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2013 Part C & Part D
Technical Notes

DRAFT

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Document Change Log

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09/06/2012	Updated Part C measure averages for data and stars	9/11/2012

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Introduction

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

All of the health/drug plan quality and performance measure data described in this document are reported at the contract level. Table 1 lists the contract year 2013 organization types and whether they are included in the Part C and/or Part D Plan Ratings.

Table 1: Contract Year 2013 Organization Types Reported in the 2013 Plan Ratings

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

* Note: These organization types are Medicare Advantage Organizations

The Plan Ratings strategy is consistent with CMS' Three Aims (better care, healthier people/healthier communities, and lower costs through improvements) with measures spanning the following five broad categories:

1. Outcomes: Outcome measures focus on improvements to a beneficiary's health as a result of the care that is provided.
2. Intermediate outcomes: Intermediate outcome measures help move closer to true outcome measures. Controlling Blood Pressure is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with hypertension.
3. Patient experience: Patient experience measures represent beneficiaries' perspectives about the care they have received.
4. Access: Access measures reflect issues that may create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
5. Process: Process measures capture the method by which health care is provided.

Differences between the 2012 Plan Ratings and 2013 Plan Ratings

There have been several changes between the 2012 Plan Ratings and the 2013 Plan Ratings. This section provides a synopsis of the significant differences; the reader should examine the entire document for full details about the 2013 Plan Ratings.

1. Changes
    a. Part C measure: C34 - Plan Makes Timely Decisions about Appeals, now includes the timeliness of dismissed appeals.
    b. Part D measure: D13 - MPF Price Accuracy, was MPF Composite in 2012, removed price stability portion of the measure.
    c. Part C & D measures: C31 & D07 - Beneficiary Access and Performance Problems, replaced the contract effectiveness score with the percent of elements passed out of all elements audited.

   d. Part C & D measures: C36 & D02 - Call Center – Foreign Language Interpreter and TTY/TDD Availability, includes data from Special Needs Plans and changes to collection methodology.
   e. Part D measure: D14 - High Risk Medication - CMS increased the number of HRM fills from one to two fills. Due to this specification change, the previously established 4-star threshold is not applied for the 2013 Plan Ratings.
   f. Part C Domain Ratings of Plan Responsiveness and Care renamed to Member Experience with Health Plan.
   g. Part C Domain Member Complaints, Problems Getting Services, and Choosing to Leave the Plan renamed to Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance.
   h. Part D Domain Member Complaints, Problems Getting Services, and Choosing to Leave the Plan renamed to Member Complaints, Problems Getting Services, and Improvement in the Drug Plan's Performance.

2. Additions
   a. Part C measure: C29 - Care Coordination
   b. Part C measure: C33 - Health Plan Quality Improvement
   c. Part C measure: C37 - Enrollment Timeliness
   d. Part D measure: D09 - Drug Plan Quality Improvement

3. Transitioned (Moved to the display measures which can be found on the CMS website at this address: http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp)
   a. Part C measure: Pneumonia Vaccine
   b. Part C measure: Access to Primary Care Doctor Visits
   c. Part D MPF Stability (removed from last year's MPF Composite measure)

The complete history of measures used in the Plan Ratings can be found in Attachment J.

Contract Enrollment Data

The enrollment data used in the Part C and D "Complaints about the Health/Drug Plan" measures were pulled from the HPMS. These enrollment files represent the number of beneficiaries the contract was paid for in a specific month. For this measure, six months of enrollment files were pulled (January 2012 through June 2012) and the average enrollment from those months was used in the calculations.

The enrollment data used in the Part D "Appeals Auto–Forward" measure were pulled from the HPMS. These enrollment files represent the number of beneficiaries the contract was paid for in a specific month. For this measure, twelve months of enrollment files were pulled (January 2011 through December 2011) and the average enrollment from those months was used in the calculations.

Enrollment data are also used to combine plan level data into contract level data in the three Part C Care for Older Adults HEDIS measures. This only occurs when the eligible population was not included in the submitted SNP HEDIS data and the submitted rate was NR (see following section). For these measures, twelve months of plan level enrollment files were pulled (January 2011 through December 2011) and the average enrollment in the plan for those months was used in calculating the combined rate.

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

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

For the Healthcare Effectiveness Data and Information Set (HEDIS) data, NRs are assigned when the individual measure score is materially biased (e.g., the auditor informs the contract the data cannot be reported to the National Committee for Quality Assurance (NCQA) or CMS) or the contract decides not to report the data for a particular measure. When NRs have been assigned for a HEDIS measure rate, because the contract has had materially biased data or the contract has decided not to report the data, the contract receives a “1” star for each of these measures and the numerical value will be set to: “CMS identified issues with this plan’s data”. The measure score will also receive the footnote: “Not reported. There were problems with the plan's data” for materially biased data or "Measure was not reported by plan" for unreported data.

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

How the Data are Reported

For 2013, the Part C and D Plan Ratings are reported using five different levels of detail.

Base: At the base level, with the most detail, are the individual measures. They are comprised of numeric data for all of the quality and performance measures except for the improvement measures which is explained in the section titled “Applying the Improvement Measure(s)”.

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

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

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

Overall: The highest level is the overall rating which applies only to MA-PDs. This overall rating summarizes all of the Part C and Part D measures for each contract. The highest level for PDPs is the Part D rating. The highest level for MA-only contracts is the Part C rating. For the highest rating, the improvement measure(s) may not be used under certain circumstances which is explained in the section titled “Applying the Improvement Measure(s)”.

There are a total of 9 domains (topic areas) comprised of up to 55 measures.

1. MA-only contracts are measured on 5 domains with up to 37 measures.
2. PDPs are measured on 4 domains with up to 18 measures.
3. MA-PD contracts are measured on all 9 domains with up to 49 unique measures.

Methodology for Assigning Part C and D Measure Star Ratings

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

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

CMS does not transform the Plan Ratings data into 5-star categories for every measure. For example, in the health plan measure of Osteoporosis management in women that had a fracture, the 4-star threshold is ≥ 60%. In the 2013 Plan Ratings, nine contracts surpassed this threshold while the majority of contracts’ scores fell into the 1-star and 2-star ranges.

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

Predetermined Thresholds

CMS has set fixed 4-star thresholds for most measures and 3-star thresholds for measures when an absolute regulatory standard has been established (such as answering a pharmacy call within 2 minutes). Additionally, CMS sets these thresholds in order to define expectations about what it takes to be a high quality contract and to drive quality improvement. These target 4-star thresholds are based on contract performance in prior years; therefore they have not been set for revised measures or for measures with less than 2 years of measurement experience.

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

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

Methodology for Calculating Stars for Individual Measures

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

A. Relative Distribution and Clustering:

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

Detailed description:

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

   $Scale_{min}$ = 0.025 and $Scale_{max}$=0.975

   $$\text{Scaled measure value} = \left(Scale_{max} - Scale_{min}\right) \times \frac{(X - M_{min})}{(M_{max} - M_{min})} + Scale_{min}$$

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

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

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

B. Relative Distribution and Significance Testing (CAHPS):

This method is applied to determine valid star thresholds for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars, a contract's CAHPS measure score needs to be ranked above the 80th percentile and be statistically significantly higher than the national average CAHPS measure score. A contract is assigned 4 stars if it does not meet the 5-star criteria, but the contract's average CAHPS measure score exceeds a pre-determined threshold, except for Care Coordination where the cutoff is defined by the 60th percentile of contract means in CAHPS reports for the same measure. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and the contract's CAHPS measure score must be statistically significantly lower than the national average CAHPS measure score.

C. CMS Standard, Relative Distribution, and Clustering:

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

Methodology for Calculating Stars at the Domain Level

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

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

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

Table 2: Domain Rating Requirements

	Domain		Contract Type					
Part	ID	Name	1876 Cost †	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
C	1	Staying Healthy: Screenings, Tests and Vaccines	6 of 10	6 of 10	6 of 10	6 of 10	N/A	6 of 10
C	2	Managing Chronic (Long Term) Conditions	5 of 9	6 of 10	7 of 13	6 of 10	N/A	6 of 10
C	3	Member Experience with Health Plan	4 of 6	4 of 6	4 of 6	4 of 6	N/A	4 of 6
C	4	Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance	3 of 4	3 of 4	3 of 4	3 of 4	N/A	3 of 4
C	5	Health Plan Customer Service	2 of 3	3 of 4	3 of 4	2 of 3	N/A	3 of 4
D	1	Drug Plan Customer Service	2 of 3*	3 of 5	3 of 5	N/A	3 of 5	3 of 5
D	2	Member Complaints, Problems Getting Services, and Improvement in the Drug Plan's Performance	3 of 4*	3 of 4	3 of 4	N/A	3 of 4	3 of 4
D	3	Member Experience with the Drug Plan	2 of 3*	2 of 3	2 of 3	N/A	2 of 3	2 of 3
D	4	Patient Safety and Accuracy of Drug Pricing	4 of 6*	4 of 6	4 of 6	N/A	4 of 6	4 of 6

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

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

Weighting of Measures

For the 2013 Plan Ratings, CMS assigned the highest weight to outcomes and intermediate outcomes, followed by patient experience/complaints and access, and then process measures. Process measures were weighted the least. The Part C, Part D, and overall MA-PD ratings are thus calculated as weighted averages of the ratings of individual measures. The weights assigned to each measure for summary and overall star ratings are shown in Attachment G. A measure given a weight of 3 counts three times as much as a measure given a weight of 1. For both the summary and overall ratings, the rating for a single contract is calculated as a weighted average of the measures available for that contact. The first step in this calculation would be to multiply each individual measure's weight by the measure's star rating and then sum all results for all the measures available for each contract. The second step would be to divide this result by the sum of the weights for the measures available for the contract.

Methodology for Calculating Part C and Part D Rating

The Part C and Part D ratings are calculated by taking a weighted average of the measure level ratings for Part C and D, respectively. To receive a Part C and/or D Rating, a contract must meet or exceed the minimum number of individual measures with a star rating. The Part C and D improvement measures are not included in the count for the minimum number of measures needed. The minimum number of measures required is determined as follows:

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

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

Table 3: Part C and Part D Rating Requirements

Rating	1876 Cost †	Local, E-Local & Regional CPP w/o SNP	Local, E-Local & Regional CPP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Part C Rating	16 of 31	17 of 33	18 of 36	16 of 32	N/A	17 of 33
Part D Rating	8 of 15	9 of 17	9 of 17	N/A	9 of 17	9 of 17

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

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

Additionally, to incorporate performance stability into the rating process, CMS has used an approach that utilizes both the mean and the variance of individual performance ratings to differentiate contracts for the summary score. That is, a measure of individual performance score dispersion, specifically an integration factor (i-Factor), has been added to the mean score to reward contracts if they have both high and stable relative performance. Details about the i-Factor can be found in the section titled "Applying the Integration Factor".

Methodology for Calculating the Overall MA-PD Rating

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

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

There are a total of 55 measures (37 in Part C, 18 in Part D). The following four measures are contained in both the Part C and D measure lists:

1. Complaints about the Health/Drug Plan (CP)
2. Beneficiary Access and Performance Problems (BAPP)
3. Members Choosing to Leave the Plan (MCLP)
4. Enrollment Timeliness (ET)

These measures share the same data source, so CMS has only included the measure once in calculating the overall Plan Rating. The Part C and D improvement measures are also not included in the count for the minimum number of measures. This results in a total of 49 measures (the Part D CP, BAPP, MCLP and ET measures are duplicates of the Part C measures).

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

Table 4: Overall Rating Requirements

Rating	1876 Cost †	Local, E-Local & Regional CPP w/o SNP	Local, E-Local & Regional CPP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Overall Rating	21 of 42*	23 of 46	25 of 49	N/A	N/A	23 of 46

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

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

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

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

Applying the Improvement Measure(s)

The improvement measures (Part C measure C33 and Part D measure D09) compare the underlying numeric data from the 2012 Plan Ratings with the data from the 2013 Plan Ratings. The Part C measure uses only data from Part C and the Part D measure uses only data from Part D. To qualify for use in the improvement calculation, a measure must exist in both years and not have had a significant change in its specification.

The measures and formulas used can be found in Attachment I. The result of these calculations is a measure star rating; there are no numeric data for the measure for public reporting purposes. To receive a star rating in the improvement measure, a contract must have data in at least half of the measures used.

The improvement measures are not included in the minimum number of measures needed for calculating the Part C, Part D or overall ratings.

Since high performing contracts have less room for improvement and consequently may have lower ratings on these measure(s), CMS has developed the following rules to not penalize contracts receiving 4 or more stars for their highest rating.

MA-PD Contracts

1. There are separate Part C and Part D improvement measures (C33 & D09) for MA-PD contracts. C33 is used in calculating the Part C summary rating, and D09 is used in calculating the Part D summary rating for an MA-PD contract. Both measures will be used when calculating the overall rating in step 3.
2. Calculate the overall rating for MA-PD contracts without including the improvement measures.
3. Calculate the overall rating for MA-PD contracts using both improvement measures.
4. If a MA-PD contract in step 2 has 4 or more stars, compare the two overall ratings calculated in steps 2 & 3. If the rating in step 3 is less than the value in step 2, use the overall rating from step 2. For all other contracts, use the overall rating from step 3.

MA-only Contracts

1. Only the Part C improvement measure (C33) is used for MA-only contracts.
2. Calculate the Part C summary rating for MA-only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-only contracts using the Part C improvement measure.
4. If a MA-only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2. For all other contracts, use the Part C summary rating from step 3.

PDP Contracts

1. Only the Part D improvement measure (D09) is used for PDP contracts.
2. Calculate the Part D summary rating for PDP contracts without including the improvement measure.
3. Calculate the Part D summary rating for PDP contracts using the Part D improvement measure.
4. If a PDP contract in step 2 has 4 or more stars, compare the two Part D summary ratings. If the rating in step 3 is less than the value in step 2, use the Part D summary rating from step 2. For all other contracts, use the Part D summary rating from step 3.

Applying the Integration Factor

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

- Calculate the mean and the variance of all of the individual quality and performance measure stars at the contract level.
  - The mean is the summary or overall rating before the i-Factor is applied, which is calculated as described in the section titled “Weighting of Measures”.
  - Using weights in the variance calculation accounts for the relative importance of measures in the i-Factor calculation. To incorporate the weights shown in Attachment G into the variance calculation of the available individual performance measures for a given contract, the steps are as follows:
    - Subtract the summary or overall star from each performance measure’s star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
    - Sum these results; call this ‘SUMWX.’
    - Set n equal to the number of individual performance measures available for the given contract.
    - Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.

- The weighted variance for the given contract is calculated as: n*SUMWX/(W*(n-1)) (for the complete formula, please see Attachment H: Calculation of Weighted Star Rating and Variance Estimates).

