

Medicare Part C and Part D Reporting Requirements
Data Validation Procedure Manual

Appendix K: Pass/Not Pass Determination Methodology

Version 3.0

Prepared by:
Centers for Medicare & Medicaid Services
Center for Medicare
Medicare Drug Benefit and C & D Data Group

[Last Updated: February 28, 2013](#)

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1 INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) requires that organizations contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly review to validate data reported to CMS on a variety of reporting requirements.¹ The purpose of the independent data validation (DV) is to ensure that Part C and Part D organizations (sponsoring organizations) (SOs) are reporting health and drug plan data that are reliable, valid, complete, comparable, and timely.

SOs are responsible for contracting with an independent data validation contractor (reviewer) to conduct retrospective DV reviews for Part C and Part D reporting sections and provide the findings to CMS. CMS has developed Data Validation Standards, which include general standards and reporting section criteria that data validation reviewers must use to determine whether the data each SO reported to CMS per the Part C/Part D Reporting Requirements are accurate, valid, timely, and reliable. The reviewer must rely on the DV standards to assess an SO's information systems' capabilities and overall processes for collecting, storing, compiling, and reporting the required data. CMS requires that DV be conducted annually.

The DV reviewer must determine compliance with each of the DV standards and record the appropriate finding for each standard, sub-standard, and/or data element. At the conclusion of each DV review and the finalization of findings, the reviewer must report these findings directly to CMS via the Plan Reporting Data Validation Module (PRDVM) in the Health Plan Management System (HPMS). Following the completion of the DV cycle, CMS analyzes the results submitted by the reviewer and makes a Pass/Not Pass determination. The graphic shown in Exhibit 1 illustrates where data entry into the HPMS PRDVM and the Pass/Not Pass determination occur within the DV process.

Exhibit 1. Overview of Findings Data Collection Process and Pass/Not Pass Determination



~~To translate findings into Pass/Not Pass determinations, CMS assigns a score to each Data Validation Standard or Sub-Standard based on the findings submitted by reviewers for each data measure and each contract. Individual scores from each Standard or Sub-Standard are summed to calculate individual data measure scores within each contract. Each measure score that meets or exceeds the score threshold set by CMS receives a Pass determination, while any measure score that falls below the threshold receives a Not Pass determination. The overall score for all Part C data measures as a group, which includes an average of all Part C measures reviewed for each contract, also needs to meet or exceed a threshold established by CMS to receive a Pass determination. CMS uses a similar methodology to assign the overall score for all Part D data measures as a group, and a combined Part C and Part D score for those contracts reporting both Part C and Part D data. CMS will score all data validation reviews after the annual deadline for~~

¹ See 42 CFR §422.516(g) and §423.514(g)

~~submission of findings to CMS, and will provide scores to sponsoring organizations in the fall of the calendar year of the data validation review.~~

CMS makes a Pass/Not Pass determination for all DV reviews after the annual deadline for submission of findings, and provides the aggregate results to SOs in the fall of the same calendar year Note that the determinations for the 2013 DV review are based on the results of reporting year 2012 data and the reporting year 2011 data that are subject to validation in year 2013 (i.e., Special Needs Plans (SNP) Care Management, Serious Reportable Adverse Events (SRAEs), and Long Term Care (LTC) Utilization).

To translate findings into Pass/Not Pass determinations, CMS performs the following steps per contract:

1. Sums the standard/sub-standard scores for each reporting section; these scores are derived from the Yes/No findings for each standard/sub-standard.
2. Calculates the average Part C (if applicable) score by summing the scores for all Part C reporting sections and dividing by the number of reporting sections.
3. Calculates the average Part D (if applicable) score by summing the scores for all Part D reporting sections and dividing by the number of reporting sections.
4. Calculates the overall (average) Part C and Part D score (if applicable) by summing the result of steps 3 and 4 and dividing by two.
5. Using the results of steps 3, 4, and 5, above, assigns an overall Part C and/or Part D “Pass” threshold.

Exhibit 2 provides a description of all of the standards and sub-standards from the *Data Validation Standards* that are referenced throughout the remaining portion of this document.

