The master table includes each Health Plan quality and performance measure shown in the table. All data are reported at the contract level.

I. Staying Healthy: Screenings, Tests, and Vaccines

A. Breast Cancer Screening

1. % of (denominator) female MA enrollees ages 50 to 69 who (numerator) had a mammogram during the measurement year or the year prior to the measurement year.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

B. Colorectal Cancer Screening

1. % of (denominator) MA enrollees aged 50 to 80 who (numerator) had appropriate screening for colorectal cancer.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

C. Cholesterol Screening

1. Average of:
   - % of (denominator) MA enrollees with ischemic vascular disease who (numerator) had LDL-C test performed during the measurement year; and
   - % of (denominator) diabetic MA enrollees who had an LDL-C test performed (numerator) during the measurement year, or the year prior to the measurement year.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

D. Glaucoma Testing

1. % of (denominator) MA enrollees aged 65 or older without a prior diagnosis of glaucoma who (numerator) had at least one glaucoma exam by an eye doctor during the measurement year.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

E. Appropriate Monitoring of Patients Taking Long-term Medications

1. % of (denominator) MA enrollees who received at least a 180 day supply of either Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARB), digoxin, diuretics, anticonvulsants, or statins, and who (numerator) received at least one monitoring event appropriate for the specific therapeutic agent during the measurement year.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

F. Annual Flu Vaccine

1. % of (denominator) sampled Medicare enrollees who (numerator) received an influenza vaccination between September – December during the measurement year.
   - Did you get a flu shot last year, that is anytime after September 2008?
2. Data Source: CAHPS, conducted February – June, 2009

G. Pneumonia Vaccine

1. % of (denominator) sampled Medicare enrollees who (numerator) reported ever having received a pneumococcal vaccine.
   - Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.
2. Data Source: CAHPS, conducted February – June, 2009

H. Improving or Maintaining Physical Health

1. % of (denominator) sampled Medicare enrollees whose (numerator) physical health status was better than expected or remained the same.
2. Data Source: HOS, conducted April - August, 2008

I. Improving or Maintaining Mental Health

1. % of (denominator sampled Medicare enrollees whose (numerator) mental health status was better than expected or remained the same.
2. Data Source: HOS, conducted April – August 2008

Osteoporosis Testing

3. % of (denominator) sampled Medicare female enrollees 65 years of age or older who (numerator) report ever having received a bone density test to check for osteoporosis.
4. Data Source: HOS, conducted April – August 2008

J. Monitoring Physical Activity

1. % of (denominator) sampled Medicare enrollees 65 years of age or older who (numerator) had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity.
2. Data Source: HOS, conducted April – August 2008

K. Access to Primary Care Doctor Visits

1. This measure is defined as the percent of (denominator) MA enrollees who (numerator) had an ambulatory or preventive care visits during the measurement year.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

II. Managing Chronic (Long-Lasting) Conditions

A. Osteoporosis Management

1. % of (denominator) female MA enrollees 67 and older who suffered a fracture during the measurement year, and (numerator) who subsequently had either a bone mineral density test or were prescribed a drug to treat or prevent osteoporosis in the six months after the fracture.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

B. Diabetes Care

1. Average of:
   - Eye Care - % of (denominator) diabetic MA enrollees who (numerator) had a retinal or dilated eye exam by an eye care professional during the measurement year;
   - Kidney Disease Monitoring - % of (denominator) diabetic MA enrollees who (numerator) either had a urine microalbumin test during the measurement year, or who had received medical attention for nephropathy during the measurement year;
   - Blood Sugar Controlled - % of (denominator) diabetic MA enrollees (numerator) whose most recent HbA1c level is greater than 9, or who were not tested during the measurement year. (This measure for public reporting is reversed score so higher scores are better.); and
   - Cholesterol Controlled - % of (denominator) diabetic MA enrollees (numerator) whose most recent LDL-C level during the measurement year was 100 or less.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