- Categorize the variance into three categories:
  - low (0 to < 30th percentile),
  - medium (≥ 30th to < 70th percentile) and
  - high (≥ 70th percentile)
- Develop the i-Factor as follows:
  - i-Factor = 0.4 (for contract w/ low variability & high mean (mean ≥ 85th percentile))
  - i-Factor = 0.3 (for contract w/ medium variability & high mean (mean ≥ 85th percentile))
  - i-Factor = 0.2 (for contract w/ low variability & relatively high mean (mean ≥ 65th & < 85th percentile))
  - i-Factor = 0.1 (for contract w/ medium variability & relatively high mean (mean ≥ 65th & < 85th percentile))
  - i-Factor = 0.0 (for all other contracts)
- Develop final summary score or overall scores using 0.5 as the star scale (create 10 possible overall scores as: 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0).
- Apply rounding to final summary or overall scores such that stars that are within the distance of 0.25 above or below any half-star scale will be rounded to that half-star scale.
- Tables 5 and 6 show the final threshold values used in i-Factor calculations for the 2013 Plan Ratings:

Table 5: Performance Summary Thresholds

Percentile	Part C Rating	Part D Rating	Overall Rating
65th	3.60	3.65	3.47
85th	4.01	4.11	3.89

Table 6: Variance Thresholds

Percentile	Part C Rating	Part D Rating	Overall Rating
30th	1.10	1.23	1.16
70th	1.45	1.96	1.54

Rounding Rules for Measure Scores:

Measure scores are rounded to the nearest whole number. Using standard rounding rules, raw measure scores that end in 0.49 or less are rounded down and raw measure scores that end in 0.50 or more are rounded up. So, for example, a measure score of 83.49 rounds down to 83 while a measure score of 83.50 rounds up to 84.

Rounding Rules for Summary and Overall Scores:

Summary and overall scores are rounded to the nearest half star (i.e., 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0). Table 7 shows how scores are rounded.

Table 7: Rounding Rules for Summary and Overall Scores

Raw Summary / Overall Score	Final Summary / Overall Score
≥ 0 and < 0.25	0
≥ 0.25 and < 0.75	0.5
≥ 0.75 and < 1.25	1.0
≥ 1.25 and < 1.75	1.5
≥ 1.75 and < 2.25	2.0
≥ 2.25 and < 2.75	2.5
≥ 2.75 and < 3.25	3.0

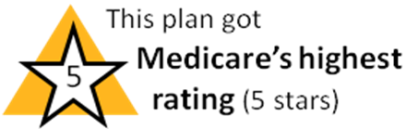
Raw Summary / Overall Score	Final Summary / Overall Score
≥ 3.25 and < 3.75	3.5
≥ 3.75 and < 4.25	4.0
≥ 4.25 and < 4.75	4.5
≥ 4.75	5.0

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

Methodology for Calculating the High Performing Icon

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

Figure 1: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C or D measures. The low performing icon is calculated by evaluating the Part C rating for the current year and the past two years (i.e., the 2011, 2012 and 2013 Plan Ratings). If the contract had a Part C rating of 2.5 or lower for all three years of data, it is marked with a low performing icon. A contract must have a Part C rating for all three years to be considered for this icon.

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

Figure 2: The Low Performing Icon

Adjustments for Contracts Under Sanctions

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

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

Special Needs Plan (SNP) Data

CMS has included three SNP-specific measures in the 2013 Plan Ratings. All three measures are based on data from the HEDIS Care for Older Adults measure. Since these data are reported at the plan benefit package (PBP) level and the Plan Ratings are reported by contract, CMS has combined the reported rates for all PBPs within a contract using the NCQA-developed methodology described in Attachment E.

CAHPS Methodology

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

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

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

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

4 base stars: Always stays 4 Final Stars.

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

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

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

Plan Ratings and Marketing

Plan sponsors must ensure the Plan Ratings document and all marketing of Plan Ratings information is compliant with CMS' Medicare Marketing Guidelines. Failure to follow CMS' guidance may result in compliance action~~s~~ against the contract. The Medicare Marketing Guidelines were issued as Chapters 2 and 3 of the Prescription Drug Benefit Manual and the Medicare Managed Care Manual, respectively. Please direct questions about marketing Plan Ratings information to your Account Manager.

Contact Information

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

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

If you have questions or require information about the specific subject areas associated with the Plan Ratings please write to those contacts directly and cc the relevant C and/or D Metric mailboxes.

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

Part C Domain and Measure Details

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

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

Measure: C01 - Breast Cancer Screening

Label for Stars: Breast Cancer Screening

Label for Data: Breast Cancer Screening

HEDIS Label: Breast Cancer Screening (BCS)

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 79

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

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

Exclusions: (optional) Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies. Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 80, Table BCS-B for codes to identify exclusions.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0031

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 74%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 43%	≥ 43% to < 64%	≥ 64% to < 74%	≥ 74% to < 83%	≥ 83%

Measure: C02 - Colorectal Cancer Screening

Label for Stars: Colorectal Cancer Screening

Label for Data: Colorectal Cancer Screening

HEDIS Label: Colorectal Cancer Screening (COL)

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 84

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

Metric: The percentage of MA enrollees aged 50 to 75 (denominator) who had one or more

appropriate screenings for colorectal cancer (numerator).

Exclusions: (optional) Members with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the member's history. Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 85, Table COL-B for codes to identify exclusions.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0034

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 58%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 35%	≥ 35% to < 51%	≥ 51% to < 58%	≥ 58% to < 67%	≥ 67%

Measure: C03 - Cardiovascular Care – Cholesterol Screening

Label for Stars: Cholesterol Screening for Patients with Heart Disease

Label for Data: Cholesterol Screening for Patients with Heart Disease

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 132

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

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

Exclusions: None listed.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0075

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 66%	≥ 66% to < 80%	≥ 80% to < 85%	≥ 85% to < 89%	≥ 89%

Measure: C04 - Diabetes Care – Cholesterol Screening

Label for Stars: Cholesterol Screening for Patients with Diabetes

Label for Data: Cholesterol Screening for Patients with Diabetes

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 146

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

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

Exclusions: (optional)

• Members with a diagnosis of polycystic ovaries (Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 156, Table CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 148, Table CDC-B) during the measurement year or the year before the measurement year. Diagnosis may occur at any time in the member’s history, but must have occurred by December 31 of the measurement year.

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

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 1780

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 69%	≥ 69% to < 81%	≥ 81% to < 85%	≥ 85% to < 90%	≥ 90%

Measure: C05 - Glaucoma Testing

Label for Stars: Glaucoma Testing

Label for Data: Glaucoma Testing

HEDIS Label: Glaucoma Screening in Older Adults (GSO)

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 92

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

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

Exclusions: (optional) Members who had a prior diagnosis of glaucoma or glaucoma suspect. Look for evidence of glaucoma as far back as possible in the member's history through December 31 of the measurement year. Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 93, Table GSO-B for codes to identify exclusions.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 70%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 54%	≥ 54% to < 62%	≥ 62% to < 70%	≥ 70% to < 74%	≥ 74%

Measure: C06 - Annual Flu Vaccine

Label for Stars: Annual Flu Vaccine

Label for Data: Annual Flu Vaccine

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

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

General Notes: This measure is not case mix adjusted.

CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

• Have you had a flu shot since September 1, 2011?

CMS Framework Area: Clinical care

NQF #: 0040

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 71%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 60%	≥ 60% to < 65%	≥ 65% to < 71%	≥ 71% to < 75%	≥ 75%

Measure: C07 - Improving or Maintaining Physical Health

Label for Stars: Improving or Maintaining Physical Health

Label for Data: Improving or Maintaining Physical Health

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

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

Exclusions: Contracts with less than 30 responses are suppressed.

Data Source: HOS

Data Source Description: 2009-2011 Cohort 12 Performance Measurement Results (2009 Baseline data collection, 2011 Follow-up data collection)

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 04/18/2011 - 07/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 57%	≥ 57% to < 59%	≥ 59% to < 60%	≥ 60% to < 66%	≥ 66%

Measure: C08 - Improving or Maintaining Mental Health

Label for Stars: Improving or Maintaining Mental Health

Label for Data: Improving or Maintaining Mental Health

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

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

Exclusions: Contracts with less than 30 responses are suppressed.

Data Source: HOS

Data Source Description: 2009-2011 Cohort 12 Performance Measurement Results (2009 Baseline data collection, 2011 Follow-up data collection)

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 04/18/2011 - 07/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 73%	≥ 73% to < 79%	≥ 79% to < 85%	≥ 85% to < 86%	≥ 86%

Measure: C09 - Monitoring Physical Activity

Label for Stars: Monitoring Physical Activity

Label for Data: Monitoring Physical Activity

HEDIS Label: Physical Activity in Older Adults (PAO)

Measure Reference: NCQA HEDIS 2012 Specifications for The Medicare Health Outcomes Survey Volume 6, page 33

Description: Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.

Metric: The percentage of sampled Medicare members 65 years of age or older (denominator) who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity (numerator).

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

Data Source: HEDIS / HOS

Data Source Description: Cohort 12 Follow-up Data collection (2011) and Cohort 14 Baseline data collection (2011).

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

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: 0029

Data Time Frame: 04/18/2011 - 07/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 44%	≥ 44% to < 52%	≥ 52% to < 60%	≥ 60% to < 62%	≥ 62%

Measure: C10 - Adult BMI Assessment

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

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

HEDIS Label: Adult BMI Assessment (ABA)

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 56

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

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

Exclusions: (optional) Members who have a diagnosis of pregnancy (Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 57, Table ABA-C) during the measurement year or the year prior to the measurement year.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 1690

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 25%	≥ 25% to < 50%	≥ 50% to < 61%	≥ 61% to < 80%	≥ 80%

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C11 - Care for Older Adults – Medication Review

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

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

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 94

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

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

Exclusions: None listed.

General Notes: The formula used to calculate this measure can be found in Attachement E.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0553

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	No	Yes	No	No	No

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 44%	≥ 44% to < 63%	≥ 63% to < 81%	≥ 81% to < 92%	≥ 92%

Measure: C12 - Care for Older Adults – Functional Status Assessment

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

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

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 94

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

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

Exclusions: None listed.

General Notes: The formula used to calculate this measure can be found in Attachement E.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	No	Yes	No	No	No

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 29%	≥ 29% to < 54%	≥ 54% to < 75%	≥ 75% to < 89%	≥ 89%

Measure: C13 - Care for Older Adults – Pain Screening

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

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

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 94

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

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and

older (denominator) who received at least one pain screening or pain management plan during the measurement year (numerator).

Exclusions: None listed.

General Notes: The formula used to calculate this measure can be found in Attachement E.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	No	Yes	No	No	No

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 27%	≥ 27% to < 41%	≥ 41% to < 56%	≥ 56% to < 78%	≥ 78%

Measure: C14 - Osteoporosis Management in Women who had a Fracture

Label for Stars: Osteoporosis Management

Label for Data: Osteoporosis Management

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 168

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

Metric: The percentage of female MA enrollees 67 and older who suffered a fracture during the measurement year (denominator), and who subsequently had either a bone mineral density test or were prescribed a drug to treat or prevent osteoporosis in the six months after the fracture (numerator).

Exclusions: None listed.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0053

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 24%	≥ 24% to < 38%	≥ 38% to < 60%	≥ 60% to < 67%	≥ 67%

Measure: C15 - Diabetes Care – Eye Exam

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

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

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 146

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

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

Exclusions: None listed.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0055

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 64%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 47%	≥ 47% to < 54%	≥ 54% to < 64%	≥ 64% to < 81%	≥ 81%

Measure: C16 - Diabetes Care – Kidney Disease Monitoring

Label for Stars: Kidney Function Testing for Members with Diabetes

Label for Data: Kidney Function Testing for Members with Diabetes

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 146

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

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

Exclusions: None listed.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0062

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 78%	≥ 78% to < 82%	≥ 82% to < 85%	≥ 85% to < 90%	≥ 90%

Measure: C17 - Diabetes Care – Blood Sugar Controlled

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

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

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 146

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

Metric: The percentage of diabetic MA enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, 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.

Exclusions: None listed.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0059

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 80%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 41%	≥ 41% to < 68%	≥ 68% to < 80%	≥ 80% to < 88%	≥ 88%

Measure: C18 - Diabetes Care – Cholesterol Controlled

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

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

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 146

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

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

Exclusions: None listed.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0064

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 53%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 34%	≥ 34% to < 48%	≥ 48% to < 53%	≥ 53% to < 60%	≥ 60%

Measure: C19 - Controlling Blood Pressure

Label for Stars: Controlling Blood Pressure

Label for Data: Controlling Blood Pressure

HEDIS Label: Controlling High Blood Pressure (CBP)

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 136

Description: Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.

Metric: The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) during the measurement year (numerator).

Exclusions: (optional)
• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 139, Table CBP-C) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

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

• Exclude from the eligible population all members who had an admission to a nonacute inpatient setting during the measurement year. Refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 187 Table FUH-B for codes to identify nonacute care.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0018

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 63%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 43%	≥ 43% to < 53%	≥ 53% to < 63%	≥ 63% to < 70%	≥ 70%

Measure: C20 - Rheumatoid Arthritis Management

Label for Stars: Rheumatoid Arthritis Management

Label for Data: Rheumatoid Arthritis Management

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 166

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

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

Exclusions: (optional)
• Members diagnosed with HIV (refer to NCQA HEDIS 2012 Technical Specifications Volume 2, page 167, Table ART-D). Look for evidence of HIV diagnosis as far back as possible in the member's history through December 31 of the measurement year.
• Members who have a diagnosis of pregnancy (Table ART-D) during the measurement year.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0054

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 78%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 49%	≥ 49% to < 66%	≥ 66% to < 78%	≥ 78% to < 86%	≥ 86%

Measure: C21 - Improving Bladder Control

Label for Stars: Improving Bladder Control

Label for Data: Improving Bladder Control

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

Measure Reference: NCQA HEDIS 2012 Specifications for The Medicare Health Outcomes Survey Volume 6, page 31

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

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

Exclusions: None listed.

Data Source: HEDIS / HOS

Data Source Description: Cohort 12 Follow-up Data collection (2011) and Cohort 14 Baseline data collection (2011).

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

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

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

CMS Framework Area: Clinical care

NQF #: 0030

Data Time Frame: 04/18/2011 - 07/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 31%	≥ 31% to < 36%	≥ 36% to < 60%	≥ 60% to < 71%	≥ 71%

Measure: C22 - Reducing the Risk of Falling

Label for Stars: Reducing the Risk of Falling

Label for Data: Reducing the Risk of Falling

HEDIS Label: Fall Risk Management (FRM)

Measure Reference: NCQA HEDIS 2012 Specifications for The Medicare Health Outcomes Survey Volume 6, page 35

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

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

Exclusions: None listed.

Data Source: HEDIS / HOS

Data Source Description: Cohort 12 Follow-up Data collection (2011) and Cohort 14 Baseline data collection (2011).

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

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

HOS Survey Question 51: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
• Suggest that you use a cane or walker

• Check your blood pressure lying or standing
• Suggest that you do an exercise or physical therapy program
• Suggest a vision or hearing testing

CMS Framework Area: Clinical care

NQF #: 0035

Data Time Frame: 04/18/2011 - 07/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 59%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 49%	≥ 49% to < 53%	≥ 53% to < 59%	≥ 59% to < 67%	≥ 67%

Measure: C23 - Plan All-Cause Readmissions

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

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

HEDIS Label: Plan All-Cause Readmissions (PCR)

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 317

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

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

For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. To calculate the observed rate and expected rate for contract A for members 65 years and older, the following formulas were used:

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

2. The expected readmission rate for contract A equals the sum of the average

adjusted probabilities across the three age bands (65-74, 75-84 and 85+), weighted by the percentage of index stays in each age band.

