The master table includes reporting time periods for each Medicare Part D performance or quality measure shown in the table. All data are reported at the contract level and the following plan and organization types are excluded: National PACE, Cost plans, Employer Group Health plans (EGHPs), Continuing Care Retirement Community demonstrations (CCRCs), End Stage Renal Disease Networks (ESRDs), and Demonstration plans. 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. See the appendix for the assignment process for all levels of Part D star ratings.

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 CMS standard for this measure is an average hold time of 2 minutes or less. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.
3. Data Source: Call center surveillance monitoring data collected by CMS. The "Customer Service for Current Members – Part D" phone number associated with each contract was monitored.
4. Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to the survey callers.

B. 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 CMS standard for this measure is an average hold time of 2 minutes or less. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.
3. Data Source: Call center surveillance data collected by CMS. The "Pharmacy Technical Help Desk" phone number associated with each contract was monitored.
4. Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.

C. Accuracy of Information Members Get When They Call the Drug Plan

1. This measure is defined as the percent of the time CSRs answered questions correctly. The calculation of this measure is the number of times the CSR answered the questions correctly divided by the number of questions asked.
2. The evaluation of this measure is based on a relative ranking through adjusted percentile method.

3. Data Source: Data were collected by CMS; the "Customer Service for Current Prospective Members – Part D" phone number associated with each contract was monitored.
4. Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.

D. Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan

1. This measure is defined as the percent of the time a foreign language interpreter or TTY/TDD service was available to callers who spoke a foreign language or were hearing impaired. The calculation of this measure is the number of successful contacts with the interpreter or TTY/TDD divided by the number of attempted contacts.
2. The evaluation of this measure is based on a relative ranking through adjusted percentile method.
3. Data Source: Data were collected by CMS; the "Customer Service for Prospective Members – Part D" phone number associated with each plan was monitored.
4. Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.

E. Drug Plan's Timeliness in Giving a Decision for Members Who Make an Appeal

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 hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.
4. Exclusions: This rate is not calculated for contracts with less than 800 enrollees.

F. Fairness of Drug Plan's Denials to a Member's Appeal, Based on an Independent Reviewer

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)] * 100. 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 hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.
4. Exclusions: A percent is not calculated for contracts with fewer than 5 total cases reviewed by the IRE.

G. Drug Plan Provides Pharmacist with Up-To-Date and Complete Enrollment Information About Plan Members

1. This measure is defined as percent of time CMS generated enrollments were completed within the 72 hour processing time frame requirement. The calculation of this measure is based on the percentage of the number of successful transactions with 4Rx information received within 120 hours from when the Transaction Reply Report (TRR) was sent divided by the total number of CMS-generated enrollment transactions sent to the plan on the TRR.

2. The evaluation of this measure is based on relative ranking.
3. Data Source: Medicare Advantage Prescription Drug System (MARx)
4. Exclusions: Contracts with a total of 5 or fewer transactions in the measurement period are excluded from this data set.

II. Drug Plan Member Complaints, Members Who Choose to Leave, and Medicare Audit Findings

A. Complaints about Joining and Leaving the Drug Plan

1. For each contract, this rate is calculated as: [(Number of Part D complaints related to enrollment and disenrollment issues logged into the Complaints Tracking Module (CTM)) / (Average Medicare Part D enrollment)] * 1,000 * 30 / (Number of Days in Period).
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: 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. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
   These complaints include the following subcategories:
   - Delayed enrollment processing
   - Inconsistent enrollment practices in same state
   - Enrollment denied inappropriately
   - Inappropriate enrollment
   - Inappropriate disenrollment
   - Beneficiary has not received Part D card or enrollment materials
   - Delayed Disenrollment processing
   - Difficulty switching between plans
   - Low Income Subsidy (LIS)
   - Retroactive Disenrollment (RD)
   - Enrollment Reconciliation - Dissatisfied with Decision
   - Retroactive Enrollment (RE)
   - Other Enrollment/Disenrollment issue

B. All Other Complaints about the Drug Plan

1. For each contract, this rate is calculated as: [(Total number of all other Part D complaints logged into the CTM other than enrollment and disenrollment issues) / (Average Medicare Part D enrollment)] * 1,000 * 30 / (Number of Days in Period).
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: 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. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
4. Exclusions: Complaints included in measure II.A. are excluded from this data set.

***General Notes about Complaint Measures:**

- Enrollment numbers used to calculate the complaint rate were based on the average Medicare Part D enrollment adjusted over the time period measured for each contract.
- Data Exclusions: Some complaints that cannot be clearly attributed to the plan are excluded. These include the following complaint types: complaints regarding 1-800-

MEDICARE, websites, State Health Insurance Programs (SHIPs), Social Security Administration (SSA), or Medicare Drug Integrity Contractors (MEDICs); enrollment reconciliation issues, facilitated enrollment issues; beneficiary loss of LIS status/eligibility; enrollment exceptions; complaints identified as a CMS issue; or Part D premium overcharge issues.

