Medicare
2014 Part C & D
Star Rating
Technical Notes

Updated – 04/02/2014

Document Change Log

Previous Version	Description of Change	Revision Date
-	Initial release of the Final 2014 Part C & D Star Ratings Technical Notes – incorporates all changes from preview versions	09/27/2013
09/27/2013	Corrected the Overall Rating variance threshold at the 70th percentile, correct value is 1.524, previously it was 1.518.	04/02/2014
09/27/2013	Added the without i-Factor improvement threshold values to tables 7 & 8. Previously only the with improvement i-Factor values were published.	04/02/2014
09/27/2013	Added a sentence to the end of paragraph 8 in "Attachment I: Calculating the Improvement Measure and the Measure Used" to clarify that the i-Factor is recalculated without the improvement measures included.	04/02/2014
09/27/2013	Added missing 1876 Cost organization decision path for Price Accuracy measure (D10) in Attachment N: Missing Data Messages	04/02/2014
09/27/2013	Final release of 2014 Star Ratings Technical Notes	04/02/2014

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Introduction

This document describes the methodology for creating the Part C and D Star Ratings displayed in the Medicare Plan Finder (MPF) tool on http://www.medicare.gov/ and posted on the CMS website at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

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 2014 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2014 Organization Types Reported in the 2014 Star 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	Yes	Yes	No	Yes	No	Yes	Yes	No	No	Yes	Yes
Part D Ratings	Yes (If drugs are offered)	No	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes

* Note: These organization types are Medicare Advantage Organizations

The Star 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 2013 Plan Ratings and 2014 Star Ratings

There have been several changes between the 2013 Plan Ratings and the 2014 Star Ratings. This section provides a synopsis of the significant differences; the reader should examine the entire document for full details about the 2014 Star Ratings.

1. Changes
    a. Part C & D measures: C36 & D01 - Call Center – Foreign Language Interpreter and TTY Availability, for Puerto Rico contracts only, English is measured as a foreign language.
    b. Quality Improvement: C33 & D07 – Modified methodology so that contracts with 5 stars in individual measures over two years are not harmed by values that demonstrate a statistically significant decline (at the 0.05 significance level) on the eligible measure.

c. Part C & D measures: C33 & D07 – Measures are now weighted 3, since these outcome measures have been in the ratings for two years.

d. With the 2014 release, CMS refers to these as Star Ratings; previously they were referred to as Plan Ratings.

2. Additions

   None

3. Transitioned measures (Moved to the display measures which can be found on the CMS website at this address: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html)

   a. Part C & D measures: Enrollment Timeliness

   b. Part D measure: Getting Information from Drug Plan

   c. Part D measure: Call Center - Pharmacy Hold Time

The complete history of measures used in the Star 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 2013 through June 2013) 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 2012 through December 2012) 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 2012 through December 2012), 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

The data used for CMS' Star Ratings must be accurate and reliable. CMS has identified issues with some contracts' data used for Star Ratings, and CMS has taken several steps in the past years to protect the integrity of the data. We continue to guard against new vulnerabilities when inaccurate or biased data are included. CMS' policy is to reduce a contract's measure rating to 1 star and set the numerical data value to "CMS identified issues with this plan's data" if it is identified that biased or erroneous data have been submitted by the plan or identified by CMS.

This would include cases where CMS finds plans' mishandling of data, inappropriate processing, or implementation of incorrect practices has resulted in biased or erroneous data. Examples would include, but are not limited to: a contract's failure to adhere to HEDIS, HOS, or CAHPS reporting requirements; a contract's failure to adhere to Plan Finder data requirements; a contract's errors in processing coverage determinations, organizational determinations, and appeals; a contract's failure to adhere to CMS-approved point-of-sale edits; compliance actions taken against the contract due to errors in operational areas that would directly impact the data reported or processed for specific measures; and a contract's failure to pass data validation directly related to data reported for specific measures.

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 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 2014, the Part C and D Star 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 summary rating for a contract. There is also a Part D summary rating formed by grouping the Part D measures.

Overall: All the Part C and Part D measures are grouped together to form the Overall rating for a contract.

Because different organization types offer different benefits, CMS must classify contracts into three categories that we call contract types. Each of these contract types has a different highest level rating associated with it because of the set of measures available. Table 2 illustrates how CMS classifies contracts for purposes of the Star Ratings.

Table 2: Highest Rating by Contract Type

Contract Type	Offers Part C or 1876 Cost	Offers Part D	Highest Rating
MA-Only	Yes	No	Part C rating
MA-PD	Yes	Yes	Overall rating
PDP	No	Yes	Part D rating

Table 3 relates the three contract types to the organization types reported on in the 2014 Star Ratings.

Table 3: Relation of 2014 Organization Types to Contract Types in the 2014 Star Ratings

Organization Type	1876 Cost (not offering drugs)	1876 Cost (offers drugs)	Demo	Employer/Union Only Direct Contract			Local CCP	MSA	PDP	PFFS	Regional CCP
				Local CCP	PDP	PFFS					
Rated As	MA-Only	MA-PD	MA-PD	MA-PD	PDP	MA-PD	MA-PD	MA-Only	PDP	MA-PD	MA-PD

For the highest rating, the improvement measure(s) may not be used under certain circumstances which are explained in the section titled “Applying the Improvement Measure(s)”.

There are a total of 9 domains (topic areas) comprised of up to 51 measures.

1. MA-only contracts are measured on 5 domains with up to 36 measures.
2. PDPs are measured on 4 domains with up to 15 measures.
3. MA-PD contracts are measured on all 9 domains with up to 48 unique measures.

Methodology for Assigning Part C and D Measure Star Ratings

CMS develops Part C and Part D Star 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 Star 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 Star Ratings data into 5-star categories for every measure. For example, in the health plan measure of Osteoporosis Management in Women who 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 (the 2014 Star Ratings does not contain any measures with a regulatory standard). Additionally, CMS originally set these thresholds in order to define expectations about what it takes to be a high quality contract and to drive quality improvement. These target 4-star thresholds are based on the performance of all contracts in prior years; therefore they have not been set for revised measures or for measures with less than 2 years of measurement experience and may be dropped if there is a significant change in a measures metric. No new 4-star thresholds were set for the 2014 Star Ratings as CMS analyzed the impact of the thresholds on the scoring methodology.

The distribution of data is evaluated to assign the other star values. For example, in the breast cancer screening measure, a contract that has a rate of 74% or more will receive at least 4 stars. A contract that had a breast cancer screening rate of 98% will receive 5 stars since they 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' Star 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 O), 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 O 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 predetermined 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. There are currently no measures for which a CMS standard has been set. Previously, the instance in which this method applied was the call center hold time measure. Contracts that meet or exceeded the CMS standard were 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 were 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 4 shows each domain and the number of measures needed for each contract type.

Table 4: Domain Rating Requirements

Part	Domain ID	Domain Name	Contract Type: 1876 Cost †	Demo	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	6 of 10	N/A	6 of 10
C	2	Managing Chronic (Long Term) Conditions	5 of 9	7 of 13	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	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	3 of 4	N/A	3 of 4
C	5	Health Plan Customer Service	2 of 2	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3
D	1	Drug Plan Customer Service	2 of 2*	2 of 3*	2 of 3	2 of 3	N/A	2 of 3	2 of 3
D	2	Member Complaints, Problems Getting Services, and Improvement in the Drug Plan's Performance	3 of 4*	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 2*	2 of 2*	2 of 2	2 of 2	N/A	2 of 2	2 of 2
D	4	Patient Safety and Accuracy of Drug Pricing	3 of 5*	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 2014 Star 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 is 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 is 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 Summary Ratings

The Part C and Part D summary 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 summary rating, a contract must meet the minimum number of individual measures with assigned 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 15 required Part D measures for the organization, 15 / 2 = 7.5, when rounded the result is 8. The contract needs at least 8 measures with ratings out of the 15 total measures to receive a Part D summary 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 36 required Part C measures for the organization, 36 / 2 = 18. The contract needs at least 18 measures with ratings out of the 36 total measures to receive a Part C summary rating.

Table 5 shows the minimum number of measures having a rating needed by each contract type to receive a rating.

Table 5: Part C and Part D Summary Rating Requirements

Rating	1876 Cost †	Demo	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	15 of 30	18 of 35	16 of 32	18 of 35	16 of 32	N/A	16 of 32
Part D Rating	6 of 12	7 of 14	7 of 14	7 of 14	N/A	7 of 14	7 of 14

† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 6 out of 11 measures to receive a Part D rating.

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

Additionally, to reward consistently high performance, CMS 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), is 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 summary rating and the Part D summary rating. If a MA-PD contract has only one of the two required summary ratings, it will show as, “Not enough data available”.

The overall Star 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 51 measures (36 in Part C, 15 in Part D). The following three measures are contained in both the Part C and D measure lists:

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

These measures share the same data source, so CMS has only included the measure once in calculating the overall Star 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 48 distinct measures (the Part D CTM, BAPP and MCLP 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 summary ratings. Table 6 shows the minimum number of measures having a rating needed by each contract type to receive an overall rating.

Table 6: Overall Rating Requirements

Rating	1876 Cost †	Demo	Local, E-Local & Regional CPP w/o SNP	Local, E-Local & Regional CPP with SNP	MSA	E-PDP & PDP	E-PFFS & PFFS
Overall Rating	20 of 39*	23 of 46	22 of 43	23 of 46	N/A	N/A	22 of 43

* 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 22 out of 44 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 D07) compare the underlying numeric data from the 2013 Plan Ratings with the data from the 2014 Star 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 & D07) for MA-PD contracts. C33 is used in calculating the Part C summary rating, and D07 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 (D07) 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 (Reward for Consistently High Performance)

The following represents the steps taken to calculate and include the i-Factor in the Star 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 7 and 8 show the final threshold values used in i-Factor calculations for the 2014 Star Ratings:

Table 7: Performance Summary Thresholds

Improvement	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
with	65th	3.705	3.746	3.729	3.686
with	85th	4.100	4.097	4.169	3.973
without	65th	3.711	3.774	3.698	3.667
without	85th	4.130	4.107	4.143	4.000

Table 8: Variance Thresholds

Improvement	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
with	30th	1.065	1.234	1.090	1.148
with	70th	1.455	1.988	1.765	1.524
without	30th	1.054	1.257	1.158	1.166
without	70th	1.459	2.044	1.788	1.534

Calculation Precision

CMS and its contractors have always used software called SAS (pronounced "sass", an integrated system of software products provided by SAS Institute Inc.) to perform the calculations used in the Star Ratings. For all measures, except the improvement measures, the precision used in scoring the measure is indicated next to the label “Data Display” within the detailed description of each measure. The improvement measures are discussed further below. The domain ratings are the average of the star measures and are rounded to the nearest integer.