See Attachment F: Calculating Measure C23: Plan All-Cause Readmissions for the complete formula, example calculation and National Average Observation value used to complete this measure.

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

General Notes: In HEDIS 2012, five 1876 Cost contracts voluntarily reported data in this measure even though they were not required to do so. CMS has rated these five contracts based on their submitted data. We did not use the cost contracts data when calculating the NatAvgObs or when determining the cut points for this measure. This measure is not used in the final Part C summary or overall ratings for 1876 Cost contracts.

Data Source: HEDIS

CMS Framework Area: Care coordination

NQF #: 1768

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
> 17%	> 13% to ≤ 17%	> 11% to ≤ 13%	> 3% to ≤ 11%	≤ 3%

Domain: 3 - Member Experience with Health Plan

Measure: C24 - Getting Needed Care

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

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

Description: Percent of the best possible score the plan 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.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

• In the last 6 months, how often was it easy to get appointments with specialists?

• In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: 0006

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 81%	≥ 81% to < 84%	≥ 84% to < 85%	≥ 85% to < 88%	≥ 88%

Measure: C25 - Getting Appointments and Care Quickly

Label for Stars: Getting Appointments and Care Quickly

Label for Data: Getting Appointments and Care Quickly

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

Metric: This case-mix adjusted composite measure is used to assess how quickly the member was able to 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.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

• In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

• In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: 0006

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 75%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 72%	≥ 72% to < 74%	≥ 74% to < 75%	≥ 75% to < 79%	≥ 79%

Measure: C26 - Customer Service

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

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

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

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: 0006

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 88%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 85%	≥ 85% to ≤ 86%	> 86% to < 88%	≥ 88% to < 91%	≥ 91%

Measure: C27 - Overall Rating of Health Care Quality

Label for Stars: Overall Rating of Health Care Quality

Label for Data: Overall Rating of Health Care Quality

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

Metric: This case-mix adjusted measure is used to assess the 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.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question numbers vary depending on survey type):

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: 0006

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

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

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

Measure: C28 - Overall Rating of Plan

Label for Stars: Members' Overall Rating of Health Plan

Label for Data: Members' Overall Rating of Health Plan

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

Data Source Description: CAHPS Survey Question (question numbers vary depending on survey type):

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: 0006

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 83%	≥ 83% to < 84%	≥ 84% to < 85%	≥ 85% to < 89%	≥ 89%

Measure: C29 - Care Coordination

Label for Stars: Coordination of Members' Health Care Services

Label for Data: Coordination of Members' Health Care Services

Description: Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they need 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. Some of the questions for the Medicare Advantage CAHPS survey are new and all of the questions were drawn from existing CAHPS surveys.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

- Whether doctor had medical records and other information about the enrollee's care,
- Whether there was follow up with the patient to provide test results,
- How quickly the enrollee got the test results,
- Whether the doctor spoke to the enrollee about prescription medicines,
- Whether the enrollee received help managing care, and
- Whether the personal doctor is informed and up-to-date about specialist care.

CMS Framework Area: Care coordination

NQF #: None

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Not Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 82%	≥ 82% to < 84%	≥ 84% to < 86%	≥ 86% to < 87%	≥ 87%

Domain: 4 - Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance

Measure: C30 - Complaints about the Health Plan

Label for Stars: Complaints about the Health Plan (**more stars** are better because it means fewer complaints)

Label for Data: Complaints about the Health Plan (number of complaints for every 1,000 members) (**lower numbers** are better because it means fewer complaints)

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

Metric: Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as:
((Total number of all complaints logged into the Complaint Tracking Module (CTM) / (Average Contract enrollment) * 1,000 * 30) / (Number of Days in Period).
• Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data.
• Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.

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

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

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

Data Source: CTM

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 01/01/2012 - 06/30/2012

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Rate with 2 decimal points

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
> 0.57	> 0.38 to ≤ 0.57	> 0.19 to ≤ 0.38	> 0.12 to ≤ 0.19	≤ 0.12

Measure: C31 - Beneficiary Access and Performance Problems

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

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

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

Metric: This measure is based on CMS' performance audits of health and drug plans (contracts), sanctions, civil monetary penalties (CMP) as well as Compliance Activity Module (CAM) data (this includes: notices of non compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity). While CMS utilized a risk-based strategy to identify contracts for performance audits in 2011, compliance or other actions may be taken against contracts as a result of other issues or concerns being identified.

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

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

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

Where: NC = Number of Notices of Non Compliance

woBP = Number of Warning Letters without Business Plan

wBP = Number of Warning Letters with Business Plan

NAHC = Number of Ad-Hoc CAPs

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

3 – ad-hoc CAP with beneficiary access impact

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

1 – ad-hoc CAP no beneficiary impact

Data Source: CMS Administrative Data

Data Source Description: Findings of CMS audits, ad hoc and compliance actions that occurred during the 12 month past performance review period between January 1, 2011 and December 31, 2011. For compliance actions, the date the action was issued is used when pulling the data from HPMS.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

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

Measure: C32 - Members Choosing to Leave the Plan

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

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

Description: The percent of plan members who chose to leave the plan in 2011. (This does not include members who did not **choose** to leave the plan, such as members who moved out of the service area.)

Metric: The percent of members who chose to leave the plan come from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the plan between January 1, 2011–December 31, 2011 divided by all members enrolled in the plan at any time during 2011.

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

General Notes: This measure includes members who disenrolled from the contract with the following disenrollment reason codes:
11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).

Data Source: Medicare Beneficiary Database Suite of Systems

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
> 17%	> 14% to ≤ 17%	> 10% to ≤ 14%	> 7% to ≤ 10%	≤ 7%

Measure: C33 - Health Plan Quality Improvement

Label for Stars: Improvement (if any) in the Health Plan's Performance

Label for Data: Improvement (if any) in the Health Plan's Performance

Description: This shows how much the health plan's performance has improved or declined from one year to the next year.
To calculate the plan's improvement rating, Medicare compares the plan's previous scores to its current scores for all of the topics shown on this website. Then Medicare averages the results to give the plan its improvement rating.
If a plan receives **1 or 2 stars**, it means, on average, the plan's **scores have declined** (gotten worse).
If a plan receives **3 stars**, it means, on average, the plan's scores have **stayed about the same**.
If a plan receives **4 or 5 stars**, it means, on average, the plan's **scores have improved**.
Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.

Metric: The numerator is the net improvement which is a sum of the number of significantly improved measures minus the number of significantly declined measures.
The denominator is the number of measures eligible for the improvement measure (i.e, the measures that were included in the 2012 and 2013 Plan Ratings for this contract and had no specification changes).

Exclusions: Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.

General Notes: Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measues were used.

Data Source: Plan Ratings

Data Source Description: 2012 and 2013 Plan Ratings

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Outcome Measure

Weighting Value: 1

Data Display: Not Applicable

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< -0.063	≥ -0.063 to < 0.117	≥ 0.117 to < 0.197	≥ 0.197 to < 0.366	≥ 0.366

Domain: 5 - Health Plan Customer Service

Measure: C34 - Plan Makes Timely Decisions about Appeals

Label for Stars: Health Plan Makes Timely Decisions about Appeals

Label for Data: Health Plan Makes Timely Decisions about Appeals

Description: Percent of plan members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.

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

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

If the denominator is ≤ 10, the result is —"Not enough data available".

Exclusions: Withdrawn appeals are excluded from this measure.

General Notes: This measure includes all Standard Coverage, Standard Claim, and Expedited appeals (including Dismissals) received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.

Data Source: IRE

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 52%	≥ 52% to < 71%	≥ 71% to < 85%	≥ 85% to < 94%	≥ 94%

Measure: C35 - Reviewing Appeals Decisions

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

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

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

Metric: Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: ([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available".

Exclusions: 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 Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year they were received by the IRE not the date a decision was reached. If a Reopening occurs and is decided prior to April 1, 2012, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after April 1, 2012 will not be reflected in this data. Appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	Yes	No	Yes

4-Star Threshold: ≥ 87%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 66%	≥ 66% to < 80%	≥ 80% to < 87%	≥ 87% to < 91%	≥ 91%

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

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

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

Description: Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.

Metric: The calculation of this measure is the number of successful contacts with the interpreter or TTY/TDD divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with a translator and either starting or completing survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-English language about the plan sponsor's Medicare benefits. Successful contact with a TTY/TDD service is defined as establishing contact with a TTY/TDD operator who can answer questions about the plan's Medicare Part C or D benefit.

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.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/30/2012 - 05/18/2012 (Monday - Friday)

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	Yes	Yes	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 39%	≥ 39% to < 63%	≥ 63% to < 85%	≥ 85% to < 91%	≥ 91%

Measure: C37 - Enrollment Timeliness

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

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

Description: The percentage of plan generated enrollment requests submitted to the Medicare Program within 7 calendar days of the application date.

Metric: Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date
Denominator = The total number of plan generated enrollment transactions submitted to CMS
Calculation = [(The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date) / (The total number of plan

generated enrollment transactions submitted to CMS)] * 100

Exclusions: 1. Contracts with 25 or fewer enrollment submissions during the measurement period, when summed. 2. Election Types: ICEP, IEP and IEP2. 3. Employer/Union enrollments. 4. 1876 Cost contract MA-only members. 5. Special Needs Plans. 6. Transaction Reply Codes 1 (TRC1) equal to any of the below: TRC's: ('001', '002', '003', '004', '006', '007', '008', '009', '019', '020', '032', '033', '034', '035', '036', '037', '038', '039', '042', '044', '045', '048', '056', '060', '062', '102', '103', '104', '105', '106', '107', '108', '109', '110', '114', '116', '122', '123', '124', '126', '127', '128', '129', '130', '133', '139', '156', '157', '162', '166', '169', '176', '184', '196', '200', '201', '202', '203', '211', '220', '257', '258', '263', '600', '601', '602', '603', '605', '611') TRCs are defined in the Plan Communication Users Guide Appendix Table I-2.

Data Source: Medicare Advantage and Prescription Drug System (MARx)

Data Source Description: The data timeframe is the monthly enrollment files for January - June, 2012, which represents submission dates of 01/01/2012 - 06/30/2012.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2012 - 06/30/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 82%	≥ 82% to < 88%	≥ 88% to < 91%	≥ 91% to < 94%	≥ 94%

Part D Domain and Measure Details

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

Domain: 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Pharmacy Hold Time

Label for Stars: Time on Hold When Pharmacist Calls Plan

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

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

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

Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.

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

Data Source: Call Center

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 02/06/2012 - 05/18/2012 (Monday - Friday)

General Trend: Lower is better

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

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Time

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	NA	> 2:15 to ≤ 2:37	> 0:15 to ≤ 2:15	> 0:11 to ≤ 0:15	≤ 0:11
PDP	NA	NA	> 0:28 to ≤ 2:15	> 0:12 to ≤ 0:28	≤ 0:12

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

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

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

Description: Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.

Metric: The calculation of this measure is the number of successful contacts with the

interpreter or TTY/TDD divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with a translator and either starting or completing survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-English language about the plan sponsor's Medicare benefits. Successful contact with a TTY/TDD service is defined as establishing contact with a TTY/TDD operator who can answer questions about the plan's Medicare Part C or D benefit.

Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.

Data Source: Call Center

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/30/2012 - 05/18/2012 (Monday - Friday)

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
No	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 10% to < 80%	≥ 80% to < 85%	≥ 85% to < 87%	≥ 87% to < 89%	≥ 89%
PDP	≥ 10% to < 70%	≥ 70% to < 81%	≥ 81% to < 86%	≥ 86% to < 88%	≥ 88%

Measure: D03 - Appeals Auto–Forward

Label for Stars: Drug Plan Makes Timely Decisions about Appeals

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

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

Metric: This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000. There is no minimum number of cases required to receive a rating.

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

Data Source: IRE

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with 1 decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	> 5.3 to ≤ 39.3	> 2.2 to ≤ 5.3	> 1.3 to ≤ 2.2	> 0.3 to ≤ 1.3	≤ 0.3
PDP	> 6.4 to ≤ 49.7	> 1.3 to ≤ 6.4	> 1.0 to ≤ 1.3	> 0.3 to ≤ 1.0	≤ 0.3

Measure: D04 - Appeals Upheld

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

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

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

Metric: This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100. Total number of cases reviewed is defined all cases received by the IRE during the timeframe and receiving a decision within 20 days after the last day of the timeframe. The denominator is equal to the number of cases upheld, fully reversed, and partially reversed. Dismissed, remanded and withdrawn cases are not included in the denominator. Auto-forward cases are included, as these are considered to be adverse decisions per Subpart M rules. Contracts with no IRE cases reviewed will not receive a score in this measure.

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

Data Source: IRE

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2012 - 6/30/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 17% to < 48%	≥ 48% to < 57%	≥ 57% to < 72%	≥ 72% to < 88%	≥ 88%
PDP	≥ 20% to < 46%	≥ 46% to < 63%	≥ 63% to < 68%	≥ 68% to < 74%	≥ 74%

Measure: D05 - Enrollment Timeliness

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

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

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

Metric: Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date
Denominator = The total number of plan generated enrollment transactions submitted to CMS
Calculation = [(The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date) / (The total number of plan generated enrollment transactions submitted to CMS)] * 100

Exclusions: 1. Contracts with 25 or fewer enrollment submissions during the measurement period, when summed. 2. Election Types: ICEP, IEP and IEP2. 3. Employer/Union enrollments. 4. 1876 Cost contract MA-only members. 5. Special Needs Plans. 6. Transaction Reply Codes 1 (TRC1) equal to any of the below: TRC's: ('001', '002', '003', '004', '006', '007', '008', '009', '019', '020', '032', '033', '034', '035', '036', '037', '038', '039', '042', '044', '045', '048', '056', '060', '062', '102', '103', '104', '105', '106', '107', '108', '109', '110', '114', '116', '122', '123', '124', '126', '127', '128', '129', '130', '133', '139', '156', '157', '162', '166', '169', '176', '184', '196', '200', '201', '202', '203', '211', '220', '257', '258', '263', '600', '601', '602', '603', '605', '611') TRCs are defined in the Plan Communication Users Guide Appendix Table I-2.

Data Source: Medicare Advantage and Prescription Drug System (MARx)

Data Source Description: The data timeframe is the monthly enrollment files for January - June, 2012, which represents submission dates of 01/01/2012 - 06/30/2012.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2012 - 06/30/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 7% to < 82%	≥ 82% to < 88%	≥ 88% to < 91%	≥ 91% to < 94%	≥ 94%
PDP	≥ 35% to < 85%	≥ 85% to < 90%	≥ 90% to < 92%	≥ 92% to < 94%	≥ 94%

Domain: 2 - Member Complaints, Problems Getting Services, and Improvement in the Drug Plan's Performance

Measure: D06 - Complaints about the Drug Plan

Label for Stars: Complaints about the Drug Plan (**more** stars are better because it means fewer complaints)

Label for Data: Complaints about the Drug Plan (for every 1,000 members) (**lower numbers** are better because it means fewer complaints)

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

Metric: Rate of complaints about the drug plan per 1,000 members. For each contract, this rate is calculated as:
((Total number of all complaints logged into the Complaint Tracking Module (CTM) / (Average Contract enrollment) * 1,000 * 30) / (Number of Days in Period).
• Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data.
• Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.