Exhibit 2. Data Validation Standards

VALIDATION STANDARDS	
1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ol style="list-style-type: none"> a. Source documents and output are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via <u>HPMSCMS systems</u>. b. Source documents create all required data fields for reporting requirements. c. Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, <u>use correct fields, have appropriate data selection, etc.</u>). d. All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets). e. Data file locations are referenced correctly. f. If used, macros are properly documented. g. Source documents are clearly and adequately documented. h. Titles and footnotes on reports and tables are accurate. i. Version control of source documents is appropriately applied.

VALIDATION STANDARDS	
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Reporting Section Criteria (Refer to Reporting Section criteria section below):</u></p> <ol style="list-style-type: none"> The appropriate date range(s) for the reporting period(s) is captured. Data are assigned at the applicable level (e.g., plan benefit package or contract level). Appropriate deadlines are met for reporting data (e.g., quarterly). Terms used are properly defined per CMS regulations, guidance and <i>Reporting Requirements Technical Specifications</i>. The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ol style="list-style-type: none"> Data elements are accurately entered/ uploaded into the HPMS tool CMS systems and entries match corresponding source documents. All source, intermediate, and final stage data sets and other outputs relied upon to enter data into HPMSCMS systems are archived.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>
5	<p>Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).</p>
6	<p><i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.</p>
7	<p><i>If data collection and/or reporting for this reporting section is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/downstream contractor.</p>

2 SCORING METHODOLOGY

2.1 Scoring Standards, Sub-Standards and Data Elements

A total of seven standards are evaluated for each reporting section; each standard includes one or more sub-standards. Some sub-standards also include an evaluation of each data element reported for the reporting section. For example, Sub-Standard 2.e requires the reviewer to examine each data element separately to ensure compliance with reporting section criteria. The number of data elements varies depending on the reporting section, from a low of **43** in the Part **C Special Needs Plan (SNP) Care Management ~~D Appeals~~** reporting section to a high of **1796** in the Part **DC Medication Therapy Management (MTM) Programs ~~Provider Network Adequacy~~** reporting section.

For each of the standards, sub-standards, and data elements, the reviewer must assess a “Yes/No” finding. Each “Yes/No” finding is associated with CMS-assigned percentage points and can vary depending on the sub-standard or data element being scored. A “No” finding; however, will always result in a score of zero percentage points.

Exhibit 3 illustrates how Standard 1 and its nine (1a – 1i) sub-standards might be scored. A “Yes” finding for Sub-Standard 1.a equals 0.9 percentage points. A “Yes” finding for Sub-Standard 1.b would result in 2.6 percentage points added to the reporting section’s score, as would a “Yes” finding for Sub-Standard

1.c. As shown below, a “Yes” finding for all nine Sub-Standards associated with Standard 1 would result in a maximum total score of 11.1%.

Exhibit 3. Scores Assigned to Data Validation Standard 1

Standard/ Sub- Standard ID	Standard/Sub-Standard Description	Maximum Possible Score ¹
1	A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	
1.a	Source documents and output are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via HPMS.	0.9%
1.b	Source documents create all required data fields for reporting requirements.	2.6%
1.c	Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors).	2.6%
1.d	All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	0.9%
1.e	Data file locations are referenced correctly.	0.9%
1.f	If used, macros are properly documented.	0.9%
1.g	Source documents are clearly and adequately documented.	0.9%
1.h	Titles and footnotes on reports and tables are accurate.	0.9%
1.i	Version control of source documents is appropriately applied.	0.9%
Total Maximum Score for Standard 1		11.1%

¹ Figures may not sum to totals due to rounding.

Standards 2 through 7 are scored in a similar fashion, although points for each data element in Standards 2 and 3 differ among each reporting section because each reporting section contains a differing number of data elements. The aggregate points for data elements in Sub-Standard 2.e, (20.0%) and 3.a (26.7%) will not vary across reporting sections, but points for an individual data element will vary between reporting sections because the aggregate points are evenly distributed among data elements and the number of data elements varies across reporting section.

