



**2019**  
**Medicare-Medicaid Plan**  
**Performance Data**  
**Technical Notes**

Updated – April 2019

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## Introduction

Under the Medicare-Medicaid Financial Alignment Initiative (FAI) capitated model, the Centers for Medicare & Medicaid Services (CMS) is collecting a variety of measures that examine plan performance and the quality of care provided to enrollees. The Medicare-Medicaid Plan (MMP) performance data published here represent currently available data on MMP performance on certain Medicare Parts C and D quality measures as well as select CMS core and state-specific measures that MMPs are required to report. The data show MMP performance on quality measures during 2017 and the results of surveys of MMP enrollees conducted in 2017 or 2018. The measures are organized into five domains that largely track the potential domains under a future MMP star ratings system described in the [Medicare-Medicaid Plan Quality Ratings Strategy](#) published in November 2015.

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

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

We also note that there are not yet available data based on the Health Outcomes Survey for MMPs that began enrolling members after January 1, 2016, and a number of MMPs had too limited enrollment to be able to report reliable data for a number of individual measures. Despite these limitations, we are publishing MMP performance data to provide greater transparency on MMP performance during the initial years of the FAI, and as a first step toward equipping the public with a robust set of performance data.

Questions about the MMP performance data should be addressed to: [mmcocapsmodel@cms.hhs.gov](mailto:mmcocapsmodel@cms.hhs.gov).

## State Weighted Averages

Within the MMP Performance Data File, state weighted averages are provided for each measure. Depending on the measure type, the averages are weighted by the enrollment of each MMP with valid data for the measure or by the eligible population for the measure as reported for each MMP. More specifically, averages for measures from the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey are weighted using the total number of members enrolled in February 2017 and January 2018, respectively, to align with the timeframe during which each survey's sampling frame was drawn. Averages for the Call Center Foreign Language Interpreter and TTY Availability measures are weighted using the total number of members enrolled in February 2018 to align with the timeframe during which call center monitoring commenced. Averages for all other measures are weighted using each MMP's eligible population for the measure (i.e., the denominator for each MMP).

## Differences between the 2018 and 2019 MMP Performance Data File and Technical Notes

There were several changes between the 2018 and 2019 versions of the MMP Performance Data File and Technical Notes. This section provides a summary of the notable differences.

### *Revisions:*

- Where applicable, measure numbers, measure specifications, and related attachments were updated to comport with the Medicare 2019 Part C & D Star Ratings Technical Notes.
- The following measures were incorrectly listed in the 2018 MMP Performance Data Technical Notes under the Member Experience with Integrated Plan and Care Providers domain. As of the 2019 MMP Performance Data Technical Notes, they are correctly listed under the Managing Chronic (Long Term) Conditions/Health Outcomes domain.
  - Reducing the Risk of Falling (C18)
  - Improving Bladder Control (C19)

- Medication Reconciliation Post-Discharge (C20)
- The MTM Program Completion Rate for CMR (D13) measure was moved from the Safety of Care domain to the Managing Chronic (Long Term) Conditions/Health Outcomes domain.

**Additions:**

- The following measures were added to the MMP Performance Data File and Technical Notes:
  - Statin Therapy for Patients with Cardiovascular Disease (C22)
  - Statin Use in Persons with Diabetes (D14)
- The MMP Performance Data File was updated to include MMPs that terminated at the end of the measurement year (previous versions of the file excluded terminated MMPs). The MMPs that terminated are marked with an asterisk in the file. Note that certain measures are not reportable for terminated MMPs; those measures are noted within the measure specifications where applicable and also within [Attachment F: Missing Data Messages](#).

**Removals:**

- No measures were removed from the MMP Performance Data File and Technical Notes.
- The Safety of Care domain was removed from the MMP Performance Data File and Technical Notes following the move of the MTM Program Completion Rate for CMR (D13) measure, the only measure under the Safety of Care domain, to the Managing Chronic (Long Term) Conditions/Health Outcomes domain.

## Framework and Definitions for the Domain and Measure Details Section

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

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

#### Measure: The measure ID and common name of the measure

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

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

### Measure: M21 - Comprehensive Health Risk Assessment

| Title                 | Description  |
|-----------------------|--|
| Description:          | Percent of members who received a health risk assessment within 90 days of enrollment in the MMP.  |
| Metric:               | This measure captures the total number of members with a health risk assessment completed within the first 90 days of enrollment. When calculating the completion rate, the members that were unreachable (after at least three contact attempts) and the members that refused the assessment are subtracted from the denominator. |
| Primary Data Source:  | Measure Core 2.1 from the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | Members that were unreachable (after at least three contact attempts) and members that refused the assessment are subtracted from the denominator.   |
| General Notes:        | A full description of the measure specifications is available in the <a href="#">CY 2017 Core Reporting Requirements</a> .   |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| Case-mix adjusted:    | No   |
| NQF #:                | Not Applicable   |
| Data Display:         | Percentage with no decimal place   |

### Measure: M32 - Care Plan Completion

| Title                 | Description   |
|-----------------------|---|
| Description:          | Percent of members who had a care plan completed within the requisite timeframe.  |
| Metric:               | This measure captures the total number of members with a care plan completed within the requisite timeframe based on state-specific requirements (e.g., 90 days from enrollment, 30 days from assessment completion). When calculating the completion rate, the members that were unreachable (after the requisite number of contact attempts) and the members that refused the care plan are subtracted from the denominator. See <a href="#">Attachment J</a> for the state-specific requirements for this measure. |
| Primary Data Source:  | Various state-specific measures from the individual Medicare-Medicaid Capitated Financial Alignment Model State-Specific Reporting Requirements   |
| Data Source Category: | Health and Drug Plans   |
| Exclusions:           | Members that were unreachable (after the requisite number of contact attempts) and members that refused the care plan are subtracted from the denominator.  |
| General Notes:        | Specifications for the care plan completion measure vary by state, and can be found in the individual <a href="#">State-Specific Reporting Requirements</a> .   |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Higher is better  |
| Case-mix adjusted:    | No  |
| NQF #:                | Not Applicable  |
| Data Display:         | Percentage with no decimal place  |

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

| Title                 | Description   |
|-----------------------|---|
| Description:          | Percent of members whose doctor has done a functional status assessment to see how well they are able to do Activities of Daily Living such as dressing, eating, and bathing.   |
| HEDIS Label:          | Care for Older Adults (COA) – Functional Status Assessment  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 93  |
| Metric:               | The percentage of MMP enrollees 66 years and older (denominator) who received at least one functional status assessment (Functional Status Assessment Value Set) during the measurement year (numerator).   |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Exclusions:           | MMPs whose enrollment was less than 30 as of the February 2017 Monthly Enrollment by Plan Report were excluded from this measure.<br><br>This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs. |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Higher is better  |
| Case-mix adjusted:    | No  |
| NQF #:                | Not Applicable  |
| Data Display:         | Percentage with no decimal place  |

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

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

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Yearly Review of All Medications and Supplements Being Taken   |
| Description:          | Percent of members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.   |
| HEDIS Label:          | Care for Older Adults (COA) – Medication Review  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 93   |
| Metric:               | The percentage of MMP enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator). |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | MMPs whose enrollment was less than 30 as of the February 2017 Monthly Enrollment by Plan Report were excluded from this measure.<br><br>This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.              |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| Case-mix adjusted:    | No   |

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

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

| Title  | Description |
|--|-------------|
| Label for Data: Yearly Pain Screening or Pain Management Plan  |             |
| Description: Percent of plan members who had a pain screening at least once during the year.   |             |
| HEDIS Label: Care for Older Adults (COA) – Pain Screening  |             |
| Measure Reference: NCQA HEDIS 2018 Technical Specifications Volume 2, page 93  |             |
| Metric: The percentage of MMP enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator). |             |
| Primary Data Source: HEDIS   |             |
| Data Source Category: Health and Drug Plans  |             |
| Exclusions: MMPs whose enrollment was less than 30 as of the February 2017 Monthly Enrollment by Plan Report were excluded from this measure.  |             |
| This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.         |             |
| Data Time Frame: 01/01/2017 - 12/31/2017   |             |
| General Trend: Higher is better  |             |
| Case-mix adjusted: No  |             |
| NQF #: Not Applicable  |             |
| Data Display: Percentage with no decimal place   |             |

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

| Title   | Description |
|---|-------------|
| Label for Data: Osteoporosis Management   |             |
| Description: Percent of female members who broke a bone and got screening or treatment for osteoporosis within 6 months.  |             |
| HEDIS Label: Osteoporosis Management in Women Who Had a Fracture (OMW)  |             |
| Measure Reference: NCQA HEDIS 2018 Technical Specifications Volume 2, page 165  |             |
| Metric: The percentage of woman MMP enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator). |             |
| Primary Data Source: HEDIS  |             |
| Data Source Category: Health and Drug Plans   |             |
| Exclusions: This measure is not included for Massachusetts MMPs because it is calculated for individuals age 67 - 85 and only individuals younger than 65 can enroll in Massachusetts MMPs.   |             |
| Data Time Frame: 01/01/2017 - 12/31/2017  |             |
| General Trend: Higher is better   |             |
| Case-mix adjusted: No   |             |
| NQF #: 0053   |             |
| Data Display: Percentage with no decimal place  |             |

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**Measure: C13 - Diabetes Care – Eye Exam**

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Eye Exam to Check for Damage from Diabetes   |
| Description:          | Percent of members with diabetes who had an eye exam to check for damage from diabetes during the year.  |
| HEDIS Label:          | Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed   |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 140  |
| Metric:               | The percentage of diabetic MMP enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).  |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.<br><br>Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator.<br><br>If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| Case-mix adjusted:    | No   |
| NQF #:                | 0055   |
| Data Display:         | Percentage with no decimal place   |

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**Measure: C14 - Diabetes Care – Kidney Disease Monitoring**

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Kidney Function Testing for Members with Diabetes  |
| Description:          | Percent of members with diabetes who had a kidney function test during the year.   |
| HEDIS Label:          | Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 140  |
| Metric:               | The percentage of diabetic MMP enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator).  |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. |

| Title | Description   |
|-------|---|
|       | <p>Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (&lt;7.0%) for a Selected Population denominator.</p> <p>If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.</p> <p>Data Time Frame: 01/01/2017 - 12/31/2017</p> <p>General Trend: Higher is better</p> <p>Case-mix adjusted: No</p> <p>NQF #: 0062</p> <p>Data Display: Percentage with no decimal place</p> |