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

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

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

Data Source: CTM

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 01/01/2012 - 06/30/2012

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Rate with 2 decimal points

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	> 0.57 to ≤ 4.11	> 0.38 to ≤ 0.57	> 0.19 to ≤ 0.38	> 0.12 to ≤ 0.19	≤ 0.12
PDP	> 0.44 to ≤ 2.12	> 0.30 to ≤ 0.44	> 0.22 to ≤ 0.30	> 0.14 to ≤ 0.22	≤ 0.14

Measure: D07 - Beneficiary Access and Performance Problems

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

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

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

Metric: This measure is based on CMS' performance audits of health and drug plans (contracts), sanctions, civil monetary penalties (CMP) as well as Compliance Activity Module (CAM) data (this includes: notices of non compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity). While CMS utilized a risk-based strategy to identify contracts for performance audits in 2011, compliance or other actions may be taken against contracts as a result of other issues or concerns being identified.

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

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

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

Where: NC = Number of Notices of Non Compliance

woBP = Number of Warning Letters without Business Plan

wBP = Number of Warning Letters with Business Plan

NAHC = Number of Ad-Hoc CAPs

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

3 – ad-hoc CAP with beneficiary access impact

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

1 – ad-hoc CAP no beneficiary impact

Data Source: CMS Administrative Data

Data Source Description: Findings of CMS audits, ad hoc and compliance actions that occurred during the 12 month past performance review period between January 1, 2011 and December 31, 2011. For compliance actions, the date the action was issued is used when pulling the data from HPMS.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 0 to ≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80
PDP	≥ 0 to ≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80

Measure: D08 - Members Choosing to Leave the Plan

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

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

Description: The percent of plan members who chose to leave the plan in 2011. (This does not include members who did not **choose** to leave the plan, such as members who moved out of the service area.)

Metric: The percent of members who chose to leave the plan come from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the plan between January 1, 2011–December 31, 2011 divided by all members enrolled in the plan at any time during 2011.

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

General Notes: This measure includes members who disenrolled from the contract with the following disenrollment reason codes:
11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).

Data Source: Medicare Beneficiary Database Suite of Systems

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	> 17% to ≤ 62%	> 14% to ≤ 17%	> 10% to ≤ 14%	> 7% to ≤ 10%	≤ 7%
PDP	> 19% to ≤ 54%	> 14% to ≤ 19%	> 10% to ≤ 14%	> 8% to ≤ 10%	≤ 8%

Measure: D09 - Drug Plan Quality Improvement

Label for Stars: Improvement (if any) in the Drug Plan's Performance

Label for Data: Improvement (If any) in the Drug Plan's Performance

Description: This shows how much the drug plan's performance has improved or declined from one year to the next year.
To calculate the plan's improvement rating, Medicare compares the plan's previous scores to its current scores for all of the topics shown on this website. Then Medicare averages the results to give the plan its improvement rating.
If a plan receives **1 or 2 stars**, it means, on average, the plan's **scores have declined** (gotten worse).
If a plan receives **3 stars**, it means, on average, the plan's scores have **stayed about the same**.
If a plan receives **4 or 5 stars**, it means, on average, the plan's **scores have improved**.
Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.

Metric: The numerator is the net improvement which is a sum of the number of significantly improved measures minus the number of significantly declined measures.
The denominator is the number of measures eligible for the improvement measure (i.e, the measures that were included in the 2012 and 2013 Plan Ratings for this contract and had no specification changes).

Exclusions: Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.

General Notes: Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measues were used.

Data Source: Plan Ratings

Data Source Description: 2012 and 2013 Plan Ratings

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Outcome Measure

Weighting Value: 1

Data Display: Not Applicable

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ -0.571 to < -0.133	≥ -0.091 to < 0.100	≥ 0.125 to < 0.400	≥ 0.417 to < 0.571	≥ 0.600 to 0.933
PDP	≥ -0.571 to < -0.133	≥ -0.091 to < 0.100	≥ 0.125 to < 0.400	≥ 0.417 to < 0.571	≥ 0.600 to 0.933

Domain: 3 - Member Experience with the Drug Plan

Measure: D10 - Getting Information From Drug Plan

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

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

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

Metric: This case-mix adjusted measure is used to assess member satisfaction related to getting help from the drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

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

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

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 78%	≥ 78% to < 80%	≥ 80% to < 82%	≥ 82% to < 86%	≥ 86%
PDP	< 76%	≥ 76% to < 78%	≥ 78% to < 80%	≥ 80% to < 82%	≥ 82%

Measure: D11 - Rating of Drug Plan

Label for Stars: Members' Overall Rating of Drug Coverage

Label for Data: Members' Overall Rating of Drug Coverage

Description: The percent of the best possible score the plan earned from members who rated the plan's coverage of prescription drugs.

Metric: This case-mix adjusted measure is used to assess member satisfaction related to the beneficiary's overall rating of the plan. The CAHPS score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 82%	≥ 82% to < 83%	≥ 83% to < 84%	≥ 84% to < 87%	≥ 87%
PDP	< 80%	≥ 80% to < 81%	NA	≥ 81% to < 86%	≥ 86%

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

Measure: D12 - Getting Needed Prescription Drugs

Label for Stars: Ease of Getting Prescriptions Filled When Using the Plan

Label for Data: Ease of Getting Prescriptions Filled When Using the Plan

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

Metric: This case-mix adjusted measure is used to assess member satisfaction related to the ease with which a beneficiary gets the medicines their doctor prescribed. The CAHPS score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2012. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

• In the last 6 months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?

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

CMS Framework Area: Person- and caregiver- centered experience and outcomes

NQF #: None

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 89%	≥ 89% to < 90%	≥ 90% to < 91%	≥ 91% to < 93%	≥ 93%
PDP	< 88%	≥ 88% to < 89%	NA	≥ 89% to < 92%	≥ 92%

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

Domain: 4 - Patient Safety and Accuracy of Drug Pricing

Measure: D13 - MPF Price Accuracy

Label for Stars: Plan Provides Accurate Drug Pricing Information for This Website

Label for Data: Plan Provides Accurate Drug Pricing Information for This Website (**higher** scores are better because they mean more accurate prices)

Description: A score comparing the prices members actually pay for their drugs to the drug prices the plan provided for this Web site (Medicare's Plan Finder Website). (**Higher** scores are better because they mean the plan provided more accurate prices.)

Metric: This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index.

The accuracy price index compares point-of-sale PDE prices to plan-reported MPF prices and determines the magnitude of differences found. Using each PDE's date of service, the price displayed on MPF is compared to the PDE price.

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

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

The best possible accuracy index is 1. An index of 1 indicates that a plan did not have PDE prices greater than MPF prices.

A contract's score is computed using its accuracy index as:
100 – ((accuracy index - 1) x 100).

Exclusions: A contract must have at least 30 claims over the year for the price accuracy index. PDEs must also meet the following criteria:

- Pharmacy number on PDE must appear in MPF pharmacy cost file
- Drug must appear in formulary file and in MPF pricing file
- PDE must be for retail and/or specialty pharmacy
- PDE must be a 30 day supply
- Date of service must occur at a time that data are not suppressed for the plan on MPF
- PDE must not be a compound claim
- PDE must not be a non-covered drug

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

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

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

CMS Framework Area: Efficiency and cost reduction

NQF #: None

Data Time Frame: 01/01/2011 - 09/30/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Rate with no decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	NA	NA	≥ 85 to < 98	≥ 98 to < 100	≥ 100
PDP	NA	NA	≥ 94 to < 99	NA	≥ 99

Measure: D14 - High Risk Medication

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

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

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

Metric: This measure calculates the percentage of Medicare Part D beneficiaries 65 years or older who received two or more prescription fills for a drug with a high risk of serious side effects in the elderly. This percentage is calculated as:

[(Number of member-years of enrolled beneficiaries 65 years or older who received two or more prescription fills for an HRM during the period measured)/ (Number of member-years of enrolled beneficiaries 65 years and older during the period measured)].

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

See the medication list for this measure. The HRM rate is calculated using the NDC lists maintained by the PQA. The complete National Drug Code (NDC) lists are posted along with these technical notes. The updated PQA HRM measure drug list based upon the new American Geriatrics Society (AGS) recommendations will not used to calculate the 2013 Plan Rating.

Exclusions: A percentage is not calculated for contracts with 30 or fewer enrolled beneficiary member years (in the denominator)

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Also, member-years of enrollment is the adjustment made by CMS to account for enrollment for only part of the benefit year. For instance, if a beneficiary is enrolled for

six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.

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 for January 1, 2011-December 31, 2011 by June 30, 2012. Only final action PDE claims are used to calculate the patient safety measures. PDE claims are limited to members over 65 years of age, and for those Part D covered drugs identified to have high risk of serious side effects in patients 65 years of age or older. PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Safety

NQF #: 0022

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	> 10.2% to ≤ 28.1%	> 8.7% to ≤ 10.2%	> 7.0% to ≤ 8.7%	> 5.0% to ≤ 7.0%	≤ 5.0%
PDP	> 10.7% to ≤ 15.4%	> 9.5% to ≤ 10.7%	> 8.1% to ≤ 9.5%	> 6.6% to ≤ 8.1%	≤ 6.6%

Measure: D15 - Diabetes Treatment

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

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

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

Metric: This is defined as the percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension whose treatment included a renin angiotensin system (RAS) antagonist (an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor) medication which are recommended for people with diabetes. This percentage is calculated as:

[(Number of member-years of enrolled beneficiaries from eligible population who received a RAS antagonist medication during period measured)/ (Number of member-years of enrolled beneficiaries in period measured who were dispensed at least one prescription for an oral hypoglycemic agent or insulin and at least one prescription for an antihypertensive agent during the measurement period)].

This measure is adapted from one endorsed by the Pharmacy Quality Alliance (PQA) - Diabetes: Appropriate Treatment for Hypertension. Initially, this PQA measure was the Diabetes Suboptimal Treatment measure. The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009.

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

Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).

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

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 for January 1, 2011-December 31, 2011 by June 30, 2012. Only final action PDE claims are used to calculate the patient safety measures. PDE claims were limited to members who received at least one prescription for an oral diabetes drug or insulin and at least one prescription for a high blood pressure drug. Members who received a RAS antagonist medication were identified. PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Clinical care

NQF #: 0546

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 56.5% to < 82.0%	≥ 82.0% to < 83.2%	≥ 83.2% to < 86.0%	≥ 86.0% to < 87.8%	≥ 87.8%
PDP	≥ 71.7% to < 80.5%	≥ 80.5% to < 81.8%	≥ 81.8% to < 83.0%	≥ 83.0% to < 84.1%	≥ 84.1%

Measure: D16 - Part D Medication Adherence for Oral Diabetes Medications

Label for Stars: Taking Oral Diabetes Medication as Directed

Label for Data: Taking Oral Diabetes Medication as Directed

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

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

[(Number of member-years of enrolled beneficiaries 18 years or older with a proportion of days covered (PDC) at 80 percent or over across the classes of oral diabetes medications during the measurement period.)/ (Number of member-years of enrolled beneficiaries 18 years or older with at least two fills of medication(s) across any of the drug classes during the measurement period.)] The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or medications in its therapeutic category. Beneficiaries with one of more fills for insulin in the measurement period are excluded. Patients 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 Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009 as a "time-limited endorsed measure". In September 2011, the NQF Consensus Standards Committee removed the "time-limited endorsed" label and fully endorsed the PDC Adherence measures.

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

Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).

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

Please see Attachment L: Part D Medication Adherence Measure Calculations for more information about these calculations.

Data Source: Prescription Drug Event (PDE) data; Inpatient (IP) Data File

Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2011-December 31, 2011 by June 30, 2012. Only final action PDE claims are used to calculate the patient safety measures. PDE claims are limited to members who received at least two prescriptions for oral diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Clinical care

NQF #: 0541

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 52.4% to < 68.3%	≥ 68.3% to < 72.0%	≥ 72.0% to < 75.7%	≥ 75.7% to < 79.0%	≥ 79.0%
PDP	≥ 55.1% to < 69.4%	≥ 69.4% to < 75.5%	≥ 75.5% to < 77.3%	≥ 77.3% to < 79.6%	≥ 79.6%

Measure: D17 - Part D Medication Adherence for Hypertension (RAS antagonists)

Label for Stars: Taking Blood Pressure Medication as Directed

Label for Data: Taking Blood Pressure Medication as Directed

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

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

[(Number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or over for RAS antagonist medications during the measurement period) / (Number of member-years of enrolled beneficiaries 18 years or older with at least two fills of either the same medication or medications in the drug class during the measurement period.)] The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Patients 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 Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009 as a "time-limited endorsed measure". In September 2011, the NQF Consensus Standards Committee removed the "time-limited endorsed" label and fully endorsed the PDC Adherence measures.

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

Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).

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

Please see Attachment L: Part D Medication Adherence Measure Calculations for more information about these calculations.

Data Source: Prescription Drug Event (PDE) data; Inpatient (IP) Data File

Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2011-December 31, 2011 by June 30, 2012. Only final action PDE claims are used to calculate the patient safety measures. PDE claims are limited to members who received at least two prescriptions for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Clinical care

NQF #: 0541

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 52.4% to < 67.8%	≥ 67.8% to < 72.6%	≥ 72.6% to < 76.5%	≥ 76.5% to < 79.7%	≥ 79.7%
PDP	≥ 59.7% to < 71.9%	≥ 71.9% to < 76.2%	≥ 76.2% to < 78.5%	≥ 78.5% to < 80.7%	≥ 80.7%

Measure: D18 - Part D Medication Adherence for Cholesterol (Statins)

Label for Stars: Taking Cholesterol Medication as Directed

Label for Data: Taking Cholesterol Medication as Directed

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

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

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

Only final action PDE claims are used to calculate the patient safety measures. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure which was developed and endorsed by the Pharmacy Quality Alliance (PQA). The measure was submitted to the National Quality Forum for review by their Medication Management Steering Committee. The NQF Consensus Standards Committee endorsed this measure in July 2009 as a "time-limited endorsed measure". In September 2011, the NQF Consensus Standards Committee removed the "time-limited endorsed" label and fully endorsed the PDC Adherence measures.

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

Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).

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

Please see Attachment L: Part D Medication Adherence Measure Calculations for

more information about these calculations.