- Exclusions: Complaint rates are not calculated for plans with enrollment less than 800 beneficiaries.

C. Members Choosing to Leave the Drug Plan

1. This measure is defined as the percent of plan members who chose to leave the plan. The measure is calculated as the number of beneficiaries who voluntarily disenrolled from a Part C or D contract anytime during the measurement period, divided by the number of all individual beneficiaries enrolled in the contract on the first day of the measurement period.
2. The evaluation of this measure is based on a relative ranking through adjusted percentile methodology.
3. Data Source: The data used to determine the percent of members that chose to leave the plan came from Medicare's enrollment system.
4. Exclusions: National PACE, 1876 Cost, 1833 Cost, Demonstration plans, SNPs, EGHPs, terminated plans, and withdrawn contracts were excluded from the analysis. In addition, any contract that was rolled over during the measurement period was replaced with the 'Rolled Over To' contract, and the enrollments or Disenrollments of the 'Rolled Over from' contract were attributed to the "Rolled Over To' contract.

D. Seriousness of Problems Medicare Found During an Audit of the Drug Plan

1. This score is based on CMS's audit findings of health and drug plans. A health or drug plan may be audited as part of CMS's routine monitoring and oversight activities, or as an ad-hoc activity due to CMS identifying an issue or concern. Standardized CMS audit guides are used to review many different areas of a contract's operations.
    - Each element in CMS's audit guides were categorized by the potential harm to beneficiaries either through financial impact or access to services or medications, or if a contract did not meet CMS's standards. Each category was then assigned a point value. The following points were assigned to each category:
        i. No beneficiary harm, with no risk of financial impact – 1 point
        ii. No beneficiary harm, with financial impact – 3 points
        iii. Beneficiary harm, with no risk of financial impact - 5 points
        iv. Beneficiary harm, with risk of financial impact – 7 points
        v. Beneficiary harm, with risk of impact to access to services or medications – 10 points
        vi. For each failed ad-hoc audit – additional 10 points
    - For contracts audited in the measurement time period, a score was calculated using the formula: contract score = ((Sum of points for failed elements)/ Sum of points for audited elements))*100) + (Points from failed ad-hoc audits). The maximum score that could be received by a contract was 100.
    - Contracts that were neither audited in the measurement time period nor had an ad hoc finding are displayed as, "Information is not available". A footnote also states, "No information is shown because Medicare did not audit this contract during 2008. This is neither good nor bad, because Medicare does not always audit contracts every year."

2. The evaluation of this measure is based on relative ranking.
3. Data Source: Findings of CMS audits and adhoc activities performed during the measurement time period.
4. Exclusions: Contracts with 3 or fewer reviewed elements or that were not audited in the measurement period are not assigned a score.

III. Member Experience with Drug Plan

A. Drug Plan Provides Information or Help When Members Need It

1. This measure is used to assess member satisfaction related to getting help from the drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Results from the CAHPS survey.

B. Members' Overall Rating of Drug Plan

1. This measure is used to assess member satisfaction related to the beneficiary's overall rating of the plan. The CAHPS score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Results from the CAHPS survey.

C. Members' Ability to Get Prescriptions Filled Easily When Using the Drug Plan

1. This measure is used to assess member satisfaction related to the ease to which a beneficiary gets the medicines his/her doctor prescribed. The CAHPS score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Results from the CAHPS survey.

***Important Notes on CAHPS Star Rating Assignment:**

CAHPS Star ratings are designed to compare CAHPS measure scores for each plan to all other plans. In particular, they are based on the percentile rank of each plan's score and tests of significance versus the National average score (i.e. the overall mean score). The numerical ratings describe the underlying scores from which stars are derived, but because the average (mean) performance and number of respondents vary across measures, a given score may translate into a different number of stars for different measures. Star assignments are made using the following rules.

- A plan is assigned 5 stars if the plan's average CAHPS measure score is ranked above the 85^{th} percentile and the plan's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.
- A plan is assigned 4 stars if it does not meet the 5 star criteria, but meets at least one of these two criteria: (a) the plan's average CAHPS measure score is higher than the 70^{th} percentile OR (b) the plan's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

- A plan is assigned 1 star if the plan's average CAHPS measure score is ranked below the 15th percentile and the plan's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.
- A plan is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the plan's average CAHPS measure score is lower than the <30th percentile OR (b) the plan's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.
- A plan is assigned 3 stars if the plan's average CAHPS measure score is ranked between the 30th and 70th percentiles (inclusive) and the plan's average CAHPS measure score is NOT statistically significantly different than the national average CAHPS measure score.