**Measure: C15 - Diabetes Care – Blood Sugar Controlled**

| Title                 | Description   |
|-----------------------|---|
| Label for Data:       | Members with Diabetes whose Blood Sugar is Under Control  |
| Description:          | Percent of members with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control.  |
| HEDIS Label:          | Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 140   |
| Metric:               | The percentage of diabetic MMP enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.  |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Exclusions:           | (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.  |
|                       | <p>Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (&lt;7.0%) for a Selected Population denominator.</p> <p>If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.</p> <p>Data Time Frame: 01/01/2017 - 12/31/2017</p> <p>General Trend: Higher is better</p> <p>Case-mix adjusted: No</p> <p>NQF #: 0059</p> <p>Data Display: Percentage with no decimal place</p> |

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**Measure: C16 - Controlling Blood Pressure**

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Controlling Blood Pressure   |
| Description:          | Percent of members with high blood pressure who got treatment and were able to maintain a healthy pressure.  |
| HEDIS Label:          | Controlling High Blood Pressure (CBP)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 122  |
| Metric:               | The percentage of MMP members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year (numerator).  |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | (optional) <ul style="list-style-type: none"><li>• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.</li><li>• Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.</li><li>• Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:<ol style="list-style-type: none"><li>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li><li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.</li><li>3. Identify the discharge date for the stay.</li></ol></li></ul> |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| Case-mix adjusted:    | No   |
| NQF #:                | 0018   |
| Data Display:         | Percentage with no decimal place   |

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**Measure: C17 - Rheumatoid Arthritis Management**

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Rheumatoid Arthritis Management  |
| Description:          | Percent of members with rheumatoid arthritis who got one or more prescriptions for an anti-rheumatic drug.   |
| HEDIS Label:          | Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)   |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 162  |
| Metric:               | The percentage of MMP members who were diagnosed with rheumatoid arthritis during the measurement year (denominator), and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) (numerator). |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | (optional)   |

| Title              | Description  |
|--------------------|--|
|                    | <ul style="list-style-type: none"> <li>• A diagnosis of HIV (HIV Value Set) any time during the member's history through December 31 of the measurement year.</li> <li>• A diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.</li> </ul> |
| Data Time Frame:   | 01/01/2017 - 12/31/2017  |
| General Trend:     | Higher is better   |
| Case-mix adjusted: | No   |
| NQF #:             | 0054   |
| Data Display:      | Percentage with no decimal place   |

**Measure: C18 - Reducing the Risk of Falling**

| Title                    | Description  |
|--------------------------|--|
| Label for Data:          | Reducing the Risk of Falling   |
| Description:             | Percent of members with a problem falling, walking, or balancing, who discussed it with their doctor and received a recommendation for how to prevent falls during the year.   |
| HEDIS Label:             | Fall Risk Management (FRM)   |
| Measure Reference:       | NCQA HEDIS 2017 Specifications for The Medicare Health Outcomes Survey Volume 6, page 36   |
| Metric:                  | The percentage of members 65 years of age or older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).   |
| Primary Data Source:     | HEDIS / HOS  |
| Data Source Description: | Cohort 20 Baseline data collection (2017).<br>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?<br>HOS Survey Question 49: Did you fall in the past 12 months?<br>HOS Survey Question 50: In the past 12 months have you had a problem with balance or walking?<br>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: <ul style="list-style-type: none"> <li>• Suggest that you use a cane or walker</li> <li>• Suggest that you do an exercise or physical therapy program</li> <li>• Suggest a vision or hearing testing</li> </ul> |
| Data Source Category:    | Survey of Enrollees  |
| Exclusions:              | Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.<br><br>This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.   |
| Data Time Frame:         | 04/01/2017 – 07/31/2017  |
| General Trend:           | Higher is better   |

| Title  | Description |
|--|-------------|
| Case-mix adjusted: No                          |             |
| NQF #: 0035                                    |             |
| Data Display: Percentage with no decimal place |             |

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**Measure: C19 - Improving Bladder Control**

| Title  | Description  |
|--|--|
| Label for Data: Improving Bladder Control  |  |
| Description: Percent of members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.   |  |
| HEDIS Label: Management of Urinary Incontinence in Older Adults (MUI)  |  |
| Measure Reference: NCQA HEDIS 2017 Specifications for The Medicare Health Outcomes Survey Volume 6, page 31  |  |
| Metric: The percentage of members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).  |  |
| Primary Data Source: HEDIS / HOS   |  |
| Data Source Description: Cohort 20 Baseline data collection (2017).  |  |
|  | HOS Survey Question 42: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?  |
|  | HOS Survey Question 45: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? |
|  | Member choices must be as follows to be included in the denominator:   |
|  | <ul style="list-style-type: none"> <li>• Q42 = "Yes."</li> <li>• Q45 = "Yes" or "No."</li> </ul>   |
|  | The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider.   |
|  | Member choice must be as follows to be included in the numerator:  |
|  | <ul style="list-style-type: none"> <li>• Q45 = "Yes."</li> </ul>   |
| Data Source Category: Survey of Enrollees  |  |
| Exclusions: Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded. |  |
|  | This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.   |
| Data Time Frame: 04/01/2017 – 07/31/2017   |  |
| General Trend: Higher is better  |  |
| Case-mix adjusted: No  |  |
| NQF #: 0030  |  |
| Data Display: Percentage with no decimal place   |  |

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**Measure: C20 - Medication Reconciliation Post-Discharge**

| Title                 | Description   |
|-----------------------|---|
| Label for Data:       | The MMP Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge  |
| Description:          | This shows the percent of members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed. |
| HEDIS Label:          | Medication Reconciliation Post-Discharge (MRP)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 212   |
| Metric:               | The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).  |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Data Time Frame:      | 01/01/2017 – 12/31/2017   |
| General Trend:        | Higher is better  |
| Case-mix adjusted:    | No  |
| NQF #:                | 0554  |
| Data Display:         | Percentage with no decimal place  |

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**Measure: C21 - Plan All-Cause Readmissions**

| Title              | Description   |
|--------------------|---|
| Label for Data:    | Readmission to a Hospital within 30 Days of Being Discharged (lower ratios are better because it means fewer members are being readmitted than would be expected for the MMP's population)  |
| Description:       | The ratio of the MMP's observed readmission rate to the MMP's expected readmission rate. The readmission rate is based on the percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This "risk-adjustment" helps make the comparisons between MMPs fair and meaningful.) |
| HEDIS Label:       | Plan All-Cause Readmissions (PCR)   |
| Measure Reference: | NCQA HEDIS 2018 Technical Specifications Volume 2, page 379   |
| Metric:            | The MMP's observed readmission rate (i.e., the percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days), as compared to the readmission rate that the MMP is expected to have given its case mix. This analysis is referred to as the observed-to-expected (O/E) ratio.   |
|                    | The O/E ratio is calculated as the observed readmission rate divided by the expected readmission rate. To calculate the observed readmission rate and expected readmission rate, the following formulas were used:  |
|                    | 1. The observed readmission rate equals the sum of the count of 30-day readmissions across all age bands divided by the sum of the count of index stays across all age bands.   |

| Title                 | Description   |
|-----------------------|---|
|                       | 2. The expected readmission rate equals the sum of the expected readmissions rates across all age bands, weighted by the percentage of index stays in each age band.<br>See <a href="#">Attachment C</a> : Calculating Measure C21: Plan All-Cause Readmissions for the complete formula. |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Exclusions:           | As listed in the HEDIS Technical Specifications. Additionally, CMS has excluded contracts whose denominator (i.e., number of index stays) was 10 or less.   |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Lower is better   |
| Case-mix adjusted:    | Yes   |
| NQF #:                | 1768  |
| Data Display:         | Numeric with two decimal places   |

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### Measure: C22 - Statin Therapy for Patients with Cardiovascular Disease

| Title                 | Description   |
|-----------------------|---|
| Label for Data:       | The MMP Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol  |
| Description:          | This rating is based on the percent of members with heart disease who get the right type of cholesterol-lowering drugs. Health plans can help make sure their members are prescribed medications that are more effective for them.  |
| HEDIS Label:          | Statin Therapy for Patients with Cardiovascular Disease (SPC)   |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 133   |
| Metric:               | The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).  |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Exclusions:           | Exclude members who meet any of the following criteria: <ul style="list-style-type: none"> <li>• Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year.</li> <li>• In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year.</li> <li>• Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year.</li> <li>• ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year.</li> <li>• Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.</li> <li>• Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year.</li> </ul> |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Higher is better  |
| Case-mix adjusted:    | No  |
| NQF #:                | Not Applicable  |

| Title         | Description                      |
|---------------|----------------------------------|
| Data Display: | Percentage with no decimal place |

**Measure: D10 - Medication Adherence for Diabetes Medications**

| Title | Description |
|-------|-------------|
|-------|-------------|

Label for Data: Taking Diabetes Medication as Directed

Description: Percent of members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.  
 One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The MMP, the doctor, and the member can work together to find ways to do this. (“Diabetes medication” means a *biguanide drug*, a *sulfonylurea drug*, a *thiazolidinedione drug*, a *DPP-IV inhibitor*, an *incretin mimetic drug*, a *meglitinide drug*, or an *SGLT2 inhibitor*. Members who take insulin are not included.)

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator).

The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic category. Beneficiaries with one or more fills for insulin or an ESRD diagnoses or coverage dates anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).

See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes. NDCs with obsolete dates are included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.

Primary Data Source: Prescription Drug Event (PDE) data

Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare by June 30, 2018 with dates of service from January 1, 2017-December 31, 2017. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation are not reflected in this measure.

Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS).