The improvement measures, summary and overall ratings are calculated with at least six digits of precision after the decimal. During plan previews, we display three digits after the decimal in HPMS for easier human readability. We used to only display two digits after the decimal, but there were instances where this artificially rounded value made it appear that values had achieved a boundary when they actually did not. There will still be instances when displaying three digits that values will appear to be at a boundary. When those cases occur, the Part C and Part D ratings mailboxes can be contacted; they will provide the exact precision values which were used in the actual calculations.

It is not possible to replicate CMS’ calculations exactly due to factors including, but not limited to, rounding of published raw measure data and CMS excluding some contracts’ ratings from publically-posted data (e.g., terminated contracts).

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 9 shows how scores are rounded.

Table 9: Rounding Rules for Summary and Overall Scores

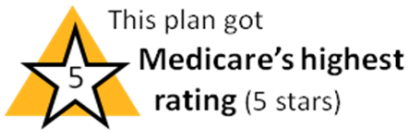
Raw Summary / Overall Score	Final Summary / Overall Score
≥ 0.000 and < 0.250	0
≥ 0.250 and < 0.750	0.5
≥ 0.750 and < 1.250	1.0
≥ 1.250 and < 1.750	1.5
≥ 1.750 and < 2.250	2.0
≥ 2.250 and < 2.750	2.5
≥ 2.750 and < 3.250	3.0
≥ 3.250 and < 3.750	3.5
≥ 3.750 and < 4.250	4.0
≥ 4.250 and < 4.750	4.5
≥ 4.750	5.0

For example, a summary or overall score of 3.749 rounds down to 3.5, and a measure score of 3.751 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 and/or Part D summary rating. The low performing icon is calculated by evaluating the Part C and Part D summary level ratings for the current year and the past two years (i.e., the 2012, 2013 and 2014 Star Ratings). If the contract had any combination of Part C and/or Part D summary rating of 2.5 or lower in all three years of data, it is marked with a low performing icon (LPI). A contract must have a rating in either Part C and/or Part D for all three years to be considered for this icon.

Table 10 shows example contracts which will receive an LPI.

Table 10: Example LPI contracts

Contract/Rating	Rated As	2012 C	2013 C	2014 C	2012 D	2013 D	2014 D	LPI Awarded	LPI Reason
HAAAA	MA-PD	2	2.5	2.5	3	3	3	Yes	Part C
HBBBB	MA-PD	3	3	3	2.5	2	2.5	Yes	Part D
HCCCC	MA-PD	2.5	3	3	3	2.5	2.5	Yes	Part C or D
HDDDD	MA-PD	3	2.5	3	2.5	3	2.5	Yes	Part C or D
HEEEE	MA-PD	2.5	2	2.5	2	2.5	2.5	Yes	Part C and D
HFFFF	MA-Only	2.5	2	2.5	-	-	-	Yes	Part C
SAAAA	PDP	-	-	-	2.5	2.5	2	Yes	Part D

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 in their highest rating. If a contract under sanction already has 2.5 stars or below in their highest rating, 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 highest Star Rating reduced in that fall's rating on MPF.
- March 31st: Star 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 highest Star Rating restored. A contract that received a sanction after August 31st will have its highest Star 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 2014 Star 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 Star 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.

Star Ratings and Marketing

Plan sponsors must ensure the Star Ratings document and all marketing of Star Ratings information is compliant with CMS' Medicare Marketing Guidelines. Failure to follow CMS' guidance may result in compliance actions 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 Star Ratings information to your Account Manager.

Contact Information

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

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

If you have questions or require information about the specific subject areas associated with the Star 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: CallCenterMonitoring@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

Framework and definitions for the Domain and Measure Details section

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

Domain: Contains the domain to which the measures below it belong

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

Label for Stars:	The label that will appear with the stars for this measure on Medicare.gov.
Label for Data:	The label that will appear with the numeric data for this measure on Medicare.gov.
HEDIS Label:	Optional – this sub-section is displayed for HEDIS measures only, it contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – when listed, this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS/HOS measures.
Description:	The English language measure description that will be shown for the measure on Medicare.gov. The text in this sub-section has been cognitively tested with beneficiaries to aid in their understanding the purpose of the measure.
Metric:	Defines how the measure is calculated.
Exclusions:	Optional – when listed, this sub-section will contain any exclusions applied to the data in the final measure.
Standard:	Optional – when listed, this sub-section will contain information about any CMS standards that apply for the measure.
General Notes:	Optional – when listed, this sub-section contains additional information about the measure and the data used.
Data Source:	The source of the data used in the measure.
Data Source Description:	Optional – when listed, this sub-section contains additional information about the data source for the measure.
CMS Framework Area:	Contains the area where this measure fits into the CMS Quality Framework.
NQF #:	The National Quality Framework (NQF) number for the measure or “None” if the measure is not NQF endorsed.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS is unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Statistical Method:	The methodology used for assigning stars in this measure, see the section titled “Methodology for Assigning Part C and Part D Measure Star Ratings” for an explanation of each of the possible entries in this sub-section.
Improvement Measure:	Indicates whether this measure is included in the improvement measure or not.
Weighting Category:	The category this measure belongs to for weighting.
Weighting Value:	The numeric weight that will be used for this measure in the summary and overall rating calculations.
Data Display:	The format that will be used to the display the numeric data on Medicare.gov
Reporting Requirements:	Table indicating which organization types were required to report the measure. “Yes” for organizations required to report, “No” for organizations not required to report.
4-Star Threshold:	Contains the 4-star threshold for the measure or “Not predetermined” if there is none.
Cut Points:	Table containing the cut points used in the measure. For CAHPS measures, these cut points were used prior to the final star rules being applied.

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 2013 Technical Specifications Volume 2, page 81

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 2013 Technical Specifications Volume 2, page 82, Table BCS-B for codes to identify exclusions.

Contracts that reported HEDIS 2013, whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0031

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 74%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 50%	≥ 50% to < 63%	≥ 63% to < 74%	≥ 74% to < 81%	≥ 81%

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 2013 Technical Specifications Volume 2, page 86

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 2013 Technical Specifications Volume 2, page 87, Table COL-B for codes to identify exclusions.

Contracts that reported HEDIS 2013, whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0034

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 58%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 40%	≥ 40% to < 49%	≥ 49% to < 58%	≥ 58% to < 65%	≥ 65%

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 2013 Technical Specifications Volume 2, page 138

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: Contracts that reported HEDIS 2013, whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0075

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 78%	≥ 78% to < 83%	≥ 83% 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 2013 Technical Specifications Volume 2, page 152

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 2013 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 2013 Technical Specifications Volume 2, page 156, 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.

Contracts that reported HEDIS 2013, whose enrollment was less than 1,000 as of the

July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 1780

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 79%	≥ 79% to < 83%	≥ 83% to < 85%	≥ 85% to < 93%	≥ 93%

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 2013 Technical Specifications Volume 2, page 94

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 2013 Technical Specifications Volume 2, page 95, Table GSO-B for codes to identify exclusions.

Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 70%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 29%	≥ 29% to < 64%	≥ 64% to < 70%	≥ 70% to < 77%	≥ 77%

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 2013. 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, 2012?

CMS Framework Area: Clinical care

NQF #: 0040

Data Time Frame: 02/15/2013 - 05/31/2013

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 71%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 64%	≥ 64% to < 68%	≥ 68% to < 71%	≥ 71% to < 78%	≥ 78%

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: 2010-2012 Cohort 13 Performance Measurement Results (2010 Baseline data collection, 2012 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: 04/18/2012 - 07/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 58%	≥ 58% to < 59%	≥ 59% to < 60%	≥ 60% to < 67%	≥ 67%

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: 2010-2012 Cohort 13 Performance Measurement Results (2010 Baseline data collection, 2012 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: 04/18/2012 - 07/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 76%	≥ 76% to < 81%	≥ 81% 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 2013 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 13 Follow-up Data collection (2012) and Cohort 15 Baseline data collection (2012).

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: 04/18/2012 - 07/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 43%	≥ 43% to < 51%	≥ 51% to < 60%	≥ 60% to < 64%	≥ 64%

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 2013 Technical Specifications Volume 2, page 58

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 2013 Technical Specifications Volume 2, page 59, Table ABA-C) during the measurement year or the year prior to the measurement year.

Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 1690

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 52%	≥ 52% to < 68%	≥ 68% to < 77%	≥ 77% to < 89%	≥ 89%

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 2013 Technical Specifications Volume 2, page 96

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: SNP benefit packages whose enrollment was less than 30 as of February 2012 SNP Comprehensive Report were excluded from this measure.

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

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0553

Data Time Frame: 01/01/2012 - 12/31/2012

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

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 51%	≥ 51% to < 65%	≥ 65% to < 75%	≥ 75% 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 2013 Technical Specifications Volume 2, page 96

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: SNP benefit packages whose enrollment was less than 30 as of February 2012 SNP Comprehensive Report were excluded from this measure.

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

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2012 - 12/31/2012

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

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 30%	≥ 30% to < 42%	≥ 42% to < 62%	≥ 62% to < 87%	≥ 87%

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 2013 Technical Specifications Volume 2, page 96

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: SNP benefit packages whose enrollment was less than 30 as of February 2012 SNP Comprehensive Report were excluded from this measure.

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

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2012 - 12/31/2012

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

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 36%	≥ 36% to < 52%	≥ 52% to < 76%	≥ 76% to < 91%	≥ 91%

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 2013 Technical Specifications Volume 2, page 174

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: Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0053

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 60%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 16%	≥ 16% to < 36%	≥ 36% to < 60%	≥ 60% to < 70%	≥ 70%

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 2013 Technical Specifications Volume 2, page 152

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: Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0055

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 64%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 41%	≥ 41% to < 53%	≥ 53% to < 64%	≥ 64% to < 70%	≥ 70%

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 2013 Technical Specifications Volume 2, page 152

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: Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0062

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 80%	≥ 80% to < 83%	≥ 83% to < 85%	≥ 85% to < 89%	≥ 89%

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 2013 Technical Specifications Volume 2, page 152

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: Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0059

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 80%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 48%	≥ 48% to < 64%	≥ 64% to < 80%	≥ 80% to < 84%	≥ 84%

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 2013 Technical Specifications Volume 2, page 152

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: Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0064

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 53%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 31%	≥ 31% to < 44%	≥ 44% to < 53%	≥ 53% to < 59%	≥ 59%

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 2013 Technical Specifications Volume 2, page 142

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 2013 Technical Specifications Volume 2, page 145, 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 2013 Technical Specifications Volume 2, page 192 Table FUH-B for codes to identify nonacute care.

Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0018

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 63%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 37%	≥ 37% to < 49%	≥ 49% to < 63%	≥ 63% to < 77%	≥ 77%

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 2013 Technical Specifications Volume 2, page 172

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 2013 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.

Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0054

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 78%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 51%	≥ 51% to < 66%	≥ 66% to < 78%	≥ 78% to < 83%	≥ 83%

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 2013 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 13 Follow-up Data collection (2012) and Cohort 15 Baseline data collection (2012).

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: 04/18/2012 - 07/31/2012

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	Demo	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	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 2013 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 13 Follow-up Data collection (2012) and Cohort 15 Baseline data collection (2012).

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: 04/18/2012 - 07/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 59%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 50%	≥ 50% to < 54%	≥ 54% to < 59%	≥ 59% to < 71%	≥ 71%

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 2013 Technical Specifications Volume 2, page 331

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.

Contracts whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

General Notes: In the 2013 Plan Ratings, 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. The data for 1876 Cost contracts will be handled the same way in this measure for the 2014 Star Ratings.

Data Source: HEDIS

CMS Framework Area: Care coordination

NQF #: 1768

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
> 21%	> 14% to ≤ 21%	> 11% to ≤ 14%	> 9% to ≤ 11%	≤ 9%

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 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	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 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	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 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	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 - Rating of Health Care Quality

Label for Stars: Member's Rating of Health Care Quality

Label for Data: Member's Rating of Health Care Quality

Description: Percent of the best possible score the plan earned from members who rated the 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 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	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 contracts with fewer than 3 base stars may have been assigned 3 final stars.

Measure: C28 - Rating of Health Plan

Label for Stars: Member's Rating of Health Plan

Label for Data: Member's Rating of Health Plan

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	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 < 88%	≥ 88%

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.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	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

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: 01/01/2013 - 06/30/2013

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	Demo	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	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
> 0.50	> 0.32 to ≤ 0.50	> 0.16 to ≤ 0.32	> 0.10 to ≤ 0.16	≤ 0.10

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 2012, 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 1/1/2013 or later are marked as "Plan too new to be measured".
  - All contracts with an effective date prior to 1/1/2013 begin with a score 100.
  - Contracts that received a performance audit have their score reduced to the percentage of elements passed out of all elements audited.
- Contracts placed under sanction anytime during the data time frame are reduced to a score of 0. This is separate from the deduction applied at the overall score level for contracts with more recent sanctions.
- 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 noncompliance, 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 individual ad-hoc 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, 2012 and December 31, 2012. 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: 01/01/2012 - 12/31/2012

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	Demo	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	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 2012. (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, 2012–December 31, 2012 divided by all members enrolled in the plan at any time during 2012.

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 contract 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: 01/01/2012 - 12/31/2012

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: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Demo	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	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
> 20%	> 14% to ≤ 20%	> 11% to ≤ 14%	> 8% to ≤ 11%	≤ 8%

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 2013 and 2014 Star 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 measures were used.

Data Source: Star Ratings

Data Source Description: 2013 and 2014 Star 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: 3

Data Display: Not Applicable

Reporting Requirements:

1876 Cost	Demo	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	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< -0.296	≥ -0.296 to < 0.000	≥ 0.000 to < 0.148	≥ 0.148 to < 0.368	≥ 0.368

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.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 85%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 44%	≥ 44% to < 73%	≥ 73% to < 85%	≥ 85% to < 92%	≥ 92%

Measure: C35 - Reviewing Appeals Decisions

Label for Stars: Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer

Label for Data: Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer

Description: This measure/rating shows how often an Independent Reviewer thought the health plan's decision to deny an appeal was fair. This includes appeals made by plan members and out-of-network providers. (This rating is not based on how often the plan denies appeals, but rather *how fair* the plan is when they do deny an 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, 2013, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after April 1, 2013 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: 01/01/2012 - 12/31/2012

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	Demo	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	Yes	No	Yes

4-Star Threshold: ≥ 87%

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 69%	≥ 69% to < 80%	≥ 80% to < 87%	≥ 87% to < 95%	≥ 95%

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

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

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

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

Metric: The calculation of this measure is the number of successful contacts with the interpreter or TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter 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 service is defined as establishing contact with a TTY operator who can answer questions about the plan's Medicare Part C 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: 02/11/2013 – 05/31/2013 (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	Demo	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	Yes	No	Yes

4-Star Threshold: Not predetermined

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 32%	≥ 32% to < 60%	≥ 60% to < 81%	≥ 81% to < 93%	≥ 93%

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 – Foreign Language Interpreter and TTY Availability

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

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

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

Metric: The calculation of this measure is the number of successful contacts with the interpreter or TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter 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 service is defined as establishing contact with a TTY operator who can answer questions about the plan's Medicare Part 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: 02/11/2013 – 05/31/2013 (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	Demo	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	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	< 88%	≥ 88% to < 91%	≥ 91% to < 95%	≥ 95% to < 97%	≥ 97%
PDP	< 70%	≥ 70% to < 82%	≥ 82% to < 91%	≥ 91% to < 93%	≥ 93%

Measure: D02 - 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: Percent of plan members who got a timely response when they made an appeal request to the drug plan about a decision to refuse payment or coverage.

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: 01/01/2012 - 12/31/2012

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	Demo	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	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	> 3.4	> 1.8 to ≤ 3.4	> 1.3 to ≤ 1.8	> 0.3 to ≤ 1.3	≤ 0.3
PDP	> 4.6	> 1.9 to ≤ 4.6	> 1.0 to ≤ 1.9	> 0.4 to ≤ 1.0	≤ 0.4

Measure: D03 - Appeals Upheld

Label for Stars: Fairness of Drug Plan's Appeal Decisions, Based on an Independent Reviewer

Label for Data: Fairness of Drug Plan's Appeal Decisions, Based on an Independent Reviewer

Description: This measure/rating shows how often an Independent Reviewer thought the drug plan's decision to deny an appeal was fair. This includes appeals made by plan members and out-of-network providers. (This rating is not based on how often the plan denies appeals, but rather *how fair* the plan is when they do deny an 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: 01/01/2013 - 6/30/2013

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	Demo	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	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	< 60%	≥ 60% to < 69%	≥ 69% to < 72%	≥ 72% to < 86%	≥ 86%
PDP	< 57%	≥ 57% to < 63%	≥ 63% to < 68%	≥ 68% to < 75%	≥ 75%

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

Measure: D04 - 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 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

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: 01/01/2013 - 06/30/2013

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	Demo	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	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	> 0.50	> 0.32 to ≤ 0.50	> 0.16 to ≤ 0.32	> 0.10 to ≤ 0.16	≤ 0.10
PDP	> 0.43	> 0.15 to ≤ 0.43	> 0.12 to ≤ 0.15	> 0.08 to ≤ 0.12	≤ 0.08

Measure: D05 - 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 2012, 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 1/1/2013 or later are marked as "Plan too new to be measured".
  - All contracts with an effective date prior to 1/1/2013 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 placed under sanction anytime during the data time frame are reduced to a score of 0. This is separate from the deduction applied at the overall score level for contracts with more recent sanctions.
- 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 noncompliance, 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 individual ad-hoc 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, 2012 and December 31, 2012. 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: 01/01/2012 - 12/31/2012

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	Demo	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	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	≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80
PDP	≤ 20	> 20 to ≤ 40	> 40 to ≤ 60	> 60 to ≤ 80	> 80

Measure: D06 - 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 2012. (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, 2012–December 31, 2012 divided by all members enrolled in the plan at any time during 2012.

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 contract 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: 01/01/2012 - 12/31/2012

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: Percentage with no decimal point

Reporting Requirements:

1876 Cost	Demo	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	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	> 20%	> 14% to ≤ 20%	> 11% to ≤ 14%	> 8% to ≤ 11%	≤ 8%
PDP	> 16%	> 11% to ≤ 16%	> 8% to ≤ 11%	> 5% to ≤ 8%	≤ 5%

Measure: D07 - 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 2013 and 2014 Star 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 measures were used.

Data Source: Star Ratings

Data Source Description: 2013 and 2014 Star 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: 3

Data Display: Not Applicable

Reporting Requirements:

1876 Cost	Demo	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	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	< -0.154	≥ -0.154 to < 0.000	≥ 0.000 to < 0.385	≥ 0.385 to < 0.571	≥ 0.571
PDP	< -0.154	≥ -0.154 to < 0.000	≥ 0.000 to < 0.385	≥ 0.385 to < 0.571	≥ 0.571

Domain: 3 - Member Experience with the Drug Plan

Measure: D08 - Rating of Drug Plan

Label for Stars: Members' Rating of Drug Plan

Label for Data: Members' Rating of Drug Plan

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2013. 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 prescription drug plan?

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

NQF #: None

Data Time Frame: 02/15/2013 - 05/31/2013

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	Demo	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	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%	*	≥ 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 contracts with fewer than 3 base stars may have been assigned 3 final stars.

Measure: D09 - 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 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 2013. 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: 02/15/2013 - 05/31/2013

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	Demo	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	Yes

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

Cut Points:

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

* Due to rounding and the placement of the predetermined 4-star cutoff, no contracts were assigned 2 or 3 base stars; all contracts meeting the cutoff for 2 or 3 base stars also met the cutoff for 4 base stars. However after application of the further criteria of significance and reliability, some contracts with fewer than 2 base stars may have been assigned 2 or 3 final stars.

Domain: 4 - Patient Safety and Accuracy of Drug Pricing

Measure: D10 - 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 Website (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 measurement period 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
- PDE must be for retail pharmacy (pharmacies marked retail and mail order/HI/LTC are excluded)

General Notes: Contracts receive only 3, 4 or 5 stars in this measure, due to the distribution of the data. Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.