For example, Sub-Standard 2.e for the Part C Grievances reporting section has 187 data elements and for the Part D Grievances reporting section has 84 data elements. The score for each data element in the Part C Grievances reporting section is 1.1111111%~~2.9%~~ (20.0% ÷ 187) while the score for each data element in the Part D Grievances reporting section is 2.5%~~5.0%~~ (20.0% ÷ 84.) Exhibit 4 and Exhibit 5 illustrate the Part C and Part D Grievances reporting section scoring at the data element level for Sub-Standard 2.e.

Exhibit 4. Part C Grievances Sub-Standard 2.e

Data Element	Percentage of Total Score ¹
5.1	<u>1.1111111%</u> 2.9%
5.2	<u>1.1111111%</u> 2.9%
5.3	<u>1.1111111%</u> 2.9%
5.4	<u>1.1111111%</u> 2.9%
5.5	<u>1.1111111%</u> 2.9%

Exhibit 5. Part D Grievances Sub-Standard 2.e

Data Element	Percentage of Total Score ¹
A	<u>2.5%</u> 5.0%
B	<u>2.5%</u> 5.0%
C	<u>2.5%</u> 5.0%
D	<u>2.5%</u> 5.0%
<u>E</u>	<u>2.5%</u>

Data Element	Percentage of Total Score ¹
5.6	<u>1.111111%</u> 2.9%
5.7	<u>1.111111%</u> 2.9%
<u>5.8</u>	<u>1.111111%</u>
<u>5.9</u>	<u>1.111111%</u>
<u>5.10</u>	<u>1.111111%</u>
<u>5.11</u>	<u>1.111111%</u>
<u>5.12</u>	<u>1.111111%</u>
<u>5.13</u>	<u>1.111111%</u>
<u>5.14</u>	<u>1.111111%</u>
<u>5.15</u>	<u>1.111111%</u>
<u>5.16</u>	<u>1.111111%</u>
<u>5.17</u>	<u>1.111111%</u>
<u>5.18</u>	<u>1.111111%</u>
Total, Sub-Standard 2.e	20.0%

¹ Percentages may not sum to totals due to rounding

Data Element	Percentage of Total Score ¹
<u>F</u>	<u>2.5%</u>
<u>G</u>	<u>2.5%</u>
<u>H</u>	<u>2.5%</u>
Total, Sub-Standard 2.e	20.0%

¹ Percentages may not sum to totals due to rounding.

Exhibit 6 illustrates the scoring at the standard and sub-standard level, where scores for each standard and sub-standard are displayed as a percentage of the maximum possible score for a reporting section. Since Standard 2 and Standard 3 focus on accurate calculation and entry/upload of data into the HPMS Plan Reporting Module, and this is the primary focus of the DV review, these two standards receive the majority of points in the total score for a reporting section. Note that these percentages will vary for reporting sections that include standards, sub-standards, or data elements that are “Not Applicable.”

Exhibit 6. Scoring Aggregated at the Standard and Sub-Standard Level

Standard	Sub-Standard	Percentage of Total Score ¹
1		
	1.a	0.9%
	1.b	2.6%
	1.c	2.6%
	1.d	0.9%
	1.e	0.9%
	1.f	0.9%
	1.g	0.9%
	1.h	0.9%
	1.i	0.9%
	Standard 1 Subtotal	
2		
	2.a	3.3%
	2.b	3.3%
	2.c	3.3%
	2.d	3.3%

Standard	Sub-Standard	Percentage of Total Score ¹
	2.e	20.0%
Standard 2 Subtotal		33.3%
3		
	3.a	26.7%
	3.b	6.7%
Standard 3 Subtotal		33.3%
4		5.6%
5		5.6%
6		5.6%
7		5.6%
Total¹		100.0%

¹ Percentages may not sum to totals due to rounding.

Note that with the exception of “Not Applicable” standards or sub-standards, percentage points for Standards 1, 4, 5, 6, and 7 will not vary across reporting sections. As explained earlier, percentage points for each data element within Sub-Standards 2.e and 3.a will vary across reporting sections depending upon the number of data elements included in a reporting section. Every reporting section’s final Percentage Score is based on a maximum score of 100 percent. Refer to Appendix A to determine individual sub-standard and data element scores for all Part C and Part D reporting sections.