- CME is used for enrollment information.
- EDB is used for hospice enrollment and ESRD status (using the ESRD indicator).

| Title                 | Description  |
|-----------------------|--|
|                       | <ul style="list-style-type: none"> <li>• CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient stays for PDPs and MA-PDs, and skilled nursing facility stays for PDPs.</li> <li>• RAPS is used for diagnosis information, RxHCC – Dialysis Status (most recent available Payment Year).</li> </ul>   |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | Contracts with 30 or fewer enrolled member-years (in the denominator)  |
| General Notes:        | <p>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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.</p> <p>The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (<math>3/12 + 3/12 = 6/12</math>).</p> <p>The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the Medi-Span generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, hospice enrollments, and stays in skilled nursing facilities (SNFs). The SNF adjustment only applies to PDPs because SNF data are not currently available for MA-PDs. Please see <a href="#">Attachment D: Medication Adherence Measure Calculations</a> for more information about these calculation adjustments.</p> <p>When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.</p> |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| Case-mix adjusted:    | No   |
| NQF #:                | 0541   |
| Data Display:         | Percentage with no decimal place   |

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

| Title           | Description  |
|-----------------|--|
| Label for Data: | Taking Blood Pressure Medication as Directed   |
| Description:    | <p>Percent of members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.</p> <p>One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The MMP, the doctor, and the member can work together to do this. ("Blood pressure medication" means an ACE (<i>angiotensin converting enzyme</i>) inhibitor, an ARB (<i>angiotensin receptor blocker</i>), or a direct renin inhibitor drug.)</p> |
| Metric:         | This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the   |

| Title                    | Description   |
|--------------------------|---|
|                          | <p>number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two blood pressure medication fills on unique dates of service during the measurement period (denominator).</p> <p>The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic category. Beneficiaries with ESRD diagnosis or coverage dates, or that received one or more prescriptions for sacubitril/valsartan anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.</p> <p>The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).</p> <p>See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes. NDCs with obsolete dates are included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.</p> |
| Primary Data Source:     | Prescription Drug Event (PDE) data  |
| Data Source Description: | <p>The data for this measure come from PDE data files submitted by drug plans to Medicare by June 30, 2018 with dates of service from January 1, 2017-December 31, 2017. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation are not reflected in this measure.</p> <p>Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS).</p> <ul style="list-style-type: none"> <li>• CME is used for enrollment information.</li> <li>• EDB is used for hospice enrollment and ESRD status (using the ESRD indicator).</li> <li>• CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient stays for PDPs and MA-PDs, and skilled nursing facility stays for PDPs.</li> <li>• RAPS is used for diagnosis information, RxHCC – Dialysis Status (most recent available Payment Year).</li> </ul>   |
| Data Source Category:    | Health and Drug Plans   |
| Exclusions:              | Contracts with 30 or fewer enrolled member-years (in the denominator)   |
| General Notes:           | <p>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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.</p> <p>The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a</p>   |

| Title  | Description   |
|--|---|
| <p>Data Time Frame: 01/01/2017 - 12/31/2017</p> <p>General Trend: Higher is better</p> <p>Case-mix adjusted: No</p> <p>NQF #: 0541</p> <p>Data Display: Percentage with no decimal place</p> | <p>three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (<math>3/12 + 3/12 = 6/12</math>).</p> <p>The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the Medi-Span generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, hospice enrollments, and stays in skilled nursing facilities (SNFs). The SNF adjustment only applies to PDPs because SNF data are not currently available for MA-PDs. Please see <a href="#">Attachment D: Medication Adherence Measure Calculations</a> for more information about these calculation adjustments.</p> <p>When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.</p> |

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**Measure: D12 - Medication Adherence for Cholesterol (Statins)**

| Title   | Description   |
|---|---|
| <p>Label for Data: Taking Cholesterol Medication as Directed</p> <p>Description:</p> <p>Metric:</p> <p>Primary Data Source:</p> | <p>Percent of members with a prescription for a cholesterol medication (a <i>statin drug</i>) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.</p> <p>One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The MMP, the doctor, and the member can work together to do this.</p> <p>This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator).</p> <p>The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.</p> <p>The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).</p> <p>See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list is posted along with these technical notes. NDCs with obsolete dates are included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.</p> |

| Title                    | Description  |
|--------------------------|--|
| Data Source Description: | <p>The data for this measure come from PDE data files submitted by drug plans to Medicare by June 30, 2018 with dates of service from January 1, 2017-December 31, 2017. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin drug(s). PDE adjustments made post-reconciliation are not reflected in this measure.</p> <p>Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF).</p> <ul style="list-style-type: none"> <li>• CME is used for enrollment information.</li> <li>• EDB is used for hospice enrollment.</li> <li>• CWF is used to identify inpatient stays for PDPs and MA-PDs, and skilled nursing facility stays for PDPs.</li> </ul>  |
| Data Source Category:    | Health and Drug Plans  |
| Exclusions:              | Contracts with 30 or fewer enrolled member-years (in the denominator)  |
| General Notes:           | <p>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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.</p> <p>The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (<math>3/12 + 3/12 = 6/12</math>).</p> <p>The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the Medi-Span generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, hospice enrollments, and stays in skilled nursing facilities (SNFs). The SNF adjustment only applies to PDPs because SNF data are not currently available for MA-PDs. Please see <a href="#">Attachment D: Medication Adherence Measure Calculations</a> for more information about these calculation adjustments.</p> <p>When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.</p> |
| Data Time Frame:         | 01/01/2017 - 12/31/2017  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | No   |
| NQF #:                   | 0541   |
| Data Display:            | Percentage with no decimal place   |

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**Measure: D13 - MTM Program Completion Rate for CMR**

| Title           | Description   |
|-----------------|---|
| Label for Data: | Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications   |
| Description:    | Some members are in a program (called a <i>Medication Therapy Management</i> program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the MMP. |

| Title | Description  |
|-------|--|
|       | <p>The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.</p> <p>Metric: This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period.</p> <p>Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period.</p> <p>Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded.</p> <p>A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.</p> <p>Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.</p> <p>Primary Data Source: Part D Plan Reporting</p> <p>Data Source Description: Additional data sources used to calculate the measure: Medicare Enrollment Database (EDB) File.</p> <p>Data were reported by contracts to CMS per the Part D Reporting Requirements. Validation of these data was performed retrospectively during the 2018 Data Validation cycle.</p> <p>Data Source Category: Health and Drug Plans</p> <p>Exclusions: Contracts that terminated effective December 31, 2017 are excluded from the measure and listed as "Not reportable due to plan termination." Contracts that terminated after December 31, 2017 but before the deadline to submit data validation results to CMS (June 30, 2018) are excluded and listed as "No data available." The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported</p> |

| Title | Description   |
|-------|---|
|       | <p>in accordance with model terms and conditions and not included in the measure calculation.</p> <p>MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation:</p> <ul style="list-style-type: none"> <li>• HICN or RRB Number (Element B)</li> <li>• Met the specified targeting criteria per CMS – Part D requirements (Element G)</li> <li>• Date of MTM program enrollment (Element I)</li> <li>• Date met the specified targeting criteria per CMS – Part D requirements (Element J)</li> <li>• Date of MTM program opt-out, if applicable (Element K)</li> <li>• Received annual CMR with written summary in CMS standardized format (Element O)</li> <li>• Date(s) of CMR(s) with written summary in CMS standardized format (Element Q)</li> </ul> <p>MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as “CMS identified issues with this plan's data.”</p> <p>Contracts can view their data validation results in HPMS (<a href="https://hpms.cms.gov/">https://hpms.cms.gov/</a>). From the home page, select Monitoring   Plan Reporting Data Validation. If you cannot see the Plan Reporting Data Validation module, contact <a href="mailto:CMSHPMS_Access@cms.hhs.gov">CMSHPMS_Access@cms.hhs.gov</a>.</p> <p>Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "Not enough data available."</p> <p>Data Time Frame: 01/01/2017 - 12/31/2017</p> <p>General Trend: Higher is better</p> <p>Case-mix adjusted: No</p> <p>NQF #: Not Applicable</p> <p>Data Display: Percentage with no decimal place</p> |

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

| Title   | Description  |
|---|--|
| <p>Label for Data:</p> <p>Description:</p> <p>Metric:</p> | <p>The MMP Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol</p> <p>To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of members with diabetes who take the most effective cholesterol-lowering drugs. MMPs can help make sure their members get these prescriptions filled.</p> <p>This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills during the measurement period (denominator).</p> <p>Beneficiaries with an ESRD diagnosis or coverage dates, or enrolled in hospice are excluded.</p> |

| Title                   | Description  |
|-------------------------|--|
|                         | <p>The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA).</p> <p>See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted with the <a href="#">Part C and D Medicare Star Ratings Data</a>. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.</p>  |
| Primary Data Source:    | Prescription Drug Event (PDE) data   |
| Data Source Description | <p>The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2017-December 31, 2017, and processed by June 30, 2018. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Risk Adjustment Processing System (RAPS).</p> <ul style="list-style-type: none"> <li>• CME is used for enrollment information.</li> <li>• EDB is used for hospice enrollment and ESRD status (using the ESRD indicator).</li> <li>• CWF is used to identify exclusion diagnoses based on ICD-10-CM codes</li> <li>• RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year)</li> </ul>  |
| Data Source Category:   | Health and Drug Plans  |
| Exclusions:             | A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).   |
| General Notes:          | <p>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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.</p> <p>The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (<math>3/12 + 3/12 = 6/12</math>).</p> <p>When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.</p> |
| Data Time Frame:        | 01/01/2017 - 12/31/2017  |
| General Trend:          | Higher is better   |
| Case-mix adjusted:      | No   |
| NQF #:                  | 2712   |
| Data Display:           | Percentage with no decimal place   |

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

| Title | Description  |
|-------|--|
|       | <p>Description: The percent of members who were hospitalized for certain mental health disorders who received follow-up care within 30 days of leaving the hospital.</p> |

| Title                 | Description  |
|-----------------------|--|
| HEDIS Label:          | Follow-Up After Hospitalization for Mental Illness (FUH)   |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 179  |
| Metric:               | The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator).   |
| Exclusions:           | <p>Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions and direct transfers to an acute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li> <li>2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>These discharges are excluded from the measure because re-hospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.</p> |
| Data Source:          | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| Case Mix Adjusted:    | No   |
| NQF#:                 | 0576   |
| Data Display:         | Percentage with no decimal place   |

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

| Title              | Description   |
|--------------------|---|
| Description:       | The percent of members with a diagnosis of major depression who received an antidepressant medication for at least 180 days.  |
| HEDIS Label:       | Antidepressant Medication Management (AMM)  |
| Measure Reference: | NCQA HEDIS 2018 Technical Specifications Volume 2, page 170   |
| Metric:            | The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (numerator).                               |
| Exclusions:        | Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSP, through the IPSP and the 60 days after the IPSP. Members who meet any of the following criteria remain in the eligible population: |

| Title                 | Description   |
|-----------------------|---|
|                       | <ul style="list-style-type: none"> <li>An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> <li>AMM Stand Alone Visits Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).</li> <li>AMM Visits Value Set with AMM POS Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).</li> <li>Telephone Visits Value Set with Major Depression Value Set.</li> <li>ED Value Set with Major Depression Value Set.</li> </ul> </li> <li>An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient stays: <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</li> <li>Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.</li> </ol> <p>For a direct transfer, use the discharge date from the last discharge</p> </li> </ul> |
| Data Source:          | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Higher is better  |
| Case Mix Adjusted:    | No  |
| NQF#:                 | 0105  |
| Data Display:         | Percentage with no decimal place  |

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

| Title                 | Description   |
|-----------------------|---|
| Description:          | The percent of members with a new episode of alcohol or other drug (AOD) abuse or dependence who received treatment within 14 days of being diagnosed as needing treatment.   |
| HEDIS Label:          | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)   |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 287   |
| Metric:               | The percentage of adolescent and adult members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. |
| Exclusions:           | None listed.  |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Higher is better  |
| Case Mix Adjusted:    | No  |
| NQF #:                | 0004  |
| Data Display:         | Percentage with no decimal place  |

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

| Title                 | Description  |
|-----------------------|--|
| Description:          | The percent of members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and had two or more services for alcohol or drug treatment within 34 days of their first visit. |
| HEDIS Label:          | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 287  |
| Metric:               | The percentage of adolescent and adult members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.  |
| Exclusions:           | None listed.   |
| Data Source:          | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| Case Mix Adjusted:    | No   |
| NQF#:                 | 0004   |
| Data Display:         | Percentage with no decimal place   |

