Medicare
Health & Drug Plan
Quality and Performance Ratings
2012 Part C & Part D
Technical Notes

Updated – 02/15/2012

Document Change Log:

Previous Version	Description of Change	Revision Date
10/11/2011	Measure C08 - Improving or Maintaining Physical Health: Removed +P107 from end of Data Source	01/18/2012
10/11/2011	Measure D06 - Complaints about the Drug Plan metric was updated to match Measure C31 - Complaints about the Health Plan	01/18/2012
10/11/2011	Measure C33 - Members Choosing to Leave the Plan & D08 - Members Choosing to Leave the Plan, updated the list of exclusions to include members who disenrolled due to the requirement that SNP disenroll disproportionate share member who do not meet the SNP criteria.	01/18/2012
10/11/2011	Fixed spelling error (changed weighed to weighted) in C25 – Plan All-Cause Readmissions Weighting Value section in measure description and in Attachment G.	01/18/2012
10/11/2011	Updated the metric for C19 to place "*(numerator)*" in the correct position after "enrollees 18-75" vice where it was previously after "measurement year".	01/18/2012
10/11/2011	D03 - Appeals Auto–Forward – Deleted "for Part D reconsiderations " from end of Data Source Description	01/18/2012
01/18/2012	Revised placement of "*(numerator)*" and "*(denominator)*" in measure C19 again.	02/15/2012

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Introduction

This document describes the methodology for creating the Part C and D Plan Ratings displayed in the Medicare Plan Finder (MPF) tool on http://www.medicare.gov/. These ratings are also displayed in the Health Plan Management System (HPMS) for contracts and sponsors. In the HPMS Quality and Performance section, the Part C data can be found in the Part C Performance Metrics module in the Part C Report Card Master Table section. The Part D data are located in the Part D Performance Metrics and Report module in the Part D Report Card Master Table section.

All of the health/drug plan quality and performance measure data described in this document are reported at the contract level. Table 1 lists the contract year 2012 organization types and whether they are included in the Part C and/or Part D Plan Ratings.

Table 1: Organization Types Reported in the 2012 Plan Ratings

Organization Type	1876 Cost	Chronic Care	Employer/Union Only Direct Contract PDP	Employer/Union Only Direct Contract PFFS*	HCPP - 1833 Cost	Local CCP*	MSA*	National PACE	PDP	PFFS*	Regional CCP*
Part C Ratings	Yes	No	No	No	No	Yes	Yes	No	No	Yes	Yes
Part D Ratings	Yes (If drugs are offered)	No	No	No	No	Yes	No	No	Yes	Yes	Yes

* Note: These organization types are Medicare Advantage Organizations

Differences between the 2011 Plan Ratings and 2012 Plan Ratings

There have been several changes between the 2011 Plan Ratings and the 2012 Plan Ratings. This section provides a synopsis of the significant differences; the reader should examine the entire document for full details about the 2012 Plan Ratings.

1. Changes
    a. Combined Part C and D Plan Ratings Technical Notes into one document
    b. Part C & D measures: C32 & D07 - Beneficiary Access and Performance Problems, renamed from “Corrective Action Plans” and changes in methodology. Because of the change in methodology, comparisons should not be made between 2012 and previous years.
    c. Part D measure: D04 - Appeals Upheld, changes in methodology
    d. Part D measure: D06 - Complaints about the Drug Plan, combined last year’s two measures into one
    e. Part D measure: D12 - MPF Composite, changes in the methodology
    f. Part D measure: D13 - High Risk Medication, updated 4-star threshold
    g. Established a 4-star thresholds for:
        i. Part C measure: C36 - Call Center – Foreign Language Interpreter and TTY/TDD Availability
        ii. Part D measure: D02 - Call Center – Foreign Language Interpreter and TTY/TDD Availability
        iii. Part D measure: D14 - Diabetes Treatment
2. Additions
    a. Weighting of Measures
    b. High Performing icon
    c. Sanction Reductions
    d. Part C measure: C12 - Adult BMI Assessment
    e. Part C measure: C13 - Care for Older Adults – Medication Review

f. Part C measure: C14 - Care for Older Adults – Functional Status Assessment
g. Part C measure: C15 - Care for Older Adults – Pain Screening
h. Part C measure: C25 - Plan All-Cause Readmissions
i. Part C & D measures: C33 & D08 - Members Choosing to Leave the Plan
j. Part D measure: D05 - Enrollment Timeliness
k. Part D measure: D15 - Part D Medication Adherence for Oral Diabetes Medications
l. Part D measure: D16 - Part D Medication Adherence for Hypertension (ACEI or ARB)
m. Part D measure: D17 - Part D Medication Adherence for Cholesterol (Statins)

3. Retired (Moved to the display measures which can be found on the CMS website at this address: http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp)
   a. Part C measure: Appropriate Monitoring for Patients Taking Long Term Medications
   b. Part C measure: Osteoporosis Testing
   c. Part C measure: Doctors who Communicate Well
   d. Part C measure: Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)
   e. Part C measure: Call Center – Customer Hold Time
   f. Part C measure: Call Center – Information Accuracy
   g. Part D measure: Call Center – Beneficiary Hold Time
   h. Part D measure: Call Center – Information Accuracy
   i. Part D measure: Drug Plan Provides Pharmacists with Up-to-Date and Complete Enrollment Information about Plan Members
   j. Part D measure: Completeness of the Drug Plan's Information on Members Who Need Extra Help

Contract Enrollment Data

The enrollment data used in the Part C and D "Complaints about the Health/Drug Plan" measures were pulled from the HPMS. These enrollment files represent the number of beneficiaries the contract was paid for in a specific month. For this measure, six months of enrollment files were pulled (January 2011 through June 2011) and the average enrollment from those months was used in the calculations.

The enrollment data used in the Part D "Appeals Auto–Forward" measure were pulled from the HPMS. These enrollment files represent the number of beneficiaries the contract was paid for in a specific month. For this measure, twelve months of enrollment files were pulled (January 2010 through December 2010) and the average enrollment from those months was used in the calculations.

Enrollment data are also used to combine plan level data into contract level data in the three Part C Care for Older Adults HEDIS measures. This only occurs when the eligible population was not included in the submitted SNP HEDIS data and the submitted rate was NR (see following section). For these measures, twelve months of plan level enrollment files were pulled (January 2010 through December 2010) and the average enrollment in the plan for those months was used in calculating the combined rate.

Handling of Biased, Erroneous and/or Not Reportable (NR) Data

CMS has identified issues with some contracts attempting to manipulate data or erroneously reporting data in an attempt to receive higher ratings. In these cases, the contract will receive a "1" star rating for each of the measures and a footnote: "CMS identified issues with this plan's data."

For the Healthcare Effectiveness Data and Information Set (HEDIS) data, NRs are assigned when the individual measure score is materially biased (e.g., the auditor informs the contract the data cannot be reported to the National Committee for Quality Assurance (NCQA) or CMS) or the contract decides not to report the

data for a particular measure. When NRs have been assigned for a HEDIS measure rate, because the contract has had materially biased data or the contract has decided not to report the data, the contract receives a “1” star for each of these measures and the numerical value will be set at the worst possible value (a zero for most HEDIS measures, 100 for the Plan All-Cause Readmission measure). The measure score will also receive the footnote: “Not reported. There were problems with the plan's data” for materially biased data or "Measure was not reported by plan" for unreported data.

If an approved CAHPS vendor does not submit a contract’s CAHPS data by the data submission deadline, the contract will automatically receive a rating of 1 star for the CAHPS measures.

How the Data are Reported

For 2012, the Part C and D Plan Ratings are reported using five different levels of detail.

1. At the base level, with the most detail, are the individual measures. They are comprised of numeric data for all of the quality and performance measures.

2. Each of the base level measure ratings are then scored on a 5-star scale.

3. Each measure is also grouped with similar measures into a second level called a domain. A domain is assigned a star rating.

4. All of the Part C measures are grouped together to form the Part C rating for a contract. There is also a Part D rating formed by grouping the Part D measures.

5. The highest level is the overall rating which applies only to MA-PDs. This overall rating summarizes all of the Part C and Part D measures for each contract. The highest level for PDPs is the Part D rating. The highest level for MA-only contracts is the Part C rating.

There are a total of 9 domains (topic areas) comprised of up to 53 individual measures.

1. MA-only contracts are measured on 5 domains with up to 36 individual measures.

2. PDPs are measured on 4 domains with up to 17 individual measures.

3. MA-PD contracts are measured on all 9 domains with up to 50 individual measures.

Methodology for Assigning Part C and D Measure Star Ratings

CMS develops Part C and Part D Plan Ratings in advance of the annual enrollment period each fall. Ratings are calculated at the contract level.

The principle for assigning star ratings for a measure is based on evaluating the maximum score possible, and testing initial percentile star thresholds with actual scores. Scores are grouped using statistical techniques to minimize the distance between scores within a grouping (or “cluster”) and maximize the distance between scores in different groupings. Most datasets that are utilized for Plan Ratings, however, are not normally distributed. This necessitates further adjustments to the star thresholds to account for gaps in the data.

CMS does not force the Plan Ratings data into 5-star categories for every measure. For example, in the health plan measure of Osteoporosis management in women that had a fracture, the 4-star threshold is ≥ 60%. For 2012, four contracts have surpassed this threshold while the majority of contracts’ scores fall into the 1-star and 2-star ranges.

In the MPF composite measure, we will continue to assign only 3, 4 or 5 stars, due to the distribution of the measure data.

Predetermined Thresholds

CMS has set fixed 4-star thresholds for most measures and 3-star thresholds for measures when an absolute regulatory standard has been established (such as answering a pharmacy call within 2 minutes). Additionally, CMS set these thresholds in order to define expectations about what it takes to be a high quality contract and

to drive quality improvement. These target 4-star thresholds are based on contract performance in prior years; therefore they have not been set for revised measures or for measures with less than 2 years of measurement experience.

The distribution of data is evaluated to assign the other star values. For example, in the call center hold time measure, a contract that has a hold time of 2 minutes or less will receive at least 3 stars. A contract that has a hold time of only 15 seconds will receive 5 stars as they met the CMS standard and were well above the upper limit of all other contracts.

When CMS has not set a fixed 3 or 4-star threshold for a measure, the maximum score possible is considered as a first step in setting the initial thresholds. Again, these thresholds may require adjustments to accommodate the actual distribution of data.

Methodology for Calculating Stars for Individual Measures

CMS assigns stars for each measure by applying one of three different methods: relative distribution and clustering; relative distribution and significance testing; and CMS standard, relative distribution, and clustering. Each method is described in detail below.

A. Relative Distribution and Clustering:

This method is applied to the majority of CMS' Plan Ratings for star assignments, ranging from operational and process-based measures, to HEDIS and other clinical care measures. The following sequential statistical steps are taken to derive thresholds based on the relative distribution of the data. The first step is to assign initial thresholds using an adjusted percentile approach and a two-stage clustering analysis method. These methods jointly produce initial thresholds to account for gaps in the data and the relative number of contracts with an observed star value.

Detailed description:

1. By using the Euclidean metric (defined in Attachment I), scale the raw measures to comparable metrics, and group them into clusters. Clusters are defined as contracts with similar Euclidean distances between their data values and the center data value. Six different clustering scenarios are tested, where the smallest number of clusters is 10, and the largest number of clusters is 35. The results from each of these clustering scenarios are evaluated for potential star thresholds. The formula for scaling a contract's raw measure value (X) for a measure (M) is the following, where $Scale_{\min} = 0.025$ and $Scale_{\max} = 0.975$:

   Scaled measure value = $(Scale_{\max} - Scale_{\min}) * \frac{(X - M_{\min})}{(M_{\max} - M_{\min})} + Scale_{\min}$

2. Determine up to five star groupings and their corresponding thresholds from the means of each cluster derived in Step 1.

In applying these two steps, goodness of fit analysis using an empirical distribution function test in an iterative process is performed as needed to test the properties of the raw measure data distribution in contrast to various types of continuous distributions. Additional sub-tests are also applied and include: Kolmogorov-Smirnov statistic, Cramér-von-Mises statistic, and Anderson-Darling statistic. See Attachment I for definitions of these tests.

Following these steps, the estimates of thresholds for star assignments derived from the adjusted percentile and clustering analyses are combined to produce final individual measure star ratings.

B. Relative Distribution and Significance Testing:

This method is applied to determine valid star thresholds for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars a contract's CAHPS measure score needs to be ranked above the 80th percentile and be statistically significantly higher than the national average CAHPS

measure score. A contract is assigned 4 stars if it does not meet the 5-star criteria, but the contract's average CAHPS measure score exceeds a cutoff defined by the 60th percentile of contract means in 2009 CAHPS reports for the same measure. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and the contract's CAHPS measure score must be statistically significantly lower than the national average CAHPS measure score.

C. CMS Standard, Relative Distribution, and Clustering:

For measures with a CMS published standard, the CMS standard has been incorporated into star thresholds. Currently, the instance in which this method applies is the call center hold time measure. Contracts meeting or exceeding the CMS standard are assigned at least 3 stars. To determine the thresholds of the other star ratings (e.g., 1, 2, 4, and 5 stars), the steps outlined above for relative distribution and clustering are applied.

Methodology for Calculating Stars at the Domain Level

The domain rating is a weighted average of the star ratings assigned to each individual measure within the domain. To receive a domain rating, the contract must meet or exceed the minimum number of individual rated measures within the domain. The minimum number of measures required is determined as follows:

- If the total number of measures required for the organization type in the domain is odd, divide the number by two and round it to a whole number.
  - Example: there are 3 required measures in the domain for the organization, 3 / 2 = 1.5, when rounded the result is 2. The contract needs to have at least 2 measures with a rating out of 3 measures for the domain to be rated.
- If the total number of measures required for the organization type in the domain is even, divide the number by two and then add one to the result.
  - Example: there are 6 required measures in the domain for the organization, 6 / 2 = 3, add one to that result, 3 + 1 = 4. The contract needs at least 4 measures with star ratings out of the 6 measures for the domain to be rated.

