data are not available for the 2021 MMP Performance Data File. These measures are noted below with an asterisk (*) and were assigned the missing data message "No data available" in the 2021 MMP Performance Data File.

CMS uses a standard set of messages in the MMP Performance Data File when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages.

Measure level messages

Table E-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table E-1: Measure level missing data messages

Message	Measure Level
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules.
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report.
Plan too new to be measured	The contract is too new to have submitted measure data.
No data available	There were no data for the contract included in the source data for the measure.
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules.
Plan not required to report measure	The contract was not required to report the measure due to low plan enrollment.
Not reportable due to plan termination	The contract was excluded from the measure due to plan termination effective December 31, 2019.
N/A based on demonstration's target population (Massachusetts MMPs only) [3]	Massachusetts MMPs are excluded because the age range for the measure does not align with the demonstration's target population (only individuals younger than 65 can enroll in Massachusetts MMPs).

Assignment rules for Part C measure messages

Appeals (IRE) measures (C30 & C31):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Is there a valid numeric measure rate?
  - Yes: Display the numeric measure rate
  - No: Is the contract effective date > 01/01/2019?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C21, C22, C23, C24, C25, & C26):*

Is the contract still active as of 01/01/2020?
- Yes: Is there a valid numeric CAHPS measure rate?
  - Yes: Display the numeric CAHPS measure rate
  - No: Is the contract effective date > 07/01/2019?
    - Yes: Display message: Plan too new to be measured
    - No: Is the CAHPS measure rate NR?
      - Yes: Display message: Not enough data available
      - No: Is the CAHPS measure rate NA?
        - Yes: Display message: No data available
        - No: Display message: Plan too small to be measured
- No: Display message: Not reportable due to plan termination

[3] For Massachusetts MMPs, this missing data message applies to the following measures: C06, C09, C10, C11, C12, C17, and C18.

Call Center – Foreign Language Interpreter and TTY Availability measure (C32):

Is the contract still active as of 01/01/2020?
- Yes: Is there a valid call center numeric rate?
  - Yes: Display the call center numeric rate
  - No: Is the contract effective date > 01/01/2020?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available
- No: Display message: Not reportable due to plan termination

Complaints (CTM) measure (C27):

Is the contract effective date > 01/01/2019?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2019?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

HEDIS measures (C01, C02, C07, C12 – C16, C19, C20, DMC01, DMC02, DMC13, DMC14, & DMC16):*

Was the contract required to report HEDIS?
- Yes: What is the HEDIS measure audit designation?
  - BD: Display message: CMS identified issues with this plan's data
  - BR: Display message: CMS identified issues with this plan's data
  - NA: Display message: Not enough data available
  - NB: Display message: Benefit not offered by plan
  - NR: Display message: CMS identified issues with this plan's data
  - NQ: Display message: Plan not required to report measure
  - R: Was a valid patient level detail file 1 submitted and the measure data usable?
    - Yes: Display the HEDIS measure numeric rate
    - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2019?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR measure (DMC23):*

Was the contract required to report HEDIS?
- Yes: What is the HEDIS measure audit designation?
  - BD: Display message: CMS identified issues with this plan's data
  - BR: Display message: CMS identified issues with this plan's data
  - NA: Display message: Not enough data available
  - NB: Display message: Benefit not offered by plan
  - NR: Display message: CMS identified issues with this plan's data
  - NQ: Display message: Plan not required to report measure
  - R: Was a valid patient level detail file 2 submitted and the measure data usable?
    - Yes: Did the contract report more than 150 index stays?
      - Yes: Display the HEDIS measure numeric rate
      - No: Display message: Not enough data available
    - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2019?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS SNP measures (C09, C10, & C11):*

Does the contract have < 30 members enrolled as of 02/01/2019?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2019?
  - Yes: Display message: Plan too new to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NA: Display message: Not enough data available
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Is there a valid HEDIS measure numeric rate?
      - Yes: Display the HEDIS measure numeric rate
      - No: Display message: No data available

HEDIS / HOS measures (C06, C17, & C18):

Is there a valid HEDIS / HOS numeric rate?
- Yes: Display the HEDIS / HOS numeric rate
- No: Is the contract effective date > 01/01/2018?
  - Yes: Display message: Plan too new to be measured
  - No: Is the contract enrollment < 500?
    - Yes: Display message: Plan too small to be measured
    - No: Is there a HEDIS / HOS rate code?
      - Yes: Assign message according to value below:
        - NA: Display message: Not enough data available
        - NB: Display message: Benefit not offered by plan
      - No: Display message: No data available

Members Choosing to Leave the Plan (C28):

Is the contract active as of 01/01/2020?
- Yes: Is there a valid numeric voluntary disenrollment rate?
  - Yes: Display the numeric voluntary disenrollment rate
  - No: Is the contract effective date ≥ 01/01/2020?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available
- No: Display message: Not reportable due to plan termination

Assignment rules for Part D measure messages

Appeals Auto-Forward (IRE) measure (D02):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Was the average contract enrollment < 800 in 2019?
  - Yes: Display message: Not enough data available
  - No: Is the contract effective date > 12/31/2019?
    - Yes: Display message: Plan too new to be measured
    - No: Is there a valid numeric measure rate?
      - Yes: Display numeric measure rate
      - No: Display message: No data available

Appeals Upheld (IRE) measure (D03):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2019?