Data Source: Prescription Drug Event (PDE) data; Inpatient (IP) Data File

Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2011-December 31, 2011 by June 30, 2012. PDE claims are limited to members who received at least two prescriptions for a statin drug(s). PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Clinical care

NQF #: 0541

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measures

Weighting Value: 3

Data Display: Percentage with 1 decimal point

Reporting Requirements:

1876 Cost	Local, E-Local & Regional CCP w/o SNP	Local, E-Local & Regional CCP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Yes	Yes	Yes	No	Yes	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≥ 32.9% to < 63.0%	≥ 63.0% to < 67.3%	≥ 67.3% to < 71.6%	≥ 71.6% to < 75.4%	≥ 75.4%
PDP	≥ 33.1% to < 69.2%	≥ 69.2% to < 71.4%	≥ 71.4% to < 74.3%	≥ 74.3% to < 76.6%	≥ 76.6%

Attachment A: CAHPS Case-Mix Adjustment

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

For example, for the measure "Get Needed Care", the coefficient for "age 80-84" is +0.0022, indicating that respondents in that age range tend to score their plans 0.0022 point higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligibles tend to respond -0.0388 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 80-84 age range will be adjusted downwards to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are dual eligibles will be adjusted upwards to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures.

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

Table A-1: Part C CAHPS Measures

Predictor	Get Needed Care (Comp)	Get Care Quickly (Comp)	Health Plan Customer Service (Comp)	Rate Care	Rate Health Plan	Coordination of Care (Comp)
Age: 64 or under	-0.0857	-0.0471	-0.0248	-0.2177	-0.2280	-0.0043
Age: 65 - 69	-0.0061	0.0073	0.0062	-0.0557	-0.0428	0.0046
Age: 75 - 79	0.0037	0.0037	0.0049	0.0497	0.1071	0.0050
Age: 80 - 84	0.0022	-0.0064	0.0072	0.0788	0.1776	-0.0093
Age: 85 and older	-0.0012	-0.0068	0.0275	0.0922	0.1884	-0.0281
Less than an 8th grade education	-0.0205	-0.0142	-0.0028	-0.0276	0.0627	0.0100
Some high school	0.0055	-0.0168	0.0172	0.0233	0.1257	0.0058
Some college	-0.0632	-0.0212	-0.0388	-0.1411	-0.2055	-0.0286
College graduate	-0.0542	-0.0045	-0.0590	-0.1529	-0.2920	-0.0391
More than a bachelor's degree	-0.0778	0.0058	-0.0777	-0.1913	-0.3740	-0.0534
General health rating: excellent	0.1133	0.0973	0.0666	0.4006	0.3771	0.0607
General health rating: very good	0.0452	0.0495	0.0504	0.2143	0.1710	0.0268
General health rating: fair	-0.0497	-0.0364	-0.0222	-0.2206	-0.1731	-0.0310
General health rating: poor	-0.0966	-0.0454	-0.0911	-0.4701	-0.2993	-0.0689
Mental health rating: excellent	0.1290	0.1036	0.0599	0.4456	0.3457	0.1276
Mental health rating: very good	0.0458	0.0363	0.0191	0.1897	0.1291	0.0488
Mental health rating: fair	-0.0447	-0.0133	-0.0304	-0.1706	-0.0868	-0.0358
Mental health rating: poor	-0.0310	-0.0241	-0.0716	-0.3209	-0.1396	-0.0632
Proxy helped	-0.0172	-0.0551	-0.0554	-0.2519	-0.1870	0.0035
Proxy answered	0.0016	0.0132	-0.0491	-0.0505	-0.1286	0.0011
Medicaid dual eligible	-0.0388	-0.0160	0.0443	0.0018	0.2653	-0.0060
Low-income subsidy (LIS)	-0.0176	-0.0141	0.0036	-0.0532	0.1435	0.0080

Table A-2: Medicare Advantage – Prescription Drug Plan (MA-PD) Part D CAHPS Measures

Predictor	Rate Drug Plan	Getting Information from Drug Plan	Getting Needed Prescription Drugs
Age: 64 or under	-0.3637	-0.0488	-0.0767
Age: 65 - 69	-0.1089	-0.0033	-0.0143
Age: 75 - 79	0.1197	-0.0175	0.0049
Age: 80 - 84	0.2624	0.0473	0.0148
Age: 85 and older	0.3354	-0.0159	0.0084
Less than an 8th grade education	0.0376	-0.0499	-0.0570
Some high school	0.0880	-0.0610	-0.0120
Some college	-0.2296	-0.0419	-0.0340
College graduate	-0.2785	-0.0729	-0.0316
More than a bachelor's degree	-0.4358	-0.0799	-0.0550
General health rating: excellent	0.4026	-0.0009	0.0200
General health rating: very good	0.1886	0.0521	0.0280
General health rating: fair	-0.1764	-0.0809	-0.0400
General health rating: poor	-0.2684	-0.1439	-0.0568
Mental health rating: excellent	0.3036	0.0880	0.0915
Mental health rating: very good	0.1400	0.0560	0.0484
Mental health rating: fair	-0.0318	-0.0384	-0.0297
Mental health rating: poor	-0.1433	-0.0888	-0.0530
Proxy helped	-0.2478	0.0159	-0.0086
Proxy answered	-0.1559	0.1144	0.0428
Medicaid dual eligible	0.5643	0.0458	0.0304
Low-income subsidy (LIS)	0.4823	0.0546	0.0391

Table A-3: Prescription Drug Plan (PDP) Part D CAHPS Measures

Predictor	Rate Drug Plan	Getting Information from Drug Plan	Getting Needed Prescription Drugs
Age: 64 or under	-0.3650	-0.0445	-0.0595
Age: 65 - 69	-0.2382	0.0592	-0.0244
Age: 75 - 79	0.1146	0.0005	0.0018
Age: 80 - 84	0.1169	-0.0738	0.0006
Age: 85 and older	0.2916	0.1639	0.0420
Less than an 8th grade education	0.1276	-0.1248	-0.0406
Some high school	0.0565	-0.1226	-0.0064
Some college	-0.1932	0.0054	-0.0151
College graduate	-0.2983	-0.0993	-0.0462
More than a bachelor's degree	-0.5261	-0.1041	-0.0830
General health rating: excellent	0.1330	-0.1232	-0.0255
General health rating: very good	0.1631	0.0744	0.0350
General health rating: fair	-0.0350	0.0129	-0.0410
General health rating: poor	-0.2229	-0.1001	-0.1304
Mental health rating: excellent	0.2828	0.0837	0.0624
Mental health rating: very good	0.1285	-0.0169	0.0379
Mental health rating: fair	-0.0946	-0.0990	-0.0185
Mental health rating: poor	-0.1784	-0.0820	-0.0262
Proxy helped	-0.2591	0.0555	-0.0399
Proxy answered	-0.1175	0.0331	0.0407
Medicaid dual eligible	0.8410	0.0393	0.0557
Low-income subsidy (LIS)	0.6934	-0.0013	0.0616

Attachment B: Complaints Tracking Module Exclusion List

Table B-1 contains the current exclusions applied to the CTM based on the revised categories and subcategories that became effective September 25, 2010.

Table B-1: Exclusions effective September 25, 2010

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

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

Table B-2 contains the categories and subcategories that are excluded if they were entered into the CTM prior to current exclusion criteria.

Table B-2: Exclusions prior to September 25, 2010

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

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

Table B-3 contains the current exclusions applied to the CTM based on the revised categories and subcategories that became effective December 16, 2011.

Table B-3: Exclusions effective December 16, 2011

Category ID	Category Description	Subcategory ID	Subcategory Description
26	Contractor/Partner Performance	90	Other Contractor/Partner Performance
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
		90	Other Equitable Relief/Good Cause Request
49	Contractor/Partner Performance	90	Other Contractor/Partner Performance
50	Contractor/Partner Performance	90	Other Contractor/Partner Performance

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of the numeric and star values for each measure reported in the 2013 Plan Ratings.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	68%	3
C02	Colorectal Cancer Screening	58%	4
C03	Cardiovascular Care – Cholesterol Screening	88%	4
C04	Diabetes Care – Cholesterol Screening	88%	4
C05	Glaucoma Testing	66%	3
C06	Annual Flu Vaccine	68%	3
C07	Improving or Maintaining Physical Health	65%	4
C08	Improving or Maintaining Mental Health	77%	2
C09	Monitoring Physical Activity	48%	2
C10	Adult BMI Assessment	66%	4
C11	Care for Older Adults – Medication Review	68%	3
C12	Care for Older Adults – Functional Status Assessment	56%	3
C13	Care for Older Adults – Pain Screening	54%	3
C14	Osteoporosis Management in Women who had a Fracture	21%	1
C15	Diabetes Care – Eye Exam	65%	3
C16	Diabetes Care – Kidney Disease Monitoring	89%	4
C17	Diabetes Care – Blood Sugar Controlled	72%	3
C18	Diabetes Care – Cholesterol Controlled	52%	3
C19	Controlling Blood Pressure	61%	4
C20	Rheumatoid Arthritis Management	74%	3
C21	Improving Bladder Control	35%	2
C22	Reducing the Risk of Falling	59%	3
C23	Plan All-Cause Readmissions	12%	3
C24	Getting Needed Care	85%	4
C25	Getting Appointments and Care Quickly	76%	3
C26	Customer Service	88%	3
C27	Overall Rating of Health Care Quality	86%	4
C28	Overall Rating of Plan	86%	3
C29	Care Coordination	85%	3
C30	Complaints about the Health Plan	0.26	3
C31	Beneficiary Access and Performance Problems	65	4
C32	Members Choosing to Leave the Plan	11%	4
C33	Health Plan Quality Improvement	Medicare shows only a star rating for this topic	3
C34	Plan Makes Timely Decisions about Appeals	87%	4
C35	Reviewing Appeals Decisions	83%	3
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	83%	4
C37	Enrollment Timeliness	90%	4

Table C-2: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD Numeric Average	MA-PD Star Average	PDP Numeric Average	PDP Star Average
D01	Call Center – Pharmacy Hold Time	0:16	4.1	0:17	4.3
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	83%	3.1	82%	3.5
D03	Appeals Auto–Forward	2.7	3.5	4.5	2.6
D04	Appeals Upheld	67%	3.1	65%	3.3
D05	Enrollment Timeliness	91%	3.6	93%	3.6
D06	Complaints about the Drug Plan	0.37	2.7	0.25	3.7
D07	Beneficiary Access and Performance Problems	65	3.5	74	3.8
D08	Members Choosing to Leave the Plan	11%	3.5	11%	3.7
D09	Drug Plan Quality Improvement	Medicare shows only a star rating for this topic	3.2	Medicare shows only a star rating for this topic	3.9
D10	Getting Information From Drug Plan	84%	3.7	79%	3.4
D11	Rating of Drug Plan	85%	3.4	83%	3.6
D12	Getting Needed Prescription Drugs	91%	3.5	90%	3.7
D13	MPF Price Accuracy	98	3.8	98	4.2
D14	High Risk Medication	7.80%	3.1	8.80%	3.1
D15	Diabetes Treatment	84.30%	3	82.30%	2.8
D16	Part D Medication Adherence for Oral Diabetes Medications	73.70%	3.1	75.80%	3.3
D17	Part D Medication Adherence for Hypertension (RAS antagonists)	73.90%	3	76.80%	3.2
D18	Part D Medication Adherence for Cholesterol (Statins)	69.00%	3.1	71.00%	3.2

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

Measure ID	Measure Name	Data Time Frame
C01	Breast Cancer Screening	01/01/2011 - 12/31/2011
C02	Colorectal Cancer Screening	01/01/2011 - 12/31/2011
C03	Cardiovascular Care – Cholesterol Screening	01/01/2011 - 12/31/2011
C04	Diabetes Care – Cholesterol Screening	01/01/2011 - 12/31/2011
C05	Glaucoma Testing	01/01/2011 - 12/31/2011
C06	Annual Flu Vaccine	02/15/2012 - 05/31/2012
C07	Improving or Maintaining Physical Health	04/18/2011 - 07/31/2011
C08	Improving or Maintaining Mental Health	04/18/2011 - 07/31/2011
C09	Monitoring Physical Activity	04/18/2011 - 07/31/2011
C10	Adult BMI Assessment	01/01/2011 - 12/31/2011
C11	Care for Older Adults – Medication Review	01/01/2011 - 12/31/2011
C12	Care for Older Adults – Functional Status Assessment	01/01/2011 - 12/31/2011
C13	Care for Older Adults – Pain Screening	01/01/2011 - 12/31/2011
C14	Osteoporosis Management in Women who had a Fracture	01/01/2011 - 12/31/2011
C15	Diabetes Care – Eye Exam	01/01/2011 - 12/31/2011
C16	Diabetes Care – Kidney Disease Monitoring	01/01/2011 - 12/31/2011
C17	Diabetes Care – Blood Sugar Controlled	01/01/2011 - 12/31/2011
C18	Diabetes Care – Cholesterol Controlled	01/01/2011 - 12/31/2011
C19	Controlling Blood Pressure	01/01/2011 - 12/31/2011
C20	Rheumatoid Arthritis Management	01/01/2011 - 12/31/2011
C21	Improving Bladder Control	04/18/2011 - 07/31/2011
C22	Reducing the Risk of Falling	04/18/2011 - 07/31/2011
C23	Plan All-Cause Readmissions	01/01/2011 - 12/31/2011
C24	Getting Needed Care	02/15/2012 - 05/31/2012
C25	Getting Appointments and Care Quickly	02/15/2012 - 05/31/2012
C26	Customer Service	02/15/2012 - 05/31/2012
C27	Overall Rating of Health Care Quality	02/15/2012 - 05/31/2012
C28	Overall Rating of Plan	02/15/2012 - 05/31/2012
C29	Care Coordination	02/15/2012 - 05/31/2012
C30	Complaints about the Health Plan	01/01/2012 - 06/30/2012
C31	Beneficiary Access and Performance Problems	01/01/2011 - 12/31/2011
C32	Members Choosing to Leave the Plan	01/01/2011 - 12/31/2011
C33	Health Plan Quality Improvement	Not Applicable
C34	Plan Makes Timely Decisions about Appeals	01/01/2011 - 12/31/2011
C35	Reviewing Appeals Decisions	01/01/2011 - 12/31/2011
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	01/30/2012 - 05/18/2012 (Monday - Friday)
C37	Enrollment Timeliness	01/01/2012 - 06/30/2012

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Data Time Frame
D01	Call Center – Pharmacy Hold Time	02/06/2012 - 05/18/2012 (Monday - Friday)
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	01/30/2012 - 05/18/2012 (Monday - Friday)
D03	Appeals Auto–Forward	01/01/2011 - 12/31/2011
D04	Appeals Upheld	01/01/2012 - 6/30/2012
D05	Enrollment Timeliness	01/01/2012 - 06/30/2012
D06	Complaints about the Drug Plan	01/01/2012 - 06/30/2012
D07	Beneficiary Access and Performance Problems	01/01/2011 - 12/31/2011
D08	Members Choosing to Leave the Plan	01/01/2011 - 12/31/2011
D09	Drug Plan Quality Improvement	Not Applicable
D10	Getting Information From Drug Plan	02/15/2012 - 05/31/2012
D11	Rating of Drug Plan	02/15/2012 - 05/31/2012
D12	Getting Needed Prescription Drugs	02/15/2012 - 05/31/2012
D13	MPF Price Accuracy	01/01/2011 - 09/30/2011
D14	High Risk Medication	01/01/2011 - 12/31/2011
D15	Diabetes Treatment	01/01/2011 - 12/31/2011
D16	Part D Medication Adherence for Oral Diabetes Medications	01/01/2011 - 12/31/2011
D17	Part D Medication Adherence for Hypertension (RAS antagonists)	01/01/2011 - 12/31/2011
D18	Part D Medication Adherence for Cholesterol (Statins)	01/01/2011 - 12/31/2011

Attachment E: NCQA Measure Combining Methodology

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

Definitions

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

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

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

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

Setup Calculations

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

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

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

Pooled Analysis

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

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

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

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

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

Attachment F: Calculating Measure C23: Plan All-Cause Readmissions

All data come from the HEDIS 2012 M12_PCRB data file.