Table 2 shows each domain and the number of measures needed for each contract type.

Table 2: Domain Rating Requirements

	Domain		Contract Type							
Part	ID	Name	1876 Cost †	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
C	1	Staying Healthy: Screenings, Tests, and Vaccines	7 of 12	7 of 12	7 of 12	6 of 10	N/A	6 of 10	6 of 11	6 of 11
C	2	Managing Chronic (Long Term) Conditions	5 of 9	6 of 10	7 of 13	4 of 7	N/A	4 of 7	6 of 10	7 of 13
C	3	Ratings of Health Plan Responsiveness and Care	3 of 5	3 of 5	3 of 5	3 of 5	N/A	3 of 5	3 of 5	3 of 5
C	4	Member Complaints, Problems Getting Services, and Choosing to Leave the Plan	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3	2 of 3
C	5	Health Plan Customer Service	2 of 2	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3	2 of 3
D	1	Drug Plan Customer Service	2 of 3*	3 of 5	3 of 5	N/A	3 of 5	3 of 5	3 of 5	3 of 5
D	2	Member Complaints, Problems Getting Services, and Choosing to Leave the Plan	2 of 3*	2 of 3	2 of 3	N/A	2 of 3	2 of 3	2 of 3	2 of 3
D	3	Member Experience with Drug Plan	2 of 3*	2 of 3	2 of 3	N/A	2 of 3	2 of 3	2 of 3	2 of 3
D	4	Drug Pricing and Patient Safety	4 of 6*	4 of 6	4 of 6	N/A	4 of 6	4 of 6	4 of 6	4 of 6

* Note: Does not apply to MA-only 1876 Cost contracts which do not offer drug benefits.

† Note: 1876 Cost contracts which do not submit data for the MPF measure must have a rating in 3 out of 5 Drug Pricing and Patient Safety measures to receive a rating in that domain.

Weighting of Measures

For the 2012 Plan Ratings, CMS assigned the highest weight to outcomes and intermediate outcomes, followed by patient experience/complaints and access measures. Process measures were weighted the least. The Part C, Part D, and overall MA-PD ratings are thus calculated as weighted averages of the ratings of individual measures. Attachment G: Weights Assigned to Individual Performance Measures shows the weights assigned to each measure for summary and overall star ratings. A measure given a weight of 3 counts three times as much as a measure given a weight of 1. For both the summary and overall ratings, the rating for a single contract is calculated as a weighted average of the measures available for that contact. The first step in this calculation would be to multiply each individual measure's weight by the measure's star rating and then sum all results for all the measures available for a given contract. The second step would be to divide this result by the sum of the weights for the measures available for the contract.

Methodology for Calculating Part C and Part D Rating

The Part C and Part D ratings are calculated by taking a weighted average of the measure level ratings for Part C and D, respectively. To receive a Part C and/or D Rating, a contract must meet or exceed the minimum number of individual measures with a star rating. The minimum number of measures required is determined as follows:

- If the total number of measures required for the organization type in the domain is odd, divide the number by two and round it to a whole number.
    - Example: there are 17 required Part D measures for the organization, 17 / 2 = 8.5, when rounded the result is 9. The contract needs to have at least 9 measures with a rating out of the 17 total measures to receive a Part D rating.
- If the total number of measures required for the organization type in the domain is even, divide the number of measures by two.
    - Example: there are 32 required Part C measures for the organization, 32 / 2 = 16. The contract needs at least 16 measures with ratings out of the 32 total measures to receive a Part C rating.

Table 3 shows the minimum number of measures having a rating needed by each contract type to receive a rating.

Table 3: Part C and Part D Rating Requirements

Rating	1876 Cost †	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Part C Summary Rating	16 of 31	17 of 33	18 of 36	14 of 28	N/A	14 of 28	16 of 32	18 of 35
Part D Summary Rating	8 of 15	9 of 17	9 of 17	N/A	9 of 17	9 of 17	9 of 17	9 of 17

† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 7 out of 14 measures to receive a Part D rating.

For this rating, half stars are also assigned to allow for more variation across contracts.

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 mean score for rewarding contracts if they have both high and stable relative performance. Details about the i-Factor can be found in the section titled Applying the Integration Factor.

Methodology for Calculating the Overall MA-PD Rating

For MA-PDs to receive an overall rating, the contract must have stars assigned to both the Part C rating and the Part D rating. If a contract has only one of the two required summary ratings, it will receive a note saying, "Not enough data to calculate overall rating".

The overall Plan Rating for MA-PD contracts is calculated by taking a weighted average of the Part C and D measure level stars.

There are a total of 53 measures (36 in Part C, 17 in Part D). The Complaints Tracking Module (CTM), Beneficiary Access and Performance Problems (BAPP) and Members Choosing to Leave the Plan (MCLP) measures for Part C and D share the same data source. Where the Part C and D measures use the same data source, CMS has only included the measure once in calculating the overall Plan Rating. This results in a total of 50 measures (the Part D CTM, BAPP and MCLP measures are equivalent to the Part C measures).

The minimum number of measures required for an overall MA-PD is determined using the same methodology as for the Part C and D ratings. Table 4 shows the minimum number of measures having a rating needed by each contract type to receive an overall rating.

Table 4: Overall Rating Requirements

Rating	1876 Cost †	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Overall Rating	22 of 43*	24 of 47	25 of 50	N/A	N/A	21 of 42	23 of 46	25 of 49

* Note: Does not apply to MA-only 1876 Cost contracts which do not offer drug benefits.

† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 21 out of 42 measures to receive an overall rating.

For the overall rating, half stars are also assigned to allow more variation across contracts.

Additionally, CMS is using the same i-Factor approach in calculating the summary level. Details about the i-Factor can be found in the section titled Applying the Integration Factor.

Applying the Integration Factor

The following represents the steps taken to calculate and include the i-Factor in the Plan Ratings summary and overall ratings:

- Calculate the mean and the variance of all of the individual performance measure stars at the contract level.
  - The mean is the summary or overall rating before the i-Factor is applied, which is calculated as described in the section titled Weighting of Measures.
  - Using weights in the variance calculation accounts for the relative importance of measures in the i-Factor calculation. To incorporate the weights shown in Attachment G into the variance calculation of the available individual performance measures for a given contract, the steps are as follows:
    - Subtract the summary or overall star from each performance measure's star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
    - Sum these results; call this 'SUMWX.'
    - Set n equal to the number of individual performance measures available for the given contract.
    - Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.
    - The weighted variance for the given contract is calculated as: n*SUMWX/(W*(n-1)) (for the complete formula, please see Attachment H: Calculation of Weighted Star Rating and Variance Estimates).
- Categorize the variance into three categories:
  - low (0 to 30th percentile),
  - medium (30th to 70th percentile) and
  - high (70th percentile and above)
- Develop the i-Factor as follows:
  - i-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)

- i-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
- i-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
- i-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
- i-Factor = 0.0 (for other types of contracts)

- Develop final summary score using 0.5 as the star scale (create 10 possible overall scores as: 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0).
- Apply rounding to final summary score such that stars that are within the distance of 0.25 above or below any half star scale will be rounded to that half star scale.
- Tables 5 and 6 show the final threshold values used in i-Factor calculations for the 2012 Plan Ratings:
- Table 5: Performance Summary Thresholds

Percentile	Part C Summary Rating	Part D Summary Rating	Overall Rating
65th	3.56	3.4717	3.50
85th	4.07	3.8980	3.85

- Table 6: Variance Thresholds

Percentile	Part C Summary Rating	Part D Summary Rating	Overall Rating
30th	1.02	1.1575	1.13
70th	1.40	1.9657	1.51

Rounding Rules for Measure Scores:

Measure scores are rounded to the nearest whole number. Using standard rounding rules, raw measure scores that end in 0.4 are rounded down and raw measure scores that end in 0.5 are rounded up. So, for example, a measure score of 83.49 rounds down to 83 while a measure score of 83.50 rounds up to 84.

Rounding Rules for Summary and Overall Scores:

Summary and overall scores are rounded to the nearest half star (i.e., 0, 0.5, 1, 1.5, 2, 2.5, 3, 3.5, 4, 4.5, 5). Table 7 shows how scores are rounded.

Table 7: Rounding Rules for Summary and Overall Scores

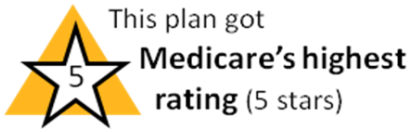
Raw Summary / Overall Score	Final Summary / Overall Score
≥0 and <0.25	0
≥0.25 and <0.75	0.5
≥0.75 and <1.25	1.0
≥1.25 and <1.75	1.5
≥1.75 and <2.25	2.0
≥2.25 and <2.75	2.5
≥2.75 and <3.25	3.0
≥3.25 and <3.75	3.5
≥3.75 and <4.25	4.0
≥4.25 and <4.75	4.5
≥4.75	5.0

For example, a summary or overall score of 3.74 rounds down to 3.5 and a measure score of 3.75 rounds up to 4.

Methodology for Calculating the High Performing Contract Indicator

A contract may receive a high performing contract indicator as a result of its performance on the Part C and D measures. The high performing contract indicator is assigned to an MA-only contract for achieving a 5-star Part C summary rating, a PDP contract for a 5-star Part D summary ratings and an MA-PD contract for a 5-star overall rating. Figure 1 shows the high performing contract indicator icon to be used in Medicare.gov Plan Finder:

Figure 1: The High Performing Contract Icon



Methodology for Calculating the Low Performing Contract Indicator

A contract can receive a low performing contract indicator as a result of its performance on the Part C or D measures. The low performing contract indicator is calculated by evaluating the Part C summary rating for the current year and the past two years (i.e., the 2010, 2011 and 2012 Plan Ratings). If the contract had a Part C summary rating of 2.5 or lower for all three years of data, it is marked as a low performing contract. A contract must have a Part C summary rating for all three years to be considered for this indicator.

A contract can also receive a separate low performing contract indicator in the Part D Plan Ratings. Using the same data years as Part C, if a contract has had a Part D summary rating of 2.5 or lower for all three years of data, it is marked as a low performing contract. A contract must have a Part D summary rating for all three years to be considered for this indicator. Figure 2 shows the low performing contract indicator icon used in the Medicare.gov plan finder:

Figure 2: The Low Performing Contract Icon

Adjustments for Contracts Under Sanctions

Contracts under an enrollment sanction are automatically assigned 2.5 stars. If a contract under sanction already has 2.5 stars or below, it will receive a 1-star reduction. Contracts under sanction will be evaluated and adjusted at two periods each year.

- August 31st: Contracts under sanction as of August 31st will have their Plan Ratings reduced in that fall's rating on Medicare Plan Finder (MPF).
- March 31st: Plan Ratings for contracts either coming off sanction or going under sanction will be updated for the MPF and Quality Bonus Payment purposes. A contract whose sanction has ended after August 31st will have its original Plan Rating restored. A contract that received a sanction after August 31st will have its Plan Rating reduced. Contracts will be informed of the changes in time to synchronize their submission of plan bids for the following year. Updates will also be displayed on MPF.

Special Needs Plan (SNP) Data

CMS has included 3 SNP specific measures in the 2012 Plan Ratings. All three measures are based on data from the HEDIS Care for Older Adults measure. Since these data are reported at the plan benefit package (PBP) level and the Plan Ratings are reported by contract, CMS has combined the reported rates for all PBPs within a contract using the NCQA developed methodology described in Attachment E.

CAHPS Methodology

The CAHPS measures are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses. See Attachment A for the case-mix adjusters.

The CAHPS star calculations also take into account statistical significance and reliability of the measure. The base stars are the number of stars assigned prior to taking into account statistical significance and reliability.

These are the rules applied to the base star values to arrive at the final CAHPS measure star value:

5 base stars: If significance is NOT above average OR reliability is low, the Final Star value equals 4.

4 base stars: Always stays 4 Final Stars.

3 base stars: If significance is below average, the Final Star value equals 2.

2 base stars: If significance is NOT below average AND reliability is low, the Final Star value equals 3.

1 base star: If significance is NOT below average AND reliability is low, the Final Star value equals 3 or
if significance is below average and reliability is low, the Final Star value equals 2 or
if significance is not below average and reliability is not low, the Final Star value equals 2.

Contact Information

The two contacts below can assist you with various aspects of the Plan Ratings.

- Part C Plan Ratings: PartCRatings@cms.hhs.gov
- Part D Plan Ratings: PartDMetrics@cms.hhs.gov

If you have questions or require information about the specific subject areas associated with the Plan Ratings please write to those contacts directly.

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: Gregory.Bottiani@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- Marketing: marketingpolicy@cms.hhs.gov
- QBP Ratings and Appeals: QBPAppeals@cms.hhs.gov

Part C Domain and Measure Details

See Attachment C for the national averages of individual Part C measures.

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening

Label for Stars: Breast Cancer Screening

Label for Data: Breast Cancer Screening

HEDIS Label: Breast Cancer Screening (BCS)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 82

Description: Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.

Metric: The percentage of female MA enrollees ages 40 to 69 (denominator) who had one or more mammograms during the measurement year or the year prior to the measurement year (numerator).

Exclusions: (optional) Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies. Refer to NCQA HEDIS 2011 Technical Specifications Volume 2 page 83, Table BCS-B for codes to identify exclusions.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 74%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 49%	≥ 49% to < 64%	≥ 64% to < 74%	≥ 74% to < 80%	≥ 80%

Measure: C02 - Colorectal Cancer Screening

Label for Stars: Colorectal Cancer Screening

Label for Data: Colorectal Cancer Screening

HEDIS Label: Colorectal Cancer Screening (COL)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 87

Description: Percent of plan members aged 50-75 who had appropriate screening for colon cancer.

Metric: The percentage of MA enrollees aged 50 to 75 (denominator) who had one or more appropriate screenings for colorectal cancer (numerator).