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

Data Source Description: 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: 01/01/2012 - 09/30/2012

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Rate with no decimal point

Reporting Requirements:

1876 Cost	Demo	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	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	< 98	≥ 98 to < 100	≥ 100
PDP	NA	NA	< 99	NA	≥ 99

Measure: D11 - 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 the same HRM 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 the same 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 same HRM is defined at the active ingredient level. The active ingredient is identified using the active ingredient flags in the PQA's NDC list. The updated PQA HRM measure drug list based upon the new American Geriatrics Society (AGS) recommendations will not be used to calculate the 2014 Star 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. Beneficiaries must be enrolled and age 65 or older in at least one month of the period measured. 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, 2012-December 31, 2012 by June 30, 2013. 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: 01/01/2012 - 12/31/2012

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 no decimal point

Reporting Requirements:

1876 Cost	Demo	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	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	> 11%	> 8% to ≤ 11%	> 5% to ≤ 8%	> 3% to ≤ 5%	≤ 3%
PDP	> 11%	> 8% to ≤ 11%	> 5% to ≤ 8%	> 3% to ≤ 5%	≤ 3%

Measure: D12 - 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 18 years or older 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 18 years or older from the eligible population who received a RAS antagonist medication during the period measured)/

(Number of member-years of enrolled beneficiaries 18 years or older in the 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, 2012-December 31, 2012 by June 30, 2013. 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: 01/01/2012 - 12/31/2012

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	Demo	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	Yes

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

Cut Points:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 82%	≥ 82% to < 85%	≥ 85% to < 86%	≥ 86% to < 87%	≥ 87%
PDP	< 80%	≥ 80% to < 82%	≥ 82% to < 83%	≥ 83% to < 84%	≥ 84%

Measure: D13 - Medication Adherence for Diabetes Medications

Label for Stars: Taking Diabetes Medication as Directed

Label for Data: Taking 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 diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. ("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 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 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 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 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. Enrollment is measured at the spell level, and inclusion in the measure is determined separately for each spell – i.e., to be included for a given spell, the beneficiary must meet the initial inclusion criteria for the measure during that spell. The measure is weighted based on the total number of member years for each spell in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three month spell, disenrolled for a six month spell, reenrolled for a three month spell, and meets the measure criteria during

each enrollment spell , s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the Medi-Span generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings.

Please see Attachment L: 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, 2012-December 31, 2012 by June 30, 2013. 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 diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Clinical care

NQF #: 0541

Data Time Frame: 01/01/2012 - 12/31/2012

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	Demo	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	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	< 67%	≥ 67% to < 71%	≥ 71% to < 74%	≥ 74% to < 77%	≥ 77%
PDP	< 73%	≥ 73% to < 76%	≥ 76% to < 79%	≥ 79% to < 82%	≥ 82%

Measure: D14 - 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. Enrollment is measured at the spell level, and inclusion in the measure is determined separately for each spell – i.e., to be included for a given spell, the beneficiary must meet the initial inclusion criteria for the measure during that spell. The measure is weighted based on the total number of member years for each spell in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three month spell, disenrolled for a six month spell, reenrolled for a three month spell, and meets the measure criteria during each enrollment spell , s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the Medi-Span generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings.

Please see Attachment L: 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, 2012-December 31, 2012 by June 30, 2013. 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: 01/01/2012 - 12/31/2012

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	Demo	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	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	< 68%	≥ 68% to < 72%	≥ 72% to < 75%	≥ 75% to < 79%	≥ 79%
PDP	< 73%	≥ 73% to < 76%	≥ 76% to < 79%	≥ 79% to < 81%	≥ 81%

Measure: D15 - 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.

The 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 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. Enrollment is measured at the spell level, and inclusion in the measure is determined separately for each spell – i.e., to be included for a given spell, the beneficiary must meet the initial inclusion criteria for the measure during that spell. The measure is weighted based on the total number of member years for each spell in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three month spell, disenrolled for a six month spell, reenrolled for a three month spell, and meets the measure criteria during each enrollment spell , s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the Medi-Span generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings.

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, 2012-December 31, 2012 by June 30, 2013. 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: 01/01/2012 - 12/31/2012

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	Demo	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	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	< 63%	≥ 63% to < 68%	≥ 68% to < 71%	≥ 71% to < 75%	≥ 75%
PDP	< 70%	≥ 70% to < 72%	≥ 72% to < 74%	≥ 74% to < 76%	≥ 76%

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 +0.009, indicating that respondents in that age range tend to score their plans 0.009 point higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligibles tend to respond -0.040 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	C24: Getting Needed Care (Comp)	C25: Getting Appointments and Care Quickly (Comp)	C26: Customer Service (Comp)	C27: Rating of Health Care Quality	C28: Rating of Health Plan	C29: Care Coordination (Comp)
Age: 64 or under	-0.094	-0.056	-0.044	-0.259	-0.273	-0.039
Age: 65 - 69	0.000	0.002	0.008	-0.081	-0.084	-0.010
Age: 75 - 79	-0.002	-0.005	0.009	0.011	0.065	-0.021
Age: 80 - 84	0.009	0.006	0.004	0.067	0.143	-0.030
Age: 85 and older	-0.033	-0.002	0.015	0.018	0.147	-0.070
Less than an 8th grade education	-0.010	-0.035	-0.009	-0.081	0.119	0.022
Some high school	0.012	0.001	-0.020	0.023	0.141	0.031
Some college	-0.054	-0.022	-0.038	-0.097	-0.155	-0.015
College graduate	-0.068	-0.013	-0.080	-0.173	-0.253	-0.043
More than a bachelor's degree	-0.077	0.001	-0.107	-0.206	-0.307	-0.045
General health rating: excellent	0.072	0.087	0.034	0.355	0.251	0.032
General health rating: very good	0.057	0.054	0.021	0.244	0.165	0.017
General health rating: fair	-0.033	-0.021	-0.022	-0.210	-0.147	-0.031
General health rating: poor	-0.097	-0.053	-0.089	-0.543	-0.355	-0.064
Mental health rating: excellent	0.160	0.123	0.086	0.457	0.399	0.119
Mental health rating: very good	0.079	0.058	0.037	0.213	0.168	0.059
Mental health rating: fair	-0.043	-0.041	-0.012	-0.156	-0.050	-0.047
Mental health rating: poor	-0.125	-0.043	-0.113	-0.456	-0.346	-0.105
Proxy helped	-0.016	-0.042	-0.074	-0.162	-0.214	0.005
Proxy answered	0.005	0.009	-0.039	-0.021	-0.101	0.015
Medicaid dual eligible	-0.040	-0.002	0.002	-0.011	0.257	0.010
Low-income subsidy (LIS)	-0.019	-0.048	0.012	-0.030	0.124	-0.038

Table A-2: Part D CAHPS Measures

Predictor	MA-PD		PDP	
	D08: Rating of Drug Plan	D09: Getting Needed Prescription Drugs (Comp)	D08: Rating of Drug Plan	D09: Getting Needed Prescription Drugs (Comp)
Age: 64 or under	-0.261	-0.058	-0.522	-0.095
Age: 65 - 69	-0.101	-0.010	-0.363	-0.037
Age: 75 - 79	0.142	0.007	0.071	0.034
Age: 80 - 84	0.241	0.015	0.348	0.029
Age: 85 and older	0.289	0.013	0.443	0.043
Less than an 8th grade education	0.039	-0.040	0.047	-0.115
Some high school	0.103	-0.019	0.235	0.012
Some college	-0.202	-0.032	-0.202	-0.046
College graduate	-0.312	-0.040	-0.307	-0.077
More than a bachelor's degree	-0.392	-0.054	-0.515	-0.084
General health rating: excellent	0.211	-0.001	0.009	0.048
General health rating: very good	0.179	0.024	0.152	0.037
General health rating: fair	-0.129	-0.025	-0.071	-0.018
General health rating: poor	-0.336	-0.061	-0.246	-0.036
Mental health rating: excellent	0.415	0.095	0.098	0.063
Mental health rating: very good	0.176	0.052	-0.027	0.044
Mental health rating: fair	-0.060	-0.029	-0.128	-0.005
Mental health rating: poor	-0.511	-0.099	-0.363	-0.096
Proxy helped	-0.270	-0.013	-0.313	-0.037
Proxy answered	-0.093	0.038	-0.155	0.033
Medicaid dual eligible	0.589	0.023	0.920	0.088
Low-income subsidy (LIS)	0.414	0.022	0.643	0.054

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 have been applied since September 25, 2010.

Table B-1: Exclusions since September 25, 2010

Category ID	Category Description	Subcategory ID	Subcategory Description	Effective Date
11	Enrollment/Disenrollment	16	Facilitated/Auto Enrollment issues	September 25, 2010
		18	Enrollment Exceptions (EE)	
13	Pricing/Co-Insurance	06	Beneficiary has lost LIS Status/Eligibility or was denied LIS	
		16	Part D IRMAA	
30	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	01	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	
		90	Other Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information Issue	
38	Contractor/Partner Performance	90	Other Contractor/Partner Performance	
26	Contractor/Partner Performance	90	Other Contractor/Partner Performance	December 16, 2011
44	Equitable Relief/Good Cause Requests	01	Good Cause - Disenrollment for Failure to Pay Premiums	
		90	Other Equitable Relief/Good Cause Request	
45	Equitable Relief/Good Cause Requests	01	Good Cause - Disenrollment for Failure to Pay Premiums	
		02	Refund/Non-Receipt Part D IRMAA	
		03	Good Cause Part D IRMAA	
		04	Equitable Relief Part D IRMAA	
		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	
03	Enrollment/ Disenrollment	11	Disenrollment Due to Loss of Entitlement	June 1, 2013
11	Enrollment/ Disenrollment	24	Disenrollment Due to Loss of Entitlement	

