Medicare Plan Ratings for Part D
Technical Notes
10/29/07

The master table includes reporting time periods for each Prescription Drug Plan quality measure shown in the table. All data are reported at the contract level. The Medicare Part D enrollment averages used in some of the measure calculations are based on the Health Plan Management System (HPMS) data for each contract.

I. Drug Plan Customer Service

A. Time on Hold When Customer Calls Drug Plan

1. This measure is defined as the average time spent on hold by the call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the "Customer Service for Current Members – Part D" phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract beneficiary customer service call center divided by the number of eligible calls made to a Part D contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the "hold" queue.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Call center surveillance data collected by CMS. The "Customer Service for Current Members – Part D" phone number associated with each contract was monitored.

B. Calls Disconnected When Customer Calls Drug Plan

1. This measure is defined as the number of disconnected ("dropped") calls made to the "Customer Service for Current Members – Part D" phone number associated with the contract divided by the total number of calls made to the "Customer Service for Current Members – Part D" phone number associated with that contract.
2. The CMS benchmark for this measure is ≤5%.
3. The evaluation of this measure is based on a fixed threshold.
4. Data Source: Call center surveillance data collected by CMS. The "Customer Service for Current Members – Part D" phone number associated with each contract was monitored.

C. Time on Hold When Pharmacist Calls Drug Plan

1. This measure is the same as A.1 above, but the "Pharmacy Technical Help Desk" phone number was used in place of the Customer Service for Current Members number.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Call center surveillance data collected by CMS. The "Pharmacy Technical Help Desk" phone number associated with each contract was monitored.

D. Calls Disconnected When Pharmacist Calls Drug Plan

1. This measure is the same as B.2 above, but the "Pharmacy Technical Help Desk" phone number was used in place of the Customer Service for Current Members number.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Call center surveillance data collected by CMS. The "Pharmacy Technical Help Desk" phone number associated with each contract was monitored.

E. Complaints about the Drug Plan

1. This measure is calculates a rate of total complaints per 1,000 enrollees at the contract level. The total complaint rate is calculated as:
   [(Total number of Part D complaints logged into the Complaints Tracking Module (CTM)) / (Average Medicare Part D enrollment)] * 1,000.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Data were obtained from the Health Plan Management System (HPMS) Complaints Tracking Module (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. Complaint rates per 1,000 enrollees are pro-rated to a 30-day basis.

4. **General Notes:**
   a) Enrollment numbers: enrollment numbers used to calculate the complaint rate were based on the average Medicare Part D enrollment over the time period measured for each contract.
   b) Data Exclusions: Some complaints that can not be clearly attributed to the plan are excluded. These include the following complaint types: complaints regarding 1-800-MEDICARE, Medicare websites, SHIPS, SSA, or MEDIC; facilitated enrollment issues; retroactive enrollment and disenrollment issues; enrollment exceptions; complaints identified as wrong contract, wrong category, or a CMS issue missing Medicaid eligibility (pending reassignment requests); or Part D premium overcharges or withholding issues. Also, the data excludes some complaints from pharmacists or other providers received by CMS.
   c) Missing Data: Complaint rates are not calculated for plans with enrollment less than 800 beneficiaries.

F. How Helpful Is Your Plan When You Need Information

1. This measure is used to assess member satisfaction related to getting help from the drug plan. Percentages reflect responses of "Usually" or "Always" to the survey questions.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

G. Rating of Drug Plan

1. This measure is used to assess member satisfaction related to the beneficiary's overall rating of the plan. Percentages reflect responses of 8, 9, or 10 to the survey question.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Results from the CAHPS survey.

II. Using Your Plan to Get Your Prescriptions Filled

A. Getting Prescriptions Easily

1. This measure is used to assess member satisfaction related to the ease to which a beneficiary gets the medicines his/her doctor prescribed. Percentages reflect responses of "Usually" or "Always" to the survey questions.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Results from the CAHPS survey.