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**Domain 3: Member Experience with Integrated Plan and Care Providers**

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**Measure: C23 - Getting Needed Care**

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)   |
| Description:             | Percent of the best possible score the MMP earned on how easy it is for members to get needed care, including care from specialists.  |
| Metric:                  | This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned. |
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"><li>• In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?</li><li>• In the last 6 months, how often was it easy to get the care, tests or treatment you needed?</li></ul>  |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).   |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.   |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |

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

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### Measure: C24 - Getting Appointments and Care Quickly

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Getting Appointments and Care Quickly (on a scale from 0 to 100)  |
| Description:             | Percent of the best possible score the MMP earned on how quickly members get appointments and care.   |
| Metric:                  | This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.  |
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"> <li>• In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?</li> <li>• In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?</li> <li>• In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</li> </ul> |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).   |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.   |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | Yes   |
| NQF #:                   | 0006  |
| Data Display:            | Numeric with no decimal place   |

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### Measure: C25 - Customer Service

| Title           | Description  |
|-----------------|--|
| Label for Data: | Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)   |
| Description:    | Percent of the best possible score the MMP earned on how easy it is for members to get information and help from the MMP when needed.  |
| Metric:         | This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned. |

| Title                    | Description   |
|--------------------------|---|
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"> <li>In the last 6 months, how often did your health plan's customer service give you the information or help you needed?</li> <li>In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?</li> <li>In the last 6 months, how often were the forms from your health plan easy to fill out?</li> </ul> |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure.<br>MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).  |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.   |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | Yes   |
| NQF #:                   | 0006  |
| Data Display:            | Numeric with no decimal place   |

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**Measure: C26 - Rating of Health Care Quality**

| Title                    | Description  |
|--------------------------|--|
| Label for Data:          | Member's Rating of Health Care Quality (on a scale from 0 to 100)  |
| Description:             | Percent of the best possible score the MMP earned from members who rated the quality of the health care they received.   |
| Metric:                  | This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned. |
| Primary Data Source:     | CAHPS  |
| Data Source Description: | CAHPS Survey Question (question numbers vary depending on survey type): <ul style="list-style-type: none"> <li>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?</li> </ul>   |
| Data Source Category:    | Survey of Enrollees  |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure.<br>MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).   |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.  |
| Data Time Frame:         | 03/2018 – 06/2018  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | Yes  |
| NQF #:                   | 0006   |
| Data Display:            | Numeric with no decimal place  |

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**Measure: C27 - Rating of Health Plan**

| Title                    | Description  |
|--------------------------|--|
| Label for Data:          | Member's Rating of Health Plan (on a scale from 0 to 100)  |
| Description:             | Percent of the best possible score the MMP earned from members who rated the health plan.  |
| Metric:                  | This case-mix adjusted measure is used to assess members' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned. |
| Primary Data Source:     | CAHPS  |
| Data Source Description: | CAHPS Survey Question (question numbers vary depending on survey type): <ul style="list-style-type: none"><li>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?</li></ul>  |
| Data Source Category:    | Survey of Enrollees  |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).  |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.  |
| Data Time Frame:         | 03/2018 – 06/2018  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | Yes  |
| NQF #:                   | 0006   |
| Data Display:            | Numeric with no decimal place  |

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**Measure: C28 - Care Coordination**

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Coordination of Members' Health Care Services (on a scale from 0 to 100)  |
| Description:             | Percent of the best possible score the MMP earned on how well the MMP coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)  |
| Metric:                  | This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.   |
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"><li>In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?</li><li>In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?</li><li>In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?</li><li>In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?</li></ul> |

| Title                 | Description  |
|-----------------------|--|
|                       | <ul style="list-style-type: none"> <li>In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?</li> <li>In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?</li> </ul> |
| Data Source Category: | Survey of Enrollees  |
| Exclusions:           | MMPs that terminated effective December 31, 2017 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).  |
| General Notes:        | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.  |
| Data Time Frame:      | 03/2018 – 06/2018  |
| General Trend:        | Higher is better   |
| Case-mix adjusted:    | Yes  |
| NQF #:                | Not Applicable   |
| Data Display:         | Numeric with no decimal place  |

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**Measure: OHP5 - Satisfaction with Care Coordination**

| Title                    | Description   |
|--------------------------|---|
| Description:             | Percent of members who are very satisfied with the help they received coordinating the care from different doctors and health providers.  |
| Metric:                  | The percentage of survey respondents who answered "Very satisfied" to the measure question on how satisfied the respondent was with the care coordination services they received in the last 6 months. No case-mix adjustment was applied to this measure.  |
| Primary Data Source:     | CAHPS Supplemental Question   |
| Data Source Description: | CAHPS Survey Question: <ul style="list-style-type: none"> <li>How satisfied are you with the help you received to coordinate your care in the last 6 months?</li> </ul>   |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. Only MMPs with at least 11 "Yes" answers to the screening question (In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?) and have at least 11 "Very satisfied" responses on the measure question have a rate displayed. |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | No  |
| NQF #:                   | Not Applicable  |
| Data Display:            | Percentage with no decimal place  |

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**Measure: CC10 - Access to Medical Equipment**

| Title                | Description  |
|----------------------|--|
| Description:         | Percent of members who said it was always easy to get or replace medical equipment that they needed.   |
| Metric:              | The percentage of survey respondents who answered "Always" to the measure question on how easy it was to get or replace medical equipment. No case-mix adjustment was applied to this measure. |
| Primary Data Source: | CAHPS Supplemental Question  |

| Title                    | Description  |
|--------------------------|--|
| Data Source Description: | CAHPS Survey Question: <ul style="list-style-type: none"> <li>In the last 6 months, how often was it easy to get or replace the medical equipment you needed through your health plan?</li> </ul>  |
| Data Source Category:    | Survey of Enrollees  |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. Only MMPs with at least 11 “Yes” answers to the screening question (In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, wheelchair or oxygen equipment?) and at least 11 “Always” responses on the measure question have a rate displayed. |
| Data Time Frame:         | 03/2018 – 06/2018  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | No   |
| NQF #:                   | Not Applicable   |
| Data Display:            | Percentage with no decimal place   |

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### Measure: CC14 - Access to Personal Care

| Title                    | Description  |
|--------------------------|--|
| Description:             | Percent of members who said it was always easy to get personal care at home.   |
| Metric:                  | The percentage of survey respondents who answered “Always” to the measure question on how often it was easy to obtain access to personal care or aide assistance at home. No case-mix adjustment was applied to this measure.  |
| Primary Data Source:     | CAHPS Supplemental Question  |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"> <li>In the last 6 months, how often was it easy to get personal care or aide assistance at home through your care plan?</li> </ul>   |
| Data Source Category:    | Survey of Enrollees  |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. Only MMPs with at least 11 “Yes” answers to the screening question (Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?) and 11 “Always” responses on the measure question have a rate displayed. |
| Data Time Frame:         | 03/2018 – 06/2018  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | No   |
| NQF #:                   | Not Applicable   |
| Data Display:            | Percentage with no decimal place   |

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### Measure: MH3 - Access to Mental Health Treatment

| Title        | Description   |
|--------------|---|
| Description: | Percent of members who said it was always easy to get treatment or counseling for a personal or family problem.   |
| Metric:      | The percentage of survey respondents who answered “Always” to the measure question on how often it was easy to get the treatment or counseling they needed. No case-mix adjustment was applied to this measure. |

| Title                    | Description  |
|--------------------------|--|
| Primary Data Source:     | CAHPS Supplemental Question  |
| Data Source Description: | CAHPS Survey Question: <ul style="list-style-type: none"> <li>In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?</li> </ul>   |
| Data Source Category:    | Survey of Enrollees  |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure.<br>Only MMPs with at least 11 "Yes" answers to the screening question (In the last 6 months, did you need any treatment or counseling for a personal or family problem?) and at least 11 "Always" responses on the measure question have a rate displayed. |
| Data Time Frame:         | 03/2018 – 06/2018  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | No   |
| NQF #:                   | Not Applicable   |
| Data Display:            | Percentage with no decimal place   |

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### Measure: D07 - Rating of Drug Plan

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Members' Rating of Drug Plan (on a scale from 0 to 100)   |
| Description:             | Percent of the best possible score the MMP earned from members who rated the prescription drug plan.  |
| Metric:                  | This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned. |
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"> <li>Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?</li> </ul>                       |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure.<br>MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).  |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.   |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | Yes   |
| NQF #:                   | Not Applicable  |
| Data Display:            | Numeric with no decimal place   |

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**Measure: D08 - Getting Needed Prescription Drugs**

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)   |
| Description:             | Percent of the best possible score the MMP earned on how easy it is for members to get the prescription drugs they need using the MMP.  |
| Metric:                  | This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.  |
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Questions (question numbers vary depending on survey type): <ul style="list-style-type: none"><li>• In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?</li><li>• In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?</li><li>• In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?</li></ul> |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).   |
| General Notes:           | CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.   |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | Yes   |
| NQF #:                   | Not Applicable  |
| Data Display:            | Numeric with no decimal place   |

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**Domain 4: Staying Healthy: Screenings, Tests and Vaccines**

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**Measure: C01 - Breast Cancer Screening**

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Breast Cancer Screening  |
| Description:          | Percent of female members aged 52-74 who had a mammogram during the past two years.  |
| HEDIS Label:          | Breast Cancer Screening (BCS)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 79   |
| Metric:               | The percentage of women MMP enrollees 50 to 74 years of age (denominator) who had a mammogram to screen for breast cancer (numerator). |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |

| Title              | Description   |
|--------------------|---|
| Exclusions:        | <p>(optional) Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:</p> <ul style="list-style-type: none"> <li>• Bilateral mastectomy (Bilateral Mastectomy Value Set).</li> <li>• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set).</li> <li>• Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15.</li> <li>• Both of the following (on the same or a different date of service): <ul style="list-style-type: none"> <li>– Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service).</li> <li>– Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service).</li> </ul> </li> <li>• Absence of the left breast (Absence of Left Breast Value Set) and absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service.</li> <li>• History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).</li> <li>• Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service.</li> </ul> |
| Data Time Frame:   | 01/01/2017 - 12/31/2017   |
| General Trend:     | Higher is better  |
| Case-mix adjusted: | No  |
| NQF #:             | 0031  |
| Data Display:      | Percentage with no decimal place  |