2.2 Scoring of “Not Applicable” Sub-Standard and Data Elements

2.2.1 Scoring of Sub-Standards and Data Elements that are Always “Not Applicable”

For certain reporting sections, some sub-standards or data elements are always “Not Applicable” for all contracts. For example, in the [Part C Employer Group Plan Sponsors and Part D Employer/Union-Sponsored Group Health Plan Sponsors measures Part D Medication Therapy Management Programs reporting section](#), Sub-Standard 2.e, data elements [A 7.1, 7.2, and 7.3 \(Part C\) and data elements A, B, and C \(Part D\)](#), will always have a “Not Applicable” finding for all contracts and for all SOs. Sub-Standard 2.e requires the DV reviewer to confirm that data elements are calculated properly according to reporting section criteria, [and this data element \(MTM A\) reports the contract number of the file uploaded to HPMS; therefore, no calculation is necessary. However, for the Part C Employer Group Plan Sponsors and Part D Employer/Union-Sponsored Group Health Plan Sponsors measures, data elements 7.1, 7.2, and 7.3 \(Part C\) and data elements A, B, and C \(Part D\), report the employer’s legal name, “doing business as” name, and federal tax ID, and therefore these data elements do not require calculation.](#) In the DV Scoring Matrix found in Appendix A, sub-standards or data elements that are always “Not Applicable” are displayed as black boxes. Points are not assigned to the actual or maximum possible score for any “Not Applicable” sub-standard or data element.

2.2.2 Scoring of Standards, Sub-Standards, and Data Elements that are Sometimes “Not Applicable”

In addition to sub-standards and data elements that are always “Not Applicable,” it is also possible that a reviewer will decide that a particular standard, sub-standard or data element is “Not Applicable” for a reporting section for a particular contract. Standard 6 provides one example of why this may occur. Standard 6 states “If organization’s data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade): Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.” In many cases, an SO’s or contract’s data systems will not undergo any changes during the reporting period, which means

the reviewer will not evaluate the reporting section using this standard and will assign a “Not Applicable” finding rather than a “Yes” or “No” finding. In instances such as this, no points are assigned to the score for the not applicable standard, sub-standard, or data element and no points are included in the reporting section’s total maximum score.

2.3 Reporting Section Scores

CMS scores each reporting section separately by summing the total number of points assigned to the reporting section for those standards, sub-standards or data elements that receive a “Yes” finding. A standard, sub-standard or data element that receives a “No” finding will receive zero points. If a particular standard, sub-standard or data element is found “Not Applicable,” CMS will add zero points to the actual score in the numerator and will also assign zero points to the maximum possible score in the denominator when calculating the Percentage Score. This additional step ensures that an SO is not penalized for receiving a “Not Applicable” for a particular data element.

To illustrate how a reporting section is scored with and without a “Not Applicable” evaluation, refer to Exhibit 7 and Exhibit 8. In both Exhibits, the first column contains the standard evaluated, the second column contains a description of the evaluation for the standard, the third column displays the maximum possible score for each standard, and the fourth column displays the actual score earned by the contract. To simplify the examples only the total score for each standard is displayed (the sum of sub-standard and/or data element scores within each standard).

2.3.1 Scoring Without a “Not Applicable” Finding

In the first example, shown in Exhibit 7, the reviewer has determined a “Yes” finding for every standard, sub-standard, and data element except Standard 5. Standard 5 received a “No” finding and therefore no points are assigned actual score for this standard. In this example there were not any “Not Applicable” findings for this reporting section. The maximum possible score for this reporting section is 100.0% and the actual score is 94.4%. The Percentage Score is calculated by dividing the actual score by the maximum possible score (94.4% ÷ 100.0%).