IV. Drug Pricing and Patient Safety

A. Completeness of the Drug Plan's Information on 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 sponsor must have the beneficiary enrolled, must indicate that the beneficiary is eligible for a low income subsidy, and must have premium and co-payment 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 reporting 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 for 3-star assignment, and on a relative distribution for other star assignments.
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. Exclusions: 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.

B. Drug Plan Prices that Don't Increase More Than Expected During the Year

1. This measure evaluates Medicare Prescription Drug Plan Finder (MPDPF) pricing data to determine the percent of Plans' drug prices on the MPDPF that did not increase more than expected over a period of time. This is calculated as: 100% - ([(Number of drugs studied 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) / (Number of drugs studied during the measurement period weighted by the total units of the purchased according to Verispan data)]*100). 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 reporting period specified, and the latest available value for the enrollment of a given plan is selected.

2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from a number of sources: MPDPF Pricing Files, HPMS approved formulary extracts, enrollment data, and data from First DataBank, Medispan, and Verispan.

C. Drug Plan's Prices on Medicare's Website Are Similar to the Prices Members Pay at the Pharmacy

1. This measure evaluates how similar pricing in a plan's Prescription Drug Event (PDE) were to the plan's submitted prices for posting on Medicare's website during the same time period. This is calculated as follows: PDE claims for drugs of clinical concern are identified and the unit costs are compared to the unit costs submitted in the Pricing File (PF) used in the MPDPF. For claims with unit costs greater than the unit cost posted on MPDPF, the difference between PDE and PF cost is determined. Within each reference NDC, the cost differences are ranked across all contracts, such that claims with larger differences between PDE and PF costs will receive a higher percentile ranking (maximum of 100). Claims with no difference between PDE and PF costs and claims where the PDE cost was lower than the PF unit cost will receive a percentile ranking of 0. Only reference NDCs with at least 30 claims across all contracts are included in the ranking. A contract's score is calculated as the average percentile ranking score of all the claims submitted by the contract in the reporting period.
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from MPDPF Pricing Files submitted by drug plans for posting during the reporting period, and Prescription Drug Event (PDE) data files with service dates during the reporting period.
4. Exclusions: PDE claims for non-reference NDCs were excluded, as PF unit costs are submitted for reference NDCs only. This analysis excluded reference NDCs with 30 or fewer claims across all contracts, and contracts with 30 or fewer studied reference NDCs due to small sample size.

D. Drug Plan's Members 65 and Older Who Received Prescriptions for Certain Drugs with a High Risk of Side Effects, when There May Be Safer Drug Choices

1. This measure calculates the percentage of Medicare Part D beneficiaries 65 years or older who received at least one prescription for a drug with a high risk of serious side effects in the elderly (a.k.a. High Risk Medication or HRM). This percentage is calculated as: [(Number of Member-Years of Enrolled Beneficiaries 65 years or older who received one HRM during the period measured)/ (Number of Member-Years of Enrolled 65 years and older during the period measured)].
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from PDE data files submitted by drug plans to Medicare for the reporting period. PDE claims are limited to members over 65 years of age, and for those Part D covered drugs identified to have high risk of serious side effects in patients 65 years of age or older.
4. Exclusions: A percentage is not calculated for contracts with 30 or fewer enrolled beneficiaries 65 years or older.

E. Using the Kind of Blood Pressure Medication That Is Recommended for People with Diabetes

1. This is defined as the percent of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication. This percentage is calculated as: [(Number of Member-Years of Enrolled Beneficiaries from eligible population who received an ACEI or ARB medication during period measured)/ (Number of Member-Years of Enrolled Beneficiaries in period measured who were dispensed at least one prescription for an oral hypoglycemic agent or insulin and at least one prescription for an antihypertensive agent during the measurement year)].
2. The evaluation of this measure is based on a relative ranking through adjusted percentile method.
3. Data Source: Data were obtained from PDE data files submitted by drug plans to Medicare for the reporting period. PDE claims were limited to members who received at least one prescription for an oral diabetes drug or insulin and at least one prescription for a high blood pressure drug. Members who received the ACEI or ARB medication were identified.

Appendix: Business Rules for Part D Star Ratings

The CMS rating system for assigning star ratings uses a series of business rules in a statistical quality control framework. The three major components of the rating process are presented in *Exhibit 1*. Details of how the three process components were implemented are as follows.