Exclusions: (optional) Members with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the

member's history. Refer to NCQA HEDIS 2011 Technical Specifications Volume 2 page 88, Table COL-B for codes to identify exclusions.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	No	No	No	No

4-Star Threshold: ≥ 58%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 37%	≥ 37% to < 47%	≥ 47% to < 58%	≥ 58% to < 66%	≥ 66%

Measure: C03 - Cardiovascular Care – Cholesterol Screening

Label for Stars: Cholesterol Screening for Patients with Heart Disease

Label for Data: Cholesterol Screening for Patients with Heart Disease

HEDIS Label: Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 130

Description: Percent of plan members with heart disease who have had a test for "bad" (LDL) cholesterol within the past year.

Metric: The percentage of members 18–75 years of age who were discharged alive for Acute Myocardial Infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year (denominator), who had an LDL-C screening test performed during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 77%	≥ 77% to < 81%	≥ 81% to < 85%	≥ 85% to < 91%	≥ 91%

Measure: C04 - Diabetes Care – Cholesterol Screening

Label for Stars: Cholesterol Screening for Patients with Diabetes

Label for Data: Cholesterol Screening for Patients with Diabetes

HEDIS Label: Comprehensive Diabetes Care (CDC) – LDL-C Screening

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 144

Description: Percent of plan members with diabetes who have had a test for "bad" (LDL) cholesterol within the past year.

Metric: The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an LDL-C screening test performed during the measurement year (numerator).

Exclusions: (optional)

• Members with a diagnosis of polycystic ovaries (Refer to NCQA HEDIS 2011 Technical Specifications Volume 2 page 154, Table CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Refer to NCQA HEDIS 2011 Technical Specifications Volume 2 page 146, Table CDC-B) during the measurement year or the year before the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by December 31 of the measurement year.

• Members with gestational or steroid-induced diabetes (CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (CDC-B) during the measurement year or the year before the measurement year. Diagnosis may occur during the measurement year or the year before the measurement year, but must have occurred by December 31 of the measurement year.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 77%	≥ 77% to < 81%	≥ 81% to < 85%	≥ 85% to < 90%	≥ 90%

Measure: C05 - Glaucoma Testing

Label for Stars: Glaucoma Testing

Label for Data: Glaucoma Testing

HEDIS Label: Glaucoma Screening in Older Adults (GSO)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 95

Description: Percent of senior plan members who got a glaucoma eye exam for early detection.

Metric: The percentage of Medicare members 65 years and older, without a prior diagnosis of glaucoma or glaucoma suspect (denominator), who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions (numerator).

Exclusions: (optional) Members who had a prior diagnosis of glaucoma or glaucoma suspect. Look for evidence of glaucoma as far back as possible in the member's history through December 31 of the measurement year. Refer to NCQA HEDIS 2011 Technical Specifications Volume 2 page 96, Table GSO-B for codes to identify exclusions.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 70%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 49%	≥ 49% to < 57%	≥ 57% to < 70%	≥ 70% to < 78%	≥ 78%

Measure: C06 - Annual Flu Vaccine

Label for Stars: Annual Flu Vaccine

Label for Data: Annual Flu Vaccine

Description: Percent of plan members who got a vaccine (flu shot) prior to flu season.

Metric: The percentage of sampled Medicare enrollees (denominator) who received an influenza vaccination during the measurement year (numerator).

General Notes: This measure is not case mix adjusted.

Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question number varies depending on survey type):

• Have you had a flu shot since September 1, 2010?

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 71%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 60%	≥ 60% to < 65%	≥ 65% to < 71%	≥ 71% to < 76%	≥ 76%

Measure: C07 - Pneumonia Vaccine

Label for Stars: Pneumonia Vaccine

Label for Data: Pneumonia Vaccine

Description: Percent of plan members who ever got a vaccine (shot) to prevent pneumonia.

Metric: The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator).

General Notes: This measure is not case mix adjusted.

Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question number varies depending on survey type):

• 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 a flu shot. It is also called the pneumococcal vaccine.

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 70%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 57%	≥ 57% to < 64%	≥ 64% to < 70%	≥ 70% to < 78%	≥ 78%

Measure: C08 - Improving or Maintaining Physical Health

Label for Stars: Improving or Maintaining Physical Health

Label for Data: Improving or Maintaining Physical Health

Description: Percent of all plan members whose physical health was the same or better than expected after two years.

Metric: The percentage of sampled Medicare enrollees (denominator) whose physical health status was the same, or better than expected (numerator).

Exclusions: Contracts with less than 30 responses are suppressed.

Data Source: HOS

Data Source Description: 2008-2010 Cohort 11 Performance Measurement Results (2008 Baseline data collection, 2010 Follow-up data collection)

2-year PCS change – Questions: 1, 2a-b, 3a-b & 5

Data Time Frame: Apr - Aug 2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 54%	≥ 54% to < 56%	≥ 56% to < 60%	≥ 60% to < 68%	≥ 68%

Measure: C09 - Improving or Maintaining Mental Health

Label for Stars: Improving or Maintaining Mental Health

Label for Data: Improving or Maintaining Mental Health

Description: Percent of all plan members whose mental health was the same or better than expected after two years.

Metric: The percentage of sampled Medicare enrollees (denominator) whose mental health status was the same or better than expected (numerator).

Exclusions: Contracts with less than 30 responses are suppressed.

Data Source: HOS

Data Source Description: 2008-2010 Cohort 11 Performance Measurement Results (2008 Baseline data collection, 2010 Follow-up data collection)

2-year MCS change – Questions: 4a-b, 6a-c & 7

Data Time Frame: Apr - Aug 2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 75%	≥ 75% to < 80%	≥ 80% to < 85%	≥ 85% to < 88%	≥ 88%

Measure: C10 - Monitoring Physical Activity

Label for Stars: Monitoring Physical Activity

Label for Data: Monitoring Physical Activity

HEDIS Label: Physical Activity in Older Adults (PAO)

Measure Reference: NCQA HEDIS 2011 Specifications for The Medicare Health Outcomes Survey Volume 6, page 33

Description: 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.

Metric: The percentage of sampled Medicare members 65 years of age or older (denominator) who 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 (numerator).

Exclusions: Members who responded "I had no visits in the past 12 months" to Question 46 are excluded from results calculations for Question 47.

Data Source: HEDIS / HOS

Data Source Description: Cohort 11 Follow-up Data collection (2010) and Cohort 13 Baseline data collection (2010).

HOS Survey Question 46: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise of physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.

HOS Survey Question 47: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Data Time Frame: Apr - Aug 2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 47%	≥ 47% to < 51%	≥ 51% to < 60%	≥ 60% to < 80%	≥ 80%

Measure: C11 - Access to Primary Care Doctor Visits

Label for Stars: At Least One Primary Care Doctor Visit in the Last Year

Label for Data: At Least One Primary Care Doctor Visit in the Last Year

HEDIS Label: Adults' Access to Preventive/Ambulatory Health Services (AAP)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 225

Description: Percent of all plan members who saw their primary care doctor during the year.

Metric: The percentage of MA enrollees age 20 and older (denominator) who had an ambulatory or preventive care visits during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 73%	≥ 73% to < 79%	≥ 79% to < 85%	≥ 85% to < 96%	≥ 96%

Measure: C12 - Adult BMI Assessment

Label for Stars: Checking to See if Members are at a Healthy Weight

Label for Data: Checking to See if Members are at a Healthy Weight

HEDIS Label: Adult BMI Assessment (ABA)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 62

Description: Percent of plan members with an outpatient visit who had their "Body Mass Index" (BMI) calculated from their height and weight and recorded in their medical records.

Metric: The percentage of members 18-74 years of age (denominator) who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year (numerator).

Exclusions: (optional) Members who have a diagnosis of pregnancy (Refer to NCQA HEDIS 2011 Technical Specifications Volume 2 page 63, Table ABA-C) during the measurement year or the year prior to the measurement year.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	No	No	Yes	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 27%	≥ 27% to < 42%	≥ 42% to < 61%	≥ 61% to < 73%	≥ 73%

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C13 - Care for Older Adults – Medication Review

Label for Stars: Yearly Review of All Medications and Supplements Being Taken (Special Needs Plans only)

Label for Data: Yearly Review of All Medications and Supplements Being Taken (Special Needs Plans only)

HEDIS Label: Care for Older Adults (COA) – Medication Review

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 97

Description: Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (This information about a yearly review of medications is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Table COA-B) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	No	Yes	No	No	No	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 24%	≥ 24% to < 45%	≥ 45% to < 67%	≥ 67% to < 82%	≥ 82%

Measure: C14 - Care for Older Adults – Functional Status Assessment

Label for Stars: Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living (Special Needs Plans only)

Label for Data: Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living (Special Needs Plans only)

HEDIS Label: Care for Older Adults (COA) – Functional Status Assessment

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 97

Description: Percent of plan members whose doctor has done a “functional status assessment” to see how well they are able to do “activities of daily living” (such as dressing, eating, and bathing). (This information about the yearly assessment is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one functional status assessment during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	No	Yes	No	No	No	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 22%	≥ 22% to < 43%	≥ 43% to < 62%	≥ 62% to < 78%	≥ 78%

Measure: C15 - Care for Older Adults – Pain Screening

Label for Stars: Yearly Pain Screening or Pain Management Plan (Special Needs Plans only)

Label for Data: Yearly Pain Screening or Pain Management Plan (Special Needs Plans only)

HEDIS Label: Care for Older Adults (COA) – Pain Screening

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 97

Description: Percent of plan members who had a pain screening or pain management plan at least once during the year. (This information about pain screening or pain management is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain screening or pain management plan during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	No	Yes	No	No	No	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 24%	≥ 24% to < 34%	≥ 34% to < 59%	≥ 59% to < 87%	≥ 87%

Measure: C16 - Osteoporosis Management in Women who had a Fracture

Label for Stars: Osteoporosis Management

Label for Data: Osteoporosis Management

HEDIS Label: Osteoporosis Management in Women Who Had a Fracture (OMW)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 167

Description: Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.

Metric: The percentage of female MA enrollees 67 and older who suffered a fracture during the measurement year (denominator), and 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 (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 14%	≥ 14% to < 24%	≥ 24% to < 60%	≥ 60% to < 67%	≥ 67%

Measure: C17 - Diabetes Care – Eye Exam

Label for Stars: Eye Exam to Check for Damage from Diabetes

Label for Data: Eye Exam to Check for Damage from Diabetes

HEDIS Label: Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 144

Description: Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.

Metric: The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 64%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 46%	≥ 46% to < 54%	≥ 54% to < 64%	≥ 64% to < 73%	≥ 73%

Measure: C18 - Diabetes Care – Kidney Disease Monitoring

Label for Stars: Kidney Function Testing for Members with Diabetes

Label for Data: Kidney Function Testing for Members with Diabetes

HEDIS Label: Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 144

Description: Percent of plan members with diabetes who had a kidney function test during the year.

Metric: The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	No	No	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 74%	≥ 74% to < 83%	≥ 83% to < 85%	≥ 85% to < 89%	≥ 89%

Measure: C19 - Diabetes Care – Blood Sugar Controlled

Label for Stars: Plan Members with Diabetes whose Blood Sugar is Under Control

Label for Data: Plan Members with Diabetes whose Blood Sugar is Under Control

HEDIS Label: Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 144

Description: Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.

Metric: The percentage of diabetic MA enrollees 18-75 (denominator), whose most recent HbA1c level is greater than 9% (numerator), or who were not tested during the measurement year. (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measures subtracted submitted rate from 100.

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 80%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 43%	≥ 43% to < 60%	≥ 60% to < 80%	≥ 80% to < 88%	≥ 88%

Measure: C20 - Diabetes Care – Cholesterol Controlled

Label for Stars: Plan Members with Diabetes whose Cholesterol Is Under Control

Label for Data: Plan Members with Diabetes whose Cholesterol Is Under Control

HEDIS Label: Comprehensive Diabetes Care (CDC) – LDL-C control (<100 mg/dL)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 144

Description: Percent of plan members with diabetes who had a cholesterol test during the year that showed an acceptable level of “bad” (LDL) cholesterol.

Metric: The percentage of diabetic MA enrollees 18-75 (denominator) whose most recent LDL-C level during the measurement year was 100 or less (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering
Weighting Category: Intermediate Outcome Measures
Weighting Value: 3
Data Display: Percentage with no decimal point
Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	No	No	Yes	Yes

4-Star Threshold: ≥ 53%
Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 20%	≥ 20% to < 43%	≥ 43% to < 53%	≥ 53% to < 66%	≥ 66%

Measure: C21 - Controlling Blood Pressure
Label for Stars: Controlling Blood Pressure
Label for Data: Controlling Blood Pressure
HEDIS Label: Controlling High Blood Pressure (CBP)
Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 134
Description: Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
Metric: The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) during the measurement year (numerator).
Exclusions: (optional)
• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (refer to NCQA HEDIS 2011 Technical Specifications Volume 2, page 137, Table CBP-C) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

• Exclude from the eligible population all members with a diagnosis of pregnancy (Table CBP-C) during the measurement year.

• Exclude from the eligible population all members who had an admission to a nonacute inpatient setting during the measurement year. Refer to NCQA HEDIS 2011 Technical Specifications Volume 2, page 187 Table FUH-B for codes to identify nonacute care.

Data Source: HEDIS
Data Time Frame: 01/01/2010 - 12/31/2010
General Trend: Higher is better
Statistical Method: Relative Distribution with Clustering
Weighting Category: Intermediate Outcome Measures
Weighting Value: 3
Data Display: Percentage with no decimal point
Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	No	No	Yes	Yes

4-Star Threshold: ≥ 63%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 29%	≥ 29% to < 49%	≥ 49% to < 63%	≥ 63% to < 71%	≥ 71%

Measure: C22 - Rheumatoid Arthritis Management

Label for Stars: Rheumatoid Arthritis Management

Label for Data: Rheumatoid Arthritis Management

HEDIS Label: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 164

Description: Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.

Metric: The percentage of MA members who were diagnosed with rheumatoid arthritis during the measurement year (denominator), and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) (numerator).