B. Pharmacists Have Up-to-date Plan Enrollment Information

1. For each contract, it is the average of the monthly percentage weighted by enrollment. This monthly percentage is calculated using the following:
   [(Number of enrolled beneficiaries that have a complete 4Rx record (both a 4Rx BIN and a 4Rx ID)) / Medicare Part D enrollment]* 100.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: The 4Rx report is run after the last transaction processing update of the CMS Management Information Integrated Repository (MIIR) data base after the 3rd day of each month. The source of the enrollment information was the Medicare Beneficiary Database (MBD) and the Medicare Advantage Prescription Drug System (MARx). This measure reflects the percent of enrollments with a complete 4Rx record (both a 4Rx BIN and a 4Rx ID) across all current enrollments as well as within the specific enrollment categories.
4. General Information: 4Rx is a group of four identifiers (RxBIN, Rx PCN, Rx ID, Rx Group) submitted by plans after receipt of enrollment confirmation from CMS to facilitate the proper adjudication of Part D claims for all payers covering a beneficiary.
   a) Rx BIN - Bank Identifying Number (BIN) used for network routing,
   b) Rx ID - is the member ID assigned to the beneficiary,
   c) Rx PCN - is a number assigned by the processor,
   d) Rx Group - is the identifying number assigned to the cardholder group or employer group.
   e) CMS requires complete information for RX BIN and RX ID information.
5. This measure reflects enrollment transactions for the reporting time period specified in the table. Mandatory reporting of 4Rx on enrollment transactions was implemented following the current reporting time period and is not reflected in these numbers.

C. Pharmacists Have Up-to-date Information on Plan Members Who Need Extra Help

1. For each contract, this percent is calculated using the following:
   Beneficiary-weighted monthly average of the Low-Income Subsidy (LIS) matching rate. Each month's LIS match rate used in the average is calculated as follows:
   (Number of LIS beneficiaries on CMS enrollment file that have matching enrollment and benefit records (or more favorable benefits) on plan sponsors' enrollment files) / (Number of LIS beneficiaries on CMS enrollment file).
   For a given low income subsidy beneficiary to be considered a match, the plan must have the beneficiary enrolled in the correct plan, must indicate that the beneficiary is eligible for a low income subsidy, and must have premium and copayment levels that match (or are more favorable than) CMS records.
   If two or more monthly LIS match rates cannot be calculated due to a sponsor not submitting enrollment data or not submitting a valid file format, the lowest match rate of the study period will be substituted in the weighted monthly average calculation; note: the first incidence of a non-submission or non-validation will be dismissed.
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Data on the LIS Match Rates are obtained from a CMS contractor based on enrollment data supplied by Part D sponsors compared to enrollment data based on CMS records.
4. Missing Data: Any contracts which exclusively service U.S. territories are excluded from the match rate analysis. Also, sponsors that did not have any LIS beneficiaries enrolled in their plan during the analysis period do not have match rates available.

D. Complaints about the Plan's Benefits and Access to Prescription Drugs

1. For each contract, this rate is calculated using the following:
   [(Number of Part D complaints related to benefits and access issues logged into the CTM) / (Average Medicare Part D enrollment)] * 1,000.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Data were obtained from the Health Plan Management System (HPMS) Complaints Tracking Module (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. Complaint rates per 1,000 enrollees are pro-rated to a 30-day basis.
4. The General Notes for this measure are the same as Section I.E.3 above. The data exclusions outlined in the General Notes apply to this measure, as well.
5. These complaints include the following subcategories:
   - Part D Card did not work at pharmacy
   - Pharmacy does not offer generic alternatives
   - Pharmacy incorrectly listed in Part D Tool
   - Sponsor/plan/provider discouraging Part D benefit usage (e.g., for certain drugs)
   - Pharmacy is located too far away
   - Access and availability
   - Explanation of Benefits (EOB) is inaccurate
   - TrOOP balance unavailable
   - Coordination of benefit
   - 4Rx/E1
   - Transition
   - Part B vs. Part D coverage
   - Other Benefits/Access issues

E. Complaints about Joining and Leaving the Plan

1. For each contract, this rate is calculated using the following:
   [(Number of Part D complaints related to enrollment and disenrollment issues logged into the CTM) / (Average Medicare Part D enrollment)] * 1,000.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Data were obtained from the Health Plan Management System (HPMS) Complaints Tracking Module (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. Complaint rates per 1,000 enrollees are pro-rated to a 30-day basis.