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

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

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

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

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

Example: Calculating the final rate for Contract 1

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

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

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

NatAvgObs = 0.13924

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

Expected Contract 1 =

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

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

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

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

The actual calculated NatAvgObs value used in the 2013 Plan Ratings was 0.139295325506652

Attachment G: Weights Assigned to Individual Performance Measures

Table G-1: Part C Measure Weights

Measure ID	Measure Name	Weighting Category	Part C Summary	MA-PD Overall
C01	Breast Cancer Screening	Process Measure	1	1
C02	Colorectal Cancer Screening	Process Measure	1	1
C03	Cardiovascular Care – Cholesterol Screening	Process Measure	1	1
C04	Diabetes Care – Cholesterol Screening	Process Measure	1	1
C05	Glaucoma Testing	Process Measure	1	1
C06	Annual Flu Vaccine	Process Measure	1	1
C07	Improving or Maintaining Physical Health	Outcome Measure	3	3
C08	Improving or Maintaining Mental Health	Outcome Measure	3	3
C09	Monitoring Physical Activity	Process Measure	1	1
C10	Adult BMI Assessment	Process Measure	1	1
C11	Care for Older Adults – Medication Review	Process Measure	1	1
C12	Care for Older Adults – Functional Status Assessment	Process Measure	1	1
C13	Care for Older Adults – Pain Screening	Process Measure	1	1
C14	Osteoporosis Management in Women who had a Fracture	Process Measure	1	1
C15	Diabetes Care – Eye Exam	Process Measure	1	1
C16	Diabetes Care – Kidney Disease Monitoring	Process Measure	1	1
C17	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measures	3	3
C18	Diabetes Care – Cholesterol Controlled	Intermediate Outcome Measures	3	3
C19	Controlling Blood Pressure	Intermediate Outcome Measures	3	3
C20	Rheumatoid Arthritis Management	Process Measure	1	1
C21	Improving Bladder Control	Process Measure	1	1
C22	Reducing the Risk of Falling	Process Measure	1	1
C23	Plan All-Cause Readmissions	Outcome Measure	3	3
C24	Getting Needed Care	Patients' Experience and Complaints Measure	1.5	1.5
C25	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	1.5	1.5
C26	Customer Service	Patients' Experience and Complaints Measure	1.5	1.5
C27	Overall Rating of Health Care Quality	Patients' Experience and Complaints Measure	1.5	1.5
C28	Overall Rating of Plan	Patients' Experience and Complaints Measure	1.5	1.5
C29	Care Coordination	Patients' Experience and Complaints Measure	1	1
C30	Complaints about the Health Plan	Patients' Experience and Complaints Measure	1.5	1.5
C31	Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
C32	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
C33	Health Plan Quality Improvement	Outcome Measure	1	1
C34	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	1.5	1.5
C35	Reviewing Appeals Decisions	Measures Capturing Access	1.5	1.5
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5	1.5
C37	Enrollment Timeliness	Process Measure	1	1

Table G-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary	MA-PD Overall
D01	Call Center – Pharmacy Hold Time	Measures Capturing Access	1.5	1.5
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5	1.5
D03	Appeals Auto–Forward	Measures Capturing Access	1.5	1.5
D04	Appeals Upheld	Measures Capturing Access	1.5	1.5
D05	Enrollment Timeliness	Process Measure	1	1
D06	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D07	Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
D08	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
D09	Drug Plan Quality Improvement	Outcome Measure	1	1
D10	Getting Information From Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D11	Rating of Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D12	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	1.5	1.5
D13	MPF Price Accuracy	Process Measure	1	1
D14	High Risk Medication	Intermediate Outcome Measures	3	3
D15	Diabetes Treatment	Intermediate Outcome Measures	3	3
D16	Part D Medication Adherence for Oral Diabetes Medications	Intermediate Outcome Measures	3	3
D17	Part D Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measures	3	3
D18	Part D Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measures	3	3

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

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

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

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

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

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

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

1. The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between plan rating years 2012 and 2013:

   Improvement Change Score= Score in 2013-Score in 2012

   An eligible measure was defined as a measure for which a contract was scored in both 2012 Plan Ratings and 2013 Plan Ratings and there were no significant specification changes.

2. For each measure, significant improvement or decline between plan rating years 2012 and 2013 was determined by a t-test at the 95% significance level:

   $$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} \geq 1.96\text{, then YES=significant improvement}$$

   $$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} \leq -1.96\text{, then YES=significant decline}$$

3. Net improvement was calculated for each weighting category (outcome or intermediate outcome, access or patient experience, and process) for Parts C and D separately by subtracting the total number of significantly declined measures from the total number of significantly improved measures.

   Net Improvement=# of significantly improved measures-# of significantly declined measures

4. The improvement measure score was calculated for Parts C and D separately by taking a weighted sum of net improvement divided by the weighted sum of the number of eligible measures.

   Measures were weighted as follows:
   a. Outcome or intermediary outcome measure: Weight of 3
   b. Access or patient experience measure: Weight of 1.5
   c. Process measure: Weight of 1

   $$\text{Improvement Measure Score} = \frac{\text{Net_Imp_Process} + 1.5 * \text{Net_Imp_PtExp} + 3 * \text{Net_Imp_Outcome}}{\text{Elig_Process} + 1.5 * \text{Elig_PtExp} + 3 * \text{Elig_Outcome}}$$

   Net_Imp_Process = Net improvement for process measures

   Net_Imp_PtExp = Net improvement for patient experience and access measures

   Net_Imp_Outcome = Net improvement for outcome and intermediary outcome measures

   Elig_Process = Number of eligible process measures

   Elig_PtExp = Number of eligible patient experience and access measures

   Elig_Outcome = Number of eligible outcome and intermediary outcome measures

5. Improvement measure score is converted into a star rating using the relative distribution method.

6. Hold Harmless Provision: Contracts with 4 or more stars for their highest rating that would have had their overall rating decreased with the addition of the improvement measures were held harmless. That is, the highest star rating could not be decreased from 4 or more stars when the improvement measures were added to the overall star rating calculation.

Table I-1: Part C Measures used in the Improvement Measure

Measure ID	Measure Name	Measure Usage
C01	Breast Cancer Screening	Included
C02	Colorectal Cancer Screening	Included
C03	Cardiovascular Care – Cholesterol Screening	Included
C04	Diabetes Care – Cholesterol Screening	Included
C05	Glaucoma Testing	Included
C06	Annual Flu Vaccine	Included
C07	Improving or Maintaining Physical Health	Not Included
C08	Improving or Maintaining Mental Health	Not Included
C09	Monitoring Physical Activity	Included
C10	Adult BMI Assessment	Included
C11	Care for Older Adults – Medication Review	Included
C12	Care for Older Adults – Functional Status Assessment	Included
C13	Care for Older Adults – Pain Screening	Included
C14	Osteoporosis Management in Women who had a Fracture	Included
C15	Diabetes Care – Eye Exam	Included
C16	Diabetes Care – Kidney Disease Monitoring	Included
C17	Diabetes Care – Blood Sugar Controlled	Included
C18	Diabetes Care – Cholesterol Controlled	Included
C19	Controlling Blood Pressure	Included
C20	Rheumatoid Arthritis Management	Included
C21	Improving Bladder Control	Included
C22	Reducing the Risk of Falling	Included
C23	Plan All-Cause Readmissions	Included
C24	Getting Needed Care	Included
C25	Getting Appointments and Care Quickly	Included
C26	Customer Service	Included
C27	Overall Rating of Health Care Quality	Included
C28	Overall Rating of Plan	Included
C29	Care Coordination	Not Included
C30	Complaints about the Health Plan	Included
C31	Beneficiary Access and Performance Problems	Not Included
C32	Members Choosing to Leave the Plan	Included
C33	Health Plan Quality Improvement	Not Included
C34	Plan Makes Timely Decisions about Appeals	Not Included
C35	Reviewing Appeals Decisions	Included
C36	Call Center – Foreign Language Interpreter and TTY/TDD Availability	Not Included
C37	Enrollment Timeliness	Not Included

Table I-2: Part D Measures used in the Improvement Measure

Measure ID	Measure Name	Measure Usage
D01	Call Center – Pharmacy Hold Time	Included
D02	Call Center – Foreign Language Interpreter and TTY/TDD Availability	Not Included
D03	Appeals Auto–Forward	Included
D04	Appeals Upheld	Included
D05	Enrollment Timeliness	Not Included
D06	Complaints about the Drug Plan	Included
D07	Beneficiary Access and Performance Problems	Not Included
D08	Members Choosing to Leave the Plan	Included
D09	Drug Plan Quality Improvement	Not Included
D10	Getting Information From Drug Plan	Included
D11	Rating of Drug Plan	Included
D12	Getting Needed Prescription Drugs	Included
D13	MPF Price Accuracy	Not Included
D14	High Risk Medication	Not Included
D15	Diabetes Treatment	Included
D16	Part D Medication Adherence for Oral Diabetes Medications	Included
D17	Part D Medication Adherence for Hypertension (RAS antagonists)	Included
D18	Part D Medication Adherence for Cholesterol (Statins)	Included

Attachment J: Plan Ratings Measure History

The tables below cross reference the measures code in each of the Plan Ratings releases over the past six years. Measure codes that begin with DM are display measures which are posted on CMS.gov on this page: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

Table J-1: Part C Measure History

Part	Common Measure Name	Data_Source	2013	2012	2011	2010	2009	2008	Notes
C	Access to Primary Care Doctor Visits	HEDIS	DMC12	C11	C13	C12	C13	C09	
C	Adult BMI Assessment	HEDIS	C10	C12	DMC05				
C	Annual Flu Vaccine	CAHPS	C06	C06	C07	C06	C07	C07	
C	Antidepressant Medication Management (6 months)	HEDIS	DMC03	DMC03	DMC03	DMC04	C28	C23	
C	Appeals Decisions	IRE / Maximus	C35	C35	C32	C28	C36	C29	
C	Appeals Timeliness	IRE / Maximus	C34	C34	C31	C27	C35	C28	
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS	DMC05	DMC05	C06	C05	C06	C06	
C	Audit	Administrative Data	C31	C32	C33	C30			
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	
C	Call Answer Timeliness	HEDIS	DMC02	DMC02	DMC02	DMC01	C20	C16	
C	Cardiovascular Care – Cholesterol Screening	HEDIS	C03	C03	C03		C03	C03	Part of composite measure Cholesterol Screening in 2010
C	Care Coordination	CAHPS	C29						
C	Cholesterol Screening	HEDIS				C03			Composite Measure - combined Cardiovascular Care – Cholesterol Screening and Diabetes Care – Cholesterol Screening measures
C	COA - Functional Status Assessment	HEDIS	C12	C14					
C	COA - Medication Review	HEDIS	C11	C13					
C	COA - Pain Screening	HEDIS	C13	C15					
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	
C	Complaints	CTM	C30	C31	C30	C26			
C	Continuous Beta-Blocker Treatment	HEDIS	DMC04	DMC04	DMC04	DMC05	C32	C27	
C	Controlling Blood Pressure	HEDIS	C19	C21	C19	C15	C29	C24	
C	CSR Understandability	Call Center				DMC02			
C	Customer Service	CAHPS	C26	C28	C27	C23	C22		
C	Diabetes Care	HEDIS				C14			Composite Measure - combined Diabetes Care – Blood Sugar Controlled, Diabetes Care – Cholesterol Controlled, Diabetes Care – Eye Exam and Diabetes Care – Kidney Disease Monitoring measures
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C17	C19	C17		C26	C21	Part of composite measure Diabetes Care in 2010

Part	Common Measure Name	Data_Source	2013	2012	2011	2010	2009	2008	Notes
C	Diabetes Care – Cholesterol Controlled	HEDIS	C18	C20	C18		C27	C22	Part of composite measure Diabetes Care in 2010
C	Diabetes Care – Cholesterol Screening	HEDIS	C04	C04	C04		C04	C04	Part of composite measure Cholesterol Screening in 2010
C	Diabetes Care – Eye Exam	HEDIS	C15	C17	C15		C24	C19	Part of composite measure Diabetes Care in 2010
C	Diabetes Care – Kidney Disease Monitoring	HEDIS	C16	C18	C16		C25	C20	Part of composite measure Diabetes Care in 2010
C	Doctor Follow up for Depression	HEDIS					C15	C11	
C	Doctors who Communicate Well	CAHPS	DMC08	DMC08	C25	C21	C21	C17	
C	Enrollment Timeliness	MARx	C37						
C	Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)	HEDIS	DMC01	DMC01	DMC01	DMC03	C14	C10	
C	Getting Appointments and Care Quickly	CAHPS	C25	C27	C26	C22	C17	C13	
C	Getting Needed Care	CAHPS	C24	C26	C24	C20	C16	C12	
C	Glaucoma Testing	HEDIS	C05	C05	C05	C04	C05	C05	
C	Hold Time - Bene	Call Center	DMC09	DMC09	C34	C31			
C	Improvement	Plan Ratings	C33						
C	Improving Bladder Control	HEDIS / HOS	C21	C23	C22	C18	C33		
C	Improving or Maintaining Mental Health	HOS	C08	C09	C10	C09	C10		
C	Improving or Maintaining Physical Health	HOS	C07	C08	C09	C08	C09		
C	Information Accuracy - Bene	Call Center	DMC10	DMC10	C35	C32			
C	Monitoring Physical Activity	HEDIS / HOS	C09	C10	C12	C11	C12		
C	Osteoporosis Management	HEDIS	C14	C16	C14	C13	C23	C18	
C	Osteoporosis Testing	HEDIS / HOS	DMC06	DMC06	C11	C10	C11		
C	Overall Rating of Health Care Quality	CAHPS	C27	C29	C28	C24	C18	C14	
C	Overall Rating of Health Plan	CAHPS	C28	C30	C29	C25	C19	C15	
C	Plan All-Cause Readmissions	HEDIS	C23	C25					
C	Pneumonia Vaccine	CAHPS	DMC11	C07	C08	C07	C08	C08	
C	Reducing the Risk of Falling	HEDIS / HOS	C22	C24	C23	C19	C34		
C	Rheumatoid Arthritis Management	HEDIS	C20	C22	C20	C16	C30	C25	
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC07	DMC07	C21	C17	C31	C26	
C	TTY/TDD & Language - Bene	Call Center	C36	C36	C36	C33			
C	Voluntary Disenrollment	MBDSS	C32	C33	DMC06	C29			