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

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 2014 Star Ratings.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	70%	3.3
C02	Colorectal Cancer Screening	62%	3.9
C03	Cardiovascular Care – Cholesterol Screening	89%	4.3
C04	Diabetes Care – Cholesterol Screening	88%	3.8
C05	Glaucoma Testing	69%	3.4
C06	Annual Flu Vaccine	71%	3.4
C07	Improving or Maintaining Physical Health	67%	4.5
C08	Improving or Maintaining Mental Health	78%	2.0
C09	Monitoring Physical Activity	50%	2.4
C10	Adult BMI Assessment	80%	3.8
C11	Care for Older Adults – Medication Review	76%	3.6
C12	Care for Older Adults – Functional Status Assessment	63%	3.4
C13	Care for Older Adults – Pain Screening	65%	3.2
C14	Osteoporosis Management in Women who had a Fracture	23%	1.9
C15	Diabetes Care – Eye Exam	67%	4.0
C16	Diabetes Care – Kidney Disease Monitoring	90%	4.5
C17	Diabetes Care – Blood Sugar Controlled	74%	3.3
C18	Diabetes Care – Cholesterol Controlled	52%	3.5
C19	Controlling Blood Pressure	62%	3.5
C20	Rheumatoid Arthritis Management	77%	3.7
C21	Improving Bladder Control	35%	2.3
C22	Reducing the Risk of Falling	60%	3.4
C23	Plan All-Cause Readmissions	12%	3.5
C24	Getting Needed Care	85%	3.6
C25	Getting Appointments and Care Quickly	76%	3.5
C26	Customer Service	88%	3.5
C27	Rating of Health Care Quality	86%	3.7
C28	Rating of Health Plan	86%	3.4
C29	Care Coordination	85%	3.4
C30	Complaints about the Health Plan	0.21	3.0
C31	Beneficiary Access and Performance Problems	62	3.4
C32	Members Choosing to Leave the Plan	11%	3.7
C33	Health Plan Quality Improvement	Medicare shows only a Star Rating for this topic	3.5
C34	Plan Makes Timely Decisions about Appeals	88%	4.1
C35	Reviewing Appeals Decisions	85%	3.3
C36	Call Center – Foreign Language Interpreter and TTY Availability	91%	4.4

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 – Foreign Language Interpreter and TTY Availability	89%	3	85%	3.7
D02	Appeals Auto–Forward	2.7	3.4	4.4	2.7
D03	Appeals Upheld	74%	3.3	68%	3.3
D04	Complaints about the Drug Plan	0.33	3	0.19	3.4
D05	Beneficiary Access and Performance Problems	62	3.3	74	3.8
D06	Members Choosing to Leave the Plan	11%	3.7	10%	3.3
D07	Drug Plan Quality Improvement	Medicare shows only a Star Rating for this topic	3.7	Medicare shows only a Star Rating for this topic	3.6
D08	Rating of Drug Plan	85%	3.4	83%	3.7
D09	Getting Needed Prescription Drugs	91%	3.5	90%	4.1
D10	MPF Price Accuracy	98	3.9	98	4.1
D11	High Risk Medication	6%	3.6	8%	2.8
D12	Diabetes Treatment	85%	3.2	82%	3.2
D13	Medication Adherence for Diabetes Medications	75%	3.7	77%	3.1
D14	Medication Adherence for Hypertension (RAS antagonists)	76%	3.7	78%	3.6
D15	Medication Adherence for Cholesterol (Statins)	71%	3.6	73%	3.6

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	01/01/2012 - 12/31/2012
C02	Colorectal Cancer Screening	01/01/2012 - 12/31/2012
C03	Cardiovascular Care – Cholesterol Screening	01/01/2012 - 12/31/2012
C04	Diabetes Care – Cholesterol Screening	01/01/2012 - 12/31/2012
C05	Glaucoma Testing	01/01/2012 - 12/31/2012
C06	Annual Flu Vaccine	02/15/2013 - 05/31/2013
C07	Improving or Maintaining Physical Health	04/18/2012 - 07/31/2012
C08	Improving or Maintaining Mental Health	04/18/2012 - 07/31/2012
C09	Monitoring Physical Activity	04/18/2012 - 07/31/2012
C10	Adult BMI Assessment	01/01/2012 - 12/31/2012
C11	Care for Older Adults – Medication Review	01/01/2012 - 12/31/2012
C12	Care for Older Adults – Functional Status Assessment	01/01/2012 - 12/31/2012
C13	Care for Older Adults – Pain Screening	01/01/2012 - 12/31/2012
C14	Osteoporosis Management in Women who had a Fracture	01/01/2012 - 12/31/2012
C15	Diabetes Care – Eye Exam	01/01/2012 - 12/31/2012
C16	Diabetes Care – Kidney Disease Monitoring	01/01/2012 - 12/31/2012
C17	Diabetes Care – Blood Sugar Controlled	01/01/2012 - 12/31/2012
C18	Diabetes Care – Cholesterol Controlled	01/01/2012 - 12/31/2012
C19	Controlling Blood Pressure	01/01/2012 - 12/31/2012
C20	Rheumatoid Arthritis Management	01/01/2012 - 12/31/2012
C21	Improving Bladder Control	04/18/2012 - 07/31/2012
C22	Reducing the Risk of Falling	04/18/2012 - 07/31/2012
C23	Plan All-Cause Readmissions	01/01/2012 - 12/31/2012
C24	Getting Needed Care	02/15/2013 - 05/31/2013
C25	Getting Appointments and Care Quickly	02/15/2013 - 05/31/2013
C26	Customer Service	02/15/2013 - 05/31/2013
C27	Rating of Health Care Quality	02/15/2013 - 05/31/2013
C28	Rating of Health Plan	02/15/2013 - 05/31/2013
C29	Care Coordination	02/15/2013 - 05/31/2013
C30	Complaints about the Health Plan	01/01/2013 - 06/30/2013
C31	Beneficiary Access and Performance Problems	01/01/2012 - 12/31/2012
C32	Members Choosing to Leave the Plan	01/01/2012 - 12/31/2012
C33	Health Plan Quality Improvement	Not Applicable
C34	Plan Makes Timely Decisions about Appeals	01/01/2012 - 12/31/2012
C35	Reviewing Appeals Decisions	01/01/2012 - 12/31/2012
C36	Call Center – Foreign Language Interpreter and TTY Availability	02/11/2013 – 05/31/2013 (Monday - Friday)

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Data Time Frame
D01	Call Center – Foreign Language Interpreter and TTY Availability	02/11/2013 – 05/31/2013 (Monday - Friday)
D02	Appeals Auto–Forward	01/01/2012 - 12/31/2012
D03	Appeals Upheld	01/01/2013 - 6/30/2013
D04	Complaints about the Drug Plan	01/01/2013 - 06/30/2013
D05	Beneficiary Access and Performance Problems	01/01/2012 - 12/31/2012
D06	Members Choosing to Leave the Plan	01/01/2012 - 12/31/2012
D07	Drug Plan Quality Improvement	Not Applicable
D08	Rating of Drug Plan	02/15/2013 - 05/31/2013
D09	Getting Needed Prescription Drugs	02/15/2013 - 05/31/2013
D10	MPF Price Accuracy	01/01/2012 - 09/30/2012
D11	High Risk Medication	01/01/2012 - 12/31/2012
D12	Diabetes Treatment	01/01/2012 - 12/31/2012
D13	Medication Adherence for Diabetes Medications	01/01/2012 - 12/31/2012
D14	Medication Adherence for Hypertension (RAS antagonists)	01/01/2012 - 12/31/2012
D15	Medication Adherence for Cholesterol (Statins)	01/01/2012 - 12/31/2012

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 2013 M13_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

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

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

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

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

Example: Calculating the final rate for Contract 1

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

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

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

NatAvgObs = 0.13924

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

Expected Contract 1 =

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

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

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

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

The actual calculated NatAvgObs value used in the 2014 Star Ratings was 0.136783702624749

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	Rating of Health Care Quality	Patients' Experience and Complaints Measure	1.5	1.5
C28	Rating of Health Plan	Patients' Experience and Complaints Measure	1.5	1.5
C29	Care Coordination	Patients' Experience and Complaints Measure	1.5	1.5
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	3	3
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 Availability	Measures Capturing Access	1.5	1.5

Table G-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary	MA-PD Overall
D01	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	1.5	1.5
D02	Appeals Auto–Forward	Measures Capturing Access	1.5	1.5
D03	Appeals Upheld	Measures Capturing Access	1.5	1.5
D04	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D05	Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
D06	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
D07	Drug Plan Quality Improvement	Outcome Measure	3	3
D08	Rating of Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
D09	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	1.5	1.5
D10	MPF Price Accuracy	Process Measure	1	1
D11	High Risk Medication	Intermediate Outcome Measures	3	3
D12	Diabetes Treatment	Intermediate Outcome Measures	3	3
D13	Medication Adherence for Diabetes Medications	Intermediate Outcome Measures	3	3
D14	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measures	3	3
D15	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. Contracts must have data for at least half of the attainment measures used to calculate the improvement measure to be eligible for the improvement measure.

2. The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2013 and 2014:

   Improvement Change Score = Score in 2014 - Score in 2013.

   An eligible measure was defined as a measure for which a contract was scored in both the 2013 and 2014 Star Ratings and there were no significant specification changes.

3. For each measure, significant improvement or decline between Star Ratings years 2013 and 2014 was determined by a t-test at the 95% significance level:

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

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

4. Hold Harmless Provision for Individual Measures: If a contract demonstrated statistically significant decline (at the 0.05 significance level) on an attainment measure for which they received five stars during both the current contract year and the prior contract year, then this measure will not be included in the improvement measure calculation. Measures that are held harmless as described here will be included in the count of attainment measures used to determine improvement measure eligibility.

5. Net improvement was calculated for each class of measures (outcome, access, and process) 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

6. 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 intermediate outcome measure: Weight of 3
   b. Access or patient experience measure: Weight of 1.5
   c. Process measure: Weight of 1
   d. When the weight of an individual measure changes over the two years of data used, the lower weight value will be used in the improvement calculation.

$$\text{Improvement Measure Score} = \frac{\text{Net\_Imp\_Process} + 1.5 * \text{Net\_Imp\_PtExp} + 3 * \text{Net\_Imp\_Outcome}}{\text{Elig\_Process} + 1.5 * \text{Elig\_PtExp} + 3 * \text{Elig\_Outcome}}$$

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 intermediate 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 intermediate outcome measures

7. The improvement measure score is converted into a Star Rating using the relative distribution method. Improvement scores of 0 (equivalent to no net change on the attainment measures included in the improvement measure calculation) will be centered at 3 stars when assigning the improvement measure Star Rating.

8. 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 would not be decreased from 4 or more stars when the improvement measures were added to the overall Star Rating calculation. In addition, the i-Factor is recalculated without the improvement measure included.