Exclusions: (optional)
• Members diagnosed with HIV (refer to NCQA HEDIS 2011 Technical Specifications Volume 2, page 165, Table ART-D). Look for evidence of HIV diagnosis as far back as possible in the member's history through December 31 of the measurement year.
• Members who have a diagnosis of pregnancy (Table ART-D) during the measurement year.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 78%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 54%	≥ 54% to < 71%	≥ 71% to < 78%	≥ 78% to < 84%	≥ 84%

Measure: C23 - Improving Bladder Control

Label for Stars: Improving Bladder Control

Label for Data: Improving Bladder Control

HEDIS Label: Management of Urinary Incontinence in Older Adults (MUI)

Measure Reference: NCQA HEDIS 2011 Specifications for The Medicare Health Outcomes Survey Volume 6, page 31

Description: Percent of plan members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.

Metric: The percentage of Medicare members 65 years of age or older who reported having a urine leakage problem in the past six months (denominator) and who received treatment for their current urine leakage problem (numerator).

Exclusions: None listed.

Data Source: HEDIS / HOS

Data Source Description: Cohort 11 Follow-up Data collection (2010) and Cohort 13 Baseline data collection (2010).

HOS Survey Question 42: Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?

HOS Survey Question 43: How much of a problem, if any, was the urine leakage for you?

HOS Survey Question 45: There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem?

Data Time Frame: Apr - Aug 2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 34%	≥ 34% to < 41%	≥ 41% to < 60%	≥ 60% to < 80%	≥ 80%

Measure: C24 - Reducing the Risk of Falling

Label for Stars: Reducing the Risk of Falling

Label for Data: Reducing the Risk of Falling

HEDIS Label: Fall Risk Management (FRM)

Measure Reference: NCQA HEDIS 2011 Specifications for The Medicare Health Outcomes Survey Volume 6, page 35

Description: Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.

Metric: The percentage of Medicare members 65 years of age or older who had a fall or had problems with balance or walking in the past 12 months (denominator), who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner (numerator).

Exclusions: None listed.

Data Source: HEDIS / HOS

Data Source Description: Cohort 11 Follow-up Data collection (2010) and Cohort 13 Baseline data collection (2010).

HOS Survey Question 48: A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?

HOS Survey Question 49: Did you fall in the past 12 months?

HOS Survey Question 51: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
• Suggest that you use a cane or walker
• Check your blood pressure lying or standing
• Suggest that you do an exercise or physical therapy program
• Suggest a vision or hearing testing

Data Time Frame: Apr - Aug 2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 59%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 48%	≥ 48% to < 55%	≥ 55% to < 59%	≥ 59% to < 76%	≥ 76%

Measure: C25 - Plan All-Cause Readmissions

Label for Stars: Readmission to a Hospital within 30 Days of Being Discharged (more stars are better because it means fewer members are being readmitted)

Label for Data: Readmission to a Hospital within 30 Days of Being Discharged (lower percentages are better because it means fewer members are being readmitted)

HEDIS Label: Plan All-Cause Readmissions (PCR)

Measure Reference: NCQA HEDIS 2011 Technical Specifications Volume 2, page 318

Description: Percent of senior plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This “risk-adjustment” helps make the comparisons between plans fair and meaningful.)

Metric: The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 65 years of age and older using the following formula to control for differences in the case mix of patients across different contracts.

For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected

readmission rate for contract A. This ratio is then multiplied by the national average observed rate. To calculate the observed rate and expected rate for contract A for members 65 years and older, the following formulas were used:

1. The observed readmission rate for contract A equals the sum of the count of 30-day readmissions across the three age bands (65-74, 75-84 and 85+) divided by the sum of the count of index stays across the three age bands (65-74, 75-84 and 85+).

2. The expected readmission rate for contract A equals the sum of the average adjusted probabilities across the three age bands (65-74, 75-84 and 85+), weighted by the percentage of index stays in each age band.

See Attachment F: Calculating Measure C25: Plan All-Cause Readmissions for the complete formula, example calculation and National Average Observation value used to complete this measure.

Exclusions: None listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was 10 or less.

Data Source: HEDIS

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Lower is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Outcome Measure

Weighting Value: 1 (Weighted as "1" because it is a first year measure.)

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 32%	> 17% to ≤ 32%	> 12% to ≤ 17%	> 5% to ≤ 12%	≤ 5%

Domain: 3 - Ratings of Plan Responsiveness and Care

Measure: C26 - Getting Needed Care

Label for Stars: Ease of Getting Needed Care and Seeing Specialists

Label for Data: Ease of Getting Needed Care and Seeing Specialists

Description: Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.

Metric: This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (questions numbers vary depending on survey type):

• 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?

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 81%	≥ 81% to ≤ 83%	> 83% to < 85%	≥ 85% to < 87%	≥ 87%

Measure: C27 - Getting Appointments and Care Quickly

Label for Stars: Getting Appointments and Care Quickly

Label for Data: Getting Appointments and Care Quickly

Description: Percent of best possible score the plan earned on how quickly members get appointments and care.

Metric: This case-mix adjusted composite measure is used to assess how quickly the member was able to appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (questions numbers vary depending on survey type):

• In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?

• In the last 6 months, not counting the times when you needed 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?

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 75%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 71%	≥ 71% to < 73%	≥ 73% to < 75%	≥ 75% to < 79%	≥ 79%

Measure: C28 - Customer Service

Label for Stars: Customer Service

Label for Data: Customer Service

Description: Percent of best possible score the plan earned on how easy it is to get information and help when needed.

Metric: This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (questions numbers vary depending on survey type):

• In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

• In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?

• In the last 6 months, how often were the forms for your health plan easy to fill out?

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 88%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 84%	≥ 84% to < 86%	≥ 86% to < 88%	≥ 88% to < 90%	≥ 90%

Measure: C29 - Overall Rating of Health Care Quality

Label for Stars: Overall Rating of Health Care Quality

Label for Data: Overall Rating of Health Care Quality

Description: Percent of best possible score the plan earned from plan members who rated the overall health care received.

Metric: This case-mix adjusted measure is used to assess the members view the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question number varies depending on survey type):

• Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 83%	≥ 83% to ≤ 84%	*	≥ 85% to < 88%	≥ 88%

* Due to rounding and the placement of the predetermined 4-star cutoff, no contracts were assigned 3 base stars; all contracts meeting the cutoff for 3 base stars also met the cutoff for 4 base stars. However after application of the further criteria of significance and reliability, some plans with fewer than 3 base stars may have been assigned 3 final stars.

Measure: C30 - Overall Rating of Plan

Label for Stars: Members' Overall Rating of Health Plan

Label for Data: Members' Overall Rating of Health Plan

Description: Percent of best possible score the plan earned from plan members who rated the overall plan.

Metric: This case-mix adjusted measure is used to assess the overall view the members have about their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question number varies depending on survey type):

• Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Data Time Frame: Feb - June 2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 82%	≥ 82% to < 84%	≥ 84% to < 85%	≥ 85% to < 88%	≥ 88%

Domain: 4 - Member Complaints, Problems Getting Services, and Choosing to Leave the Plan

Measure: C31 - Complaints about the Health Plan

Label for Stars: Complaints about the Health Plan

Label for Data: Complaints about the Health Plan (number of complaints for every 1,000 members)

Description: How many complaints Medicare received about the health plan.

Metric: Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).

• Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.

• A contract's failure to follow CMS' CTM Standard Operating Procedures will not result in CMS' adjustment of the data used for these measures.

Exclusions: Some complaints that cannot be clearly attributed to the plan are excluded, please see Attachment B: Complaints Tracking Module Exclusion List.

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

Data Source: CTM

Data Time Frame: 1/1/2011 - 06/30/2011

General Trend: Lower is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Rate with 2 decimal points

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 0.68	> 0.49 to ≤ 0.68	> 0.28 to ≤ 0.49	> 0.17 to ≤ 0.28	≤ 0.17

Measure: C32 - Beneficiary Access and Performance Problems

Label for Stars: Problems Medicare Found in Members' Access to Services and in the Plan's Performance (more stars are better because it means fewer serious problems)

Label for Data: Problems Medicare Found in Members' Access to Services and in the Plan's Performance (on a scale from 0 to 100, higher numbers are better because it means fewer serious problems)

Description: To check on whether members are having problems getting access to services and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.

Metric: This measure is based on CMS' performance audits of health and drug plans (contracts), sanctions, civil monetary penalties (CMP) as well as Compliance Actions Module (CAM) data (this includes: notices of non compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity). While CMS utilizes a risk-based strategy to identify contracts for performance audits, compliance or other actions may be taken against contracts as a result of other issues or concerns being identified.

- Contracts' scores are based on a scale of 0-100 points.
- The starting score for each contract works as follows:
  - Contracts with an effective date of 1/1/2012 are marked as "Plan too new to be measured".
  - Contracts that received a full performance audit start with the percent effectiveness score determined by the audit.
  - All other contracts begin with a score 100.
- Contracts under sanction during the measurement period are reduced to a score of 0*.
- The following deductions are taken from contracts whose score is above 0:
  - Contracts that received a CMP with beneficiary impact related to access: 40 points.
  - Contracts that received a CMP with beneficiary impact not related to access: 20 points.
  - Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows:
    - 0 – 2 CAM Score – 0 points
    - 3 – 9 CAM Score – 20 points
    - 10 – 19 CAM Score – 40 points
    - 20 – 29 CAM Score – 60 points
    - ≥30 CAM Score – 80 points

Calculation of the CAM Score combines the notices of non compliance, warning letters (with or without business plan) and ad-hoc CAPs and their severity. The formula used is as follows:

CAM Score = (NC * 1) + (woBP * 3) + (wBP * 4) + (NAHC * (6 * CAP Severity))

Where: NC = Number of Notices of Non Compliance

woBP = Number of Warning Letters without Business Plan

wBP = Number of Warning Letters with Business Plan

NAHC = Number of Ad-Hoc CAPs

CAP Severity = Sum of the severity of each CAP given to a contract during the measurement period. Each CAP is rated as one of the following:

3 – ad-hoc CAP with beneficiary access impact

2 – ad-hoc CAP with beneficiary non-access impact

1 – ad-hoc CAP no beneficiary impact

Data Source: CMS Administrative Data

Data Source Description: Findings of CMS audits, ad hoc and compliance actions that occurred during the 14 month past performance review period between January 1, 2010 and February 28, 2011.

Data Time Frame: 01/01/2010 - 02/28/2011

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with 0 decimal points

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80

Measure: C33 - Members Choosing to Leave the Plan

Label for Stars: Members Choosing to Leave the Plan (more stars are better because it means fewer members are choosing to leave the plan)

Label for Data: Members Choosing to Leave the Plan (lower percentages are better because it means fewer members choose to leave the plan)

Description: The percent of plan members who chose to leave the plan in 2010. (This does not include members who did not choose to leave the plan, such as members who moved out of the service area.)

Metric: The percent of members who chose to leave the plan come from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the plan between January 1, 2010–December 31, 2010 divided by all members enrolled in the plan at any time during 2010.

Exclusions: Members who left their plan due to circumstances beyond their control (such as members who moved out of the service area, members affected by a service area reduction, PBP termination, LIS reassignments, employer group members and members who disenrolled due to the requirement that SNP disenroll disproportionate share member who do not meet the SNP criteria) are excluded from the numerator. Also members in PBPs that were granted special enrollment exceptions have been removed. The data for contracts with less than 1,000 enrollees are not reported in this measure.

General Notes: This measure includes members who disenrolled from the contract with a disenrollment reason code of 11, 13, 14 or 99.

Data Source: Medicare Beneficiary Database Suite of Systems

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Lower is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 19%	> 15% to ≤ 19%	> 11% to ≤ 15%	> 7% to ≤ 11%	≤ 7%

Domain: 5 - Health Plan Customer Service

Measure: C34 - Plan Makes Timely Decisions about Appeals

Label for Stars: Health Plan Makes Timely Decisions about Appeals

Label for Data: Health Plan Makes Timely Decisions about Appeals

Description: 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.

Metric: Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the IRE (includes only upheld, overturned and partially overturned appeals) (denominator). This is calculated as:

([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) * 100.

If the denominator is ≤10, the result is "Not enough data available to calculate the measure".

Exclusions: Dismissed and Withdrawn appeals are excluded from this measure.

General Notes: This measure includes all appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.

Data Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS for Part C appeals. The appeals used in this measure are based on the date appeals were received by the IRE, not the date a decision was reached by the IRE. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. For 2011 data, Dismissed appeals will be included.

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 57%	≥ 57% to < 71%	≥ 71% to < 85%	≥ 85% to < 91%	≥ 91%

Measure: C35 - Reviewing Appeals Decisions

Label for Stars: Fairness of Health Plan's Denials to Member Appeals, Based on an Independent Reviewer

Label for Data: Fairness of Health Plan's Denials to Member Appeals, Based on an Independent Reviewer

Description: How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.

Metric: Percent of appeals where a plan's decision was "upheld" by the IRE (numerator) out of all the plan's appeals ("upheld", "overturned" and "partially overturned" appeals only) that the IRE reviewed (denominator). This is calculated as:

([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.

If the minimum number of appeals (upheld + overturned + partially overturned) is <=10, the result is "Not enough data available to calculate the measure".

Exclusions: Dismissed and Withdrawn appeals are excluded from this measure.

General Notes: This measure includes all appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.

Data Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year they were received by the IRE not the date a decision was reached. If a Reopening occurs, the Reopened decision is used in place of the Reconsideration decision. Appeals that occur beyond Level 2 are not included in the data.

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 87%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 63%	≥ 63% to < 75%	≥ 75% to < 87%	≥ 87% to < 92%	≥ 92%

Measure: C36 - Call Center – Foreign Language Interpreter and TTY/TDD Availability

Label for Stars: Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan

Label for Data: Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan

Description: 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.

Metric: 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.

Data Source: Call Center

Data Source Description: Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.

Data Time Frame: 01/31/2011 - 05/20/2011 (Monday - Friday)

General Trend: Higher is better

Statistical Method: Relative Distribution with Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	Yes	Yes	Yes	No	Yes	Yes	Yes

4-Star Threshold: ≥ 78%

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 37%	≥ 37% to < 68%	≥ 68% to < 78%	≥ 78% to < 87%	≥ 87%

Part D Domain and Measure Details

See Attachment C for the national averages of individual Part D measures.

