The master table includes reporting time periods for each Part D performance or quality measure shown in the table. All data are reported at the contract level. The Medicare Part D enrollment averages used in some of the measure calculations are based on the Health Plan Management System (HPMS) data for each contract. Appendix A provides additional details regarding the statistical methods used for star assignments.

I. Drug Plan Customer Service

A. Time on Hold When Customer Calls Drug Plan

1. This measure is defined as the average time spent on hold by the call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the "Customer Service for Current Members – Part D" phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract beneficiary customer service call center divided by the number of eligible calls made to a Part D contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the "hold" queue.
2. The CMS standard for this measure is an average hold time of 2 minutes or less. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.
3. Data Source: Call center surveillance data collected by CMS. The "Customer Service for Current Members – Part D" phone number associated with each contract was monitored.

B. Calls Disconnected When Customer Calls Drug Plan

1. This measure is defined as the number of disconnected ("dropped") calls made to the "Customer Service for Current Members – Part D" phone number associated with the contract divided by the total number of calls made to the "Customer Service for Current Members – Part D" phone number associated with that contract.
2. The CMS benchmark for this measure is ≤5%. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.
3. Data Source: Call center surveillance data collected by CMS. The "Customer Service for Current Members – Part D" phone number associated with each contract was monitored.

C. Time on Hold When Pharmacist Calls Drug Plan

1. This measure is the same as A.1 above, but the "Pharmacy Technical Help Desk" phone number was used in place of the Customer Service for Current Members number.
2. The CMS standard for this measure is an average hold time of 2 minutes or less. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.

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

D. Calls Disconnected When Pharmacist Calls Drug Plan

1. This measure is the same as B.1 above, but the "Pharmacy Technical Help Desk" phone number was used in place of the Customer Service for Current Members number.
2. The CMS benchmark for this measure is ≤5%. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.
3. Data Source: Call center surveillance data collected by CMS. The "Pharmacy Technical Help Desk" phone number associated with each contract was monitored.

E. Drug Plan's Timeliness in Giving a Decision for Members Who Make an Appeal

1. 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 have been exceeded by the plan. This is calculated as:
   [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.
4. Missing Data: This rate is not calculated for contracts with less than 800 enrollees.

F. Fairness of Drug Plan's Denials to a Member's Appeal, Based on an Independent Reviewer

1. 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 as the number of cases Upheld + Fully Reversed + Partially Reversed. Dismissed, remanded and withdrawn cases are not included in the denominator.
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.
4. Missing data: A percent is not calculated for contracts with fewer than 5 total cases reviewed by the IRE (i.e. must have 5 or more cases reviewed to have a percent calculated).

II. Member Complaints and Staying with Drug Plan

A. Complaints about the Drug Plan's Benefits and Access to Prescription Drugs

1. For each contract, this rate is calculated using the following:
   [(Number of Part D complaints related to benefits and access issues logged into the CTM) / (Average Medicare Part D enrollment)] * 1,000 * 30 / (Number of Days in Period).
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.

3. Data Source: Data were obtained from the Complaints Tracking Module (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.
   These complaints include the following subcategories:
   - Part D Card did not work at pharmacy
   - Pharmacy does not offer generic alternatives
   - Pharmacy incorrectly listed in Part D Tool
   - Sponsor/plan/provider discouraging Part D benefit usage (e.g., for certain drugs)
   - Pharmacy is located too far away
   - Access and availability
   - Explanation of Benefits (EOB) is inaccurate
   - TrOOP balance unavailable
   - Coordination of benefit
   - 4Rx/E1
   - Transition
   - Part B vs. Part D coverage
   - Other Benefits/Access issues

B. Complaints about Joining and Leaving the Drug Plan

1. For each contract, this rate is calculated using the following:
   [(Number of Part D complaints related to enrollment and disenrollment issues logged into the CTM) / (Average Medicare Part D enrollment)] * 1,000 * 30 / (Number of Days in Period).
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: 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.
   These complaints include the following subcategories:
   - Delayed enrollment processing
   - Inconsistent enrollment practices in same state
   - Enrollment denied
   - Inappropriate enrollment
   - Inappropriate disenrollment
   - Beneficiary has not received Part D card or enrollment materials
   - Delay in receiving materials
   - Untimely processing of disenrollment requests
   - Difficulty switching between plans
   - Involuntarily switched to a different plan
   - Low Income Subsidy (LIS)
   - Untimely processing of enrollment requests