4. The General Notes for this measure are the same as Section I.E.3 above. The data exclusions outlined in the General Notes apply to this measure, as well.
5. These complaints include the following subcategories:
    - Delayed enrollment processing
    - Inconsistent enrollment practices in same state
    - Enrollment denied
    - Inappropriate enrollment
    - Inappropriate disenrollment
    - Beneficiary has not received Part D card or enrollment materials
    - Delay in receiving materials
    - Untimely processing of disenrollment requests
    - Difficulty switching between plans
    - Involuntarily switched to a different plan
    - Low Income Subsidy (LIS)
    - Untimely processing of enrollment requests
    - TRR/Batch File
    - Eligibility
    - Other Enrollment/Disenrollment issue

F. Delays in Appeals Decisions

1. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations have been exceeded by the plan. This is calculated as:
   [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Data were provided by the IRE contracted by CMS for Part D reconsiderations.
4. Missing Data: This rate is not calculated for contracts with less than 800 enrollees.

G. Reviewing Appeals Decisions

1. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as:
   (Number of cases upheld) / (Total number of cases reviewed). Total number of cases reviewed is defined as the number of cases Upheld + Fully Reversed + Partially Reversed. Dismissed, remanded and withdrawn cases are not included in the denominator.
2. The evaluation of this measure is based on a fixed threshold" because we are not basing this on a percentile distribution.
3. Missing data: This value is not calculated for contracts with fewer than 5 total cases reviewed.

III. Drug Pricing Information

A. Availability of Drug Coverage and Cost Information

1. The percentage of submission windows in which the Contract's pricing data were displayed on the Medicare Prescription Drug Plan Finder (MPDPF). This is calculated as follows:
   100% - ([(Number of submission windows data suppressed) / (Total number of submission windows)]* 100).
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Data were obtained from biweekly/weekly price files submitted by Part D Sponsors for display on the MPDPF for the reporting period specified, and CMS Quality Assurance analyses of these price files. The pricing availability measure represents data submitted by plans the submission window prior to the start of the reporting time period through the submission window prior to the end of the reporting time period.

B. How Often the Plan's Drug Prices Change

1. This measure evaluates MPDPF pricing data to determine how stable the Plans' drug prices have appeared on the MPDPF over a period of time. This is calculated as:
   The number of GSNs with price increases greater than 5% in more than two time points of the measurement period weighted by the total units of the purchased according to Verispan data

divided by the number of GSNs studied during the measurement period weighted by the total units of the purchased according to Verispan data.

The proportion of drugs increasing in price is calculated for each plan and then aggregated to the contract level by weighting each plan by enrollment. The enrollment information is from HPMS from the December 2006 to June 2007 period and the latest available value for the enrollment of a given plan is selected.

2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Data were obtained from a number of sources: MPDPF Pricing Files, HPMS Approved formulary extracts, HPMS Enrollment Data, and data from First DataBank, Medispan, and Verispan.

C. Complaints about the Plan's Drug Pricing and Out-of-pocket Costs

1. For each contract, this rate is calculated using the following:
   [(Number of Part D complaints related to pricing and co-insurance issues logged into the CTM) / (Average Medicare Part D enrollment)] * 1,000.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Data were obtained from the Health Plan Management System (HPMS) Complaints Tracking Module (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. Complaint rates per 1,000 enrollees are pro-rated to a 30-day basis.
4. The General Notes for this measure are the same as Section I.E.3 above. The data exclusions outlined in the General Notes apply to this measure, as well.
5. These complaints include the following subcategories:
   - Pharmacy charging more than lowest available price
   - Pharmacy charging more co-insurance than listed on the Part D Tool on their description of benefits or TrOOP
   - Subsidy-eligible enrollees charged improper co-insurance
   - Enrollees charged improper co-insurance based on formulary tier
   - Beneficiary encountering Premium Withhold issues
   - Beneficiary has lost LIS Status/Eligibility
   - Other Pricing/Co-Insurance issue