General Standard Error Formula

Because a contract's score in one year is not independent of the score in the next year, the standard error is calculated using the standard estimation of the variance of the difference between two variables that are not necessarily independent. The standard error of the improvement change score is calculated using the formula

$$\sqrt{se(Y_{i2})^2 + se(Y_{i1})^2 - 2 * Cov(Y_{i2}, Y_{i1})}$$

Using measure C01 as an example, the change score standard error is:

$se(Y_{i2})$ Represents the 2014 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2013 standard error for contract i on measure C01

Y_{i2} Represents the 2014 rate for contract i on measure C01

Y_{i1} Represents the 2013 rate for contract i on measure C01

cov Represents the covariance between Y_{i2} and Y_{i1} computed using the correlation across all contracts observed at both time points (2014 and 2013). In other words:

$$cov(Y_{i2}, Y_{i1}) = se(Y_{i2}) * se(Y_{i1}) * Corr(Y_{i2}, Y_{i1})$$

where the correlation $Corr(Y_{i2}, Y_{i1})$ is assumed to be the same for all contracts and is computed using data for all contracts. This assumption was needed because only one score is observed for each contract in each year; therefore, it is not possible to compute the contract specific correlation.

Standard Error Numerical Example.

For measure C06, contract A:

$se(Y_{i2})$ = 2.805

$se(Y_{i1})$ = 3.000

$Corr(Y_{i2}, Y_{i1})$ = 0.901

Standard error for measure C06 for contract A = sqrt (2.805^2 + 3.000^2 – 2 * 0.901 * 2.805 * 3.000) = 1.305

Standard Error Formulas for Specific Measures

The following formulas are used for calculating the standard error for specific measures in the 2014 Star Ratings. These are modifications to the general standard error formula provide above to account for the specific type of data in the measure.

1. Standard Error Formula for Measures C01 - C05, C09, C10, and C14 - C22

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2013, 2014
$Denominator_y$ is as defined in the Measure Details section for each measure

2. Standard Error Formula for Measures C11 - C13

These measures are rolled up from the plan level to the contract level following the formula outlined in "Attachment E: NCQA Measure Combining Methodology". The standard error at the contract level is calculated as shown below. The specifications are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

The plan level standard error is calculated as:

$$SE_{yj} = \sqrt{\frac{Score_{yj} * (100 - Score_{yj})}{Denominator_{yj}}}$$

for y = 2013, 2014 and j = Plan 1, Plan 2

The contract level standard error is then calculated as:

Let Wy1 = The weight assigned to the first PBP results (estimated, auditable) for year y, where y = 2013, 2014. This result is estimated by the formula Wy1 = Ny1 / (Ny1 + Ny2)

Let Wy2 = The weight assigned to the second PBP results (estimated, auditable) for year y, where y = 2013, 2014. This result is estimated by the formula Wy2 = Ny2 / (Ny1 + Ny2)

$$SE_{yi} = \sqrt{(W_{y1})^2 * (SE_{y1})^2 + (W_{y2})^2 * (SE_{y2})^2}$$

for y = Contract Year 2013, Contract Year 2014 and i = Contract i

3. Standard Error Formula for C23

$$SE_y = \sqrt{\frac{Count\ of\ Readmissions_y}{(Expected\ Count\ of\ Readmissions_y)^2}}$$

for y = 2013, 2014

The formulas for the Observed Count of Readmissions and Expected Count of Readmissions are explained in "Attachment F: Calculating Measure C23: Plan All-Cause Readmissions".

4. Standard Error Formula for Measures C06, C24 - C29, and D08 – D09

The CAHPS measure standard errors for 2013 and 2014 were provided by the CAHPS contractor. The actual values used for each contract can be requested from the Part C and Part D rating or CAHPS mailboxes.

5. Standard Error Formulas for Measures C30 and D04

$$SE_{2013} = \sqrt{\frac{Total\ Number\ of\ Complaints_{2013}}{(Average\ Contract\ Enrollment_{2013})^2}} * \frac{1{,}000 * 30}{181}$$

$$SE_{2014} = \sqrt{\frac{Total\ Number\ of\ Complaints_{2014}}{(Average\ Contract\ Enrollment_{2014})^2}} * \frac{1{,}000 * 30}{182}$$

6. Standard Error Formula for Measures C32 and D06

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Enrollment_y}}$$

for y = 2013, 2014

7. Standard Error Formula for Measure C34, C35 and D03

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Total\ Appeals_y}}$$

for y = 2013, 2014

Where Total Appeals$_y$ = Appeals Upheld$_y$ + Appeals Overturned$_y$ + Appeals Partially Overturned$_y$

8. Standard Error Formula for Measure D02

$$SE_y = \sqrt{\frac{Total\ Number\ of\ Cases\ Auto - Forwarded\ to\ IRE_y}{(Average\ Medicare\ Part\ D\ Enrollment_y)^2}} * 10{,}000$$

9. Standard Error Formula for Measure D12

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2013, 2014

Where Denominator = 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

10. Standard Error Formula for Measures D13 - D15

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2013, 2014

Where Denominator = 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 included in the given measure during the measurement period

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

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.92853
C02	Colorectal Cancer Screening	Included	0.89694
C03	Cardiovascular Care – Cholesterol Screening	Included	0.69935
C04	Diabetes Care – Cholesterol Screening	Included	0.81948
C05	Glaucoma Testing	Included	0.86289
C06	Annual Flu Vaccine	Included	0.92856
C07	Improving or Maintaining Physical Health	Not Included	-
C08	Improving or Maintaining Mental Health	Not Included	-
C09	Monitoring Physical Activity	Included	0.83014
C10	Adult BMI Assessment	Included	0.75601
C11	Care for Older Adults – Medication Review	Included	0.70487
C12	Care for Older Adults – Functional Status Assessment	Included	0.77823
C13	Care for Older Adults – Pain Screening	Included	0.71335
C14	Osteoporosis Management in Women who had a Fracture	Included	0.83547
C15	Diabetes Care – Eye Exam	Included	0.85283
C16	Diabetes Care – Kidney Disease Monitoring	Included	0.73244
C17	Diabetes Care – Blood Sugar Controlled	Included	0.82779
C18	Diabetes Care – Cholesterol Controlled	Included	0.81493
C19	Controlling Blood Pressure	Included	0.75233
C20	Rheumatoid Arthritis Management	Included	0.8356
C21	Improving Bladder Control	Included	0.37937
C22	Reducing the Risk of Falling	Included	0.83853
C23	Plan All-Cause Readmissions	Included	0.555
C24	Getting Needed Care	Included	0.7711
C25	Getting Appointments and Care Quickly	Included	0.86961
C26	Customer Service	Included	0.67199
C27	Rating of Health Care Quality	Included	0.80334
C28	Rating of Health Plan	Included	0.78046
C29	Care Coordination	Included	0.81612
C30	Complaints about the Health Plan	Included	0.5683
C31	Beneficiary Access and Performance Problems	Not Included	-
C32	Members Choosing to Leave the Plan	Included	0.65789
C33	Health Plan Quality Improvement	Not Included	-
C34	Plan Makes Timely Decisions about Appeals	Included	0.5778
C35	Reviewing Appeals Decisions	Included	0.54423
C36	Call Center – Foreign Language Interpreter and TTY Availability	Not Included	-

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

Measure ID	Measure Name	Measure Usage	Correlation
D01	Call Center – Foreign Language Interpreter and TTY Availability	Not Included	-
D02	Appeals Auto–Forward	Included	0.26943
D03	Appeals Upheld	Included	0.38341
D04	Complaints about the Drug Plan	Included	0.58139
D05	Beneficiary Access and Performance Problems	Not Included	-
D06	Members Choosing to Leave the Plan	Included	0.65415
D07	Drug Plan Quality Improvement	Not Included	-
D08	Rating of Drug Plan	Included	0.75441
D09	Getting Needed Prescription Drugs	Included	0.69742
D10	MPF Price Accuracy	Not Included	-
D11	High Risk Medication	Not Included	-
D12	Diabetes Treatment	Included	0.88522
D13	Medication Adherence for Diabetes Medications	Included	0.88223
D14	Medication Adherence for Hypertension (RAS antagonists)	Included	0.91903
D15	Medication Adherence for Cholesterol (Statins)	Included	0.94929

Attachment J: Star Ratings Measure History

The tables below cross reference the measures code in each of the Star 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	2014	2013	2012	2011	2010	2009	2008	Notes
C	Access to Primary Care Doctor Visits	HEDIS	DMC12	DMC12	C11	C13	C12	C13	C09	
C	Adult BMI Assessment	HEDIS	C10	C10	C12	DMC05				
C	Annual Flu Vaccine	CAHPS	C06	C06	C06	C07	C06	C07	C07	
C	Antidepressant Medication Management (6 months)	HEDIS	DMC03	DMC03	DMC03	DMC03	DMC04	C28	C23	
C	Appeals Decisions	IRE / Maximus	C35	C35	C35	C32	C28	C36	C29	
C	Appeals Timeliness	IRE / Maximus	C34	C34	C34	C31	C27	C35	C28	
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS	DMC05	DMC05	DMC05	C06	C05	C06	C06	
C	Beneficiary Access and Performance Problems	Administrative Data	C31	C31	C32	C33	C30			
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	
C	Call Answer Timeliness	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC01	C20	C16	
C	Cardiovascular Care – Cholesterol Screening	HEDIS	C03	C03	C03	C03		C03	C03	Part of composite measure Cholesterol Screening in 2010
C	Care Coordination	CAHPS	C29	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	C12	C14					
C	COA - Medication Review	HEDIS	C11	C11	C13					
C	COA - Pain Screening	HEDIS	C13	C13	C15					
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	
C	Complaints	CTM	C30	C30	C31	C30	C26			
C	Continuous Beta-Blocker Treatment	HEDIS	DMC04	DMC04	DMC04	DMC04	DMC05	C32	C27	
C	Controlling Blood Pressure	HEDIS	C19	C19	C21	C19	C15	C29	C24	
C	CSR Understandability	Call Center					DMC02			
C	Customer Service	CAHPS	C26	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	C17	C19	C17		C26	C21	Part of composite measure Diabetes Care in 2010