C. Controlling Blood Pressure

1. % of (denominator) sampled MA enrollees with hypertension on or before June 30 of the measurement year, (numerator) who most recent chart notation of systolic BP was 140 or less and diastolic BP was 90 or less during the measurement year.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

D. Rheumatoid Arthritis Management

1. % of (denominator) MA enrollees diagnosed with rheumatoid arthritis during the measurement year, and (numerator) who received at least one prescription for a disease modifying anti-rheumatic drug (DMARD).
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

E. Testing to Confirm Chronic Obstructive Pulmonary Disease

1. % of (denominator) MA enrollees with a new diagnosis or newly active Chronic Obstructive Pulmonary Disease (COPD) during the measurement year, who (numerator) received appropriate spirometry testing to confirm the diagnosis.
2. Data Source: HEDIS, January 1 – December 31, 2008 measurement year.

F. Improving Bladder Control

1. % of (denominator) of Medicare members 65 years of age or older who (numerator) reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.
2. Data Source: HOS, conducted April – August, 2008

G. Reducing the Risk of Falling

1. % of (denominator) Medicare members 65 years of age or older who had a fall or had problems with balance or walking in the past 12 months, who (numerator) were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.
2. Data Source: HOS, conducted April – August, 2008

III. Ratings of Health Plan Responsiveness and Care

A. Ease of Getting Needed Care and Seeing Specialists

1. Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
   - In the last 6 months, how often was it easy to get appointments with specialists?
   - In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?
2. Data Source: CAHPS, conducted February – June, 2009

B. Doctors who Communicate Well

1. Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
   - In the last 6 months, how often did your personal doctor listen carefully to you?
   - In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
   - In the last 6 months, how often did your personal doctor show respect for what you had to say?
   - In the last 6 months, how often did your personal doctor spend enough time with you?
2. Data Source: CAHPS, conducted February – June, 2009

C. Getting Appointments and Care Quickly

1. Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
   - In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
   - In the last 6 months, not counting the times when you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
2. Data Source: CAHPS, conducted February – June, 2009

D. Overall Rating of Health Care Quality

1. Mean of CAHPS Rating converted to a scale from 0 to 100 for the following question:
   - 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?
2. Data Source: CAHPS, conducted February – June, 2009

E. Overall Rating of Health Plan

1. Mean of CAHPS Rating converted to a scale from 0 to 100 for the following question:
   - 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?
2. Data Source: CAHPS, conducted February – June, 2009

F. Customer Service

1. Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
   - 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 for your health plan easy to fill out?
2. Data Source: CAHPS, conducted February – June, 2009

IV. Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan

A. Complaints about the Health Plan

1. For each contract, this rate is calculated as [(Number of Part C complaints logged into the Complaint Tracking Module (CTM))/Average Medicare Part C enrollment)]*1,000*30/(Number of Days in Period).
2. Data source: Data were obtained from the CTM from 4/1/2008 – 3/31/2009 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 categories:
   - **(1)** Access and availability
   - **(2)** Benefits/access
   - **(3)** Confidentiality/privacy
   - **(4)** Customer service
   - **(5)** Enrollment/disenrollment
   - **(6)** Exceptions/appeals
   - **(7)** Grievances
   - **(8)** Marketing
   - **(9)** Payment/claims
   - **(10)** Plan administration
   - **(11)** Pricing/co-insurance
   - **(12)** Program integrity issues/potential fraud, waste and abuse
   - **(13)** Quality of care/clinical issues

B. Health Plan Makes Timely Decisions about Appeals

1. % of appeals timely processed by the plan (numerator) out of all the plan's appeals cases decided by the IRE (excluding dismissed cases and cases with unknown timeliness) (denominator).
2. Data Source: IRE/ Maximus, January 1 – December 31, 2008 measurement year.

C. Fairness of Health Plan's Denials to a Member's Appeal, Based on Independent Reviewer

1. % of appeals cases where a plan's decision was "upheld" by the IRE (numerator) out of all the plan's cases ("upheld" & "overturned" cases only) that the IRE reviewed (denominator)
2. Data Source: IRE/ Maximus, January 1 – December 31, 2008 measurement year.