Exhibit 7. Reporting Section Scoring Example without “Not Applicable” Finding

Standard (1)	Reviewer's Finding (2)	Maximum Possible Score (3)	Actual Score (4)
1	All Sub-Standards received "Yes" findings	11.1%	11.1%
2	All Sub-Standards and data elements received "Yes" findings	33.3%	33.3%
3	All Sub-Standards and data elements received "Yes" findings	33.3%	33.3%
4	Standard received "Yes" finding	5.6%	5.6%
5	Standard received "No" finding	5.6%	0.0%
6	Standard received "Yes" finding	5.6%	5.6%
7	Standard received "Yes" finding	5.6%	5.6%
Totals¹		100%	94.4%
Percentage Score¹		94.4% (94.4% ÷ 100.0%)	

¹ Percentages may not sum to totals due to rounding.

2.3.2 Scoring With a “Not Applicable” Finding

Exhibit 8 is identical to Exhibit 7, except that the reviewer has found Standard 6 to be “Not Applicable.” In this case, no points are included for Standard 6 in either the actual score or the maximum possible score. Calculating the Percentage Score in this case uses the same methodology as illustrated in Exhibit 7. To calculate the Percentage Score, CMS will divide the actual score, 88.9 percent%, by the maximum possible score, 94.4 percent% (deducting 5.6% from the normal maximum possible score of 100% because Standard 6 is “Not Applicable,” $100.0\% - 5.6\% = 94.4\%$), which equals .941, or in percentage terms, 94.1 percent%.

Exhibit 8. Reporting Section Scoring Example with One “Not Applicable” Finding

Standard (1)	Reviewer's Finding (2)	Maximum Possible Score (3)	Actual Score (4)
1	All Sub-Standards Received "Yes" findings	11.1%	11.1%
2	All Sub-Standards and Data Elements Received "Yes" findings	33.3%	33.3%
3	All Sub-Standards and Data Elements Received "Yes" findings	33.3%	33.3%
4	Standard received "Yes" finding	5.6%	5.6%
5	Standard received "No" finding	5.6%	0.0%
6	Standard received "Not Applicable" finding	0.0%	0.0%
7	Standard received "Yes" finding	5.6%	5.6%
Totals		94.4%	88.9%
Percentage Score¹		94.1% (88.9% ÷ 94.4%)	

¹ Percentages may not sum to totals due to rounding.

2.4 Overall Part C, Overall Part D, and Combined Score

In addition to individual reporting section scores for each Part C and Part D reporting section, CMS will calculate overall scores for Part C reporting sections as a group and/or Part D reporting sections as a group. To calculate the Overall Part C and/ or Overall Part D scores, CMS will take a simple average of the individual reporting section scores. Refer to Exhibit 9 and Exhibit 10 for an example of how the Overall Part C and Overall Part D scores are calculated. The Overall Part C score in Exhibit 9 is ~~96.15~~95.5 percent%, calculated by summing the individual reporting section Percentage Scores and dividing by the number of reporting sections ($[100\% + 91.8\% + 100\% + 92.4\% + 100\% + 87.3\% + 99.4\% + 98.3\% + 91.8\%] \div 9$).

Please note that Exhibit 9 and 10 are illustrative and assume that all reporting sections will be calculated together regardless of the reporting section year.

Exhibit 9. Example Overall Part C Score

Part C Reporting Section	Part C % Score ¹
Serious Reportable Adverse Events (SRAEs)	100.0%
Special Needs Plans (SNPs) Care Management	91.8%
Grievances	100.0%
Organization Determinations/Reconsiderations	87.3%
Plan Oversight of Agents	98.3%
Employer Group Plan Sponsors	99.4%
Procedure Frequency	100.0%

Provider Network Adequacy	92.4%
Overall Part C Score (Average of All Part C Reporting Section Scores)	95.5% 96.15%

¹ Percentages may not sum to totals due to rounding.