Part	Common Measure Name	Data_Source	2014	2013	2012	2011	2010	2009	2008	Notes
C	Diabetes Care – Cholesterol Controlled	HEDIS	C18	C18	C20	C18		C27	C22	Part of composite measure Diabetes Care in 2010
C	Diabetes Care – Cholesterol Screening	HEDIS	C04	C04	C04	C04		C04	C04	Part of composite measure Cholesterol Screening in 2010
C	Diabetes Care – Eye Exam	HEDIS	C15	C15	C17	C15		C24	C19	Part of composite measure Diabetes Care in 2010
C	Diabetes Care – Kidney Disease Monitoring	HEDIS	C16	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	DMC08	C25	C21	C21	C17	
C	Enrollment Timeliness	MARx	DMCxx	C37						
C	Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)	HEDIS	DMC01	DMC01	DMC01	DMC01	DMC03	C14	C10	
C	Getting Appointments and Care Quickly	CAHPS	C25	C25	C27	C26	C22	C17	C13	
C	Getting Needed Care	CAHPS	C24	C24	C26	C24	C20	C16	C12	
C	Glaucoma Testing	HEDIS	C05	C05	C05	C05	C04	C05	C05	
C	Hold Time - Bene	Call Center	DMC09	DMC09	DMC09	C34	C31			
C	Improvement	Star Ratings	C33	C33						
C	Improving Bladder Control	HEDIS / HOS	C21	C21	C23	C22	C18	C33		
C	Improving or Maintaining Mental Health	HOS	C08	C08	C09	C10	C09	C10		
C	Improving or Maintaining Physical Health	HOS	C07	C07	C08	C09	C08	C09		
C	Information Accuracy - Bene	Call Center	DMC10	DMC10	DMC10	C35	C32			
C	Members Choosing to Leave the Plan	MBDSS	C32	C32	C33	DMC06	C29			
C	Monitoring Physical Activity	HEDIS / HOS	C09	C09	C10	C12	C11	C12		
C	Osteoporosis Management	HEDIS	C14	C14	C16	C14	C13	C23	C18	
C	Osteoporosis Testing	HEDIS / HOS	DMC06	DMC06	DMC06	C11	C10	C11		
C	Plan All-Cause Readmissions	HEDIS	C23	C23	C25					
C	Pneumonia Vaccine	CAHPS	DMC11	DMC11	C07	C08	C07	C08	C08	
C	Rating of Health Care Quality	CAHPS	C27	C27	C29	C28	C24	C18	C14	
C	Rating of Health Plan	CAHPS	C28	C28	C30	C29	C25	C19	C15	
C	Reducing the Risk of Falling	HEDIS / HOS	C22	C22	C24	C23	C19	C34		
C	Rheumatoid Arthritis Management	HEDIS	C20	C20	C22	C20	C16	C30	C25	
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC07	DMC07	DMC07	C21	C17	C31	C26	
C	TTY & Language - Bene	Call Center	C36	C36	C36	C36	C33			

Table J-2: Part D Measure History

Part	Msr_Name	Data_Source	2014	2013	2012	2011	2010	2009	2008	Notes
D	4Rx Timeliness	Acumen/OIS (4Rx)	DMD03	DMD03	DMD03	D07	D07		D09	
D	Adherence - Cholesterol	Prescription Drug Event (PDE)	D15	D18	D17					
D	Adherence - Diabetes	Prescription Drug Event (PDE)	D13	D16	D15					
D	Adherence - Hypertension	Prescription Drug Event (PDE)	D14	D17	D16					
D	Adherence - Proportion of Days Covered	Prescription Drug Event (PDE)				DMD07				
D	Appeals - Auto–Forwarded	IRE / Maximus	D02	D03	D03	D05	D05	D05	D13	
D	Appeals - Timely Effectuation	IRE / Maximus	DMD02	DMD02	DMD02	DMD02	DMD02			
D	Appeals - Timely Receipt	IRE / Maximus	DMD01	DMD01	DMD01	DMD01	DMD01			
D	Appeals - Upheld	IRE / Maximus	D03	D04	D04	D06	D06	D06	D14	
D	Beneficiary Access and Performance Problems	Administrative Data	D05	D07	D07	D10	D11			
D	CAHPS - Drug Access	CAHPS	D09	D12	D11	D13	D14	D14	D08	
D	CAHPS - Help	CAHPS	DMDxx	D10	D09	D11	D12	D12	D06	
D	CAHPS - Rating	CAHPS	D08	D11	D10	D12	D13	D13	D07	
D	Calls Disconnected - Bene	Call Center	DMD04	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	D04	D06	D06				D05	
D	CSR Understandability	Call Center					DMD06			
D	Diabetes Medication Dosing	Prescription Drug Event (PDE)	DMD08	DMD08	DMD08	DMD06	DMD09			
D	Drug-Drug Interactions	Prescription Drug Event (PDE)	DMD07	DMD07	DMD07	DMD05	DMD08			
D	Enrollment Timeliness	MARx	DMDxx	D05	D05	DMD03	DMD03			
D	Hold Time - Bene	Call Center	DMD05	DMD05	DMD05	D01	D01	D01	D01	
D	Hold Time - Pharmacist	Call Center	DMDxx	D01	D01	D02	D02	D03	D03	
D	Improvement	Star Ratings	D07	D09						
D	Information Accuracy - Bene	Call Center	DMD06	DMD06	DMD06	D03	D03			
D	LIS Match Rates	Acumen/OIS (LIS Match Rates)	DMD09	DMD09	DMD09	D14	D15	D15	D10	

Part	Msr_Name	Data_Source	2014	2013	2012	2011	2010	2009	2008	Notes
D	Members Choosing to Leave the Plan	MBDSS	D06	D08	D08	DMD09	D10			
D	Member Retention	MBDSS						D11		
D	MPF - Accuracy	Plan Finder Data	D10	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	DMD11			D16	D17	D16	Part of composite measure MPF - Composite in 2011 - 2012
D	MPF - Updates	Plan Finder Data	DMD10	DMD10	DMD10	DMD08	DMD10	D16	D15	
D	Safety - DAE	Prescription Drug Event (PDE)	D11	D14	D13	D16	D18	D19		
D	Safety - DST	Prescription Drug Event (PDE)	D12	D15	D14	D17	D19			
D	TTY & Language - Bene	Call Center	D01	D02	D02	D04	D04			

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 20^{th}, 35^{th}, 65^{th}, and 80^{th} percentiles, and at the 20^{th}, 40^{th}, 60^{th}, and 80^{th} 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 20^{th}, 35^{th}, 65^{th}, and 80^{th} 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 Predetermined

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 predetermined, 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: 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	
	1/1/2012	**1/16/2012**	**2/1/2012**	**2/16/2012**	**3/1/2012**	**3/16/2012**
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) 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	
	1/1/2012	**1/16/2012**	**2/1/2012**	**2/16/2012**	**3/1/2012**	**3/16/2012**
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. A drug/medication is defined at the generic ingredient level in the overlapping fills adjustment. Thus a beneficiary who changes dosage or switches to a medication with the same active ingredient would still be considered to be taking the same medication. The adjustment is applied using the generic ingredient name variable from the Medi-Span database. This variable is consistent with the Generic Drug Name variable listed in the PQA medication list (populated with GPI generic name variable from Medi-Span), without the strength and form of the medication.

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	
	1/1/2012	1/16/2012	2/1/2012	2/16/2012	3/1/2012	3/16/2012	4/1/2012	4/16/2012
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 Star Ratings (using 2011 PDE data), to adjust for beneficiary stays in inpatient (IP) facilities. 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

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.

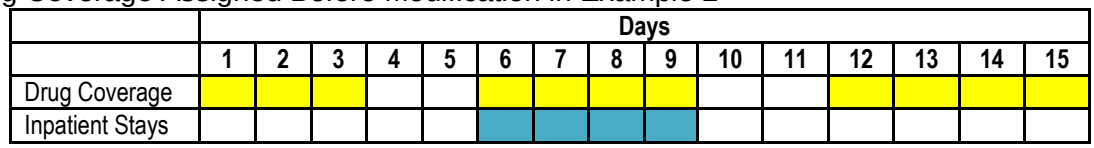
Figure 2: Drug Coverage Assigned After Modification in Example 1

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

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

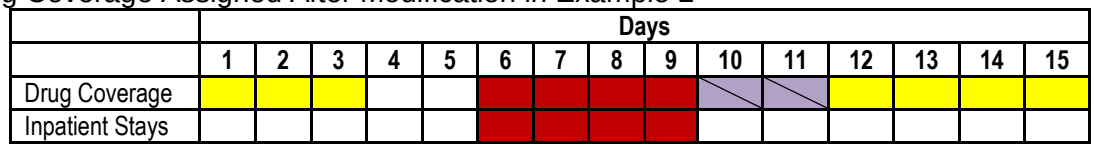
In this simplified example, one assumes the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, according to our current assignment of days of supply based on fill dates 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



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.

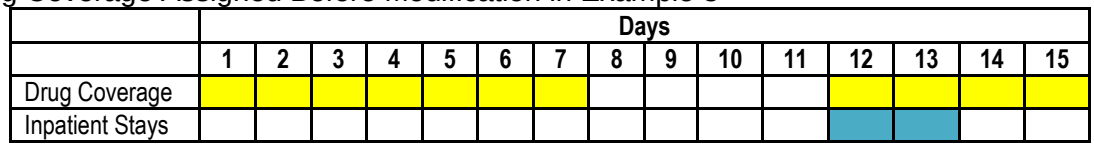
Figure 4: Drug Coverage Assigned After Modification in Example 2



Example 3 – IP stay with no post-IP coverage gap

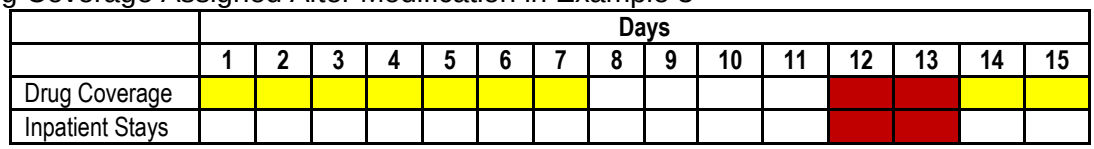
In this simplified example, one assumes the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-7 and 12-15, according to our current assignment of days of supply based on fill dates and 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



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



Attachment M: Methodology for Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (PF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the PF price to the PDE price and determining the magnitude of differences found when the latter exceeds the former. This document summarizes the methods currently used to construct each contract's accuracy index.