D. Members Choosing to Leave the Health 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 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. Data Source: The data used to determine the percent of members that chose to leave the plan came from Medicare's enrollment system for 2008.

E. Seriousness of Problems Medicare Found During an Audit of the Health 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."

V. Customer Service

A. Time on Hold When Customer Calls Health 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 C" 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 C contract beneficiary customer service call center divided by the number of eligible calls made to a Part C 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 C" phone number associated with each contract was monitored, February – June 2009.

B. Accuracy of Information Members Get When They Call the Health 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. Data Source: Data were collected by CMS; the "Customer Service for Prospective Members – Part C" phone number associated with each contract was monitored, February – June 2009.

C. Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health 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. Data Source: Data were collected by CMS; the "Customer Service for Prospective Members – Part C" phone number associated with each plan was monitored, February – June 2009.

Methodologies for Calculating Stars at the Individual Measure Level

STAYING HEALTHY: SCREENINGS, TESTS AND VACCINES		
Individual Measures	***Data Source***	***Star Assignment Rules***
Breast Cancer Screening	HEDIS	See Table 1
Colorectal Cancer Screening	HEDIS	See Table 1
Cholesterol Screening	HEDIS	See Table 2
Glaucoma Testing	HEDIS	See Table 1
Monitoring of Patients Taking Long-term Medications	HEDIS	See Table 2
Annual Flu Vaccine	CAHPS	See Table 7
Pneumonia Vaccine	CAHPS	See Table 7
Improving or Maintaining Physical Health	HOS	See Table 3
Improving or Maintaining Mental Health	HOS	See Table 2
Osteoporosis Testing	HOS	See Table 1
Monitoring Physical Activity	HOS	See Table 3
At Least One Primary Care Doctor Visit in the Last Year	HEDIS	See Table 2
MANAGING CHRONIC (LONG-LASTING) CONDITIONS		
Individual Measures	***Data Source***	***Star Assignment Rules***
Osteoporosis Management	HEDIS	See Table 3
Providing Certain Kinds of Care that Help Plan Members with Diabetes Stay Healthy	HEDIS	See Table 1
Controlling Blood Pressure	HEDIS	See Table 1
Rheumatoid Arthritis Management	HEDIS	See Table 1
Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	See Table 3
Improving Bladder Control	HOS	See Table 3
Reducing the Risk of Falling	HOS	See Table 1
RATINGS OF HEALTH PLAN RESPONSIVENESS AND CARE		
Individual Measures	***Data Source***	***Star Assignment Rules***
Ease of Getting Needed Care and Seeing Specialists	CAHPS	See Table 7
Doctors who Communicate Well	CAHPS	See Table 7
Getting Appointments and Care Quickly	CAHPS	See Table 7
Customer Service	CAHPS	See Table 7
Overall Rating of Health Care Quality	CAHPS	See Table 7
Overall Rating of Health Plan	CAHPS	See Table 7
HEALTH PLAN MEMBER COMPLAINTS, APPEALS, AND CHOOSING TO LEAVE THE HEALTH PLAN		
Individual Measures	***Data Source***	***Star Assignment Rules***
Complaints about the Health Plan (number of complaints for every 1000 members)	CTM	See Table 5
Health Plan Makes Timely Decisions about Appeals	IRE	See Table 2
Fairness of Health Plan's Denials to a Member's Appeal, Based on Independent Reviewer	IRE	See Table 1
Members Choosing to Leave the Health Plan (lower percentages are better because they mean fewer members choose to leave the plan)	Administrative	See Table 1
Seriousness of Problems Medicare Found During an Audit of the Health Plan (on a scale of 0 to 100; lower numbers are better because they mean fewer serious problems)	CMS audit findings	See Table 6
HEALTH PLAN'S TELEPHONE CUSTOMER SERVICE		
Individual Measures	***Data Source***	***Star Assignment Rules***
Time on Hold When Customer Calls Health Plan (in seconds)	CMS contractor	See Table 4
Accuracy of Information Members Get When They Call Health Plan	CMS contractor	See Table 1
Availability of TTY/TDD Services and of Foreign Language Interpretation When Members Call Health Plan	CMS contractor	See Table 1