It is possible that an entire reporting section may be found to be “Not Applicable.” For example, if a contract did not use licensed agents directly employed by the SO or licensed independent agents/brokers to conduct marketing for its Medicare products during the reporting period, then the entire Plan Oversight of Agents reporting section would be found “Not Applicable.” In this case, the overall score for Part C and/or Part D would not include a score for this reporting section (no Percentage score in the numerator and one less reporting section in the denominator). In Exhibit 10, the Overall Part D score is calculated to equal ~~96.5 percent%~~ ~~97.0%~~ $([97.4 + 100\% + 89.9\% + 92.3\% + 99.4\% + 100\% + 100\%] \div 67)$. ~~Because an entire measure, Plan Oversight of Agents, was “Not Applicable,” no score for this measure is included in the numerator and the sum of scores is divided by seven measures instead of eight.~~

Exhibit 10. Example Overall Part D Score

Part D Reporting Section	Part D % Score ¹
Long Term Care Utilization	97.4%
Plan Oversight of Agents	100.0%
Medication Therapy Management Programs	89.9%
Grievances	92.3%
Coverage Determinations and Exceptions	99.4%
Appeals Redeterminations	100.0%
Employer/Union-Sponsored Group Health Plan Sponsors	100.0%
Retail, Home Infusion, and Long Term Care Pharmacy Access	100.0%
Overall Part D Score (Average of All Part D Reporting Section Scores)	96.5% 97.0%

¹ Percentages may not sum to totals due to rounding.

Finally, for contracts that report both Part C and Part D data, CMS will calculate a Combined Part C and Part D score by averaging the Overall Part C Score and the Overall Part D Score. Using the examples in Exhibit 9 and Exhibit 10, the Combined Part C and Part D Score is calculated by taking the average of the Overall Part C Score, ~~96.15%~~ ~~95.5 percent%~~ and the Overall Part D Score, ~~96.5%~~ ~~97.0%~~, which equals ~~96.06%~~ $([96.15 + 96.5] \div 2 = 96.06\%)$.

Exhibit 11. Example Combined Part C and Part D Score

	Overall % Score ¹
Overall Part C Score	95.5% 96.15%
Overall Part D Score	96.5% 97.0%
Overall Combined Part C and Part D Score (Average of Overall Part C Score and Overall Part D Score)	96.0% 96%

3 PASS/NOT PASS SCORING THRESHOLDS

~~CMS will establish Percentage Score Thresholds for each individual Part C and Part D data measure. Measures meeting or exceeding the Percentage Score Thresholds will receive a Pass determination, those that do not will receive a Not Pass determination. In addition to setting Percentage Score Thresholds for~~

~~the individual reporting measures, CMS will also establish Overall Part C, Overall Part D, and Combined Part C and Part D Scoring Thresholds and assign Pass or Not Pass determinations in a similar fashion. CMS may notify each sponsoring organization of the Pass or Not Pass determinations via a report issued through the HPMS PRDVM.~~

As mentioned in Section 1, CMS uses the scores assigned by the reviewers to make Pass/Not Pass determinations at the contract level based on multiple factors, including the mean and standard deviation of scores across all Part C and Part D reporting sections and contracts. Thresholds for Part C, Part D and an overall combined Part C/Part D score are established annually based on the distribution of scores. Contracts meeting or exceeding the threshold receive a Pass determination, those that do not receive a Not Pass determination. SOs receive their scores via HPMS after the findings are submitted. CMS notifies the SOs of the threshold via HPMS and SOs then must determine for themselves if they passed or did not pass. Only if an SO falls below the threshold will they receive a letter from CMS notifying them of their result (Not Pass) and requesting a corrective action plan.