Table J-2: Part D Measure History

Part	Msr_Name	Data_Source	2013	2012	2011	2010	2009	2008	Notes
D	4Rx Timeliness	Acumen/OIS (4Rx)	DMD03	DMD03	D07	D07		D09	
D	Adherence - Cholesterol	Prescription Drug Event (PDE)	D18	D17					
D	Adherence - Diabetes	Prescription Drug Event (PDE)	D16	D15					
D	Adherence - Hypertension	Prescription Drug Event (PDE)	D17	D16					
D	Adherence - Proportion of Days Covered	Prescription Drug Event (PDE)			DMD07				
D	Appeals - Auto–Forwarded	IRE / Maximus	D03	D03	D05	D05	D05	D13	
D	Appeals - Timely Effectuation	IRE / Maximus	DMD02	DMD02	DMD02	DMD02			
D	Appeals - Timely Receipt	IRE / Maximus	DMD01	DMD01	DMD01	DMD01			
D	Appeals - Upheld	IRE / Maximus	D04	D04	D06	D06	D06	D14	
D	Audit	Administrative Data	D07	D07	D10	D11			
D	CAHPS - Drug Access	CAHPS	D12	D11	D13	D14	D14	D08	
D	CAHPS - Help	CAHPS	D10	D09	D11	D12	D12	D06	
D	CAHPS - Rating	CAHPS	D11	D10	D12	D13	D13	D07	
D	Calls Disconnected - Bene	Call Center	DMD04	DMD04	DMD04	DMD04	D02	D02	
D	Calls Disconnected - Pharmacist	Call Center				DMD05	D04	D04	
D	Complaint Resolution	CTM				DMD07			
D	Complaints - Benefits	CTM					D07	D11	
D	Complaints - Enrollment	CTM			D08	D08	D08	D12	
D	Complaints - Other	CTM			D09	D09	D10		
D	Complaints - Pricing	CTM					D09	D17	
D	Complaints - Total	CTM	D06	D06				D05	
D	CSR Understandability	Call Center				DMD06			
D	Diabetes Medication Dosing	Prescription Drug Event (PDE)	DMD08	DMD08	DMD06	DMD09			
D	Drug-Drug Interactions	Prescription Drug Event (PDE)	DMD07	DMD07	DMD05	DMD08			
D	Enrollment Timeliness	MARx	D05	D05	DMD03	DMD03			
D	Hold Time - Bene	Call Center	DMD05	DMD05	D01	D01	D01	D01	
D	Hold Time - Pharmacist	Call Center	D01	D01	D02	D02	D03	D03	
D	Improvement	Plan Ratings	D09						
D	Information Accuracy - Bene	Call Center	DMD06	DMD06	D03	D03			
D	LIS Match Rates	Acumen/OIS (LIS Match Rates)	DMD09	DMD09	D14	D15	D15	D10	
D	Member Retention	MBDSS					D11		

Part	Msr_Name	Data_Source	2013	2012	2011	2010	2009	2008	Notes
D	MPF - Accuracy	Plan Finder Data	D13			D17	D18		Part of composite measure MPF - Composite in 2011 - 2012
D	MPF - Composite	Plan Finder Data		D12	D15				Composite measure - combined MPF - Accuracy and MPF Stability
D	MPF - Stability	Plan Finder Data	DMD11			D16	D17	D16	Part of composite measure MPF - Composite in 2011 - 2012
D	MPF - Updates	Plan Finder Data	DMD10	DMD10	DMD08	DMD10	D16	D15	
D	Safety - DAE	Prescription Drug Event (PDE)	D14	D13	D16	D18	D19		
D	Safety - DST	Prescription Drug Event (PDE)	D15	D14	D17	D19			
D	TTY/TDD & Language - Bene	Call Center	D02	D02	D04	D04			
D	Voluntary Disenrollment	MBDSS	D08	D08	DMD09	D10			

Attachment K: Individual Measure Star Assignment Process

This attachment illustrates detailed steps of the "Relative Distribution and Clustering" method to develop individual measure stars. These steps include the implementation of the following set of methodologies:

1. Adjusted percentile approach (referred to as "AP")
2. Two-stage cluster analysis (referred to as "CA")
3. Hybrid approach to combine the results from the AP and CA methods, and produce the final thresholds (cut-off points) for individual measure stars.

1. Produce the Star Thresholds by the Adjusted Percentile Method

The AP method evaluates contracts relative to each other by assigning initial thresholds based on a particular percentile distribution. CMS has no pre-specified star distribution, so the initial thresholds are set under two parameterized choices of percentile values, i.e., at the 20th, 35th, 65th, and 80th percentiles, and at the 20th, 40th, 60th, and 80th percentiles, respectively. This produces two sets of initial thresholds (zero-gap adjusted). The use of two sets of percentile values will result in a rating process which is less sensitive to the initial distribution of contracts.

These initial percentile thresholds are then adjusted by evaluating the observed gaps between adjacent measure values around the initial thresholds in the data after the data are sorted. Two sets of gap adjustments to each initial threshold are performed, using a 3-gap and 7-gap adjustment which is described below. This adjustment intends to avoid a situation in which two contracts with very close measure values have different star ratings.

In the case of a 3-gap adjustment, a total of seven measure values with respect to an initial threshold (e.g., a 4-star threshold when the 20th, 35th, 65th, and 80th percentile is used) are identified. These seven values include the initial threshold values, the three most adjacent measure values above the initial threshold, and three most adjacent measure values below. From there, six gaps among these seven measure values (i.e., differences between two adjacent measure values) are calculated and compared. The adjusted threshold is set as the midpoint of the largest gap amongst the six. This exercise above is repeated for each of the four initial thresholds.

After the implementation of the AP method, a total of 24 candidate thresholds, or six sets for each star level, are produced. This includes two zero-gap adjusted, two 3-gap adjusted, and two 7-gap adjusted thresholds. These candidate thresholds will be processed under the hybrid approach to determine the final thresholds.

2. Produce the Star Thresholds by the Two-stage Cluster Analysis

A two-stage clustering analysis is implemented separately from the AP method. The clustering approach keeps contracts with similar measure values together, assuring that these contracts receive the same star rating. In the first stage, the number of clusters is parameterized as 10, 15, 20, 25, 30, and 35, respectively, to account for the variation of individual measure distributions. The second stage then clusters the centers of these first stage clusters into five (star) groups to assign thresholds and star ratings. This step results in a total of 24 candidate shields (i.e., a set of four thresholds for each the six choices of the number of first-stage clusters).

Jointly, the AP and CA analyses produce a total of 48 candidate thresholds to be used under the hybrid approach.

3. Produce the Star Thresholds by the Hybrid Approach

The hybrid approach serves as a post-processing step to use the candidate thresholds from both the AP and CA methods to obtain the final star thresholds. There are five steps to determine the final hybrid thresholds:

Step 1: Sort the raw measure values to produce the cumulative frequency of each distinctive measure value.

Step 2: Compare each of the 48 candidate thresholds to all the distinct raw measure values to flag raw measures that are closest to the candidate threshold.

Step 3: For each distinct raw measure values, count the total number of flags (in Step 2) from 24 AP candidate thresholds and 24 CA candidate thresholds, respectively.

Step 4: Calculate the hybrid count as a weighted sum of total flags (hybrid counts) from the AP and CA methods. A higher weight is assigned to the AP match count than to the CA match count.

Step 5: Based on the hybrid count, determine the final cutoff points (hybrid thresholds) to be the distinctive measure values among those with the highest hybrid count, considering the number of stars and minimum number of contracts in each star level.

4. Special Case: Produce Hybrid Thresholds When 3- or 4-star Thresholds are Pre-determined

CMS pre-determines thresholds at certain star values for some measures. In this case, the 48 candidate thresholds from the AP and CA methods are again produced first. Then step 1 through step 4 is implemented. However, prior to implementing step 5 under Section 3 above, the data are divided into two subsets by the predetermined threshold, and then step 5 is performed to identify the final thresholds. For example, in the event that a 4-star threshold is pre-determined, one threshold between 4 and 5 stars is to be identified in the upper section of the data. In the bottom section of the dataset, two cut-off points (between 1 and 2, and between 2 and 3 stars) are identified. The approach to treat the special case corresponds to the “CMS standard, relative distribution, and clustering” method.

Attachment L: Part 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.

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 therapeutic area. This number of days is based on the prescription fill date and days of supply. The number of covered days is divided 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' section that follows.

In the first example below, a beneficiary is taking Benazepril and Captopril, two drugs in the RAS antagonist hypertension therapeutic area. The covered days do not overlap, meaning the patient filled the Captopril prescription the day after the days supply for the Benazepril medication ended.

Example 1: Non-Overlapping Fills of Two Different Drugs

	January		February		March	
	1/1/2010	1/16/2010	2/1/2010	2/16/2010	3/1/2010	3/16/2010
Benazepril	15	16	15	14		
Captopril					15	16

Calculation

Covered Days = 90

Measurement Period = 90

PDC = 100%

If a beneficiary refills the same drug (defined at the generic level[i]) prior to the end of the days supply of the first fill, then we adjust the days covered to account for the overlap in days covered.

Example 2: Overlapping Fills of the Same Drug

	January		February		March	
	1/1/2010	1/16/2010	2/1/2010	2/16/2010	3/1/2010	3/16/2010
Lisinopril	15	16				
Lisinopril		16	15			
Lisinopril			15	14		

Calculation

Covered Days = 91

Measurement Period = 90

PDC = 100% (PDC > 100% rounded to 100%)

This adjustment is only made for fills for the same drug.

In the third example, a beneficiary is refilling both Lisinopril and Captopril. When the two Lisinopril prescriptions overlap, we make the adjustment described in Example 2. When Lisinopril overlaps with Captopril, we do not make any adjustment in the days covered.

Example 3: Overlapping Fills of the Same and Different Drugs

	January		February		March		April	
	1/1/2010	1/16/2010	2/1/2010	2/16/2010	3/1/2010	3/16/2010	4/1/2010	4/16/2010
Lisinopril	15	16						
Lisinopril		16	15					
Captopril					15	16		
Lisinopril						16	15	

Calculation

Covered Days = 108

Measurement Period = 120

PDC = 90%

Days Covered Modification for Inpatient Stays

In response to sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Plan Ratings (using 2011 PDE data), to adjust for beneficiary stays in inpatient facilities (IPs). Under Medicare rules, beneficiaries who receive care at an IP may receive Medicare-covered medications directly from the IP, rather than by filling prescriptions through their Part D contracts; thus, their medication fills during an IP stay would not be included in the PDE claims used to calculate the Patient Safety adherence measures. The PDC modification for IP 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, and the adjustment may impact the rates positively or negatively. In addition, testing indicated that the data required to calculate the same adjustment for stays in Skilled Nursing Facilities (SNFs) are not consistent for both MA-PDs and PDPs. Thus, at this time, the modification will be implemented for IP stays.

Calculating the PDC Adjustment for IP Stays

The PDC modification for IP stays is based on two assumptions: 1) a beneficiary receives their medications through the hospital during the IP stay, and 2) if a beneficiary accumulates extra supply of their Part D medication during an IP stay, that supply can be used once they returns home. The following examples provide illustrations of the implementation of these assumptions when calculating PDC. The legend below applies to all examples.

Legend	
	Day of drug coverage
	Day of no supply
	Inpatient Stay
	Day deleted from observation period (due to IP stay)
	Gap assumed to be covered by Part D unused drugs

1. **Example 1 – IP Stay with excess post-IP coverage gap**

In this simplified example, one assumes 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, according to our current assignment of days of supply based on fill dates and days of supply reported through PDE claims data, on days 1-8 and 12-15. They also had an IP stay on days 5 and 6. Before the modification, as illustrated in Figure 1 below, the beneficiary's PDC is equivalent to 13 days covered out of 15, or 86.7%.

Figure 1: Drug Coverage Assigned Before Modification in Example 1

	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage															
Inpatient Stays															

After the modification, as illustrated in Figure 2 below, the beneficiary's PDC is equivalent to 12 days covered out of 13, or 92.3%. This change in PDC before and after the modification occurs because days 5 and 6 (the days of IP stay) 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 their medication through the hospital on days 5 and 6, then they accumulated two extra days of supply during the inpatient stay. That extra supply is used to cover gaps in Part D drug coverage in days 9 and 10.

Figure 2: Drug Coverage Assigned After Modification in Example 1

	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage															
Inpatient Stays															

2. Example 2– IP stay with post-IP coverage gap < IP length of stay

In this simplified example, one assumes 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, according to our current assignment of days of supply based on fill dates and days of supply reported through PDE claims data. They also had an IP stay on days 6-9. Before the modification, as illustrated in Figure 3 below, the beneficiary's PDC is equivalent to 11 days covered out of 15, or 73.3%.

Figure 3: Drug Coverage Assigned Before Modification in Example 2

	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage				B	B										
Inpatient Stays				B	B										

After the modification, as illustrated in Figure 4 below, the beneficiary's PDC is equivalent to 10 days covered out of 13, or 76.9%. This change in PDC before and after the modification occurs because days 6-9 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days of no supply *after* the IP stay, based on the assumption that the beneficiary received their medication through the hospital on days 6-9. In this case, there are only two days of no supply after the IP stay (days 10 and 11), so two days of supply are "rolled over" to days 10 and 11.

Figure 4: Drug Coverage Assigned After Modification in Example 2

	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage															
Inpatient Stays															

3. Example 3– IP stay with no post-IP coverage gap

In this simplified example, one assumes 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, according to our current assignment of days of supply based on fill dates and days of supply reported through PDE claims data. They also had an IP stay from days 12-13. Before the modification, as illustrated in Figure 5 below, the beneficiary's PDC is equivalent to 11 days covered out of 15, or 73.3%.

Figure 5: Drug Coverage Assigned Before Modification in Example 3

	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage															
Inpatient Stays															

After the modification, as illustrated in Figure 6 below, the beneficiary's PDC is equivalent to 9 days covered out of 13, or 69.2%. This change in PDC before and after the modification occurs because days 12-13 are deleted from the measurement period (denominator). Additionally, the two days of supply from days 12-13 cannot be applied to any days of no supply *after* the IP stay.

Figure 6: Drug Coverage Assigned After Modification in Example 3

	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage															
Inpatient Stays															

Attachment M: Glossary of Terms

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

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

	the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
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).
SNP	A Special Needs Plan (SNP) is an MA coordinated care plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more severe or disabling chronic conditions.
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how unlikely differences as big as those observed are to appear due to chance when plans are actually the same. CMS uses statistical tests (e.g., t-test) to determine if a contract’s measure value is statistically significantly greater or less than the national average for that measure, or whether conversely the observed differences from the national average could have arisen by chance.
TTY/TDD	A Teletypewriter (TTY) or telecommunications device for the deaf (TDD) s an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.
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 N: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS to understand the various pages and fields shown in the Part C Report Card Master Table and the Part D Report Card Master Table modules. These modules employ standard HPMS user access rights so that users can only see contracts associated with their user id.