Handling of Non-reported HEDIS Data

In the HEDIS data, NRs are assigned when the score is materially biased and the auditor tells the contract it cannot be reported to NCQA/CMS. When NRs have been assigned for a HEDIS measure, because the contract has had materially biased data or the contract has decided not to report the data, the contract has received a "1" star rating for each of these measures and a zero in the measure score with a note "Not reported. There were problems with the plan's data."

Table 1: Star assignment cut-points for normally distributed Part C measures

Percentile Rank (National)	***Star Assignment***
$< 15^{th}$ percentile	1 star
$\geq 15^{th}$ and $< 35^{th}$ percentile	2 star
$\geq 35^{th}$ and $< 65^{th}$ percentile	3 star
$\geq 65^{th}$ and $< 85^{th}$ percentile	4 star
$\geq 85^{th}$ percentile	5 star

Table 2: Absolute value based Star assignment cut-points for Part C measures which skewed high.

Rate Value	***Star Assignment***
≥ 0% and < 50%	1 star
≥ 50% and < 75%	2 star
≥ 75% and < 85%	3 star
≥ 85% and < 95%	4 star
≥ 95%	5 star

Table 3: Absolute value based Star assignment cut-points for Part C measures which skewed low.

Rate Value	***Star Assignment***
≥ 0% and < 20%	1 star
≥ 20% and < 40%	2 star
≥ 40% and < 60%	3 star
≥ 60% and < 85%	4 star
≥ 85%	5 star

Table 4: Absolute value based Star assignment cut-points for Time on Hold when Customer Calls Plan measure

Value	***Star Assignment***
> 144 seconds	1 star
≥ 120 and < 144 seconds	2 star
≥ 59 and < 120 seconds	3 star
≥ 37 and < 59 seconds	4 star
≥ 0 and < 37 seconds	5 star

Table 5: Absolute value based Star assignment cut-points for CTM measure Complaints about the Health Plan (complaints per 1000 members)

Value	***Star Assignment***
≥ 8 complaints per 1000 members	1 star
≥ 6 and < 8 complaints per 1000 members	2 star
≥ 4 and < 6 complaints per 1000 members	3 star
≥ 2 and < 4 complaints per 1000 members	4 star
≥ 0 and < 2 complaints per 1000 members	5 star

Table 6: Absolute value based Star assignment cut-points for Seriousness of Problems with Medicare Found during an Audit of the Health Plan

Rate Value	***Star Assignment***
≥ 50	1star
≥ 25 and < 50	2 star
≥ 15 and < 25	3 star
≥ 5 and < 15	4 star
≥ 0 and < 5	5 star

Table 7: CAHPS Star Assignments

Star ratings are designed to compare CAHPS measure case-mix adjusted mean scores for each plan to all other plans. In particular, they are based on the percentile rank of each plan's case-mix adjusted mean 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.

Number of Stars	Rule
1	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.
2	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.
3	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.
4	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 70th percentile OR (b) the plan's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.
5	A plan is assigned 5 stars if the plan's average CAHPS measure score is ranked above the 85th percentile and the plan's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Cut-point Values for Measures Using Table 1 Star Assignment Rules

Measure Name	Percentiles			
	15th	35th	65th	85th
Breast Cancer Screening	56.25	63.46	71.28	77.98
Colorectal Cancer Screening	35.65	45.39	58.03	68.46
Glaucoma Testing	46.20	55.27	67.03	74.04
Osteoporosis Testing	56.71	64.40	72.98	78.11
Diabetes Care	49.58	60.26	69.22	76.16
Controlling Blood Pressure	48.66	56.20	63.35	68.10
Rheumatoid Arthritis Management	61.42	70.45	77.94	82.25
Reducing the Risk of Falling	49.10	53.35	59.02	64.54
Fairness of Health Plan's Denials to a Member's Appeal	65.16	73.77	82.14	88.35
Members choosing to Leave the Health Plan	28.52	16.84	8.70	4.39
Accuracy of Information Members Get when they call Health Plan	60.00	70.00	77.00	82.00
Call Center - Foreign Language interpreter and TTY/TDD availability	34.00	61.00	71.00	82.00

Methodology for Calculating Stars at the Domain Level

Methodology: Simple average of star values from the star values assigned to each measure based on the business logic.