APPENDIX A: DATA VALIDATION SCORING MATRIX

Part C Reporting Sections

Number of Data Elements/Sub-Elements		23	21	96	718	6	9	6	4
Standard/ Sub-Standard	Data Element/Sub-Element Used for Sub-Standards 2e and 3a	Procedure-Frequency	Serious Reportable Adverse Events (SRAEs)	Provider Network Adequacy	Grievances	Organization Determinations/Reconsiderations	Employer Group Plan Sponsors	Plan Oversight of Agents	Special Needs Plans (SNPs) Care Management
1.a		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.b		2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%
1.c		2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%
1.d		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.e		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.f		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.g		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.h		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.i		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
2.a		4.4444444%	4.4444444%	4.4444444%	3.3333333%	3.3333333%	4.4444444%	4.4444444%	4.4444444%
2.b		4.4444444%	4.4444444%	4.4444444%	3.3333333%	3.3333333%	4.4444444%	4.4444444%	4.4444444%
2.c		4.4444444%	4.4444444%	4.4444444%	3.3333333%	3.3333333%	4.4444444%	4.4444444%	4.4444444%
2.d					3.3333333%	3.3333333%			
2.e	1	0.8695652%	0.9523810%	0.2083333%	2.85714285714286 1.1111111%	3.3333333%		3.3333333%	5.0000000%
2.e	2	0.8695652%	0.9523810%	0.2083333%	2.85714285714286 1.1111111%	3.3333333%		3.3333333%	5.0000000%
2.e	3	0.8695652%	0.9523810%	0.2083333%	2.85714285714286 1.1111111%	3.3333333%		3.3333333%	5.0000000%
2.e	4	0.8695652%	0.9523810%	0.2083333%	2.85714285714286 1.1111111%	3.3333333%	4.0000000%	3.3333333%	5.0000000%
2.e	5	0.8695652%	0.9523810%	0.2083333%	2.85714285714286 1.1111111%	3.3333333%		3.3333333%	
3.a	1	1.1594203%	1.2698413%	0.2777778%	3.80952380952381 1.4814815%	4.4444444%	2.9629630%	4.4444444%	6.6666667%
3.b		6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%
4		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%
5		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%
6		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%
7		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%

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 4. Blue-colored sections indicate that scores differ across reporting sections.

Part D Reporting Sections

Number of Data Elements/ Sub-Elements		10	11 17	4 8	10 14	3 4	8	9	6
Standard/ Sub-Standard	Data Element/ Sub-Element Used for Sub-Standards 2e and 3a	Retail, Home- Infusion, and Long- Term-Care- Pharmacy-Access	Medication Therapy Management Programs	Grievances	Coverage Determinations and Exceptions	Appeals- Redeterminations	Long Term Care Utilization	-Employer/Union- Sponsored Group Health Plan- Sponsors	Plan Oversight of Agents
1.a		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.b		2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%
1.c		2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%	2.5641026%
1.d		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.e		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.f		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.g		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.h		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
1.i		0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%	0.8547009%
2.a		4.4444444%	4.4444444-3.3333333%	3.3333333%	3.3333333%	3.3333333%	4.4444444%	4.4444444%	4.4444444%
2.b		4.4444444%	4.4444444-3.3333333%	3.3333333%	3.3333333%	3.3333333%	4.4444444%	4.4444444%	4.4444444%
2.c		4.4444444%	4.4444444-3.3333333%	3.3333333%	3.3333333%	3.3333333%	4.4444444%	4.4444444%	4.4444444%
2.d			3.3333333%	3.3333333%	3.3333333%	3.3333333%			
2.e	A	2.0000000%		5.0000000-2.5000000%	2.0000000-1.4285714%	6.6666666-5.0000000%	2.5000000%		3.3333333%
2.e	B	2.0000000%	1.8181818-1.2500000%	5.0000000-2.5000000%	2.0000000-1.4285714%	6.6666666-5.0000000%	2.5000000%		3.3333333%
2.e	C	2.0000000%	1.8181818-1.2500000%	5.0000000-2.5000000%	2.0000000-1.4285714%	6.6666666-5.0000000%	2.5000000%		3.3333333%
2.e	D	2.0000000%	1.8181818-1.2500000%	5.0000000-2.5000000%	2.0000000-1.4285714%	5.0000000%	2.5000000%	4.0000000%	3.3333333%
2.e	E	2.0000000%	1.8181818-1.2500000%	2.5000000%	2.0000000-1.4285714%		2.5000000%		3.3333333%
3.a	A	2.6666667%		6.6666666-3.3333333%	2.6666666-1.9047619%	8.8888888-6.6666667%	3.3333333%	2.9629630%	4.4444444%
3.b		6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%	6.6666667%
4		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%
5		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%
6		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%
7		5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%	5.5555556%

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