Domain: 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Pharmacy Hold Time

Label for Stars: Time on Hold When Pharmacist Calls Plan

Label for Data: Time on Hold When Pharmacist Calls Plan (minutes:seconds)

Description: How long pharmacists wait on hold when they call the plan's pharmacy help desk.

Metric: This measure is defined as the average time spent on hold by the call surveyor following navigation of the Interactive Voice Response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person for the Pharmacy Technical Help Desk phone number.

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.

Standard: The CMS standard for this measure is an average hold time of 2 minutes or less.

Data Source: Call Center

Data Source Description: Call center data collected by CMS. The Pharmacy Technical Help Desk phone number associated with each contract was monitored.

Data Time Frame: 01/31/2011 - 05/27/2011

General Trend: Lower is better

Statistical Method: CMS Standard, Relative Distribution, and Clustering.

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Time

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	Yes	Yes	No	Yes	Yes	Yes	Yes

3-Star Threshold: MA-PD: ≤ 2:15 (≤ 135 Seconds), PDP: ≤ 2:15 (≤ 135 Seconds)

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	NA	> 2:15 to ≤ 3:31	> 0:35 to ≤ 2:15	> 0:25 to ≤ 0:35	≤ 0:25
PDP	NA	NA	> 0:44 to ≤ 2:15	> 0:18 to ≤ 0:44	≤ 0:18

Measure: D02 - Call Center – Foreign Language Interpreter and TTY/TDD Availability

Label for Stars: Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan

Label for Data: Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan

Description: The data used to measure the performance of the drug plan's customer service come from call center surveillance data collected by Medicare. The drug plan's call centers received weekly survey phone calls to track how often TTY/TDD services and Foreign Language Interpretation was available when the member called the drug plan. The drug plan's "Customer Service for Prospective Members – Part D" phone number was monitored. These data were collected from January 31, 2011 to May 20, 2011.

Metric: 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.

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.

Data Source: Call Center

Data Source Description: Data were collected by CMS; the Customer Service for Prospective Members – Part D phone number associated with each plan was monitored.

Data Time Frame: 01/31/2011 - 05/20/2011 (Monday - Friday)

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
No	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≥ 80.0, PDP: ≥ 82.0

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 72.9	≥ 72.9 to < 77.3	≥ 77.3 to < 80.0	≥ 80.0 to < 85.7	≥ 85.7
PDP	< 69.4	≥ 69.4 to < 78.6	≥ 78.6 to < 82.0	≥ 82.0 to < 85.5	≥ 85.5

Measure: D03 - Appeals Auto–Forward

Label for Stars: Drug Plan Makes Timely Decisions about Appeals

Label for Data: Drug Plan Makes Timely Decisions about Appeals (for every 10,000 members)

Description: How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.Click here for more information on Medicare appeals: www.medicare.gov/basics/appeals.asp

Metric: 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 were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000. There is no minimum number of cases required to receive a rating.

Exclusions: This rate is not calculated for contracts with less than 800 enrollees.

Data Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS.

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≤ 1.3, PDP: ≤ 1.0

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 27.6	> 3.4 to ≤ 27.6	> 1.3 to ≤ 3.4	> 0.3 to ≤ 1.3	≤ 0.3
PDP	> 4.4	> 2.3 to ≤ 4.4	> 1.0 to ≤ 2.3	> 0.6 to ≤ 1.0	≤ 0.6

Measure: D04 - Appeals Upheld

Label for Stars: Fairness of Drug Plan's Denials to Member Appeals, Based on an Independent Reviewer

Label for Data: Fairness of Drug Plan's Denials to Member Appeals, Based on an Independent Reviewer

Description: How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal.

Metric: 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 all cases received by the IRE during the timeframe and receiving a decision within 20 days after the last day of the timeframe. The denominator is equal to the number of cases upheld, fully reversed, and partially reversed. Dismissed, remanded and withdrawn cases are not included in the denominator. Auto-forward cases are included, as these are considered to be adverse decisions per Subpart M rules. Contracts with no IRE cases reviewed will not receive a score in this measure.

Exclusions: A percent is not calculated for contracts with fewer than 5 total cases reviewed by the IRE.

Data Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS for Part D reconsiderations. The appeals used in this measure are based on the date they were received by the IRE.

Data Time Frame: 01/01/2011-06/30/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≥ 72%, PDP: ≥ 68.0%

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 33.3%	≥ 33.3% to < 61.5%	≥ 61.5% to < 72.0%	≥ 72.0% to < 90.0%	≥ 90.0%
PDP	< 43.1%	≥ 43.1% to < 66.7%	≥ 66.7% to < 68.0%	≥ 68.0% to < 81.6%	≥ 81.6%

Measure: D05 - Enrollment Timeliness

Label for Stars: Plan Handles New Enrollment Requests within 7 Days

Label for Data: Plan Handles New Enrollment Requests within 7 Days

Description: The percentage of enrollment requests that the plan sent to the Medicare Program within 7 days

Metric: This measure is defined as the percent of plan generated enrollment transactions submitted to CMS within 7 days of the application date.
Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 days of the application date
Denominator = The total number of plan generated enrollment transactions submitted to CMS
This is calculated as: [(The number of plan generated enrollment transactions submitted to CMS within 7 days of the application date) / (The total number of plan generated enrollment transactions submitted to CMS)] * 100

Exclusions: Contracts with a total of 25 or fewer transactions in the measurement period are excluded from this data set. The beneficiaries of seamless conversion in the Initial Coverage Election Period (ICEP) and beneficiaries of qualified State Pharmaceutical Assistance Programs (SPAPs) in the 2011 Annual Election Period (AEP) are excluded from the metrics. Employer/Union enrollments are excluded from this metric.

Data Source: Medicare Advantage Prescription Drug System (MARx)

Data Source Description: This data used for this measure is from the Medicare Advantage Prescription Drug System (MARx). It presents the percentage of new enrollment requests from beneficiaries that the plan submitted to Medicare within 7 days of the application date. These data were collected from November 13, 2010 to April 27, 2011.

Data Time Frame: 11/13/2010 - 04/27/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Rate with 2 decimal points

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 82.68	≥ 82.68 to < 89.91	≥ 89.91 to < 94.69	≥ 94.69 to < 96.50	≥ 96.50
PDP	< 84.62	≥ 84.62 to < 90.86	≥ 90.86 to < 95.32	≥ 95.32 to < 97.26	≥ 97.26

Domain: 2 - Member Complaints, Problems Getting Services, and Choosing to Leave the Plan

Measure: D06 - Complaints about the Drug Plan

Label for Stars: Complaints about the Drug Plan

Label for Data: Complaints about the Drug Plan (for every 1,000 members)

Description: How many complaints Medicare received about the drug plan.

Metric: Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).

• Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.

• A contract's failure to follow CMS' CTM Standard Operating Procedures will not result in CMS' adjustment of the data used for these measures.

Exclusions: Some complaints that cannot be clearly attributed to the plan are excluded, please see Attachment B: Complaints Tracking Module Exclusion List.

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

Data Source: CTM

Data Source Description: Data were obtained from the CTM based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.

Data Time Frame: 01/01/2011 - 06/30/2011

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Rate with 2 decimal points

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 0.68	> 0.49 to ≤ 0.68	> 0.28 to ≤ 0.49	> 0.17 to ≤ 0.28	≤ 0.17
PDP	> 0.47	> 0.26 to ≤ 0.47	> 0.17 to ≤ 0.26	> 0.13 to ≤ 0.17	≤ 0.13

Measure: D07 - Beneficiary Access and Performance Problems

Label for Stars: Problems Medicare Found in Members' Access to Services and in the Plan's Performance (more stars are better because it means fewer serious problems)

Label for Data: Problems Medicare Found in Members' Access to Services and in the Plan's Performance (on a scale from 0 to 100, higher numbers are better because it means fewer problems)

Description: To check on whether members are having problems getting access to services and to be sure that plans are following all of Medicare's rules, Medicare conducts

audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.

Metric: This measure is based on CMS' performance audits of health and drug plans (contracts), sanctions, civil monetary penalties (CMP) as well as Compliance Actions Module (CAM) data (this includes: notices of non compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity). While CMS utilizes a risk-based strategy to identify contracts for performance audits, compliance or other actions may be taken against contracts as a result of other issues or concerns being identified.

- Contracts' scores are based on a scale of 0-100 points.
- The starting score for each contract works as follows:
  - Contracts with an effective date of 1/1/2012 are marked as "Plan too new to be measured".
  - Contracts that received a full performance audit start with the percent effectiveness score determined by the audit.
  - All other contracts begin with a score 100.
- Contracts under sanction during the measurement period are reduced to a score of 0*.
- The following deductions are taken from contracts whose score is above 0:
  - Contracts that received a CMP with beneficiary impact related to access: 40 points.
  - Contracts that received a CMP with beneficiary impact not related to access: 20 points.
  - Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows:
    - 0 – 2 CAM Score – 0 points
    - 3 – 9 CAM Score – 20 points
    - 10 – 19 CAM Score – 40 points
    - 20 – 29 CAM Score – 60 points
    - ≥30 CAM Score – 80 points

Calculation of the CAM Score combines the notices of non compliance, warning letters (with or without business plan) and ad-hoc CAPs and their severity. The formula used is as follows:

CAM Score = (NC * 1) + (woBP * 3) + (wBP * 4) + (NAHC * (6 * CAP Severity))

Where: NC = Number of Notices of Non Compliance

woBP = Number of Warning Letters without Business Plan

wBP = Number of Warning Letters with Business Plan

NAHC = Number of Ad-Hoc CAPs

CAP Severity = Sum of the severity of each CAP given to a contract during the measurement period. Each CAP is rated as one of the following:

3 – ad-hoc CAP with beneficiary access impact

2 – ad-hoc CAP with beneficiary non-access impact

1 – ad-hoc CAP no beneficiary impact

Data Source: CMS Administrative Data

Data Source Description: Findings of CMS audits, ad hoc and compliance actions that occurred during the 14 month past performance review period between January 1, 2010 and February 28, 2011.

Data Time Frame: 01/01/2010 - 02/28/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80
PDP	≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80

Measure: D08 - Members Choosing to Leave the Plan

Label for Stars: Members Choosing to Leave the Plan (more stars are better because it means fewer members are choosing to leave the plan)

Label for Data: Members Choosing to Leave the Plan (lower percentages are better because it means fewer members choose to leave the plan)

Description: The percent of plan members who chose to leave the plan in 2010. (This does not include members who did not choose to leave the plan, such as members who moved out of the service area.)

Metric: The percent of members who chose to leave the plan come from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the plan between January 1, 2010–December 31, 2010 divided by all members enrolled in the plan at any time during 2010.

Exclusions: Members who left their plan due to circumstances beyond their control (such as members who moved out of the service area, members affected by a service area reduction, PBP termination, LIS reassignments, employer group members and members who disenrolled due to the requirement that SNP disenroll disproportionate share member who do not meet the SNP criteria) are excluded from the numerator. Also members in PBPs that were granted special enrollment exceptions have been removed. The data for contracts with less than 1,000 enrollees are not reported in this measure.

General Notes: This measure includes members who disenrolled from the contract with a disenrollment reason code of 11, 13, 14 or 99.

Data Source: Medicare Beneficiary Database Suite of Systems

Data Time Frame: 01/01/2010 – 12/31/2010

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 19%	> 15% to ≤ 19%	> 11% to ≤ 15%	> 7% to ≤ 11%	≤ 7%
PDP	> 19%	> 14% to ≤ 19%	> 11% to ≤ 14%	> 9% to ≤ 11%	≤ 9%

Domain: 3 - Member Experience with Drug Plan

Measure: D09 - Getting Information From Drug Plan

Label for Stars: Drug Plan Provides Information or Help When Members Need It

Label for Data: Drug Plan Provides Information or Help When Members Need It

Description: The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost.

Metric: This case-mix adjusted 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.

Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (questions numbers vary depending on survey type):

• In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?

• In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?

• In the last 6 months, how often did your health plan give you all the information you needed about which prescription medicines were covered?

• In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?

Data Time Frame: 02/01/2011 – 06/30/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≥ 82%, PDP: ≥ 80%

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 77%	≥ 77% to < 80%	≥ 80% to < 82%	≥ 82% to < 86%	≥ 86%
PDP	< 73%	≥ 73% to < 75%	≥ 75% to < 80%	*	≥ 80%

* Due to rounding and the placement of the predetermined 4-star cutoff, no contracts were assigned 4 base stars; all contracts meeting the cutoff for 4 base stars also met the cutoff for 5 base stars. However after application of the further criteria of significance and reliability, some plans with 5 base stars may have been assigned 4 final stars.

Measure: D10 - Rating of Drug Plan

Label for Stars: Members' Overall Rating of Drug Plan

Label for Data: Members' Overall Rating of Drug Plan

Description: The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.

Metric: This case-mix adjusted 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.

Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (questions numbers vary depending on survey type):

• Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?

Data Time Frame: 02/01/2011 – 06/30/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≥ 84%, PDP: ≥ 81%

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 81%	≥ 81% to < 83%	≥ 83% to < 84%	≥ 84% to < 86%	≥ 86%
PDP	< 77%	≥ 77% to < 79%	≥ 79% to < 81%	≥ 81% to < 83%	≥ 83%

Measure: D11 - Getting Needed Prescription Drugs

Label for Stars: Members' Ability to Get Prescriptions Filled Easily When Using the Plan

Label for Data: Members' Ability to Get Prescriptions Filled Easily When Using the Plan

Description: The percent of the best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan.

Metric: This case-mix adjusted measure is used to assess member satisfaction related to the ease with 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.

Data Source: CAHPS

Data Source Description: CAHPS Survey Questions (questions numbers vary depending on survey type):

• In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?

• In the last 6 months, how often was it easy to use your health plan to fill a

prescription at a local pharmacy?