Part C Domain and Missing/Insufficient Data Thresholds

Domain	Minimum Number of Measures Needed to Calculate a Domain Score
Staying Healthy : Screenings, Tests, and Vaccines	6 out of 12
Managing Chronic (Long-Lasting) Conditions	3 out of 7
Ratings of Health Plan Responsiveness and Care	3 out of 6
Customer Service	2 out of 3
Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan	3 out of 5

Methodology for Calculating Stars at the Summary Level for Part C

Summary scores for Part C are calculated by taking an average of the measure level stars. Additionally, to incorporate performance stability into the rating process, CMS has used an approach that utilizes both the mean and the variance of individual performance ratings to differentiate contracts for the summary score. That is, a measure of individual performance score dispersion, specifically an integration factor (I factor), has been added to the arithmetic mean composite score for rewarding certain contracts if they have both high *and* stable relative performance. For the summary score half scores are also assigned to allow more variation across contracts. To have a summary score a contract needs to have at least 17 of the 33 Part C measures.

SNP Measures

Similar to last year the SNP HEDIS measures will be posted on www.cms.hhs.gov instead of Medicare Options Compare on www.medicare.gov**.**

The number of measures has been expanded this year to include eight measures. The eight measures include:

- Controlling High Blood Pressure
- Appropriate Monitoring of Patients Taking Long Term Medications
- Board Certified Physicians (This is an average of the four reported measures.)
- Board Certified Physicians – Geriatricians
- Care for Older Adults – Advance Care Planning
- Care for Older Adults – Medication Review
- Care for Older Adults – Functional Status Assessment
- Care for Older Adults – Pain Screening

A pdf file will be available on www.cms.hhs.gov with the actual scores for each of the SNPs reporting data. There are no star calculations for the SNP-specific measures. Plans that were required to report a measure and did not do so because the data were materially biased or they decided not to report received a "zero" for the particular measure and a footnote "Not reported. There were problems with the plan's data."

CY 2010 Part C Plan Ratings Language for Medicare Options Compare

This is a draft of the beneficiary friendly language that will be used on Medicare Options Compare when the CY 2010 Part C Plan Ratings are released. This is provided for informational purposes.

1. Part C Composite – Label, description

Label	Description
Summary Rating of Health Plan Quality	This summary rating gives an **overall score** on the health plan's quality and performance on **33 different topics in 5 categories**: • **Staying healthy: screenings, tests, and vaccines.** Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy. • **Managing chronic (long-term) conditions.** Includes how often members with different conditions got certain tests and treatments that help them manage their condition. • **Ratings of health plan responsiveness and care.** Includes ratings of member satisfaction with the plan. • **Health plan member complaints, appeals, and choosing to leave the health plan.** Includes how often members have made complaints against the plan and how often members choose to leave the plan. • **Health plan telephone customer service.** Includes how well the plan handles calls from members. The information described above is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases it is based on results from Medicare's regular monitoring activities. **Why is the summary rating important?** A single overall rating makes it easy for you to compare health plans based on quality and performance. In addition to using the summary rating: • You can look up how well the health plan is doing in each of the 5 categories that make up the summary rating. • You can also look up how well the health plan is doing in the 33 individual topics that make up the ratings in those 5 categories.