Part C Report Card Master Table

The Part C Report Card Master Table contains the Part C data and stars which will be displayed in MPF along with much of the detailed data that went into various calculations. To access the Part C Report Card Master Table, on the HPMS home page, select *Quality and Performance*. From the Quality and Performance Fly-out menu choose *Part C Performance Metrics*. The *Part C Performance Metrics* home page will be displayed.

On the *Part C Performance Metrics* home page, select *Part C Report Card Master Table* from the left hand menu. You will be presented with a screen that allows you to select a report period. The information below describes the year 2013.

A. Measure Data page

The Measure Data page displays the numeric data for each Part C measure. This page is available during the first plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure data which will display in MPF. There is one column for each of the Part C measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the data associated with an individual contract.

B. Measure Detail page

The Measure Detail page contains the underlying data used for the Part C Complaints (C30) and Appeals measures (C34 & C35). This page is available during the first plan preview. Table M-1 below explains each of the columns displayed on this page.

Table M-1: Measure Detail page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Number of Complaints	The total number of non-excluded complaints for the contract
Complaint Average Enrollment	The average enrollment used in the final calculation
Complaints Less than 800 Enrolled	Yes / No, Yes = average enrollment < 800, No = average enrollment ≥ 800
Total Appeals Cases	Total number of Part C appeals cases processed by the IRE (Maximus)
Number of Appeals Upheld	The number of Part C appeals which were upheld
Number of Appeals Overturned	The number of Part C appeals which were overturned
Number of Appeals Partly Overturned	The number of Part C appeals which were partially overturned
Number of Appeals Dismissed	The number of Part C appeals which were dismissed
Number of Appeals Withdrawn	The number of Part C appeals which were withdrawn
Percent of Timely Appeals	The percent of Part C appeals which were processed in a timely manner

C. Measure Detail – SNP page

The Measure Detail – SNP page contains the underlying data used to calculate the three Part C SNP measures (C11, C12 & C13). The formulas used to calculate the SNP measures are detailed in Attachment E. This page is available during the first plan preview. Table M-2 below explains each of the columns displayed on this page.

Table M-2: Measure Detail – SNP page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
PBP ID	The Plan Benefit Package number associated with the data
Eligible Population	The eligible population, as entered into the NCQA data submission tool (field eligpop)
Average Plan Enrollment	The average enrollment in the PBP during 2011 (see section Contract Enrollment Data)
COA - MR Rate	The contract entered COA Medication Review Rate as entered into the NCQA data submission tool (Field: ratemr) for the associated contract/PBP
COA – FSA Rate	The contract entered COA Functional Status Assessment Rate as entered into the NCQA data submission tool (Field: ratefsa) for the associated contract/PBP
COA – PS Rate	The contract entered COA Pain Screening Rate as entered into the NCQA data submission tool (Field: rateps) for the associated contract/PBP
COA - MR Audit Designation	The audit designation for the COA Medication Review Rate for the associated contract/PBP (the codes are defined in Table M-3: HEDIS 2012 Audit Designations and 2013 Plan Ratings below)
COA – FSA Audit Designation	The audit designation for the COA Functional Status Assessment Rate for the associated contract/ PBP the codes are defined in Table M-3: HEDIS 2012 Audit Designations and 2013 Plan Ratings below)
COA – PS Audit Designation	The audit designation for the COA Pain Screening Rate for the associated contract/ PBP the codes are defined in Table M-3: HEDIS 2012 Audit Designations and 2013 Plan Ratings below)

Table M-3: HEDIS 2012 Audit Designations and 2013 Plan Ratings

Audit Designation	Description	Resultant Rating
R	Reportable	1 to 5 stars depending on reported value
NB	Required benefit not offered	Benefit not offered by plan
NA	Denominator fewer than 30	Not enough data available to calculate measure
BR	Calculated rate was materially biased	1 star, numeric data set to “CMS identified issues with this plan’s data”
NR	Plan chose not to report	1 star, numeric data set to “CMS identified issues with this plan’s data”
Error	Plan not required to report	Plan not required to report measure
Error	Measure Unselected	Plan not required to report measure

D. Measure Detail – CTM page

The Measure Detail – CTM page contains the case level data of the non-excluded cases used in producing the Part C Complaints measure (C30). This page is available during the first plan preview. Table M-4 below explains each of the columns displayed on this page.

Table M-4: Measure Detail – CTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Complaint ID	The case number associated with the complaint in the HPMS CTM module

HPMS Field Label	Field Description
Complaint Category ID	The complaint category identifier associated with this case
Category Description	The complaint category description associated with this case
Complaint Subcategory ID	The complaint subcategory identifier associated with this case
Subcategory Description	The complaint subcategory description associated with this case

E. Measure Detail – Improvement page

The Measure Detail – Improvement page is constructed in the same manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part C measure. There is one column for each of the Part C measures. The measure columns are identified by measure id and measure name. There is one additional column all the way to the right which contains the final improvement score. This is the numeric result from step 4 as described in Attachment I: “Calculating the Improvement Measure”.

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate final improvement measure. All subsequent rows contain the data associated with an individual contract.

The possible results for measure calculations are shown in Table M-5 below.

Table M-5: Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new

F. Measure Stars page

The Measure Stars page displays the star rating for each Part C measure. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure stars which will display in MPF. There is one column for each of the Part C measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the stars associated with an individual contract.

G. Domain Stars page

The Domain Stars page displays the star rating for each Part C domain. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part C domains. The domain columns are identified by the domain id and domain name. All subsequent rows contain the stars associated with an individual contract.

H. Summary Rating page

The Summary Rating page displays the Part C rating and data associated with calculating the final summary rating. This page is available during the second plan preview. Table M-6 below explains each of the columns contained on this page.

Table M-6: Part C Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP (Yes/No)
Number Measures Required	The minimum number of measures required to calculate a final rating out of the total number of measures required for this contract type.
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Variance Category	The integration factor variance category for the contract
Integration Factor	The integration factor for the contract
Integration Summary	Contains the sum of the Calculated Summary Mean and the Integration Factor
Improvement Measure Usage	Was the improvement measure (C33) used in the final Part C Summary Rating? (Yes/No)
2013 Part C Summary Rating	The final rounded 2013 Part C Summary Rating
Low Performing Icon	Will the contract receive a Low Performing Icon (Yes/No)
High Performing Icon	Will the contract receive a High Performing Icon (Yes/No)
Sanction Deduction	Did this contract receive an adjustment for contracts under sanction (Yes/No)
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance

I. Overall Rating page

The Overall Rating page displays the overall rating for MA-PD contracts and data associated with calculating the final overall rating. This page is available during the second plan preview. Table M-7 below explains each of the columns contained on this page.

Table M-7: Overall Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP (Yes/No)
Number Measures Required	The minimum number of measures required to calculate a final rating out of the total number of measures required for this contract type.
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures

HPMS Field Label	Field Description
Calculated Variance	The variance of the calculated summary mean
Variance Category	The integration factor variance category for the contract
Integration Factor	The integration factor for the contract
Integration Summary	Contains the sum of the Calculated Summary Mean and the Integration Factor
2013 Part C Summary Rating	The 2013 Part C Summary Rating
2013 Part D Summary Rating	The 2013 Part D Summary Rating
Improvement Measure Usage	Were the improvement measures (C33 & D09) used to produce the final Overall Rating? (Yes/No)
2013 Overall Rating	The final 2013 Overall Rating
Low Performing Icon	Will the contract receive a Low Performing Icon (Yes/No)
High Performing Icon	Will the contract receive a High Performing Icon (Yes/No)
Sanction Deduction	Did this contract receive an adjustment for contracts under sanction (Yes/No)
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance

J. Technical Notes link

The Technical Notes link provides the user with a copy of the 2013 Plan Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur if errors are identified outside of the plan preview periods and the release data on MPF

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2013 Plan Ratings technical notes. Right clicking on the Technical Notes link will pop up a context menu which contains Save Target As…, clicking on this will allow the user to download and save a copy of the PDF document.

Part D Report Card Master Table

The Part D Report Card Master Table contains the Part D data and stars which will be displayed in MPF along with much of the detailed data that went into various calculations. To access the Part D Report Card Master Table, on the HPMS home page, select *Quality and Performance*. From the Quality and Performance Fly-out menu choose *Part D Performance Metrics and Reports*. The *Part D Performance Metrics and Reports* home page will be displayed.

On the *Part D Performance Metrics and Reports* home page, select *Part D Report Card Master Table* from the left hand menu. You will be presented with a screen that allows you to select a report period. The information below describes the year 2013.

A. Measure Data page

The Measure Data page displays the numeric data for each Part D measure. This page is available during the first plan preview.

The first five columns contain contract identifying information. The remaining columns contain the measure data which will display in MPF. There is one column for each of the Part D measures. The measure columns are identified by measure id and measure name. The two rows immediately above this measure information contain the domain id and domain name and the data time frame. All subsequent rows contain the data associated with an individual contract.

B. Measure Detail page

The Measure Detail page contains the underlying data used for the Part D Appeals (D03 & D04) and Complaints measures (D06). This page is available during the first plan preview. Table M-8 below explains each of the columns displayed on this page.

Table M-8: Measure Detail page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Type	The contract's organization type
Contract Name	The name the contract is known by in HPMS
Organization Marketing Name	The name the contract markets to members
Parent Organization	The parent organization of the contract
Appeals Total Auto-Forward Cases	The total number of Part D appeals that were not processed in a timely manner, and subsequently auto-forwarded to the IRE (Maximus)
2011 part D enrollment	The average 2011 monthly enrollment
Appeals Upheld Total Cases	Total number of Part D appeals cases which were upheld
Upheld Cases	The number of Part D appeals cases which were upheld
Upheld: Fully Reversed	The number of Part D appeals cases which were reversed
Upheld: Partially Reversed	The number of Part D appeals cases which were partially reversed
Total CTM Complaints	The total number of non-excluded complaints for the contract
Complaint Average Enrollment	The average enrollment used in the final calculation

C. CTM IDs page

The CTM IDs page contains the case-level data of the non-excluded cases used in producing the Part D Complaints measure (D06). This page is available during the first plan preview. Table M-9 below explains each of the columns displayed on this page.

Table M-9: CTM IDs page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Complaint ID	The case number associated with the complaint in the HPMS CTM module
Complaint Category ID	The complaint category identifier associated with this case
Category Description	The complaint category description associated with this case
Complaint Subcategory ID	The complaint subcategory identifier associated with this case
Subcategory Description	The complaint subcategory description associated with this case

D. Auto-Forward Details page

The Auto-Forward Details page contains the case-level data of the non-excluded cases used in producing the Part D Appeals Auto-Forward measure (D03). This page is available during the first plan preview. Table M-10 below explains each of the columns displayed on this page.

Table M-10: Auto-Forward Details page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Appeal Number	The case ID assigned to the appeal request
Request Received Date	The date the appeal was received by the IRE
Request Type	The type of appeal (auto-forward)
Appeal Priority	The priority of the appeal (standard or expedited)
Appeal Disposition	The disposition of the IRE (Maximus)
Appeal End Date	The end date of the appeal

E. Upheld Details page

The Upheld Details page contains the case-level data of the non-excluded cases used in producing the Part D Appeals Upheld measure (D04). This page is available during the first plan preview. Table M-11 below explains each of the columns displayed on this page.

Table M-11: Upheld Details page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Appeal Number	The case ID assigned to the appeal request
Request Received Date	The date the appeal was received by the IRE
Deadline	The deadline for the decision
Appeal Priority	The priority of the appeal (standard or expedited)
Appeal Disposition	The disposition of the IRE (Maximus)
Appeal End Date	The end date of the appeal
Status	The status of the appeal

F. Plan Improvement page

The Plan Improvement page is constructed in the same manner as the Measure Data page. This page is available during the second plan preview.

The first five columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part D measure. There is one column for each of the Part D measures. The measure columns are identified by measure id and measure name. There is one additional column all the way to the right which contains the final improvement score. This is the numeric result from step 4 as described in Attachment I: “Calculating the Improvement Measure”.

The two rows immediately above this measure information contain the domain id and domain name and the data time frame of the measure. The row below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate final improvement measure. All subsequent rows contain the data associated with an individual contract.

The possible results for measure calculations are shown in Table M-12 below.

Table M-12: Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new

G. Measure Star page

The Measure Star page displays the numeric data for each Part D measure. This page is available during the second plan preview.

The first five columns contain contract identifying information. The remaining columns contain the measure data which will display in MPF. There is one column for each of the Part D measures. The measure columns are identified by measure id and measure name. The two rows immediately above this measure information contain the domain id and domain name and the data time frame. All subsequent rows contain the stars associated with an individual contract.

H. Domain Star page

The Domain Star page displays the star rating for each Part D domain. This page is available during the second plan preview.

The first five columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part D domains. The domain columns are identified by the domain name. All subsequent rows contain the stars associated with an individual contract.

I. Summary Rating page

The Summary Rating page displays the Part D rating and data associated with calculating the final summary rating. This page is available during the second plan preview. Table M-13 below explains each of the columns contained on this page.

Table M-13: Part D Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Number Missing	Number of missing measure stars
Number Non-Missing	Number of available measure stars
Calculated Summary	Weighted mean

HPMS Field Label	Field Description
Calculated Variance	Weighted variance
Variance Category	Weighted variance category
iFactor	Weighted i-Factor
Sumnsumifact	Weighted mean plus weighted i-Factor
Summary Score	Final summary score (i.e., rounded Sumnsumifact)
Calculated Score Percentile Rank	Percentile ranking of Sumnsumifact
Variance Percentile Rank	Percentile ranking of weighted variance
PartDO	Part D offered flag
SNP	Special Needs Plan flag
Contract Type	The contract plan type used to compute the ratings
Low Performing Icon	Will the contract receive a Low Performing Icon (Yes/No)
High Performing Icon	Will the contract receive a High Performing Icon (Yes/No)
Improvement Measure Usage	Was the improvement measure (D09) used in the final Part D Summary Rating? (Yes/No)
Sanction Deduction	Did this contract receive an adjustment for contracts under sanction (Yes/No)

J. Technical Notes link

The Technical Notes link provides the user with a copy of the 2013 Plan Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur if errors are identified outside of the plan preview periods and the release data on MPF.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF of the 2013 Plan Ratings technical notes. Right clicking on the technical notes link will pop up a context menu which contains Save Target As…, clicking on this will allow the user to download and save a copy of the PDF document.

K. Medication NDC List – Part D High Risk Medication Measure link

The Medication NDC List – Part D High Risk Medication Measure link provides the user a means to download a copy of the medication list used for the Part D High Risk Medication measure (D14). This downloadable file is in Excel format.

L. Medication NDC List – Part D Diabetes Treatment Measure link

The Medication NDC List – Part D Diabetes Treatment Measure link provides the user a means to download a copy of the medication list used for the Part D Diabetes Treatment measure (D15). This downloadable file is in Excel format.

M. Medication NDC List – Part D Medication Adherence Measure link

The Medication NDC List – Part D Medication Adherence Measure link provides the user a means to download a copy of the medication list used for the Part D Medication Adherence measures (D16, D17 & D18). This downloadable file is in Excel format.