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**Measure: C02 - Colorectal Cancer Screening**

| Title                 | Description  |
|-----------------------|--|
| Label for Data:       | Colorectal Cancer Screening  |
| Description:          | Percent of members aged 50-75 who had appropriate screening for colon cancer.  |
| HEDIS Label:          | Colorectal Cancer Screening (COL)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 86   |
| Metric:               | The percentage of MMP enrollees aged 50 to 75 (denominator) who had appropriate screenings for colorectal cancer (numerator).  |
| Primary Data Source:  | HEDIS  |
| Data Source Category: | Health and Drug Plans  |
| Exclusions:           | (optional) Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year. |
| Data Time Frame:      | 01/01/2017 - 12/31/2017  |
| General Trend:        | Higher is better   |
| NQF #:                | 0034   |
| Data Display:         | Percentage with no decimal place   |

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**Measure: C03 - Annual Flu Vaccine**

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Annual Flu Vaccine  |
| Description:             | Percent of members who got a vaccine (flu shot) prior to flu season.  |
| Metric:                  | The percentage of sampled members (denominator) who received an influenza vaccination during the measurement year (numerator).  |
| Primary Data Source:     | CAHPS   |
| Data Source Description: | CAHPS Survey Question (question number varies depending on survey type): <ul style="list-style-type: none"><li>• Have you had a flu shot since July 1, 2017?</li></ul>  |
| Data Source Category:    | Survey of Enrollees   |
| Exclusions:              | MMPs that terminated effective December 31, 2017 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).                     |
| General Notes:           | This measure is not case-mix adjusted.<br>CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. |
| Data Time Frame:         | 03/2018 – 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | No  |
| NQF #:                   | 0040  |
| Data Display:            | Percentage with no decimal place  |

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**Measure: C06 - Monitoring Physical Activity**

| Title                    | Description  |
|--------------------------|--|
| Label for Data:          | Monitoring Physical Activity   |
| Description:             | Percent of members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.  |
| HEDIS Label:             | Physical Activity in Older Adults (PAO)  |
| Measure Reference:       | NCQA HEDIS 2017 Specifications for The Medicare Health Outcomes Survey Volume 6, page 34   |
| Metric:                  | The percentage of sampled 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).  |
| Primary Data Source:     | HEDIS / HOS  |
| Data Source Description: | Cohort 20 Baseline data collection (2017).<br>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.<br>HOS Survey Question 47: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program. |
| Data Source Category:    | Survey of Enrollees  |

| Title              | Description   |
|--------------------|---|
| Exclusions:        | Members who responded "I had no visits in the past 12 months" to Question 46 are excluded from results calculations for Question 47. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.<br><br>This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs. |
| Data Time Frame:   | 04/01/2017 – 07/31/2017   |
| General Trend:     | Higher is better  |
| Case-mix adjusted: | No  |
| NQF #:             | 0029  |
| Data Display:      | Percentage with no decimal place  |

### Measure: C07 - Adult BMI Assessment

| Title                 | Description   |
|-----------------------|---|
| Label for Data:       | Checking to See if Members Are at a Healthy Weight  |
| Description:          | Percent of members with an outpatient visit who had their "Body Mass Index" (BMI) calculated from their height and weight and recorded in their medical record.   |
| HEDIS Label:          | Adult BMI Assessment (ABA)  |
| Measure Reference:    | NCQA HEDIS 2018 Technical Specifications Volume 2, page 58  |
| Metric:               | The percentage of MMP enrollees 18-74 years of age (denominator) who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior the measurement year (numerator). |
| Primary Data Source:  | HEDIS   |
| Data Source Category: | Health and Drug Plans   |
| Exclusions:           | (optional) Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.   |
| Data Time Frame:      | 01/01/2017 - 12/31/2017   |
| General Trend:        | Higher is better  |
| Case-mix adjusted:    | No  |
| NQF #:                | 0421  |
| Data Display:         | Percentage with no decimal place  |

## Domain 5: Plan Performance on Administrative Measures

### Measure: C29 - Complaints about the Health Plan

| Title           | Description   |
|-----------------|---|
| Label for Data: | Complaints about the Health Plan (lower numbers are better because it means fewer complaints)   |
| Description:    | Rate of members filing complaints with Medicare about the health plan.  |
| Metric:         | Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as:<br>$\left[ \frac{\text{(Total number of all complaints logged into the Complaints Tracking Module (CTM))}}{\text{(Average Contract enrollment)}} \right] * 1,000 * 30 / \text{(Number of Days in Period)}$ |

| Title | Description  |
|-------|--|
|       | <p>Number of Days in Period = 366 for leap years, 365 for all other years.</p> <ul style="list-style-type: none"> <li>• Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data.</li> <li>• Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.</li> <li>• A contract's failure to follow CMS' CTM Standard Operating Procedures will not result in CMS' adjustment of the data used for these measures.</li> </ul> <p>Primary Data Source: Complaints Tracking Module (CTM)</p> <p>Data Source Description: Data were obtained from the CTM based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS' CTM Standard Operating Procedures. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.</p> <p>Data Source Category: CMS Administrative Data</p> <p>Exclusions: Some complaints that cannot be clearly attributed to the MMP are excluded, please see <a href="#">Attachment B: Complaints Tracking Module Exclusion List</a>.</p> <p>Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.</p> <p>Data Time Frame: 01/01/2017 - 12/31/2017</p> <p>General Trend: Lower is better</p> <p>Case-mix adjusted: No</p> <p>NQF #: Not Applicable</p> <p>Data Display: Numeric with two decimal places</p> |

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### Measure: C30 - Members Choosing to Leave the Plan

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Members Choosing to Leave the Plan (lower percentages are better because it means fewer members choose to leave the plan)   |
| Description:             | Percent of plan members who chose to leave the plan.  |
| Metric:                  | The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2017–December 31, 2017 (numerator) divided by all members enrolled in the contract at any time during 2017 (denominator).   |
| Primary Data Source:     | MBDSS   |
| Data Source Description: | Medicare Beneficiary Database Suite of Systems (MBDSS)  |
| Data Source Category:    | CMS Administrative Data   |
| Exclusions:              | <p>Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically:</p> <ul style="list-style-type: none"> <li>• Members affected by a contract service area reduction</li> <li>• Members affected by PBP termination</li> <li>• Members in PBPs that were granted special enrollment exceptions</li> <li>• Members affected by PBP service area reductions where there are no PBPs let within the contract that the enrollee is eligible to enroll into</li> <li>• Members affected by LIS reassignments</li> </ul> |

| Title | Description  |
|-------|--|
|       | <ul style="list-style-type: none"> <li>• Members who are enrolled in employer group plans</li> <li>• Members who were passively enrolled into a Demonstration (MMP)</li> <li>• 1876 Cost contract disenrollments into the transition MA contract (H contract)</li> <li>• Members where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled</li> </ul> <p>MMPs that terminated effective December 31, 2017 are not included in the measure.</p> <p>MMPs with less than 1,000 enrollees are also excluded from this measure.</p> <p>General Notes: This measure includes members with a disenrollment effective date between 1/1/2017 and 12/31/2017 who disenrolled from the contract with any one of the following disenrollment reason codes:</p> <ul style="list-style-type: none"> <li>11 - Voluntary Disenrollment through plan</li> <li>13 - Disenrollment because of enrollment in another Plan</li> <li>14 - Retroactive</li> <li>99 - Other (not supplied by beneficiary).</li> </ul> <p>If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be “Not enough data available”.</p> <p>The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview, as part of Medicare Plan Finder and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.</p> <p>Data Time Frame: 01/01/2017 - 12/31/2017</p> <p>General Trend: Lower is better</p> <p>Case-mix adjusted: No</p> <p>NQF #: Not Applicable</p> <p>Data Display: Percentage with no decimal place</p> |

**Measure: C32 - Plan Makes Timely Decisions about Appeals**

| Title | Description   |
|-------|---|
|       | <p>Label for Data: Health Plan Makes Timely Decisions about Appeals</p> <p>Description: Percent of members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.</p> <p>Metric: Percent of appeals timely processed by the MMP (numerator) out of all the MMP’s appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned and partially overturned appeals) (denominator). This is calculated as:<br/> <math display="block">([\text{Number of Timely Appeals}] / ([\text{Appeals Upheld}] + [\text{Appeals Overturned}] + [\text{Appeals Partially Overturned}])) * 100.</math></p> <p>Primary Data Source: Independent Review Entity (IRE)</p> <p>Data Source Description: Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received (or should have been received) by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to May 1, 2018, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2018 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.</p> <p>Data Source Category: Data Collected by CMS Contractors</p> |

| Title              | Description  |
|--------------------|--|
| Exclusions:        | If the denominator is $\leq 10$ , the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.   |
| General Notes:     | This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.<br><br>The number of timely appeals can be calculated using this formula:<br>[Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) - [Late] |
| Data Time Frame:   | 01/01/2017 - 12/31/2017  |
| General Trend:     | Higher is better   |
| Case-mix adjusted: | No   |
| NQF #:             | Not Applicable   |
| Data Display:      | Percentage with no decimal place   |

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### Measure: C33 - Reviewing Appeals Decisions

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer  |
| Description:             | This rating shows how often an <b>independent reviewer</b> thought the health plan's decision to deny an appeal was fair. This includes appeals made by members and out-of-network providers. (This rating is not based on how often the MMP denies appeals, but rather <i>how fair</i> the MMP is when they deny an appeal.)   |
| Metric:                  | Percent of appeals where an MMP's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the MMP's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: $(\text{[Appeals Upheld]} / (\text{[Appeals Upheld]} + \text{[Appeals Overturned]} + \text{[Appeals Partially Overturned]})) * 100$ .   |
| Primary Data Source:     | Independent Review Entity (IRE)   |
| Data Source Description: | Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received (or should have been received) by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to May 1, 2018, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2018 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data. |
| Data Source Category:    | Data Collected by CMS Contractors   |
| Exclusions:              | If the minimum number of appeals (upheld + overturned + partially overturned) is $\leq 10$ , the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.   |
| General Notes:           | This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.  |
| Data Time Frame:         | 01/01/2017 - 12/31/2017   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | No  |

| Title         | Description                      |
|---------------|----------------------------------|
| NQF #:        | Not Applicable                   |
| Data Display: | Percentage with no decimal place |

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### Measure: D02 - Appeals Auto-Forward

| Title                    | Description  |
|--------------------------|--|
| Label for Data:          | Drug Plan Fails to Make Timely Decisions about Appeals (for every 10,000 members)  |
| Description:             | Rate of members who failed to get a timely response when they made an appeal request to the drug plan about a decision to refuse payment or coverage. If you would like more information about Medicare appeals, click on <a href="http://www.medicare.gov/claims-and-appeals/index.html">http://www.medicare.gov/claims-and-appeals/index.html</a>  |
| Metric:                  | This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because the MMP exceeded decision timeframes for coverage determinations or redeterminations. This is calculated as:<br>$[(\text{Total number of cases auto-forwarded to the IRE}) / (\text{Average Medicare Part D enrollment})] * 10,000.$ <p>There is no minimum number of cases required to receive a rating.</p> |
| Primary Data Source:     | Independent Review Entity (IRE)  |
| Data Source Description: | Data were obtained from the Independent Review Entity (IRE) contracted by CMS.   |
| Data Source Category:    | Data Collected by CMS Contractors  |
| Exclusions:              | Rates are not calculated for contracts with average enrollment less than 800 enrollees during the measurement period. Cases the IRE remands back to the MMP are not included in these data.  |
| Data Time Frame:         | 01/01/2017 - 12/31/2017  |
| General Trend:           | Lower is better  |
| Case-mix adjusted:       | No   |
| NQF #:                   | Not Applicable   |
| Data Display:            | Numeric with 1 decimal place   |