2. Part C domains – labels, descriptions

Domain label	Description
Staying Healthy: Screenings, Tests and Vaccines	**Does the health plan do a good job detecting and preventing illness?** This category addresses how well each health plan works to detect and prevent illness, and improve or maintain physical and mental health. It includes whether health plan members get regular breast cancer screening with mammograms; regular screening for colon cancer and high cholesterol; vaccines for flu and pneumonia; and glaucoma and osteoporosis testing. **Why is this information important?** A health plan that screens people for risks like cholesterol and makes sure its members get necessary vaccines may prevent disease. A health plan that screens its members for conditions like cancer may identify problems early, when treatment is most effective.
Managing Chronic (Long Term) Conditions	**Does the health plan do a good job caring for people who have long-lasting or chronic conditions?** This category addresses how well each health plan helps people with chronic or long lasting health conditions. If you have a chronic health condition such as diabetes, high blood pressure, or arthritis, this information may be especially important to you. It includes whether people with diabetes are getting certain types of recommended care, whether people with high blood pressure are able to maintain a healthy blood pressure, whether people with bone fractures are tested for brittle bones, and whether people with arthritis are taking drugs to manage their condition. **Why is this information important?** Your condition may be more stable if you choose a health plan that supports testing for chronic conditions, monitors people who have them, and works with providers and members to treat problems quickly.
Ratings of Health Plan Responsiveness and Care	**Does the health plan provide timely information and care?** This category addresses how well each health plan responds when its members need information and care. It includes whether doctors take the time to carefully and clearly explain things to you, being able to get appointments and care quickly and easily, and being able to find information about the health plan when you need it. When comparing plans on this category, it's better to look at and compare star ratings than to compare plans using the number ratings. The star ratings are better because they capture more statistical information while keeping it easy to make comparisons. **Why is this information important?** When choosing a health plan, you may want to know how well it provides timely information and care. You may be more satisfied with a health plan whose doctors communicate well, and whose members give it high ratings for overall care.

Domain label	Description
Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan	**This category shows how the health plan is doing in the following areas:** • How quickly and how well each health plan handles appeals made by members. An appeal is a special kind of request you file if you disagree with a decision made by your health plan about what care the plan will cover or how much it will pay. As an extra protection for members, sometimes an outside panel of experts is asked to review the decisions made by health plans. This category tells how quickly the plan handles appeals and whether the health plan's decisions are upheld by outside experts. • How many complaints, for every 1,000 members, Medicare got about each health plan from its members. • The percent of members in each health plan who chose to leave the plan. • The seriousness of problems Medicare found when it has done audits to check on how well the health plan is following rules set by Medicare. **Why is this information important?** When choosing a health plan, you may want to consider how often members have made complaints about the plan or decided to leave the plan. You may also want to look at how quickly and how well the plan responds when members make appeals. When a plan responds promptly to appeals, you won't have to wait long to get a final decision about payment.
Health Plan Telephone Customer Service	**This rating shows how the health plan performs in the following customer service areas:** • How long members wait on hold when they call the health plan's customer call center. • How often the plan's representative gives accurate information. • How often TTY/TDD services and foreign language interpretation are available for members. **Why is this information important?** When choosing a health plan, you may want to know how well a plan handles customer service calls.