• In the last 6 months, how often was it easy to use your health plan to fill prescriptions by mail?

Data Time Frame: 02/01/2011 – 06/30/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≥ 91%, PDP: ≥ 89%

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 88%	≥ 88% to < 90%	≥ 90% to < 91%	≥ 91% to < 93%	≥ 93%
PDP	< 87%	≥ 87% to < 88%	≥ 88% to < 89%	≥ 89% to < 91%	≥ 91%

Domain: 4 - Drug Pricing and Patient Safety

Measure: D12 - MPF Composite

Label for Stars: Plan Provides Accurate Price Information for Medicare's Plan Finder Website and Keeps Drug Prices Stable

Label for Data: Plan Provides Accurate Price Information for Medicare's Plan Finder Website and Keeps Drug Prices Stable During the Year (higher scores are better)

Description: A score showing how closely the plan's drug prices on Medicare's Plan Finder Website match the prices members pay at the pharmacy, and how stable the plan's prices are during the year.

Metric: This measure evaluates both stability in a plan's prices at the point of sale and the accuracy of drug prices posted on the MPF tool. A contract's score is a composite derived from two price indices. A contract must receive a score in each price index in order to be rated in this measure.

The first price index (stability) uses final prescription drug event (PDE) data to assess changes in prices over the contract year. It is defined as the average change in price of a specified basket of drugs each quarter. A basket of drugs defined by quarter 1 PDEs is priced using quarter 1 average prices for each drug first. The same basket is then priced using quarter 2 average prices. The stability price index from quarter 1 to quarter 2 is calculated as the total price of the basket using the quarter 2 average prices divided by the total price of same basket using quarter 1 average prices. This same process is repeated using a quarter 2 basket of drugs to compute the quarter 2 to quarter 3 price index and a quarter 3 basket of drugs to compute the quarter 3 to quarter 4 price index. The overall stability price index is the average of the price index from quarter 1 to 2, quarter 2 to 3, and quarter 3 to 4. A price index of 1 indicates a plan had no increase in prices from the beginning to the end of the year. A stability index smaller than 1 indicates that prices decreased, while an index greater than 1 indicates that prices increased.

The second price index (accuracy) compares point-of-sale PDE prices to plan-reported MPF prices and determines the magnitude of differences found. For each claim, the point of sale price is compared to the MPF price displayed on the day the prescription was filled (date of service). Because the last submission date for MPF data is usually in September each year, PDEs from October to December are compared to the last MPF price submitted in September since this is the price posted on MPF throughout this time period.

The accuracy index considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF—that is, the reported price is higher than the actual price—will not count against a plan's accuracy score.

The index is computed as:
(Total amount that PDE is higher than PF + Total PDE cost)/(Total PDE cost).

The best possible accuracy index is 1. An index of 1 indicates that a plan did not have PDE prices greater than MPF prices.
A contract's score is a combination of a price stability index and a price accuracy index. It is computed as:
100 – ((stability index + accuracy index - 2) x 100).

Exclusions: A contract must have at least one drug with at least 10 claims in each quarter for the price stability index. A contract must have at least 30 claims over the year for

the price accuracy index. A rating is only assigned to contracts meeting both criteria. PDEs must also meet the following criteria:
• Pharmacy number on PDE must appear in MPF pharmacy cost file
• Drug must appear in formulary file and in MPF pricing file (accuracy index only)
• PDE must be for retail pharmacy
• PDE must be a 30 day supply (accuracy index only)
• Date of service must occur at a time that data are not suppressed for the plan on MPF
• PDE must not be a compound claim
• PDE must not be a non-covered drug

General Notes: Contracts receive only 3, 4 or 5 stars in this measure, due to the distribution of the data.

Data Source: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan

Data Source Description: Data Source: Data were obtained from a number of sources: PDE data, MPF Pricing Files, HPMS approved formulary extracts. Post-reconciliation PDE adjustments are not reflected in this measure.

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Rate with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	NA	NA	≥ 85.0 to < 97.8	≥ 97.8 to < 98.3	≥ 98.3
PDP	NA	NA	≥ 85.0 to < 96.1	≥ 96.1 to < 97.4	≥ 97.4

Measure: D13 - High Risk Medication

Label for Stars: Plan Members 65 and Older Who Received Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May Be Safer Drug Choices

Label for Data: Plan Members 65 and Older Who Received Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May Be Safer Drug Choices

Description: The percent of plan members who got prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.

Metric: 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. 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)].

Only final action PDE claims are used to calculate the patient safety measures. This measure, also named the High Risk Medication measure (HRM), was first

developed by the National Committee for Quality Assurance (NCQA), through its Healthcare Effectiveness Data and Information Set (HEDIS), and then adapted and endorsed by the Pharmacy Quality Alliance (PQA). This measure is also endorsed by the National Quality Forum (NQF).

See the medication list for this measure. The HRM rate is calculated using the NDC lists updated by the PQA. The complete National Drug Code (NDC) lists are posted along with these technical notes.

Exclusions: A percentage is not calculated for contracts with 30 or fewer enrolled beneficiaries 65 years or older.

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Also, member-years of enrollment is the adjustment made by CMS to account for enrollment for only part of the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, s/he will count as only 0.5 member-years in the rate calculation.
PDE adjustments made post-reconciliation were not reflected in this measure.

Data Source: Prescription Drug Event (PDE) data

Data Source Description: 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.

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≤ 14.0%, PDP: ≤ 19.3%

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 25.1%	> 22.2% to ≤ 25.1%	> 14.0% to ≤ 22.2%	> 9.3% to ≤ 14.0%	≤ 9.3%
PDP	> 27.7%	> 23.9% to ≤ 27.7%	> 19.3% to ≤ 23.9%	> 17.9% to ≤ 19.3%	≤ 17.9%

Measure: D14 - Diabetes Treatment

Label for Stars: Using the Kind of Blood Pressure Medication That Is Recommended for People with Diabetes

Label for Data: Using the Kind of Blood Pressure Medication That Is Recommended for People with Diabetes

Description: When people with diabetes also have high blood pressure, there are two types of blood pressure medication recommended. This tells what percent got one of the recommended types of blood pressure medicine.

Metric: This is defined as the percentage 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 which are recommended for people with diabetes. 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 period)].

Only final action PDE claims are used to calculate the patient safety measures. The Diabetes Treatment measure is adapted from the Diabetes Suboptimal Treatment measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009.

See the medication list for this measure. The Diabetes Treatment rate is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes.

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Also, member-years of enrollment is the adjustment made by CMS to account for enrollment for only part of the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, s/he will count as only 0.5 member-years in the rate calculation.
PDE adjustments made post-reconciliation were not reflected in this measure.

Data Source: Prescription Drug Event (PDE) data

Data Source Description: 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.

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: ≥ 86%, PDP: ≥ 83%

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 81.5%	≥ 81.5% to < 83.2%	≥ 83.2% to < 86.0%	≥ 86.0% to < 87.3%	≥ 87.3%
PDP	< 80.9%	≥ 80.9% to < 81.8%	≥ 81.8% to < 83.0%	≥ 83.0% to < 83.9%	≥ 83.9%

Measure: D15 - Part D Medication Adherence for Oral Diabetes Medications

Label for Stars: Taking Oral Diabetes Medication as Directed

Label for Data: Taking Oral Diabetes Medication as Directed

Description: One of the most important ways you can manage your health is by taking your medication as directed. The plan, the doctor, and the member can work together to find ways to help the member take their medication as directed. Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. ("Oral diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, or a DPP-IV inhibitor. Plan members who take insulin are not included.)

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy across four classes of oral diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors. This percentage is calculated as:

[(Number of member-years of enrolled beneficiaries 18 years or older with a proportion of days covered (PDC) at 80 percent or over across the classes of oral diabetes medications during the measurement period.)/ (Number of member-years of enrolled beneficiaries 18 years or older with at least two fills of medication(s) across any of the drug classes during the measurement period.)] The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or medications in its therapeutic category. Beneficiaries with one of more fills for insulin in the measurement period are excluded.

Only final action PDE claims are used to calculate the patient safety measures. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009 for the following drug classes: biguanides, sulfonylureas, thiazolidinediones, ACEI/ARBs, and dyslipidemia therapy. In 2011, the PQA updated the specifications for the Diabetes rate calculation, added the DPP-IV Inhibitor oral hypoglycemic drug class, and specified the exclusion of insulin patients.

See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes.

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Also, member-years of enrollment is the adjustment made by CMS to account for enrollment for only part of the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, s/he will count as only 0.5 member-years in the rate calculation.
PDE adjustments made post-reconciliation were not reflected in this measure.

Data Source: PDE

Data Source Description: The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for January 1, 2010-December 31, 2010.

PDE claims are limited to members who received at least two prescriptions for oral diabetes medication(s).

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 67.4%	≥ 67.4% to < 70.7%	≥ 70.7% to < 74.9%	≥ 74.9% to < 78.8%	≥ 78.8%
PDP	< 72.3%	≥ 72.3% to < 73.6%	≥ 73.6% to < 75.8%	≥ 75.8% to < 79.2%	≥ 79.2%

Measure: D16 - Part D Medication Adherence for Hypertension (ACEI or ARB)

Label for Stars: Taking Blood Pressure Medication as Directed

Label for Data: Taking Blood Pressure Medication as Directed

Description: One of the most important ways you can manage your health is by taking your medication as directed. The plan, the doctor, and the member can work together to find ways to help the member take their medication as directed. Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. ("Blood pressure medication" means an ACE (angiotensin converting enzyme) inhibitor or an ARB (angiotensin receptor blocker) drug.)

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy for angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medications. This percentage is calculated as:

[(Number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or over for ACEI or ARB medications during the measurement period) / (Number of member-years of enrolled beneficiaries 18 years or older with at least two fills of either the same medication or medications in the drug class during the measurement period.)] The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category.

Only final action PDE claims are used to calculate the patient safety measures. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009 for the following drug classes: biguanides, sulfonylureas, thiazolidinediones, ACEI/ARBs, and dyslipidemia therapy.

See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists are posted along with these technical notes.

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Also, member-years of enrollment is the adjustment made by CMS to account for enrollment for only part of the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, s/he will count as only 0.5 member-years in the rate calculation.
PDE adjustments made post-reconciliation were not reflected in this measure.

Data Source: PDE

Data Source Description: The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for January 1, 2010-December 31, 2010. PDE claims are limited to members who received at least two prescriptions for the ACEI/ARB blood pressure medication(s).

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 66.3%	≥ 66.3% to < 70.1%	≥ 70.1% to < 74.8%	≥ 74.8% to < 77.9%	≥ 77.9%
PDP	< 71.9%	≥ 71.9% to < 73.6%	≥ 73.6% to < 76.4%	≥ 76.4% to < 79.2%	≥ 79.2%

Measure: D17 - Part D Medication Adherence for Cholesterol (Statins)

Label for Stars: Taking Cholesterol Medication as Directed

Label for Data: Taking Cholesterol Medication as Directed

Description: One of the most important ways you can manage your health is by taking your medication as directed. The plan, the doctor, and the member can work together to find ways to help the member take their medication as directed. Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as:

[(Number of member-years of enrolled beneficiaries 18 years of older with a proportion of days covered (PDC) at 80 percent or over for statin cholesterol medication(s) during the measurement period.)/ (Number of member-years of

enrolled beneficiaries 18 years or older with at least two fills of either the same medication or medication in the drug class during the measurement period.)] The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in the therapeutic category.

Only final action PDE claims are used to calculate the patient measures. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009 for the following drug classes: biguanides, sulfonylureas, thiazolidinediones, ACEI/ARBs, and dyslipidemia therapy.

See medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes.

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Also, member-years of enrollment is the adjustment made by CMS to account for enrollment for only part of the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, s/he will count as only 0.5 member-years in the rate calculation.
PDE adjustments made post-reconciliation were not reflected in this measure.

Data Source: PDE

Data Source Description: The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for January 1, 2010-December 31, 2010. PDE claims are limited to members who received at least two prescriptions for a statin drug(s).

Data Time Frame: 01/01/2010 - 12/31/2010

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	HMO, HMOPOS, PSO w/o SNP	HMO, HMOPOS, PSO with SNP	MSA	PDP	PFFS	Local & Regional PPO w/o SNP	Local & Regional PPO with SNP
Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

4-Star Threshold: MA-PD: Not predetermined, PDP: Not predetermined

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 61.6%	≥ 61.6% to < 67.4%	≥ 67.4% to < 70.8%	≥ 70.8% to < 75.2%	≥ 75.2%
PDP	< 59.9%	≥ 59.9% to < 67.8%	≥ 67.8% to < 72.3%	≥ 72.3% to < 75.8%	≥ 75.8%

Attachment A: CAHPS Case-Mix Adjustment

The CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include dual eligibility and education among other variables. The table below includes the case-mix variables and shows the case-mix coefficients for each of the CAHPS measures included in the MPF tool. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to others with the baseline value for that characteristic, on the 0-100 scale used in consumer reports.

For example, for the measure "rating of care", the coefficient for "age 80-84" is +1.0067, indicating that respondents in that age range tend to score their plans 1.0067 point higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligibles tend to respond -0.6665 points lower on this item than otherwise similar non-duals. Contracts with above-average concentrations of respondents who are in the 80-84 age range will be adjusted downwards to compensate for the positive response tendency of their respondents. Similarly, contracts with above-average concentrations of respondents who are dual eligibles will be adjusted upwards to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. In the tables we report the average of the coefficients for these several items, for each of the categories (rows) of the table, as a summary of the adjustment for the composite.