Business Rule Logic for Medicare Part D Report Card

10/29/2007

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Domain	Measure	Rules and Valid Values	Display
Global Rule	Applies to All Columns	If the contract is new for 2008 (new_2008 = 1) then display "Plan Too New to be Measured"	**Plan Too New to be Measured**
1. Drug Plan Customer Service	Time on Hold When Customer Calls Drug Plan (mm:ss)	If average wait time of ≤30 seconds, display 5 stars.	★★★★★
		If average wait time >30 seconds and ≤ 2 minutes, display 4 stars.	★★★★
		If average wait time >2 minutes and ≤5 minutes, display 3 stars.	★★★
		If average wait time >5 minutes and ≤6 minutes, display 2 stars.	★★
		If average wait time >6 minutes, display 1 star.	★
		If average wait time is not available then display "Insufficient Data"	**Insufficient Data**
	Calls Disconnected When Customer Calls Drug Plan	If disconnection rate ≤1%, then display 5 stars.	★★★★★
		If disconnection rate is >1% and ≤3%, then display 4 stars.	★★★★
		If disconnection rate is >3% and ≤5%, then display 3 stars.	★★★
		If disconnection rate is >5% and ≤10%, then display 2 stars.	★★
		If disconnection rate is >10%, then display 1 star.	★
		If disconnection rate is not available then display "Insufficient Data"	**Insufficient Data**
	Time on Hold When Pharmacist Calls Drug Plan (mm:ss)	If average wait time of ≤30 seconds, display 5 stars.	★★★★★
		If average wait time >30 seconds and ≤2 minutes, display 4 stars.	★★★★
		If average wait time >2 minutes and ≤5 minutes, display 3 stars.	★★★
		If average wait time >5 minutes and ≤6 minutes, display 2 stars.	★★
		If average wait time >6 minutes, display 1 star.	★
		If average wait time is not available then display "Insufficient Data"	**Insufficient Data**
	Calls Disconnected When Pharmacist Calls Drug Plan	If disconnection rate ≤1%, then display 5 stars.	★★★★★
		If disconnection rate is >1% and ≤3%, then display 4 stars.	★★★★
		If disconnection rate is >3% and ≤5%, then display 3 stars.	★★★
		If disconnection rate is >5% and ≤10%, then display 2 stars.	★★
		If disconnection rate is >10%, then display 1 star.	★
		If disconnection rate is not available then display "Insufficient Data"	**Insufficient Data**

Domain	Measure	Rules and Valid Values	Display
	Complaints about the Drug Plan (Rate per 1,000 enrollees)	If total complaint rate ≤15th percentile, then display 5 stars.	★★★★★
		If total complaint rate is >15th percentile and ≤35th percentile, then display 4 stars.	★★★★
		If total complaint rate is >35th percentile and ≤65th percentile, then display 3 stars.	★★★
		If total complaint rate is >65th percentile and ≤85th percentile, then display 2 stars.	★★
		If total complaint rate is >85th percentile, then display 1 star.	★
		If enrollment <800 OR total complaint rate is not available then display "Insufficient Data"	**Insufficient Data**
	How Helpful is Your Plan When You Need Information	If total score is ≥95%, then display 5 stars.	★★★★★
		If total score is ≥85% and <95%, then display 4 stars.	★★★★
		If total score is ≥75% and <85%, then display 3 stars.	★★★
		If total score is ≥50% and <75%, then display 2 stars.	★★
		If total score <50%, then display 1 star.	★
		If total score is not available, then display "Insufficient Data"	**Insufficient Data**
	Rating of Drug Plan	If plan rating score is ≥95%, then display 5 stars.	★★★★★
		If plan rating score is ≥85% and <95%, then display 4 stars.	★★★★
		If plan rating score is ≥75% and <85%, then display 3 stars.	★★★
		If plan rating score is ≥50% and <75%, then display 2 stars.	★★
		If plan rating score <50%, then display 1 star.	★
		If plan rating score is not available, then display "Insufficient Data"	**Insufficient Data**
2. Using Your Plan to Get Your Prescriptions Filled	Getting Prescriptions Easily	If plan rating score is ≥95%, then display 5 stars.	★★★★★
		If plan rating score is ≥85% and <95%, then display 4 stars.	★★★★
		If plan rating score is ≥75% and <85%, then display 3 stars.	★★★
		If plan rating score is ≥50% and <75%, then display 2 stars.	★★
		If plan rating score <50%, then display 1 star.	★
		If drug access score is not available then display "Insufficient Data"	**Insufficient Data**
	Pharmacists Have Up-to-date Plan Enrollment Information	If completeness of 4Rx ≥99% then display 5 stars.	★★★★★
		If completeness of 4Rx is ≥97% and <99%, then display 4 stars.	★★★★
		If completeness of 4Rx is ≥95% and <97% then display 3 stars.	★★★
		If completeness of 4Rx is ≥80% and <95%, then display 2 stars.	★★
		If completeness of 4Rx is <80%, then display 1 star.	★
		If completeness of 4Rx is not available then display "Insufficient Data"	**Insufficient Data**
	Pharmacists Have Up-to-date	If LIS match rate ≥99% then display 5 stars.	★★★★★
		If LIS match rate is ≥97% and <99%, then display 4 stars.	★★★★