Yes: Display message: Plan too new to be measured
No: Were fewer than 10 cases reviewed by the IRE?
Yes: Display message: Not enough data available
No: Is there a valid numeric measure percentage?
Yes: Display numeric measure percentage
No: Display message: No data available

CAHPS measures (D07, D08):*

Is the contract still active as of 01/01/2019?
Yes: Is there a valid numeric CAHPS measure rate?
Yes: Display the numeric CAHPS measure rate
No: Is the contract effective date > 07/01/2019?
Yes: Display message: Plan too new to be measured
No: Is the CAHPS measure rate NR?
Yes: Display message: Not enough data available
No: Is the CAHPS measure rate NA?
Yes: Display message: No data available
No: Display message: Plan too small to be measured
No: Display message: Not reportable due to plan termination

Call Center – Foreign Language Interpreter and TTY Availability measure (D01):

Is the contract still active as of 01/01/2020?
Yes: Is there a valid call center numeric rate?
Yes: Display the call center numeric rate
No: Is the contract effective date > 01/01/2020?
Yes: Display message: Plan too new to be measured
No: Display message: Not enough data available
No: Display message: Not reportable due to plan termination

Patient Safety measures – Adherence (D10 – D12) & SUPD (D14):

Is the contract effective date > 12/31/2019?
Yes: Display message: Plan too new to be measured
No: Does contract have 30 or fewer enrolled beneficiary member years (measure denominator)?
Yes: Display message: Not enough data available
No: Display numeric percentage

Patient Safety measure – MTM CMR (D13):

Is the contract still active as of 01/01/2020?
Yes: Is the contract effective date > 12/31/2019?
Yes: Display message: Plan too new to be measured
No: Is Part D Offered=False?
Yes: Display message: Plan not required to report measure
No: Is there a numeric rate?
Yes: Display numeric measure percentage
No: Is there a Reason(s) for Display Message?
Yes: Display appropriate message per table E-2
No: Display message: Not reportable due to plan termination

Table E-2: MTM CMR Reason(s) for Display Message conversion

Reason(s) for Display Message	Data File Message
Contract failed to submit file and pass system validation by the reporting deadline	CMS identified issues with this plan's data
Contract did not pass element-level DV for at least one element	CMS identified issues with this plan's data
Contract had missing score on MTM section DV	CMS identified issues with this plan's data
Contract scored less than 95% on MTM section DV	CMS identified issues with this plan's data

Reason(s) for Display Message	Data File Message
Contract had all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
Contract not required to submit MTM program	Not required to report

Assignment rules for MMP measure messages

Comprehensive Health Risk Assessment and Care Plan Completion (M21 & M32):

Did the contract enroll new members during the measurement year?
- Yes: Has CMS identified issues with the contract's data?
  - Yes: Display message: CMS identified issues with this plan's data
  - No: Display the numeric measure rate
- No: Display message: No data available

Supplemental CAHPS measures (CC10, CC14, MH3, & OHP5):*

Is the contract still active as of 01/01/2020?
- Yes: Is there a valid numeric CAHPS measure rate?
  - Yes: Display the numeric CAHPS measure rate
  - No: Is the contract effective date > 07/01/2019?
    - Yes: Display message: Plan too new to be measured
    - No: Is the CAHPS measure rate NR?
      - Yes: Display message: Not enough data available
      - No: Is the CAHPS measure rate NA?
        - Yes: Display message: No data available
        - No: Display message: Plan too small to be measured
- No: Display message: Not reportable due to plan termination

Attachment F: Contract Enrollment Data

The enrollment data used in the Part C "Complaints about the Health Plan" and Part D "Appeals Auto–Forward" measures are pulled from the HPMS. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2019 through December 2019) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the three Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor, there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2019 through December 2019), and the average enrollment in the plan across those months is used in calculating the combined rate.

Attachment G: Rounding Rules for Measure Scores

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using traditional rounding rules. These are standard "round to nearest" rules. To obtain a value with the specified level of precision, the single digit following the level of precision will be rounded. If the digit to be rounded is 0, 1, 2, 3 or 4, the value is rounded down, with no adjustment to the preceding digit. If the digit to be rounded is 5, 6, 7, 8 or 9, the value is rounded up, and a value of one is added to the preceding digit. After rounding, all digits after the specified level of precision are removed. If rounding to a whole number, the digit to be rounded is in the first decimal place. If the digit in the first decimal place is below 5, then after rounding the whole number remains unchanged and fractional parts of the number are deleted. If the digit in the first decimal place is 5 or greater, then the whole number is rounded up by adding a value of 1 and fractional parts of the number are deleted. For example, a measure listed with a Data Display of "Percentage with no decimal place" that has a value of 83.499999 rounds down to 83, while a value of 83.500000 rounds up to 84.

Attachment H: Glossary of Terms

CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Disability Status	Based on the original reason for entitlement for Medicare.
Dual eligibles	Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
I-SNP	Institutional Special Needs Plans (I-SNPs) are 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.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.
Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality ("signal") rather than random variation ("noise"). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).

SNP	A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. There are three major types of SNPs: 1) Chronic Condition SNP (CSNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP).
Sponsor	An entity that sponsors a health or drug plan.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.
Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.