Table A: Part C CAHPS Measures

Predictor	Rate Health Plan	Rate Care	Get Care Quickly (Comp)	Get Needed Care (Comp)	Health Plan Customer Service (Comp)
Age: 64 or under	-2.1160	-1.6219	-0.2814	-1.8235	-1.2284
Age: 65 - 69	-0.4413	-0.3719	-0.0339	-0.3974	0.0226
Age: 70 - 74					
Age: 75 - 79	1.4672	0.7507	0.2559	0.2364	-0.0681
Age: 80 - 84	2.3631	1.0067	0.3044	1.2680	1.9649
Age: 85 and older	2.4894	1.1786	1.2566	0.9409	1.2913
Less than an 8th grade education	-0.9662	-1.7340	-1.4821	-2.2163	-0.6414
Some high school	0.6049	-0.5523	-0.4616	-1.3017	0.7212
High School					
Some college	-2.4154	-1.4509	-0.4550	-2.4582	-1.6513
College graduate	-2.9925	-2.1963	-1.0826	-1.9892	-1.8315
More than a bachelor's degree	-3.9597	-2.8613	-0.7290	-2.9980	-3.4713
General health rating: excellent	4.3852	4.4802	4.2458	3.5073	1.1931
General health rating: very good	2.1768	2.2671	1.4456	1.9281	0.7732
General health rating: good					
General health rating: fair	-1.4182	-2.3763	-2.0824	-2.2621	-1.7677
General health rating: poor	-1.6517	-4.4942	-1.5518	-2.2326	-2.8554
Mental health rating: excellent	3.3185	4.7950	3.2628	4.7405	2.5871
Mental health rating: very good	1.6891	2.2681	2.0315	2.2846	0.8945
Mental health rating: good					
Mental health rating: fair	-1.5093	-0.9321	-0.6570	-0.8731	-1.5914
Mental health rating: poor	-4.5770	-2.3034	-1.0109	-2.5027	-4.0258
Proxy helped	-1.3468	-1.8609	-1.0290	-1.5313	-2.7689
Proxy answered	-0.4403	0.3490	1.2539	0.7683	-0.0543
Medicaid dual eligible	1.7320	-0.6650	-0.4302	-1.2793	1.0206
Low-income subsidy (LIS)	1.0662	-1.1168	-1.7504	-2.1873	-0.9946

Table B: Medicare Advantage – Prescription Drug Plans (MA-PD) Part D CAHPS Measures

Predictor	Rate Drug Plan	Getting Information from Drug Plan	Getting Needed Prescription Drugs
Age: 64 or under	-2.2413	0.3011	-1.1524
Age: 65 - 69	-0.7125	0.5109	-0.4013
Age: 70 - 74			
Age: 75 - 79	1.7589	1.2572	0.8484
Age: 80 - 84	2.9000	1.5003	0.8203
Age: 85 and older	4.4668	3.2079	1.4065
Less than an 8th grade education	-0.3543	-2.1145	-1.5838
Some high school	1.1344	-2.3570	-0.4623
High School Grad			
Some college	-2.4641	-1.3814	-1.0613
College graduate	-3.1642	-2.2557	-1.8851
More than a bachelor's degree	-4.6093	-3.2908	-2.4089
General health rating: excellent	4.1322	-0.7890	0.4966
General health rating: very good	2.1242	1.4408	1.0496
General health rating: good			
General health rating: fair	-1.3689	-1.8829	-1.1141
General health rating: poor	-2.6663	-2.9313	-1.6472
Mental health rating: excellent	3.1867	3.2722	3.2373
Mental health rating: very good	1.9223	1.4741	1.9017
Mental health rating: good			
Mental health rating: fair	-1.2271	-2.2218	-1.6854
Mental health rating: poor	-5.4349	-1.2400	-3.1617
Proxy helped	-1.7771	-1.4652	-0.5619
Proxy answered	-1.3441	2.7103	0.8492
Medicaid dual eligible	5.6227	1.0935	0.4459
Low-income subsidy (LIS)	4.8168	-2.7270	0.0307

Table C: Prescription Drug Plan (PDP) Part D CAHPS Measures

Predictor	Rate Drug Plan	Getting Information from Drug Plan	Getting Needed Prescription Drugs
Age: 64 or under	-4.2022	-4.9303	-2.4333
Age: 65 – 69	0.0156	-2.2726	-0.1306
Age: 70 - 74			
Age: 75 - 79	1.6718	-0.8715	0.9318
Age: 80 - 84	3.9067	-0.6732	1.8915
Age: 85 and older	4.2600	-2.1678	1.6319
Less than an 8th grade education	-0.0710	-3.0265	-0.9893
Some high school	2.2590	-4.7234	-0.1304
High School Grad			
Some college	-2.8246	-2.1696	-1.5105
College graduate	-2.4274	-0.6314	-1.1214
More than a bachelor's degree	-3.5882	-4.6391	-3.0517
General health rating: excellent	1.2160	8.4604	-0.1508
General health rating: very good	1.6149	2.8123	0.6320
General health rating: good			
General health rating: fair	-0.2359	2.0085	-0.3197
General health rating: poor	-1.4514	2.3588	-3.1609
Mental health rating: excellent	1.3093	-0.7475	2.8568
Mental health rating: very good	0.1730	0.0846	1.6769
Mental health rating: good			
Mental health rating: fair	-1.6635	-1.0040	-1.8467
Mental health rating: poor	-3.3997	-12.0579	-2.2798
Proxy helped	-3.9816	-1.1662	-3.1792
Proxy answered	-3.9291	-2.3589	-0.8496
Medicaid dual eligible	9.6360	3.0150	2.5317
Low-income subsidy (LIS)	8.7225	3.9897	3.0514

Attachment B: Complaints Tracking Module Exclusion List

Table A contains the current exclusions applied to the CTM based on the revised categories and subcategories that became effective September 25, 2010.

Table A: Exclusions effective September 25, 2010

Category ID	Category Description	Subcategory ID	Subcategory Description
11	Enrollment/Disenrollment	16	Facilitated/Auto Enrollment issues
		18	Enrollment Exceptions (EE)
13	Pricing/Co-Insurance	06	Beneficiary has lost LIS Status/Eligibility or was denied LIS
		16	Part D IRMAA
30	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	01	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information
		90	Other Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information Issue
38	Contractor/Partner Performance	90	Other Contractor/Partner Performance

Note: Program Integrity complaints, which are in the CTM but not viewable by plans, are excluded as well.

Table B: contains the categories and subcategories that are excluded if they were entered into the CTM prior to current exclusion criteria.

Table B: Exclusions prior to September 25, 2010

Category ID	Category Description	Subcategory ID	Subcategory Description
03	Enrollment/Disenrollment	06	Enrollment Exceptions (EE)
		07	Retroactive Disenrollment (RD)
		09	Enrollment Reconciliation - Dissatisfied with Decision
		10	Retroactive Enrollment (RE)
		12	Missing Medicaid/ Medicare Eligibility in MBD
05	Program Integrity Issues/Potential Fraud, Waste and Abuse	01	Program Integrity Issues/Potential Fraud, Waste and Abuse
10	Customer Service	12	Plan Website
11	Enrollment/ Disenrollment	16	Facilitated/Auto Enrollment Issues
		17	Missing Medicaid/ Medicare Eligibility in MBD
		18	Enrollment Exceptions (EE)
13	Pricing/Co-Insurance	06	Beneficiary has lost LIS Status/Eligibility or was denied LIS
		08	Overcharged Premium Fees
14	Program Integrity Issues/Potential Fraud, Waste and Abuse	01	Program Integrity Issues/Potential Fraud, Waste and Abuse
24	Program Integrity Issues/Potential Fraud, Waste and Abuse	01	Program Integrity Issues/Potential Fraud, Waste and Abuse
32	Program Integrity Issues/Potential Fraud, Waste and Abuse	01	Program Integrity Issues/Potential Fraud, Waste and Abuse
34	Plan Administration	02	Plan Terminating Contract
38	Contractor/ Partner Performance	01	Quality Improvement Organization (QIO)
		02	State Health Insurance Plans (SHIPs)
		03	Social Security Administration (SSA)
		04	1-800-Medicare
		90	Other Contractor/ Partner Performance
41	Pricing/Co-Insurance	01	Premium Reconciliation - Refund or Billing Issue
		03	Beneficiary Double Billed (both premium withhold and direct pay)
		04	Premium Withhold Amount not going to Plan
		05	Part B Premium Reduction Issue
		90	Other Premium Withhold Issue

Note: Program Integrity Complaints, which are in the CTM but not viewable by plans, are excluded as well.

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of the numeric values for each measure all contracts reported in the 2012 Plan Ratings.

Table A: National Averages for Part C Measures

Measure ID	Measure Name	National Average
C01	Breast Cancer Screening	68%
C02	Colorectal Cancer Screening	53%
C03	Cardiovascular Care – Cholesterol Screening	88%
C04	Diabetes Care – Cholesterol Screening	87%
C05	Glaucoma Testing	64%
C06	Annual Flu Vaccine	68%
C07	Pneumonia Vaccine	67%
C08	Improving or Maintaining Physical Health	66%
C09	Improving or Maintaining Mental Health	78%
C10	Monitoring Physical Activity	48%
C11	Access to Primary Care Doctor Visits	94%
C12	Adult BMI Assessment	46%
C13	Care for Older Adults – Medication Review	65%
C14	Care for Older Adults – Functional Status Assessment	47%
C15	Care for Older Adults – Pain Screening	43%
C16	Osteoporosis Management in Women who had a Fracture	20%
C17	Diabetes Care – Eye Exam	63%
C18	Diabetes Care – Kidney Disease Monitoring	89%
C19	Diabetes Care – Blood Sugar Controlled	70%
C20	Diabetes Care – Cholesterol Controlled	49%
C21	Controlling Blood Pressure	59%
C22	Rheumatoid Arthritis Management	74%
C23	Improving Bladder Control	36%
C24	Reducing the Risk of Falling	59%
C25	Plan All-Cause Readmissions	13%
C26	Getting Needed Care	85%
C27	Getting Appointments and Care Quickly	75%
C28	Customer Service	88%
C29	Overall Rating of Health Care Quality	86%
C30	Overall Rating of Plan	85%
C31	Complaints about the Health Plan	0.36
C32	Beneficiary Access and Performance Problems	64
C33	Members Choosing to Leave the Plan	14%
C34	Plan Makes Timely Decisions about Appeals	89%
C35	Reviewing Appeals Decisions	79%
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	79%

Table B: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD National Average	PDP National Average
D01	Call Center – Pharmacy Hold Time	0:38	0:38
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	77.7	76.2
D03	Appeals Auto–Forward	3	3.1
D04	Appeals Upheld	51.00%	55.20%
D05	Enrollment Timeliness	86.75	90.42
D06	Complaints about the Drug Plan	0.45	0.31
D07	Beneficiary Access and Performance Problems	64%	59%
D08	Members Choosing to Leave the Plan	14	13
D09	Getting Information From Drug Plan	82%	78%
D10	Rating of Drug Plan	84%	81%
D11	Getting Needed Prescription Drugs	91%	89%
D12	MPF Composite	97.7	97.4
D13	High Risk Medication	20.00%	22.20%
D14	Diabetes Treatment	84.10%	82.20%
D15	Part D Medication Adherence for Oral Diabetes Medications	73.00%	74.40%
D16	Part D Medication Adherence for Hypertension (ACEI or ARB)	72.20%	74.30%
D17	Part D Medication Adherence for Cholesterol (Statins)	68.00%	69.10%

Attachment D: Part C and D Data Time Frames

Table A: Part C Measure Data Time Frames

Measure ID	Measure Name	Data Time Frame
C01	Breast Cancer Screening	01/01/2010 - 12/31/2010
C02	Colorectal Cancer Screening	01/01/2010 - 12/31/2010
C03	Cardiovascular Care – Cholesterol Screening	01/01/2010 - 12/31/2010
C04	Diabetes Care – Cholesterol Screening	01/01/2010 - 12/31/2010
C05	Glaucoma Testing	01/01/2010 - 12/31/2010
C06	Annual Flu Vaccine	Feb - June 2011
C07	Pneumonia Vaccine	Feb - June 2011
C08	Improving or Maintaining Physical Health	Apr - Aug 2010
C09	Improving or Maintaining Mental Health	Apr - Aug 2010
C10	Monitoring Physical Activity	Apr - Aug 2010
C11	Access to Primary Care Doctor Visits	01/01/2010 - 12/31/2010
C12	Adult BMI Assessment	01/01/2010 - 12/31/2010
C13	Care for Older Adults – Medication Review	01/01/2010 - 12/31/2010
C14	Care for Older Adults – Functional Status Assessment	01/01/2010 - 12/31/2010
C15	Care for Older Adults – Pain Screening	01/01/2010 - 12/31/2010
C16	Osteoporosis Management in Women who had a Fracture	01/01/2010 - 12/31/2010
C17	Diabetes Care – Eye Exam	01/01/2010 - 12/31/2010
C18	Diabetes Care – Kidney Disease Monitoring	01/01/2010 - 12/31/2010
C19	Diabetes Care – Blood Sugar Controlled	01/01/2010 - 12/31/2010
C20	Diabetes Care – Cholesterol Controlled	01/01/2010 - 12/31/2010
C21	Controlling Blood Pressure	01/01/2010 - 12/31/2010
C22	Rheumatoid Arthritis Management	01/01/2010 - 12/31/2010
C23	Improving Bladder Control	Apr - Aug 2010
C24	Reducing the Risk of Falling	Apr - Aug 2010
C25	Plan All-Cause Readmissions	01/01/2010 - 12/31/2010
C26	Getting Needed Care	Feb - June 2011
C27	Getting Appointments and Care Quickly	Feb - June 2011
C28	Customer Service	Feb - June 2011
C29	Overall Rating of Health Care Quality	Feb - June 2011
C30	Overall Rating of Plan	Feb - June 2011
C31	Complaints about the Health Plan	1/1/2011 - 06/30/2011
C32	Beneficiary Access and Performance Problems	01/01/2010 - 02/28/2011
C33	Members Choosing to Leave the Plan	01/01/2010 - 12/31/2010
C34	Plan Makes Timely Decisions about Appeals	01/01/2010 - 12/31/2010
C35	Reviewing Appeals Decisions	01/01/2010 - 12/31/2010
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	01/31/2011 - 05/20/2011 (Monday - Friday)