Domain	Measure	Rules and Valid Values	Display
	Information on Plan Members Who Need Extra Help	If LIS match rate is ≥ 95% and <97% then display 3 stars.	★★★
		If LIS match rate is ≥ 80% and <95%, then display 2 stars.	★★
		If LIS match rate is <80%, then display 1 star.	★
		If LIS match rate is not available then display "Insufficient Data"	**Insufficient Data**
	Complaints about the Plan's Benefits and Access to Prescription Drugs (Rate per 1,000 enrollees)	If benefits/access complaint rate ≤15th percentile, then display 5 stars.	★★★★★
		If benefits/access complaint rate is >15th percentile and ≤35th percentile, then display 4 stars.	★★★★
		If benefits/access complaint rate is >35th percentile and ≤65th percentile, then display 3 stars.	★★★
		If benefits/access complaint rate is >65th percentile and ≤85th percentile, then display 2 stars.	★★
		If benefits/access complaint rate is >85th percentile, then display 1 star.	★
		If enrollment <800 OR benefits/access complaint rate is not available then display "Insufficient Data"	**Insufficient Data**
	Complaints about Joining and Leaving the Plan (Rate per 1,000 enrollees)	If enrollment/disenrollment complaint rate ≤15th percentile, then display 5 stars.	★★★★★
		If enrollment/disenrollment complaint rate is >15th percentile and ≤35th percentile, then display 4 stars.	★★★★
		If enrollment/disenrollment complaint rate is >35th percentile and ≤65th percentile, then display 3 stars.	★★★
		If enrollment/disenrollment complaint rate is >65th percentile and ≤85th percentile, then display 2 stars.	★★
		If enrollment/disenrollment complaint rate is >85th percentile, then display 1 star.	★
		If enrollment <800 OR enrollment/disenrollment complaint rate is not available then display "Insufficient Data"	**Insufficient Data**
	Delays in Appeals Decisions (Rate per 10,000 enrollees)	If appeals autoforward rate ≤15th percentile, then display 5 stars.	★★★★★
		If appeals autoforward rate is >15th percentile and ≤35th percentile, then display 4 stars.	★★★★
		If appeals autoforward rate is >35th percentile and ≤65th percentile, then display 3 stars.	★★★
		If appeals autoforward rate is >65th percentile and ≤85th percentile, then display 2 stars.	★★
		If appeals autoforward rate is >85th percentile, then display 1 star.	★
		If enrollment <800 OR appeals autoforward rate is not available then display "Insufficient Data"	**Insufficient Data**
	Reviewing Appeals Decisions	If total appeals upheld rate >95%, then display 5 stars.	★★★★★
		If total appeals upheld rate is >90% and ≤95%, then display 4 stars.	★★★★
		If total appeals upheld rate is >75% and ≤90%, then display 3 stars.	★★★
		If total appeals upheld rate is >50% and ≤75%, then display 2 stars.	★★
		If total appeals upheld rate is ≤50%, then display 1 star.	★