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### Measure: D03 - Appeals Upheld

| Title           | Description   |
|-----------------|---|
| Label for Data: | Fairness of Drug Plan's Appeal Decisions, Based on an Independent Reviewer  |
| Description:    | How often an <b>independent reviewer</b> thought the drug plan's decision to deny an appeal was fair. This includes appeals made by members and out-of-network providers. (This rating is not based on how often the MMP denies appeals, but rather <i>how fair</i> the MMP is when they deny an appeal.)   |
| Metric:         | This measure is defined as the percent of IRE confirmations of upholding the MMPs' decisions. This is calculated as:<br>$[(\text{Number of cases upheld}) / (\text{Total number of cases reviewed})] * 100.$ <p>Total number of cases reviewed is defined as all cases received by the IRE during the timeframe and receiving a decision before May 1, 2018. The denominator is equal to the number of cases upheld, fully reversed, and partially reversed. Dismissed, remanded, and withdrawn cases are not included in the denominator. Auto-forwarded cases are included, as these are considered to be adverse decisions per Subpart M rules. If a Reopening occurs and is decided prior to May 1, 2018, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2018 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or</p> |

| Title                    | Description  |
|--------------------------|--|
|                          | Medicare Appeals Council appeals) are not included in the data. Contracts with no IRE cases reviewed will not receive a score in this measure.   |
| Primary Data Source:     | Independent Review Entity (IRE)  |
| Data Source Description: | Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part D reconsiderations. The appeals used in this measure are based on the date they were received by the IRE, not the date a decision was reached by the IRE. |
| Data Source Category:    | Data Collected by CMS Contractors  |
| Exclusions:              | Contracts with fewer than 10 cases reviewed by the IRE.  |
| Data Time Frame:         | 01/01/2017 - 12/31/2017  |
| General Trend:           | Higher is better   |
| Case-mix adjusted:       | No   |
| NQF #:                   | Not Applicable   |
| Data Display:            | Percentage with no decimal place   |

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### Measure: C34 - Call Center – Foreign Language Interpreter and TTY Availability

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan  |
| Description:             | Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.   |
| Metric:                  | The calculation of this measure is the number of successful contacts with the interpreter and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part C benefit. |
| Primary Data Source:     | Call Center   |
| Data Source Description: | Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.  |
| Data Source Category:    | Data Collected by CMS Contractors   |
| Exclusions:              | Data were not collected from MMPs that did not have a phone number accessible to survey callers, MMPs under sanction, and MMPs that terminated effective December 31, 2017.   |
| General Notes:           | Specific questions about Call Center Monitoring and requests for detail data should be directed to the <a href="mailto:CallCenterMonitoring@cms.hhs.gov">CallCenterMonitoring@cms.hhs.gov</a>   |
| Data Time Frame:         | 02/2018 - 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | No  |
| NQF #:                   | Not Applicable  |
| Data Display:            | Percentage with no decimal place  |

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

| Title                    | Description   |
|--------------------------|---|
| Label for Data:          | Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan  |
| Description:             | Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.   |
| Metric:                  | The calculation of this measure is the number of successful contacts with the interpreter and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part D benefit. |
| Primary Data Source:     | Call Center   |
| Data Source Description: | Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.  |
| Data Source Category:    | Data Collected by CMS Contractors   |
| Exclusions:              | Data were not collected from MMPs that did not have a phone number accessible to survey callers, MMPs under sanction, and MMPs that terminated effective December 31, 2017.   |
| General Notes:           | Specific questions about Call Center Monitoring and requests for detail data should be directed to the <a href="mailto:CallCenterMonitoring@cms.hhs.gov">CallCenterMonitoring@cms.hhs.gov</a>   |
| Data Time Frame:         | 02/2018 - 06/2018   |
| General Trend:           | Higher is better  |
| Case-mix adjusted:       | No  |
| NQF #:                   | Not Applicable  |
| Data Display:            | Percentage with no decimal place  |

## Attachment A: CAHPS Case-Mix Adjustment

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

For example, for the measure "Getting Needed Care," the coefficient for "age 75-79" is 0.0179, indicating that respondents in that age range tend to score their plans 0.0179 point higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligible beneficiaries tend to respond 0.0350 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are dual eligible beneficiaries will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures.

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.

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

Table A-1: Part C CAHPS Measures

| Predictor                        | C03: Annual Flu Vaccine | C23: Getting Needed Care (Comp) | C24: Getting Appointments and Care Quickly (Comp) | C25: Customer Service (Comp) | C26: Rating of Health Care Quality | C27: Rating of Health Plan | C28: Care Coordination (Comp) |
|----------------------------------|-------------------------|---------------------------------|---|------------------------------|------------------------------------|----------------------------|-------------------------------|
| Age: 64 or under                 | N/A                     | -0.0144                         | -0.0104   | -0.0354                      | -0.1148                            | -0.1554                    | -0.0064                       |
| Age: 65 - 69                     | N/A                     | -0.0118                         | -0.0039   | 0.0171                       | -0.0597                            | -0.0319                    | 0.0065                        |
| Age: 75 - 79                     | N/A                     | 0.0179                          | 0.0293  | 0.0055                       | 0.0470                             | 0.0718                     | 0.0071                        |
| Age: 80 - 84                     | N/A                     | -0.0012                         | 0.0194  | 0.0024                       | 0.0400                             | 0.0930                     | -0.0089                       |
| Age: 85 and older                | N/A                     | 0.0005                          | 0.0256  | 0.0124                       | 0.0572                             | 0.1608                     | -0.0470                       |
| Less than an 8th grade education | N/A                     | -0.0262                         | -0.0371   | -0.0242                      | -0.0207                            | 0.1161                     | -0.0045                       |
| Some high school                 | N/A                     | -0.0303                         | -0.0239   | -0.0056                      | -0.1059                            | 0.0476                     | 0.0005                        |
| Some college                     | N/A                     | -0.0305                         | -0.0055   | -0.0362                      | -0.1059                            | -0.2054                    | -0.0206                       |
| College graduate                 | N/A                     | -0.0384                         | -0.0076   | -0.0832                      | -0.1543                            | -0.3332                    | -0.0585                       |
| More than a bachelor's degree    | N/A                     | -0.0547                         | -0.0116   | -0.1208                      | -0.2220                            | -0.3904                    | -0.0417                       |
| General health rating: excellent | N/A                     | 0.0522                          | 0.1111  | 0.0083                       | 0.3767                             | 0.2886                     | 0.0627                        |
| General health rating: very good | N/A                     | 0.0514                          | 0.0478  | 0.0224                       | 0.1949                             | 0.1771                     | 0.0346                        |
| General health rating: fair      | N/A                     | -0.0632                         | -0.0451   | -0.0299                      | -0.2882                            | -0.1828                    | -0.0434                       |
| General health rating: poor      | N/A                     | -0.0968                         | -0.0370   | -0.0331                      | -0.5000                            | -0.3182                    | -0.0871                       |
| Mental health rating: excellent  | N/A                     | 0.1704                          | 0.1210  | 0.1199                       | 0.4867                             | 0.3769                     | 0.1272                        |
| Mental health rating: very good  | N/A                     | 0.0757                          | 0.0486  | 0.0578                       | 0.2234                             | 0.1876                     | 0.0518                        |
| Mental health rating: fair       | N/A                     | -0.0203                         | -0.0073   | -0.0197                      | -0.1080                            | -0.0879                    | -0.0372                       |
| Mental health rating: poor       | N/A                     | -0.1331                         | -0.1090   | -0.0526                      | -0.5556                            | -0.4349                    | -0.1032                       |
| Proxy helped                     | N/A                     | 0.0071                          | -0.0093   | -0.0104                      | -0.1186                            | -0.0459                    | 0.0400                        |
| Proxy answered                   | N/A                     | 0.0175                          | 0.0068  | -0.0336                      | -0.0166                            | -0.0450                    | 0.0150                        |
| Medicaid dual eligible           | N/A                     | -0.0350                         | -0.0317   | 0.0147                       | 0.0247                             | 0.2844                     | -0.0087                       |

| Predictor                | C03: Annual Flu Vaccine | C23: Getting Needed Care (Comp) | C24: Getting Appointments and Care Quickly (Comp) | C25: Customer Service (Comp) | C26: Rating of Health Care Quality | C27: Rating of Health Plan | C28: Care Coordination (Comp) |
|--------------------------|-------------------------|---------------------------------|---|------------------------------|------------------------------------|----------------------------|-------------------------------|
| Low-income subsidy (LIS) | N/A                     | -0.0471                         | -0.0023   | -0.0094                      | 0.0002                             | 0.0691                     | -0.0100                       |
| Chinese Language         | N/A                     | -0.2842                         | -0.4077   | -0.3308                      | -0.3235                            | -0.8711                    | -0.1307                       |

Table A-2: Part D CAHPS Measures

| Predictor                        | MA-PD D07: Rating of Drug Plan | MA-PD D08: Getting Needed Prescription Drugs (Comp) | PDP D07: Rating of Drug Plan | PDP D08: Getting Needed Prescription Drugs (Comp) |
|----------------------------------|--------------------------------|---|------------------------------|---|
| Age: 64 or under                 | -0.2105                        | -0.0469   | -0.3323                      | -0.0929   |
| Age: 65 - 69                     | -0.0605                        | -0.0157   | -0.2681                      | -0.0704   |
| Age: 75 - 79                     | 0.1228                         | 0.0295  | 0.0785                       | 0.0221  |
| Age: 80 - 84                     | 0.1898                         | 0.0285  | 0.2479                       | 0.0468  |
| Age: 85 and older                | 0.2949                         | 0.0280  | 0.4035                       | 0.0167  |
| Less than an 8th grade education | 0.1043                         | -0.0651   | 0.2482                       | -0.0866   |
| Some high school                 | 0.0866                         | -0.0078   | 0.3167                       | -0.0008   |
| Some college                     | -0.2464                        | -0.0425   | -0.2814                      | -0.0361   |
| College graduate                 | -0.3371                        | -0.0463   | -0.2145                      | -0.0560   |
| More than a bachelor's degree    | -0.3693                        | -0.0633   | -0.2559                      | -0.0813   |
| General health rating: excellent | 0.2879                         | 0.0388  | 0.2374                       | 0.0523  |
| General health rating: very good | 0.1925                         | 0.0398  | 0.1642                       | 0.0366  |
| General health rating: fair      | -0.1829                        | -0.0646   | -0.1739                      | -0.0717   |
| General health rating: poor      | -0.3672                        | -0.1052   | -0.1732                      | -0.1069   |
| Mental health rating: excellent  | 0.3347                         | 0.1040  | -0.1597                      | 0.0386  |
| Mental health rating: very good  | 0.1378                         | 0.0524  | -0.1692                      | 0.0321  |
| Mental health rating: fair       | -0.0636                        | -0.0185   | -0.0174                      | -0.0226   |
| Mental health rating: poor       | -0.2989                        | -0.0431   | -0.3051                      | -0.0386   |
| Proxy helped                     | -0.1712                        | -0.0073   | -0.2270                      | 0.0018  |
| Proxy answered                   | -0.1232                        | 0.0107  | -0.0848                      | 0.0303  |
| Medicaid dual eligible           | 0.5920                         | 0.0443  | 0.7898                       | 0.0645  |
| Low-income subsidy (LIS)         | 0.4848                         | 0.0361  | 0.8629                       | 0.1446  |
| Chinese Language                 | -0.7368                        | -0.0816   | 0.0000                       | 0.0000  |