Table B: Part D Measure Data Time Frames

Measure ID	Measure Name	Data Time Frame
D01	Call Center – Pharmacy Hold Time	01/31/2011 - 05/27/2011
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	01/31/2011 - 05/20/2011 (Monday - Friday)
D03	Appeals Auto–Forward	01/01/2010 - 12/31/2010
D04	Appeals Upheld	01/01/2011-06/30/2011
D05	Enrollment Timeliness	11/13/2010 - 04/27/2011
D06	Complaints about the Drug Plan	01/01/2011 - 06/30/2011
D07	Beneficiary Access and Performance Problems	01/01/2010 - 02/28/2011
D08	Members Choosing to Leave the Plan	01/01/2010 – 12/31/2010
D09	Getting Information From Drug Plan	02/01/2011 – 06/30/2011
D10	Rating of Drug Plan	02/01/2011 – 06/30/2011
D11	Getting Needed Prescription Drugs	02/01/2011 – 06/30/2011
D12	MPF Composite	01/01/2010 - 12/31/2010
D13	High Risk Medication	01/01/2010 - 12/31/2010
D14	Diabetes Treatment	01/01/2010 - 12/31/2010
D15	Part D Medication Adherence for Oral Diabetes Medications	01/01/2010 - 12/31/2010
D16	Part D Medication Adherence for Hypertension (ACEI or ARB)	01/01/2010 - 12/31/2010
D17	Part D Medication Adherence for Cholesterol (Statins)	01/01/2010 - 12/31/2010

Attachment E: NCQA Measure Combining Methodology

The specifications below are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions

Definitions

Let N_1 = The Total Number of Members Eligible for the HEDIS measure in the first PBP ("fixed" and auditable)

Let N_2 = The Total Number of Members Eligible for the HEDIS measure in the second PBP ("fixed" and auditable)

Let P_1 = The estimated rate (mean) for the HEDIS measure in the first PBP (auditable)

Let P_2 = The estimated rate (mean) for the same HEDIS measure in the second PBP (auditable)

Setup Calculations

Based on the above definitions, there are two additional calculations:

Let W_1 = The weight assigned to the first PBP results (estimated, auditable). This result is estimated by the formula $W_1 = N_1/(N_1+N_2)$

Let W_2 = The weight assigned to the second PBP results (estimated, auditable). This is estimated from the formula $W_2 = N_2/(N_1+N_2)$

Pooled Analysis

The pooled result from the two rates (means) is calculated as:

$P_{pooled} = W_1*P_1 + W_2*P_2$

NOTES:
Weights are based on the eligible member population. While it may be more accurate to remove all excluded members before weighting, NCQA and CMS have chosen not do this (to simplify the method) for two reasons: 1) the number of exclusions relative to the size of the population should be small, and 2) exclusion rates (as a percentage of the eligible population) should be similar for each PBP and negligibly affect the weights.

If one or more of the submissions has an audit designation of NA, those submissions are dropped and not included in the weighted rate (mean) calculations. If one or more of the submissions has a designation of NR, which has been determined to be biased or is not reported by choice of the contract, the rate is set to zero as detailed in the section titled Handling of Biased, Erroneous and/or Not reportable (NR) Data

Numeric Example Using an Effectiveness of Care Rate	
# of Total Members Eligible for the HEDIS measure in PBP 1, N_1 =	1500
# of Total Members Eligible for the HEDIS measure in PBP 2, N_2 =	2500
HEDIS Result for PBP 1, Enter as a Proportion between 0 and 1, P_1 =	0.75
HEDIS Result for PBP 2, Enter as a Proportion between 0 and 1, P_2 =	0.5
Setup Calculations - Initialize Some Intermediate Results	
The weight for PBP 1 product estimated by $W_1 = N_1/(N_1+N_2)$	0.375
The weight for PBP 2 product estimated by $W_2 = N_2/(N_1+N_2)$	0.625
Pooled Results	
$P_{pooled} = W_1*P_1 + W_2*P_2$	0.59375

Attachment F: Calculating Measure C25: Plan All-Cause Readmissions

All data come from HEDIS 2011 M11_PCR data file.

Formula Value	PCR Field	Field Description
A	ist6574	Count of Index Stays (Denominator) Total 65-74 Num
D	rt6574	Count of 30-Day readmissions (Numerator) Total 65-74 Num
G	apt6574	Average Adjusted Probability Total 65-74 Num
B	ist7584	Count of Index Stays (Denominator) Total 75-84 Num
E	rt7584	Count of 30-Day readmissions (Numerator) Total 75-84 Num
H	apt7584	Average Adjusted Probability Total 75-84 Num
C	ist85	Count of Index Stays (Denominator) Total 85+ Num
F	rt85	Count of 30-Day readmissions (Numerator) Total 85+ Num
I	apt85	Average Adjusted Probability Total 85+ Num

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{D_1+E_1+F_1}{A_1+B_1+C_1}\right)+\ldots+\left(\frac{D_n+E_n+F_n}{A_n+B_n+C_n}\right)\right)$$ Where 1 through n are all contracts with numeric data.

$$\text{Observed} = \frac{D+E+F}{A+B+C}$$

$$\text{Expected} = \left(\left(\frac{A}{A+B+C}\right)\times G\right) + \left(\left(\frac{B}{A+B+C}\right)\times H\right) + \left(\left(\frac{C}{A+B+C}\right)\times I\right)$$

$$\text{Final Rate} = \left(\left(\frac{\text{Observed}}{\text{Expected}}\right)\times \text{NatAvgObs}\right)\times 100$$

Example: Calculating the final rate for Contract 1

Formula Value	PCR Field	Contract 1	Contract 2	Contract 3	Contract 4
A	ist6574	2,217	1,196	4,157	221
D	rt6574	287	135	496	30
G	apt6574	0.126216947	0.141087156	0.122390927	0.129711036
B	ist7584	1,229	2,483	3,201	180
E	rt7584	151	333	434	27
H	apt7584	0.143395345	0.141574415	0.168403941	0.165909069
C	ist85	1,346	1,082	1,271	132
F	rt85	203	220	196	22
I	apt85	0.165292297	0.175702614	0.182608065	0.145632638

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{287+151+203}{2217+1229+1346}\right)+\left(\frac{135+333+220}{1196+2438+1082}\right)+\left(\frac{496+434+196}{4157+3201+1271}\right)+\left(\frac{30+27+22}{221+180+132}\right)\right)$$

$$\text{NatAvgObs} = \text{Average}\left((0.13376)+(0.14451)+(0.13049)+(0.14822)\right)$$

NatAvgObs = 0.13924

$$\text{Observed Contract 1} = \frac{287+151+203}{2217+1229+1346} = 0.13376$$

Expected Contract 1 =

$$\left(\left(\frac{2217}{2217+1229+1346}\right)\times 0.126216947\right)+\left(\left(\frac{1229}{2217+1229+1346}\right)\times 0.143395345\right)+\left(\left(\frac{1346}{2217+1229+1346}\right)\times 0.165292297\right)$$

Expected Contract 1 = (0.058 + 0.037 + 0.046) = 0.142

$$\text{Final Rate Contract 1} = \left(\left(\frac{0.13376}{0.142}\right)\times 0.13924\right)\times 100 = 13.1160158$$

Final Rate reported in the Plan Ratings for Contract 1 = 13%

The actual calculated NatAvgObs value used in the 2012 Plan Ratings was 0.140958563062941

Attachment G: Weights Assigned to Individual Performance Measures

Table A: Part C Measure Weights

Measure ID	Measure Name	Weighting Category	Part C Summary	MA-PD Overall
C01	Breast Cancer Screening	Process Measure	1	1
C02	Colorectal Cancer Screening	Process Measure	1	1
C03	Cardiovascular Care – Cholesterol Screening	Process Measure	1	1
C04	Diabetes Care – Cholesterol Screening	Process Measure	1	1
C05	Glaucoma Testing	Process Measure	1	1
C06	Annual Flu Vaccine	Process Measure	1	1
C07	Pneumonia Vaccine	Process Measure	1	1
C08	Improving or Maintaining Physical Health	Outcome Measure	3	3
C09	Improving or Maintaining Mental Health	Outcome Measure	3	3
C10	Monitoring Physical Activity	Process Measure	1	1
C11	Access to Primary Care Doctor Visits	Measures Capturing Access	1.5	1.5
C12	Adult BMI Assessment	Process Measure	1	1
C13	Care for Older Adults – Medication Review	Process Measure	1	1
C14	Care for Older Adults – Functional Status Assessment	Process Measure	1	1
C15	Care for Older Adults – Pain Screening	Process Measure	1	1
C16	Osteoporosis Management in Women who had a Fracture	Process Measure	1	1
C17	Diabetes Care – Eye Exam	Process Measure	1	1
C18	Diabetes Care – Kidney Disease Monitoring	Process Measure	1	1
C19	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measures	3	3
C20	Diabetes Care – Cholesterol Controlled	Intermediate Outcome Measures	3	3
C21	Controlling Blood Pressure	Intermediate Outcome Measures	3	3
C22	Rheumatoid Arthritis Management	Process Measure	1	1
C23	Improving Bladder Control	Process Measure	1	1
C24	Reducing the Risk of Falling	Process Measure	1	1
C25	Plan All-Cause Readmissions (Weighted as "1" because it is a first year measure.)	Outcome Measure	1	1
C26	Getting Needed Care	Patients' Experience and Complaints Measure	1.5	1.5
C27	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	1.5	1.5
C28	Customer Service	Patients' Experience and Complaints Measure	1.5	1.5
C29	Overall Rating of Health Care Quality	Patients' Experience and Complaints Measure	1.5	1.5
C30	Overall Rating of Plan	Patients' Experience and Complaints Measure	1.5	1.5
C31	Complaints about the Health Plan	Patients' Experience and Complaints Measure	1.5	1.5
C32	Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
C33	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
C34	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	1.5	1.5
C35	Reviewing Appeals Decisions	Measures Capturing Access	1.5	1.5
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5	1.5

Table B: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary	MA-PD Overall
D01	Call Center – Pharmacy Hold Time	Measures Capturing Access	1.5	1.5
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5	1.5
D03	Appeals Auto–Forward	Measures Capturing Access	1.5	1.5
D04	Appeals Upheld	Measures Capturing Access	1.5	1.5
D05	Enrollment Timeliness	Process Measure	1	1
D06	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D07	Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
D08	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
D09	Getting Information From Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D10	Rating of Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D11	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	1.5	1.5
D12	MPF Composite	Process Measure	1	1
D13	High Risk Medication	Intermediate Outcome Measures	3	3
D14	Diabetes Treatment	Intermediate Outcome Measures	3	3
D15	Part D Medication Adherence for Oral Diabetes Medications	Intermediate Outcome Measures	3	3
D16	Part D Medication Adherence for Hypertension (ACEI or ARB)	Intermediate Outcome Measures	3	3
D17	Part D Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measures	3	3

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) star rating for contract *j* is estimated as:

$$\bar{x}_j = \frac{\sum_{i=1}^{n_j} w_{ij} x_{ij}}{\sum_{i=1}^{n_j} w_{ij}}$$

where n_j is the number of performance measures for which contract *j* is eligible; w_{ij} is the weight assigned to performance measure *i* for contract *j*; and x_{ij} is the measure star for performance measure *i* for contract *j*. The variance of the star ratings for each contract *j*, s_j^2, must also be computed in order to estimate the integration factor (i-Factor):

$$s_j^2 = \frac{n_j}{(n_j - 1)\left(\sum_{i=1}^{n_j} w_{ij}\right)} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j\right)^2\right]$$

Thus, the $\bar{x}_j$'s are the new summary (or overall) star ratings for the contracts. The variance estimate, s_j^2, simply replaces the non-weighted variance estimate that was previously used for the i-Factor calculation. For all contracts *j*, $w_{ij} = w_i$ (i.e., the performance measure weights are the same for all contracts when estimating a given star rating (Part C or Part D summary or MA-PD overall ratings).

Attachment I: Glossary of Terms

Anderson-Darling test	This test compares the similarity of an observed cumulative distribution function to an expected cumulative distribution function.
AEP	The annual period from November 15 until December 31 when a Medicare beneficiary can enroll into a Medicare Part D plan or re-enroll into their existing Medicare Part D Plan or change into another Medicare Part D plan is known as the Annual Election Period (AEP). Beneficiaries can also switch to a Medicare Advantage Plan that has a Prescription Drug Plan (MA-PD). The chosen Medicare Part D plan coverage begins on January 1st.
CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
CCP	A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS' requirements.
Cost Plan	A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost reimbursement contract under §1876(h) of the Act.
Cramér-von-Mises criterion	This is used to judge the goodness of fit of a probability distribution, compared to a given empirical distribution function or to compare two empirical distributions.
Euclidean metric	This test is the ordinary distance between two points that one would measure with a ruler.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
ICEP	The 3 months immediately before beneficiaries are entitled to Medicare Part A and enrolled in Part B are known as the Initial Coverage Election Period (ICEP). Beneficiaries may choose a Medicare health plan during their ICEP and the plan

	must accept them unless it has reached its limit in the number of members. This limit is approved by CMS.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations.
IVR	Interactive voice response (IVR) is a technology that allows a computer to interact with humans through the use of voice and dual-tone multi-frequency keypad inputs.
Kolmogorov-Smirnov test	The Kolmogorov-Smirnov (K–S) test uses a non-parametric technique to determine if two datasets are significantly different. It compares a sample with a reference probability distribution (one-sample K–S test), or compares two samples (two-sample K–S test).
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who are eligible for the LIS will get help paying for their monthly premium, yearly deductible, prescription coinsurance and copayments and they will have no gap in coverage.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-only	An MA organization that does not offer Medicare prescription drug coverage.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
MSA	Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder).
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.
Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through the Original Medicare Plan; Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage; and Medicare Cost Plans offering Medicare prescription drug coverage.
PFFS	Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to

	the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
SNP	A Special Needs Plan (SNP) is an MA coordinated care plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more severe or disabling chronic conditions.
Sponsor	An entity that sponsors a health or drug plan.
TTY/TDD	A Teletypewriter (TTY) or telecommunications device for the deaf (TDD) s an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.