Exhibit 1: Flowchart on the Process of Assigning Star Ratings

Relative Thresholds Derived From the Data Distribution

First, two automatic processing methods are applied to derive thresholds based on the relative distribution of the data. *Adjusted percentile ratings* are used to assign initial thresholds using a percentile distribution. These initial thresholds are adjusted to account for gaps in the data and the relative number of contracts with an observed star value. *Two-stage clustering ratings* are used to assign contracts to a large number of clusters in the first stage to assure that similar contracts receive the same star rating.

In defining the first stage, raw measures are first scaled to comparable metrics, and then grouped into different choices of the number of clusters: 10, 15, 20, 25, 30 and 35. The formula for scaling a contract's raw measure value (X) for a measure (M) is the following: Scaled measure value = (scale maximum – scale minimum) * ((X – minimum value of M) /(maximum value of M – minimum of M)) + scale minimum. Then, the second stage determines at most five clusters and corresponding thresholds from the means of each cluster derived in the first stage.

In applying these two methods, goodness of fit analysis using empirical distribution function test in an iterative process is performed, as needed, to test the property of raw measure data distribution in contrast to various types of continuous distributions. Then additional sub-tests applied include: Kolmogorov-Smirnov D statistic, Cramer-von Mises W2 statistic, and Anderson-Darling A2 statistic.

A *hybrid combination* is then used to weigh and combine the two estimates of thresholds (derived from adjusted percentile and two-stage clustering) to produce automatically-generated star ratings.

Throughout the rating process, the MA-PD and PDP contracts are analyzed separately. Two primary reasons give rise to that decision: 1) The distribution of MA-PD and PDP measure data are different; and 2) MA-PD**s** and PDP**s** have different business operations, as a MA-PD's operation would be influenced by some Part C policy rules/operating procedures that a PDP contract may not be subject to.

Fixed Thresholds for Three-Star Rating Based upon Policy

These star ratings are then *manually reviewed* and a *policy based adjustment* is also applied to certain measures with pre-specified performance standards for the three-star rating.

Exception Rules

Some contracts for certain measures are subject to exception rules in calculating the measure star. Therefore, the following types of contracts have star ratings displayed as "Not enough data available to calculate measure":

- For two complaints related measures (complaints about joining and leaving the drug plan, and all other complaints), contracts that have less than 800 enrollees;
- For the delays in appeals decision measure, contracts that have less than 800 or the appeals auto-forward rate is not available; and
- For the reviewing appeals decisions measure, contracts that have less than 5 appeals.

In addition, for the reviewing appeals decisions measure, the measure star is displayed as "No Appeals Required Review" if the number of appeals is zero.

Exhibit 2 below presents how each process component is applied to respective performance measure. The checkmark "✔" means the process is applied to that specific measure.

Exhibit 2: Types of Business Rules Applied to Individual Measures

Domain	Performance Measures	Relative Thresholds	Fixed Thresholds	Exception Rules
Drug Plan Customer Service	Time on Hold When Customer Calls Drug Plan	✔	✔	
	Time on Hold When Pharmacist Calls Drug Plan	✔	✔	
	Accuracy of Information Members Get When They Call the Drug Plan	✔		
	Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan	✔		
	Drug Plan's Timeliness in Giving a Decision for Members Who Make an Appeal (for every 10,000 members)	✔		
	Fairness of Drug Plan's Denials to Member Appeals, Based on an Independent Reviewer	✔		✔
	Drug Plan Provides Pharmacists with Up-to-Date and Complete Enrollment Information about Plan Members	✔		✔
Member Complaints and Staying with Drug Plan	Complaints about Joining and Leaving the Drug Plan (for every 1,000 members)	✔		✔
	All Other Complaints about the Drug Plan (for every 1,000 members)	✔		✔
	Members Choosing to Leave the Drug Plan (lower percentages are better because they mean fewer members choose to leave the plan)	✔		
	Seriousness of Problems Medicare Found During an Audit of the Drug Plan (on a scale from 0 to 100; lower numbers are better because they mean fewer serious problems)	✔		
Member Experience with Drug Plan	Drug Plan Provides Information or Help When Members Need It	✔ †		
	Members' Overall Rating of Drug Plan	✔		
	Members' Ability to Get Prescriptions Filled Easily When Using the Drug Plan	✔		
Drug Pricing and Patient Safety	Completeness of the Drug Plan's Information on Members Who Need Extra Help	✔	✔	
	Drug Plan Prices that Don't Increase More Than Expected During the Year	✔		
	Drug Plan Prices on Medicare's Website Are Similar to the Prices Members Pay at the Pharmacy	✔		
	Drug Plan Members 65 and Older Who Receive Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May Be Safer Drug Choices	✔		
	Using the Kind of Blood Pressure Medication That Is More Effective for People with Diabetes	✔		

† A different review threshold method is applied to the CAHPS measure.