- TRR/Batch File
- Eligibility
- Other Enrollment/Disenrollment issue

C. Complaints about the Drug Plan's Pricing and Out-of-pocket Costs

1. For each contract, this rate is calculated using the following:
   [(Number of Part D complaints related to pricing and co-insurance issues logged into the CTM) / (Average Medicare Part D enrollment)] * 1,000 * 30 / (Number of Days in Period).
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: 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.
   These complaints include the following subcategories:
   - Pharmacy charging more than lowest available price
   - Pharmacy charging more co-insurance than listed on the Part D Tool on their description of benefits or TrOOP
   - Subsidy-eligible enrollees charged improper co-insurance
   - Enrollees charged improper co-insurance based on formulary tier
   - Beneficiary has lost LIS Status/Eligibility
   - Other Pricing/Co-Insurance issue

D. All Other Complaints about the Drug Plan

1. For each contract, this rate is calculated using the following:
   [(Total number of all other Part D complaints logged into the Complaints Tracking Module (CTM)) / (Average Medicare Part D enrollment)] * 1,000 * 30 / (Number of Days in Period).
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: 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.

E. General Notes about Complaint measures:

1. Enrollment numbers used to calculate the complaint rate were based on the average Medicare Part D enrollment over the time period measured for each contract.
2. Data Exclusions: Some complaints that cannot be clearly attributed to the plan are excluded. These include the following complaint types: complaints regarding 1-800-MEDICARE, Medicare websites, SHIPS, SSA, or MEDIC; facilitated enrollment issues; retroactive enrollment and disenrollment issues; enrollment exceptions; complaints identified as wrong contract, wrong category, or a CMS issue missing Medicaid eligibility (pending reassignment

requests); or Part D premium overcharges or withholding issues. Also, the data excludes some complaints from pharmacists or other providers received by CMS.

3. Missing Data: Complaint rates are not calculated for plans with enrollment less than 800 beneficiaries.

F. Members Who Stay with Their Current Drug Plan from One Year to the Next

1. This measure calculates the percent of members who choose to stay with the same drug plan from one year to the next. This is calculated as:

   [(Number of non-LIS members enrolled as of December 2007 who remained enrolled in January 2008 with the same parent organization.) / (Number of non-LIS members enrolled as of December 2007)]
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from Medicare's enrollment system.
4. Data Exclusions/Missing Data: Medicare beneficiaries who received LIS in either benefit year, as these members may be reassigned by CMS or may actively choose to switch plans due to changes in regional premium benchmarks. A percent was not calculated for contracts with 100 or fewer non-LIS members.

III. Member Experience with Drug Plan* *(see important note below)*

A. Drug Plan Provides Information or Help When Members Need It

1. This 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.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Results from the CAHPS survey.

B. Members' Overall Rating of Drug Plan

1. This 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.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Results from the CAHPS survey.

C. Members' Ability to Get Prescriptions Filled Easily When Using the Drug Plan

1. This measure is used to assess member satisfaction related to the ease to which a beneficiary gets the medicines his/her doctor prescribed. The CAHPS score uses the mean of the distribution of responses. The mean is converted into the percentage of maximum points possible. The score shown is the percentage of the best possible score each contract earned.
2. The evaluation of this measure is based on a relative distribution.
3. Data Source: Results from the CAHPS survey.

***Important Note on CAHPS Star Rating Assignment:**

CAHPS Star ratings are designed to compare CAHPS measure scores for each plan to all other plans. In particular, they are based on the percentile rank of each plan's score and tests of significance versus the National average score (i.e. the overall mean score). The numerical ratings describe the underlying scores from which stars are derived, but because the average (mean) performance and number of respondents vary across measures, a given score may translate into a different number of stars for different measures. Star assignments are made using the following rules.

1. A plan is assigned 5 stars if the plan's average CAHPS measure score is ranked above the 85th percentile and the plan's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

2. A plan is assigned 4 stars if it does not meet the 5 star criteria, but meets at least one of these two criteria: (a) the plan's average CAHPS measure score is higher than the 70th percentile OR (b) the plan's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

3. A plan is assigned 1 star if the plan's average CAHPS measure score is ranked below the 15th percentile and the plan's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

4. A plan is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the plan's average CAHPS measure score is lower than the <30th percentile OR (b) the plan's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

5. A plan is assigned 3 stars if the plan's average CAHPS measure score is ranked between the 30th and 70th percentiles (inclusive) and the plan's average CAHPS measure score is NOT statistically significantly different than the national average CAHPS measure score.

IV. Drug Pricing and Patient Safety

A. Completeness of the Drug Plan's Information on Members Who Need Extra Help

1. For each contract, this percent is calculated using the following:

   Beneficiary-weighted monthly average of the Low-Income Subsidy (LIS) matching rate:
   Each month's LIS match rate used in the average is calculated as follows:

   (Number of LIS beneficiaries on CMS enrollment file that have matching enrollment and benefit records (or more favorable benefits) on plan sponsors' enrollment files) / (Number of LIS beneficiaries on CMS enrollment file).

   For a given low income subsidy beneficiary to be considered a match, the plan sponsor must have the beneficiary enrolled, must indicate that the beneficiary is

eligible for a low income subsidy, and must have premium and co-payment levels that match (or are more favorable than) CMS records.