## Attachment B: Complaints Tracking Module Exclusion List

Some complaints that cannot be clearly attributed to the MMP are excluded; these include the following complaint types: enrollment or MMP change issues outside available enrollment period; disenrollment due to loss of Medicare entitlement; IRMAA equitable relief or good cause requests; MMP premium good cause requests; contractor or partner performance; program integrity issues; and Medicaid eligibility issues. Complaints flagged as CMS issue or requiring CMS review will also be excluded.

Table B-1 contains the exclusions applied to the CTM based on the revised categories and subcategories that were applied between September 25, 2010 and March 17, 2017.

Table B-1: Exclusions between September 25, 2010 and March 17, 2017

| Category ID | Category Description   | Subcategory ID | Subcategory Description  | Effective Date     |                                      |
|-------------|--|----------------|--|--------------------|--------------------------------------|
| 11          | Enrollment/Disenrollment   | 16             | Facilitated/Auto Enrollment issues   | September 25, 2010 |                                      |
|             |  | 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   |                    |                                      |
| 26          | Contractor/Partner Performance   | 90             | Other Contractor/Partner Performance   |                    | December 16, 2011                    |
| 44          | Equitable Relief/Good Cause Requests   | 01             | Good Cause - Disenrollment for Failure to Pay Premiums                                   |                    |                                      |
|             |  | 90             | Other Equitable Relief/Good Cause Request  |                    |                                      |
| 45          | Equitable Relief/Good Cause Requests   | 01             | Good Cause - Disenrollment for Failure to Pay Premiums                                   |                    |                                      |
|             |  | 02             | Refund/Non-Receipt Part D IRMAA  |                    |                                      |
|             |  | 03             | Good Cause Part D IRMAA  |                    |                                      |
|             |  | 04             | Equitable Relief Part D IRMAA  |                    |                                      |
| 49          | Contractor/Partner Performance   | 90             | Other Contractor/Partner Performance   |                    |                                      |
|             |  |                |  | 90                 | Other Contractor/Partner Performance |
| 50          | Contractor/Partner Performance   | 90             | Other Contractor/Partner Performance   |                    |                                      |
| 03          | Enrollment/ Disenrollment  | 11             | Disenrollment Due to Loss of Entitlement   | June 1, 2013       |                                      |
| 11          | Enrollment/ Disenrollment  | 24             | Disenrollment Due to Loss of Entitlement   |                    |                                      |

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

### Attachment C: Calculating Measure C21: Plan All-Cause Readmissions

All data come from the HEDIS 2018 M18\_PCR and HEDIS 2018 M18\_PCRb data files. The CMS SNP HEDIS Public Use File (PUF) data, which include MMPs, can be found on this page: [Medicare Advantage/Part D Contract and Enrollment Data](#).

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

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

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

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

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

## Attachment D: Medication Adherence Measure Calculations

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Website to compare their performance to overall averages and monitor their progress in improving the Part D patient safety measures over time. Sponsors are required to use the website to view and download the reports and should be engaged in performance monitoring.

Report User Guides are available on the website under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices B and C) and illustrates the days covered calculation and the modification for inpatient stays, hospice enrollments, and skilled nursing facility stays.

### Proportion of Days Covered Calculation

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

#### Example 1: Non-Overlapping Fills of Two Different Drugs

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

Table D-1: No Adjustment

| Drug       | January  |           | February |           | March    |           |
|------------|----------|-----------|----------|-----------|----------|-----------|
|            | 1/1/2017 | 1/16/2017 | 2/1/2017 | 2/16/2017 | 3/1/2017 | 3/16/2017 |
| Benazepril | 15       | 16        | 15       | 13        |          |           |
| Captopril  |          |           |          |           | 15       | 16        |

#### PDC Calculation

Covered Days: 90

Measurement Period: 90

PDC: 90/90 = 100%

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

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

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

Table D-2: Before Overlap Adjustment

| Drug              | January  |           | February |           | March    |           |
|-------------------|----------|-----------|----------|-----------|----------|-----------|
|                   | 1/1/2017 | 1/16/2017 | 2/1/2017 | 2/16/2017 | 3/1/2017 | 3/16/2017 |
| Lisinopril        | 15       | 16        |          |           |          |           |
| Lisinopril & HCTZ |          | 16        | 15       |           |          |           |
| Benazepril & HCTZ |          |           | 15       | 13        |          |           |

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

Table D-3: After Overlap Adjustment

| Drug              | January  |           | February |           | March    |           |
|-------------------|----------|-----------|----------|-----------|----------|-----------|
|                   | 1/1/2017 | 1/16/2017 | 2/1/2017 | 2/16/2017 | 3/1/2017 | 3/16/2017 |
| Lisinopril        | 15       | 16        |          |           |          |           |
| Lisinopril & HCTZ |          |           | 15       | 13        | 3        |           |
| Benazepril & HCTZ |          |           | 15       | 13        |          |           |

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

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

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

Table D-4: Before Overlap Adjustment

| Drug              | January  |           | February |           | March    |           | April    |           |
|-------------------|----------|-----------|----------|-----------|----------|-----------|----------|-----------|
|                   | 1/1/2017 | 1/16/2017 | 2/1/2017 | 2/16/2017 | 3/1/2017 | 3/16/2017 | 4/1/2017 | 4/16/2017 |
| Lisinopril        | 15       | 16        |          |           |          |           |          |           |
| Lisinopril & HCTZ |          | 16        | 15       |           |          |           |          |           |
| Captopril         |          |           |          |           | 15       | 16        |          |           |
| Lisinopril        |          |           |          |           |          | 16        | 15       |           |

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

Table D-5: After Overlap Adjustment

| Drug              | January  |           | February |           | March    |           | April    |           |
|-------------------|----------|-----------|----------|-----------|----------|-----------|----------|-----------|
|                   | 1/1/2017 | 1/16/2017 | 2/1/2017 | 2/16/2017 | 3/1/2017 | 3/16/2017 | 4/1/2017 | 4/16/2017 |
| Lisinopril        | 15       | 16        |          |           |          |           |          |           |
| Lisinopril & HCTZ |          |           | 15       | 13        | 3        |           |          |           |
| Captopril         |          |           |          |           | 15       | 16        |          |           |
| Lisinopril        |          |           |          |           |          | 16        | 15       |           |

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

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

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

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

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. While hospice information from the Medicare Enrollment Database (EDB) and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs, SNF claims are only available for Medicare Fee-for-Service (FFS) beneficiaries who are also enrolled in PDPs. Therefore, the SNF adjustment will only impact PDP sponsors at this time.

### **Calculating the PDC Adjustment for IP Stays, Hospice Enrollments, and SNF Stays**

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

1. Identify start and end dates of relevant types of stays or hospice enrollments for beneficiaries included in adherence measures.
  - Use IP claims from the CWF to identify IP stays.
  - Use SNF claims with positive payment amounts from the CWF to identify SNF stays.
  - Use hospice records from the EDB to identify hospice enrollments.
2. Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion-of-days covered calculation.
3. Shift days' supply from Part D prescription fills that overlap with the stay to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

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

#### **Example 1: Gap in Coverage after IP Stay**

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

Table D-6: Before Adjustment

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

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

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

Table D-7: After Adjustment

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

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

**Example 2: Gap in Coverage before IP Stay**

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

Table D-8: Before Adjustment:

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

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

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

Table D-9: After Adjustment

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

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

### Example 3: Gap in Coverage Before and After IP Stay

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

Table D-10: Before Adjustment

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

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

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

Table D-11: After Adjustment

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

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

## Attachment E: MTM CMR Completion Rate Measure Scoring Methodologies

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

- Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2017. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.
- Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2017.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2018), or that were not required to participate in data validation. The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation.

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

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

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

**File DV failure:** Contracts that failed to submit the CY 2017 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

**Section-level DV failure:** Contracts that score less than 95% in DV for their CY 2017 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

**Element-level DV failure:** Contracts that score 95% or higher in DV for their CY 2017 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

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

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

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

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

## Attachment F: Missing Data Messages

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

### Measure level messages

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

Table F-1: Measure level missing data messages

| Message   | Measure Level  |
|---|--|
| Not enough data available   | There were data for the contract, but not enough to pass the measure exclusion rules.  |
| CMS identified issues with this plan's data   | Data were materially biased, erroneous and/or not reported by a contract required to report.   |
| Plan too new to be measured   | The contract is too new to have submitted measure data.  |
| No data available   | There were no data for the contract included in the source data for the measure.   |
| Plan too small to be measured   | The contract had data but did not have enough enrollment to pass the measure exclusion rules.  |
| Plan not required to report measure   | The contract was not required to report the measure due to low plan enrollment.  |
| Not reportable due to plan termination  | The contract was excluded from the measure due to plan termination effective December 31, 2017.  |
| N/A based on demonstration's target population (Massachusetts MMPs only) <sup>1</sup> | Massachusetts MMPs are excluded because the age range for the measure does not align with the demonstration's target population (only individuals younger than 65 can enroll in Massachusetts MMPs). |

### Assignment rules for Part C measure messages

#### *Appeals (IRE) measures (C32 & C33):*

Has CMS identified issues with the contract's data?

Yes: Display message: CMS identified issues with this plan's data

No: Is there a valid numeric measure rate?

Yes: Display the numeric measure rate

No: Is the contract effective date > 01/01/2017?

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

#### *CAHPS measures (C03, C23, C24, C25, C26, C27, & C28):*

Is the contract still active as of 01/01/2018?

Yes: Is there a valid numeric CAHPS measure rate?