3. Metrics

Domain label	Measure label (for stars)	Measure label (for data)	Measure description	Data source
Staying Healthy: Screenings, Tests and Vaccines	At Least One Primary Care Doctor Visit in the Last Year	At Least One Primary Care Doctor Visit in the Last Year	Percent of all plan members who saw their primary care doctor during the year.	These data are from two surveys of Medicare health plan enrollees -- the Health Outcome Survey and the Medicare Satisfaction Survey -- conducted in 2008 and 2009, respectively, and clinical quality data collected in 2008 from Medicare health plans. The results have been independently validated.
Staying Healthy: Screenings, Tests and Vaccines	Breast Cancer Screening	Breast Cancer Screening	Percent of female plan members aged 50-69 who had a mammogram during the past 2 years.	
Staying Healthy: Screenings, Tests and Vaccines	Colorectal Cancer Screening	Colorectal Cancer Screening	Percent of plan members aged 50-80 who had appropriate screening for colon cancer.	
Staying Healthy: Screenings, Tests and Vaccines	Cholesterol Screening for Patients with Diabetes or Heart Disease	Cholesterol Screening for Patients with Diabetes or Heart Disease	Percent of plan members with diabetes or heart disease who have had a test for "bad" cholesterol (LDL cholesterol) (members with heart disease who have had this test within the past year; members with diabetes who have had the test within the past 2 years). While many members need to have their cholesterol checked regularly, cholesterol screening is especially important for members with diabetes or heart disease. This looks at how well the plan provides cholesterol screening to members with diabetes or heart disease because they are at highest risk.	
Staying Healthy: Screenings, Tests and Vaccines	Glaucoma Testing	Glaucoma Testing	Percent of senior plan members who got a glaucoma eye exam for early detection.	
Staying Healthy: Screenings, Tests and Vaccines	Osteoporosis Testing	Osteoporosis Testing	Percent of female, senior plan members who had a bone density test to check for osteoporosis (fragile bones).	
Staying Healthy: Screenings, Tests and Vaccines	Annual Flu Vaccine	Annual Flu Vaccine	Percent of plan members aged 65+ who got a vaccine (flu shot) prior to flu season.	
Staying Healthy: Screenings, Tests and Vaccines	Pneumonia Vaccine	Pneumonia Vaccine	Percent of plan members aged 65+ who ever got a vaccine (shot) to prevent pneumonia.	
Staying Healthy: Screenings, Tests and Vaccines	Monitoring of Patients Taking Long-term Medications	Monitoring of Patients Taking Long-term Medications	Percent of plan members who got a 6 month (or longer) prescription for a drug known to have possibly harmful side effects among seniors if used long-term, and who had at least one	

Domain label	Measure label (for stars)	Measure label (for data)	Measure description	Data source
			appropriate follow-up visit during the year to monitor these medications: Angiotensin Converting Enzyme (ACE) inhibitors, Angiotensin Receptor Blockers (ARB), digoxin, diuretics, anticonvulsants, and statins.	
Staying Healthy: Screenings, Tests and Vaccines	Monitoring Physical Activity	Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	
Staying Healthy: Screenings, Tests and Vaccines	Improving or Maintaining Physical Health	Improving or Maintaining Physical Health	Percent of all plan members whose physical health was the same or better than expected after two years.	
Staying Healthy: Screenings, Tests and Vaccines	Improving or Maintaining Mental Health	Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	
Managing Chronic (Long Term) Conditions	Osteoporosis Management	Osteoporosis Management	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.	These data are from a survey of Medicare health plan enrollees (the Health Outcome Survey) conducted in 2008 and clinical quality data collected in 2008 from Medicare health plans. The results have been independently validated.
Managing Chronic (Long Term) Conditions	Providing Certain Kinds of Care that Help Plan Members with Diabetes Stay Healthy	Providing Certain Kinds of Care that Help Plan Members with Diabetes Stay Healthy	For plan members with diabetes, this shows how well the plan is doing at providing the following care to help people with diabetes stay healthy: • An exam to check for damage in their eyes • A test of how well their kidneys are working • A test showing their blood sugar is under control • A test showing their "bad" LDL cholesterol is at a healthy level	
Managing Chronic (Long Term) Conditions	Controlling Blood Pressure	Controlling Blood Pressure	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.	
Managing Chronic (Long Term) Conditions	Rheumatoid Arthritis Management	Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got 1 or more prescription(s) for an anti-rheumatic drug.	
Managing Chronic (Long Term) Conditions	Testing to Confirm Chronic Obstructive Pulmonary	Testing to Confirm Chronic Obstructive Pulmonary	Percent of senior plan members with active Chronic Obstructive Pulmonary Disease who got appropriate spirometry testing to	