If two or more monthly LIS match rates cannot be calculated due to a sponsor not submitting enrollment data or not submitting a valid file format, the lowest match rate of the reporting period will be substituted in the weighted monthly average calculation. Note: the first incidence of a non-submission or non-validation will be dismissed.

2. Evaluation of this measure is based on a fixed threshold for 3-star assignment, and on a relative distribution for other star assignments.
3. Data Source: Data on the LIS Match Rates are obtained from a CMS contractor based on enrollment data supplied by Part D sponsors compared to enrollment data based on CMS records.
4. Missing Data: Any contracts which exclusively service U.S. territories are excluded from the match rate analysis. Also, sponsors that did not have any LIS beneficiaries enrolled in their plan during the analysis period do not have match rates available.

B. Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website

1. This measure calculates the percentage of submission windows in which the Contract's pricing data were displayed on the Medicare Prescription Drug Plan Finder (MPDPF). This is calculated as follows:

   100% - ([(Number of submission windows data suppressed) / (Total number of submission windows)]* 100).
2. The evaluation of this measure is based on a fixed threshold.
3. Data Source: Data were obtained from biweekly/weekly price files submitted by Part D Sponsors for display on the MPDPF for the reporting period specified, and CMS Quality Assurance analyses of these price files. The pricing availability measure represents data submitted by plans the submission window prior to the start of the reporting time period through the submission window prior to the end of the reporting time period.

C. Drug Plan's Prices that Did Not Increase More Than Expected During the Year

1. This measure evaluates MPDPF pricing data to determine the percent of Plans' drug prices on the MPDPF that did not increase more than expected over a period of time.
   a) This is calculated as:
      The number of drugs studied with price increases greater than 5% in more than two time points of the measurement period weighted by the total units of the purchased according to Verispan data divided by the number of drugs studied during the measurement period weighted by the total units of the purchased according to Verispan data.
   b) The proportion of drugs increasing in price is calculated for each plan and then aggregated to the contract level by weighting each plan by enrollment. The enrollment information is from HPMS from the reporting period specified, and the latest available value for the enrollment of a given plan is selected.
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.

3. Data Source: Data were obtained from a number of sources: MPDPF Pricing Files, HPMS approved formulary extracts, enrollment data, and data from First DataBank, Medispan, and Verispan.

D. Drug Plan's Prices on Medicare's Website Are Similar to the Prices Members Pay at the Pharmacy

1. This measure evaluates how similar pricing in a plan's Prescription Drug Event (PDE) were to the plan's submitted prices for posting on Medicare's website during the same time period.
    a) This is calculated as follows:
    PDE claims for drugs of clinical concern are identified and the unit costs are compared to the unit costs submitted in the Pricing File (PF) used in the MPDPF. For claims with unit costs greater than the unit cost posted on MPDPF, the difference between PDE and PF cost is determined. Within each reference NDC, the cost differences are ranked across all contracts, such that claims with larger differences between PDE and PF costs will receive a higher percentile ranking (maximum of 100). Claims with no difference between PDE and PF costs and claims where the PDE cost was lower than the PF unit cost will receive a percentile ranking of 0. Only reference NDCs with at least 30 claims across all contracts are included in the ranking.
    b) A contract's score is calculated as the average percentile ranking score of all the claims submitted by the contract in the reporting period.
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from MPDPF Pricing Files submitted by drug plans for posting during the reporting period, and Prescription Drug Event (PDE) data files with service dates during the reporting period.
4. Data Exclusions/Missing Data: PDE claims for non-reference NDCs were excluded, as PF unit costs are submitted for reference NDCs only. This analysis excluded reference NDCs with 30 or fewer claims across all contracts, and contracts with 30 or fewer studied reference NDCs due to small sample size.

E. Drug Plan's Members 65 and Older Who Received Prescriptions for Certain Drugs with a High Risk of Side Effects, when There May Be Safer Drug Choices

1. This measure calculates the percentage of a Plan's enrollees 65 years or older who received at least one prescription for drugs with a high risk of serious side effects (a.k.a. High Risk Medication or HRM). This percentage is calculated as:
[(Number of Member-Years of Enrolled Beneficiaries with at Least One HRM: Total number of member-years of beneficiaries 65 years or older who received one HRM at least once during the period measured)/ (Number of Member-Years of Enrolled Beneficiaries in Period Measured: The total number of beneficiary member-years in which the beneficiaries 65 years and older were enrolled during the period measured.)]
2. The evaluation of this measure is based on a hybrid methodology which combines a relative ranking through adjusted percentile and two-stage clustering methods.
3. Data Source: Data were obtained from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for the reporting period. PDE claims are limited to members over

65 years of age, and for those Part D covered drugs identified to have high risk of serious side effects in patients over 65 years of age.