Yes: Display the numeric CAHPS measure rate

No: Is the contract effective date > 07/01/2017?

Yes: Display message: Plan too new to be measured

No: Is the CAHPS measure rate NR?

Yes: Display message: Not enough data available

No: Is the CAHPS measure rate NA?

Yes: Display message: No data available

No: Display message: Plan too small to be measured

No: Display message: Not reportable due to plan termination

#### *Call Center – Foreign Language Interpreter and TTY Availability measure (C34):*

Is the contract still active as of 01/01/2018?

Yes: Is there a valid call center numeric rate?

Yes: Display the call center numeric rate

No: Is the organization type 1876 Cost?

<sup>1</sup> For Massachusetts MMPs, this missing data message applies to the following measures: C06, C09, C10, C11, C12, C18, and C19.

- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2018?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available
- No: Display message: Not reportable due to plan termination

*Complaints (CTM) measure (C29):*

- Is the contract effective date > 01/01/2017?
  - Yes: Display message: Plan too new to be measured
  - No: Was the average contract enrollment < 800 in 2017?
    - Yes: Display message: Not enough data available
    - No: Is there a valid numeric CTM rate?
      - Yes: Display the numeric CTM rate
      - No: Display message: No data available

*HEDIS measures (C01, C02, C07, C12 – C17, C20, C22, DMC01, DMC02, DMC13, & DMC14):*

- Was the contract required to report HEDIS?
  - Yes: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NA: Display message: Not enough data available
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
  - No: Is the contract effective date > 01/01/2017?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Plan not required to report measure

*HEDIS PCR measure (C21)*

- Was the contract required to report HEDIS?
  - Yes: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NA: Display message: Not enough data available
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 2 submitted and the measure data usable?
      - Yes: Did the contract report more than 10 index stays?
        - Yes: Display the HEDIS measure numeric rate
        - No: Display message: Not enough data available
      - No: Display message: CMS identified issues with this plan's data
  - No: Is the contract effective date > 01/01/2017?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Plan not required to report measure

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

- Does the contract have fewer than 30 members enrolled as of the February 2017 Monthly Enrollment by Plan report?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 01/01/2017?

- Yes: Display message: Plan too new to be measured
- No: What is the HEDIS measure audit designation?
  - BD: Display message: CMS identified issues with this plan's data
  - BR: Display message: CMS identified issues with this plan's data
  - NA: Display message: Not enough data available
  - NB: Display message: Benefit not offered by plan
  - NR: Display message: CMS identified issues with this plan's data
  - NQ: Display message: Plan not required to report measure
  - R: Is there a valid HEDIS measure numeric rate?
    - Yes: Display the HEDIS measure numeric rate
    - No: Display message: No data available

*HEDIS / HOS measures (C06, C18, & C19):*

Is there a valid HEDIS / HOS numeric rate?

Yes: Display the HEDIS / HOS numeric rate

No: Is the contract effective date > 01/01/2016?

Yes: Display message: Plan too new to be measured

No: Is the contract enrollment < 500?

Yes: Display message: Plan too small to be measured

No: Is there a HEDIS / HOS rate code?

Yes: Assign message according to value below:

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

No: Display message: No data available

*Members Choosing to Leave the Plan (C30):*

Is the contract active as of 01/01/2018?

Yes: Is there a valid numeric voluntary disenrollment rate?

Yes: Display the numeric voluntary disenrollment rate

No: Is the contract effective date ≥ 01/01/2018?

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

No: Display message: Not reportable due to plan termination

**Assignment rules for Part D measure messages**

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

Has CMS identified issues with the contract's data?

Yes: Display message: CMS identified issues with this plan's data

No: Was the average contract enrollment < 800 in 2017?

Yes: Display message: Not enough data available

No: Is the contract effective date > 12/31/2017?

Yes: Display message: Plan too new to be measured

No: Is there a valid numeric measure rate?

Yes: Display numeric measure rate

No: Display message: No data available

*Appeals Upheld (IRE) measure (D03):*

Has CMS identified issues with the contract's data?

Yes: Display message: CMS identified issues with this plan's data

No: Is the contract effective date > 01/01/2017?

Yes: Display message: Plan too new to be measured

No: Were fewer than 10 cases reviewed by the IRE?

Yes: Display message: Not enough data available

No: Is there a valid numeric measure percentage?

Yes: Display numeric measure percentage  
 No: Display message: No data available

*CAHPS measures (D07, D08):*

Is the contract still active as of 01/01/2018?

Yes: Is there a valid numeric CAHPS measure rate?

Yes: Display the numeric CAHPS measure rate

No: Is the contract effective date > 07/01/2017?

Yes: Display message: Plan too new to be measured

No: Is the CAHPS measure rate NR?

Yes: Display message: Not enough data available

No: Is the CAHPS measure rate NA?

Yes: Display message: No data available

No: Display message: Plan too small to be measured

No: Display message: Not reportable due to plan termination

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

Is the contract still active as of 01/01/2018?

Yes: Is there a valid call center numeric rate?

Yes: Display the call center numeric rate

No: Is the organization type 1876 Cost?

Yes: Display message: Plan not required to report measure

No: Is the contract effective date > 01/01/2018?

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

No: Display message: Not reportable due to plan termination

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

Is the contract effective date > 12/31/2017?

Yes: Display message: Plan too new to be measured

No: Does contract have 30 or fewer enrolled beneficiary member years (measure denominator)?

Yes: Display message: Not enough data available

No: Display numeric percentage

*Patient Safety measure – MTM CMR (D13)*

Is the contract still active as of 01/01/2018?

Yes: Is the contract effective date > 12/31/2017?

Yes: Display message: Plan too new to be measured

No: Is Part D Offered=False?

Yes: Display message: Plan not required to report measure

No: Is there a numeric rate?

Yes: Display numeric measure percentage

No: Is there a Reason(s) for Display Message?

Yes: Display appropriate message per table F-2

No: Display message: Not reportable due to plan termination

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

| Reason(s) for Display Message   | Data File Message                           |
|---|---|
| Contract failed to submit file and pass system validation by the reporting deadline | CMS identified issues with this plan's data |
| Contract did not pass element-level DV for at least one element                     | CMS identified issues with this plan's data |
| Contract had missing score on MTM section DV  | CMS identified issues with this plan's data |
| Contract scored less than 95% on MTM section DV                                     | CMS identified issues with this plan's data |
| Contract had all plans terminate by validation deadline                             | No data available                           |
| Contract had no MTM enrollees to report   | No data available                           |

| Reason(s) for Display Message                                       | Data File Message         |
|---|---------------------------|
| Contract has 0 Part D enrollees                                     | No data available         |
| Contract had 30 or fewer beneficiaries meeting denominator criteria | Not enough data available |
| Contract not required to submit MTM program                         | Not required to report    |

### Assignment rules for MMP measure messages

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

Did the contract enroll new members during the measurement year?

Yes: Has CMS identified issues with the contract's data?

Yes: Display message: CMS identified issues with this plan's data

No: Display the numeric measure rate

No: Display message: No data available

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

Is the contract still active as of 01/01/2018?

Yes: Is there a valid numeric CAHPS measure rate?

Yes: Display the numeric CAHPS measure rate

No: Is the contract effective date > 07/01/2017?

Yes: Display message: Plan too new to be measured

No: Is the CAHPS measure rate NR?

Yes: Display message: Not enough data available

No: Is the CAHPS measure rate NA?

Yes: Display message: No data available

No: Display message: Plan too small to be measured

No: Display message: Not reportable due to plan termination

## **Attachment G: Contract Enrollment Data**

The enrollment data used in the Part C "Complaints about the Health Plan" and Part D "Appeals Auto-Forward" measures are pulled from the HPMS. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2017 through December 2017) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the three Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor, there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2017 through December 2017), and the average enrollment in the plan across those months is used in calculating the combined rate.

## **Attachment H: Rounding Rules for Measure Scores**

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using standard round to nearest rules. Measure scores that end in 0.49 (0.049, 0.0049) or less are rounded down and measure scores that end in 0.50 (0.050, 0.0050) or more are rounded up. For example, a measure listed with a Data Display of "Percentage with no decimal place" that has a value of 83.49 rounds down to 83, while a value of 83.50 rounds up to 84.

## **Attachment I: Glossary of Terms**

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

|                      |  |
|----------------------|--|
| HOS                  | The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate. |
| IRE                  | The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.  |
| LIS                  | The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.  |
| LIS/DE               | Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.   |
| MA                   | A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.   |
| MA-PD                | An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.   |
| PDP                  | A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.  |
| Percentage           | A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.   |
| Percentile           | The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.  |
| Reliability          | A measure of the fraction of the variation among the observed measure values that is due to real differences in quality ("signal") rather than random variation ("noise"). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).  |
| Sponsor              | An entity that sponsors a health or drug plan.   |
| TTY                  | A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.   |
| Very Low Reliability | For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.  |

## Attachment J: State-Specific Requirements for the Care Plan Completion Measure

The following table provides information about the state-specific measures that were used to calculate the care plan completion rate. Full specifications for these measures are included in the individual State-Specific Reporting Requirements documents, which are available on the CMS website at the following link:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

| State             | Measure Number | Measure Name  |
|-------------------|----------------|---|
| California*       | CA1.2          | High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).   |
|                   | CA1.4          | Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).  |
| Illinois          | IL3.1          | Members with care plans within 90 days of enrollment.   |
| Massachusetts     | MA1.1          | Members with care plans within 90 days of enrollment.   |
| Michigan          | MI2.1          | Members with an Individual Integrated Care and Supports Plan (IICSP) within 90 days of enrollment.  |
| New York FIDA     | NY2.1          | Participants with Person-Centered Service Plans (PCSPs) completed within 90 days of enrollment and PCSPs updated within 30 days of a reassessment.  |
| New York FIDA-IDD | IDD1.1         | Participants with Life Plans (LPs) completed within 60 days of Comprehensive Service Planning Assessment (CSPA) completion and LPs updated within 30 days of a Comprehensive Reassessment (CR). |
| Ohio              | OH1.1          | Members with care plans within 90 days of enrollment.   |
| Rhode Island      | RI1.1          | Members with Interdisciplinary Care Plans or Wellness Plans within 15 days of a completed assessment.   |
| South Carolina    | SC2.1          | Low-, moderate-, and high-risk members with an Individualized Care Plan (ICP) completed within 90 days of enrollment.   |
| Texas             | TX1.1          | Members with Plans of Care within 90 days of enrollment.  |
| Virginia          | VA2.1          | Community Well members, vulnerable subpopulation members, EDCCD members, and nursing facility members with a Plan of Care (POC) completed within the required timeframe.                        |

\* For California MMPs, the care plan completion rate was calculated using both CA1.2 and CA1.4. Corresponding data elements for each measure were summed across 2017 quarterly reporting periods in order to calculate the annual rate.