Domain label	Measure label (for stars)	Measure label (for data)	Measure description	Data source
	Disorder	Disorder	confirm the diagnosis.	
Managing Chronic (Long Term) Conditions	Improving Bladder Control	Improving Bladder Control	Percent of members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.	
Managing Chronic (Long Term) Conditions	Reducing the Risk of Falling	Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year"	
Ratings of Health Plan Responsiveness and Care	Doctors Who Communicate Well	Doctors Who Communicate Well	Percent of best possible score the plan earned on how well doctors communicate.	These data are from a survey of Medicare health plan enrollees (the Medicare Satisfaction Survey) conducted in 2009 and clinical quality data collected in 2008 from Medicare health plans. The results have been independently validated.
Ratings of Health Plan Responsiveness and Care	Getting Appointments and Care Quickly	Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care.	
Ratings of Health Plan Responsiveness and Care	Ease of Getting Needed Care and Seeing Specialists	Ease of Getting Needed Care and Seeing Specialists	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.	
Ratings of Health Plan Responsiveness and Care	Overall Rating of Health Care Quality	Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received.	
Ratings of Health Plan Responsiveness and Care	Overall Rating of Plan	Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan.	
Ratings of Health Plan Responsiveness and Care	Customer Service	Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed.	
Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan	Complaints about the Health Plan	Complaints about the Health Plan (number of complaints for every 1,000 members)	How many complaints Medicare received about the health plan.	These data include the rate of complaints Medicare received about health plans from the Medicare Complaint Tracking Module (CTM), information from a third party Independent Review Entity (IRE), information from Medicare's enrollment system, and findings from CMS audits. The information from the Complaint Tracking Module covers complaints Medicare received from July 1, 2008 to June 30, 2009. The IRE evaluates
Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan	Health Plan Makes Timely Decisions about Appeals	Health Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	
Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan	Fairness of Health Plan's Denials to Member Appeals, Based on an Independent Reviewer	Fairness of Health Plan's Denials to Member Appeals, Based on an Independent Reviewer	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	
Health Plan Member	Members	Members	The percent of health plan	

Domain label	Measure label (for stars)	Measure label (for data)	Measure description	Data source
Complaints, Appeals, and Choosing to Leave the Health Plan	Choosing to Leave the Health Plan (**more** stars are better because they mean fewer members are choosing to leave the plan)	Choosing to Leave the Health Plan (**lower** percentages are better because they mean fewer members choose to leave the plan)	members who chose to leave the plan in 2008. (This excludes members who did not **choose** to leave the plan, such as members who moved out of the service area.)	Part C appeals after the plan's review. These data include cases processed by the IRE in 2008. The information from Medicare's enrollment system and findings from CMS audits covers calendar year 2008.
Health Plan Member Complaints, Appeals, and Choosing to Leave the Health Plan	Seriousness of Problems Medicare Found During an Audit of the Health Plan (**more** stars are better because they mean fewer serious problems)"	Seriousness of Problems Medicare Found During an Audit of the Health Plan (on a scale from 0 to 100; **lower** numbers are better because they mean fewer serious problems)"	Medicare oversees the operations of health plans by auditing. Some plans are selected at random for an audit. Other plans are audited because Medicare suspects there may be a problem. Not every plan is audited every year, so "not audited" is neither good nor bad. Medicare gives the plan a rating from 0 to 100. The rating combines ***how severe the*** problems were, ***how many*** there were, and ***how much*** they affect plan members directly.	
Health Plan Telephone Customer Service	Time on Hold When Customer Calls Health Plan	Time on Hold When Customer Calls Health Plan (minutes: seconds)	How long members wait on hold when they call the health plan's customer service number.	The data used to measure the performance of the health plan's telephone customer service come from systematic studies that Medicare does to check on how well the plan is handling calls from members. These studies are based on calls made to the plan's customer service during the period from January 1, 2009 to June 30, 2009.
Health Plan Telephone Customer Service	Accuracy of Information Members Get When They Call the Health Plan	Accuracy of Information Members Get When They Call the Health Plan	Percent of the time members are given correct information by the health plan's customer service representative.	
Health Plan Telephone Customer Service	Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan	Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	