4. Missing Data: A percentage was not calculated for contracts with 30 or fewer enrolled beneficiaries 65 years or older.

Appendix: Business Rules for Part D Individual Measure Star Ratings

A series of business rules in a statistical quality control framework were used to assign star ratings. The three major components of the rating process are presented in *Exhibit 1*. Details of how the three process components were implemented are as follows.

Exhibit 1: Flowchart on the Process of Assigning Star Ratings

Relative Thresholds Derived From the Data Distribution

First, two automatic processing methods are applied to derive thresholds based on the relative distribution of the data. *Adjusted percentile ratings* are used to assign initial thresholds using a percentile distribution. These initial thresholds are adjusted to account for gaps in the data and the relative number of contracts with an observed star value. *Two-stage clustering ratings* are used to assign contracts to a large number of clusters in the first stage to assure that similar contracts receive the same star rating. Then, the second stage determines at most five clusters to which these first-stage clusters are assigned, through which the thresholds are then identified between the clusters of the second stage. In applying these two methods, goodness of fit analysis in an iterative process is performed, as needed, to test the property of raw measure data distribution in contrast to various types of continuous distributions.

A *hybrid combination* is then used to weigh and combine the two estimates of thresholds (derived from adjusted percentile and two-stage clustering) to produce automatically-generated star ratings.

Please refer to the note in Section III regarding star rating assignments used for the three CAHPS performance measures as these represent an exception to the rating process described above.

Fixed Thresholds for Three-Star Rating Based upon Policy

These star ratings are then *manually reviewed* and a *policy based adjustment* is also applied to certain measures with pre-specified performance standards for the three-star rating.

Exception Rules for Data Suppression

Some contracts for certain measures are subject to exception rules in calculating the measure star. Therefore, the following types of contracts have star ratings displayed as "Not enough data available to calculate measure":

- For the complaints-related measures, contracts that have less than 800 enrollees;
- For the delays in appeals decision measure, contracts that have less than 800 or the appeals auto-forward rate is not available; and
- For the reviewing appeals decisions measure, contracts that have less than 5 appeals.

In addition, for the reviewing appeals decisions measure, the measure star is displayed as "No Appeals Required Review" if the number of appeals is zero.

Exhibit 2 below presents how each process component is applied to respective performance measure. The checkmark " ✔ " means the process is applied to that specific measure.

Exhibit 2: Types of Business Rules Applied to Individual Measures

Domain	Performance Measures	Relative Thresholds	Fixed Thresholds	Exception Rules
Drug Plan Customer Service	Time on Hold When Customer Calls Drug Plan	✔	✔	
	Calls Disconnected When Customer Calls Drug Plan	✔	✔	
	Time on Hold When Pharmacist Calls Drug Plan	✔	✔	
	Calls Disconnected When Pharmacist Calls Drug Plan	✔ †	✔	
	Drug Plan's timeliness in giving a decision for members who make an appeal	✔		✔
	Fairness of Drug Plan's denials to a member's appeal, based on an Independent Reviewer	✔ ‡		✔
Member Complaints and Staying with Drug Plan	Complaints about the Drug Plan's Benefits and Access to Prescription Drugs (per 1,000 members)	✔		✔
	Complaints about Joining and Leaving the Drug Plan (per 1,000 members)	✔		✔
	Complaints about the Drug Plan's Pricing and Out-of-pocket Costs (per 1,000 members)	✔		✔
	All Other Complaints about the Drug Plan (per 1,000 members)	✔		✔
	Members who stay with their current Drug Plan from one year to the next	✔		
Member Satisfaction with Drug Plans	Drug Plan Provides Information or Help When Members Need It	✔ ††		
	Members' Overall Rating of Drug Plan	✔		
	Members' Ability to Get Prescriptions Filled Easily When Using the Drug Plan	✔		
Drug Pricing and Patient Safety	Completeness of the Drug Plan's Information on Members Who Need Extra Help	✔	✔	
	Drug plan provides current information on costs and coverage for Medicare's website		✔ †††	
	Drug Plan's prices that stayed the same during the year	✔		
	Drug plan's prices on Medicare's website matches the prices members pay at the pharmacy	✔		
	Drug Plan's Members 65 and older who received prescriptions for certain drugs with a high risk of side effects, when safer drug choices may be possible	✔		

† Calls Disconnected When Pharmacist Calls did not require fixed-point adjustment on the PDP plan type using given data.

‡ Reviewing Appeals Decisions used PDP plan type estimates on MA-PD plan type due to insufficient appeals for MA-PD plan type.

†† A different relative threshold method is applied to the CAHPS measures.

††† Availability of Drug Coverage and Cost Information had only a very small number of distinct values in MA-PD and PDP plan types, and thresholds and star ratings were manually-derived.