Domain	Measure	Rules and Valid Values	Display
		If the number of IRE appeals cases reviewed (appeals_cases) is <5, excluding 0, OR confirmation percentage (appeals_upheld) is missing then display "Insufficient Data"	**Insufficient Data**
		If the number of IRE appeals cases reviewed is 0 (appeals_cases = 0) then display "No Appeals Required Review"	**No Appeals Required Review**
3. Drug Pricing Information	Availability of Drug Coverage and Cost Information	If submission rate ≥99% then display 5 stars.	★★★★★
		If submission rate is ≥95% and <99%, then display 4 stars.	★★★★
		If submission rate is ≥85% and <95% then display 3 stars.	★★★
		If submission rate is ≥75% and <85%, then display 2 stars.	★★
		If submission rate is <75%, then display 1 star.	★
		If submission rate is not available then display "Insufficient Data"	**Insufficient Data**
	How Often the Plan's Drug Prices Change	If price change ≤15th percentile, then display 5 stars.	★★★★★
		If price change is >15th percentile and ≤35th percentile, then display 4 stars.	★★★★
		If price change is >35th percentile and ≤65th percentile, then display 3 stars.	★★★
		If price change is >65th percentile and ≤85th percentile, then display 2 stars.	★★
		If price change is >85th percentile, then display 1 star.	★
		If price change is not available then display "Insufficient Data"	**Insufficient Data**
	Complaints about the Plan's Drug Pricing and Out-of-pocket Costs (Rate per 1,000 enrollees)	If pricing complaint rate ≤15th percentile, then display 5 stars.	★★★★★
		If pricing complaint rate is >15th percentile and ≤35th percentile, then display 4 stars.	★★★★
		If pricing complaint rate is >35th percentile and ≤65th percentile, then display 3 stars.	★★★
		If pricing complaint rate is >65th percentile and ≤85th percentile, then display 2 stars.	★★
		If pricing complaint rate is >85th percentile, then display 1 star.	★
		If enrollment <800 OR pricing complaint rate is not available then display "Insufficient Data"	**Insufficient Data**

Business Rule Logic for Medicare Part D Report Card Domain Scores

10/29/2007

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Domain	Rules and Valid Values	Display
Global Rule	If the contract is new for 2008 (new_2008 = 1) then display "Plan Too New to be Measured"	**Plan Too New to be Measured**
1. Drug Plan Customer Service	If the average star value is ≥4.5 then assign 5 stars.	★★★★★
	If the average star value is ≥3.5 and < 4.5 then assign 4 stars.	★★★★
	If the average star value is ≥2.5 and < 3.5 then assign 3 stars.	★★★
	If the average star value is ≥1.5 and < 2.5 then assign 2 stars.	★★
	If the average star value is < 1.5 then assign 1 star.	★
	Must have at least four (≥4) non-missing values out of the 7 measures in the domain, else do not compute a domain star value and display "Insufficient Data."	**Insufficient Data**
2. Using Your Plan to Get Your Prescriptions Filled	If the average star value is ≥4.5 then assign 5 stars.	★★★★★
	If the average star value is ≥3.5 and < 4.5 then assign 4 stars.	★★★★
	If the average star value is ≥2.5 and < 3.5 then assign 3 stars.	★★★
	If the average star value is ≥1.5 and < 2.5 then assign 2 stars.	★★
	If the average star value is < 1.5 then assign 1 star.	★
	Must have at least four (≥4) non-missing values out of the 7 measures in the domain, else do not compute a domain star value and display "Insufficient Data."	**Insufficient Data**
3. Drug Pricing Information	If the average star value is ≥4.5 then assign 5 stars.	★★★★★
	If the average star value is ≥3.5 and < 4.5 then assign 4 stars.	★★★★
	If the average star value is ≥2.5 and < 3.5 then assign 3 stars.	★★★
	If the average star value is ≥1.5 and < 2.5 then assign 2 stars.	★★
	If the average star value is < 1.5 then assign 1 star.	★
	Must have at least two (≥2) non-missing values out of the 3 measures in the domain, else do not compute a domain star value and display "Insufficient Data."	**Insufficient Data**