Contract Selection

The Part D Star Ratings rely in part on the submission of pricing data to PF. Therefore, only contracts with at least one plan meeting all of the following criteria are included in the analysis:

- Not a PACE plan
- Not a demonstration plan
- Not an employer plan
- Part D plan
- Plan not terminated during the contract year

Only contracts with at least 30 claims throughout the year are included in the accuracy measure. This ensures that the sample size of PDEs is large enough to produce a reliable accuracy score. Only covered drugs for PDEs that are not compound claims are included.

PF Price Accuracy Index

To calculate the PF Price Accuracy index, the point of sale total cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the total cost resulting from using the unit price reported on Plan Finder.[1] This comparison includes only PDEs for which a PF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. The NCPDP number for the pharmacy on the PDE claim must appear in the pharmacy cost file.
2. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.[2]
3. The reference NDC must be on the plan's formulary.
4. Because the retail unit cost reported on Plan Finder is intended to apply to a 30 day supply of a drug, only retail claims with a 30-day supply are included. Claims reporting a different day supply value and claims for different types of pharmacies (long term care, mail, or home infusion) are excluded.
5. PDEs for dates of service during which the plan was suppressed from Plan Finder or where the relevant pharmacy or drug was not reported in Plan Finder are not included since no Plan Finder cost can be assigned.
6. PDEs for compound drugs or non-covered drugs are not included.
7. The PDE must occur in quarter 1 through 3 of the year. Quarter 4 PDEs are not included because PF prices are not updated during this last quarter.

[1] Plan Finder unit costs are reported by plan, drug, and pharmacy. The plan, drug, and pharmacy from the PDE are used to assign the corresponding Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] Plan Finder prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use First Data Bank (FDB) and Medi-Span to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to PF reference NDCs.

Once PF unit ingredient costs are assigned, the total PF ingredient cost is calculated by multiplying the unit costs reported on PF by the quantity listed on the PDE.[3] The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the PF TC is the sum of the PF ingredient cost and the PF dispensing fee that corresponds to the same pharmacy and plan as that observed in the PDE. Each claim is then given a score based on the difference between the PDE TC and the PF TC. If the PDE TC is lower than the PF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when point of sale costs are lower than the advertised costs. However, if the PDE TC is higher than the PF TC, then the claim receives a score equal to the difference between the PDE TC and the PF TC.[4, 5] The contract level PF Price Accuracy index is the sum of the claim level scores across all PDEs that meet the inclusion criteria. Note that the best possible PF Price Accuracy Index is 1. This occurs when the PF TC is never higher than the PDE TC. The formula below illustrates the calculation of the contract level PF Price Accuracy Index:

$$A_j = \frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

TC_{iPDE} is the total ingredient cost plus dispensing fee reported in PDE_i, and

TC_{iPF} is the total ingredient cost plus dispensing fee calculated from PF data, based on the PDE_i reported NDC, days of supply and pharmacy.

We use the following formula to convert the Price Accuracy Index into a score:

100 – ((accuracy index – 1) x 100)

The score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table 1 shows an example of the Accuracy Index calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, date of service and pharmacy number are collected from each PDE to identify the PF data that had been submitted by the contract and posted on medicare.gov on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength and dosage form. Using the reference NDC, the following PF data are obtained: brand/generic dispensing fee (as assigned by the pharmacy cost file) and 30 day unit cost (as assigned by the Price File corresponding to that pharmacy on the date of service). The PDE total cost is the sum of the PDE ingredient cost and dispensing fee. The PF total cost is computed as the quantity dispensed from PDE multiplied by the PF unit cost plus the PF brand/generic dispensing fee (brand or generic status is assigned based on the NDC).

The last column shows the amount by which the PDE total cost is higher than the PF total cost. When PDE total cost is less than PF total cost, this value is zero. The accuracy index is the sum of the last column plus the sum of PDE total costs divided by the sum of PDE total costs.

[3] For PDEs with outlying values of reported quantities, we adjust the quantity using drug- and plan-level distributions of price and quantity.

[4] To account for potential rounding errors, this analysis requires that the PDE cost exceed the PF cost by at least half a cent ($0.005) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the PF cost is $10.242, the .008 cent difference would be counted towards plan's accuracy score. However, if the PF cost is higher than $10.245, the difference would not be considered problematic, and it would not count towards the plan's accuracy score.

[5] The PF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the PF price is lower than the floor price, the PDE price will be compared against the floor price.

Table M-1: Example of Price Accuracy Index Calculation

NDC	Pharmacy Number	PDE Data				Plan Finder Data				Calculated Values			
		DOS	Ingredient Cost	Dispensing Fee	Quantity Dispensed	Biweekly Posting Period	Unit Cost for 30 Day Supply	Dispensing Fee		Brand or Generic Status	Total Cost		Amount that PDE is higher than PF
								Brand	Generic		PDE	PF	
A	111	01/08/12	3.82	2	60	01/02/12 - 01/15/12	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/12	0.98	2	30	01/16/12 - 01/29/12	0.83	1.75	2.5	G	2.98	27.4	0
C	333	02/11/12	10.48	1.5	24	01/30/12 - 02/12/12	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/12	47	1.5	90	02/13/12 - 02/26/12	0.48	1.5	2.25	G	48.5	45.45	3.05
										Totals	69.28		5.78
										Accuracy Index			1.08343
										Accuracy Score			92

Attachment N: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no data available for a contract. This section provides the rules and messages assigned at each level of the Star Ratings.

Measure level messages

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

Table N-1: Measure level missing data messages

Message	Measure Level
Coming Soon	Used for all measures in MPF between Oct 1 and when the actual data go live
Medicare shows only a Star Rating for this topic	Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report
Not Applicable	Used in the numeric data for the Part C & Part D improvement measures in Plan Preview 1
Benefit not offered by plan	The contract was required to report this measure in HEDIS but doesn't offer the benefit to members
Plan too new to be measured	The contract is too new to have submitted measure data
No data available	There were no data for the contract included in the source data for the measure
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules
Plan not required to report measure	The contract was not required to report the measure

1. Assignment rules for Part C measure messages

Part C uses a set of rules for assigning the missing data message that varies by the data source. The rules for each data source are defined below.

Appeals (IRE) measures (C34 & C35):

- Has CMS identified issues with the contract's data?
  - Yes: Display message: CMS identified issues with this plan's data
  - No: Is there a valid numeric measure rate?
    - Yes: Display the numeric measure rate
    - No: Is the contract effective date > 01/01/2012?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: Not enough data available

Audit (CMS Administrative Data) measure (C31):

- Is there a valid numeric audit score?
  - Yes: Display the numeric audit score
  - No: Is the contract effective date ≥ 01/01/2013?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C06, C24, C25, C26, C27, C28 & C29):

- Is there a valid numeric CAHPS measure rate?
  - Yes: Display the numeric CAHPS measure rate
  - No: Is the contract effective date > 01/01/2012?
    - Yes: Display message: Plan too new to be measured
    - No: Is the CAHPS measure rate NR?
      - Yes: Display message: Not enough data available
      - No: Is the CAHPS measure rate NA?
        - Yes: Display message: No data available
        - No: Display message: Plan too small to be measured

Call Center measure (C36):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 05/31/2013?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C30):

Is the contract effective date > 06/30/2013?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2013?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

HEDIS measures (C01 - C05, C10, C14 – C20):

Was the contract enrollment < 1,000 in July 2012?
- Yes: Display message: Plan too small to be measured
- No: Is there a valid HEDIS numeric rate?
  - Yes: Display the HEDIS numeric rate
  - No: Is the HEDIS rate a code?
    - Yes: Assign message according to value below:
      - NA: Display message: Not enough data available
      - NB: Display message: Benefit not offered by plan
      - NR: Assign message according to audit designation
        - NR Display message: CMS identified issues with this plan's data
        - BR Display message: CMS identified issues with this plan's data
        - OS Display message: Plan not required to report measure
        - ER Display message: Plan not required to report measure
    - No: Is the contract effective date > 01/01/2012?
      - Yes: Display message: Plan too new to be measured
      - No: Was the contract required to report HEDIS?
        - Yes: Display message: No data available
        - No: Display message: Plan not required to report measure

HEDIS PCR measure (C23)

Is there a valid HEDIS numeric rate?
- Yes: Display the HEDIS numeric rate
- No: Is the HEDIS rate a code?
  - Yes: Assign message according to value below:
    - NA: Display message: Not enough data available
    - NB: Display message: Benefit not offered by plan
    - NR: Assign message according to audit designation
      - NR Display message: CMS identified issues with this plan's data
      - BR Display message: CMS identified issues with this plan's data
      - OS Display message: Plan not required to report measure
      - ER Display message: Plan not required to report measure
    - Else: Display message: Not enough data available
  - No: Is the contract effective date > 01/01/2012?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: No data available

HEDIS SNP measures (C11, C12 & C13):

Is the organization type (1876 Cost, PFFS, MSA) or SNP offered in 2014 = No?
- Yes: Display message: Plan not required to report measure
- No: Is there a valid HEDIS numeric rate?
  - Yes: Display the HEDIS numeric rate
  - No: Is the HEDIS rate a code?
    - Yes: Assign message according to value below:
      - NA: Display message: Not enough data available
      - NB: Display message: Benefit not offered by plan
      - NR: Assign message according to audit designation
        - NR Display message: CMS identified issues with this plan's data
        - BR Display message: CMS identified issues with this plan's data
        - OS Display message: Plan not required to report measure
        - ER Display message: Plan not required to report measure
    - No: Is the contract effective date > 01/01/2012?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

HEDIS / HOS measures (C09, C21 & C22):

Is there a valid HEDIS / HOS numeric rate?
- Yes: Display the HEDIS / HOS numeric rate
- No: Is the contract effective date > 01/01/2011?
  - Yes: Display message: Plan too new to be measured
  - No: Is the contract enrollment <500?
    - Yes: Display message: Plan too small to be measured
    - No: Is there a HEDIS / HOS rate code?
      - Yes: Assign message according to value below:
        - NA: Display message: Not enough data available
        - NB: Display message: Benefit not offered by plan
      - No: Display message: No data available

HOS measures (C07 & C08):

Is there a valid numeric HOS measure rate?
- Yes: Display the numeric HOS rate
- No: Was the HOS measure rate NA?
  - Yes: Display message: No data available
  - No: Is the contract effective date > 01/01/2009?
  - Yes: Display message: Plan too new to be measured
  - No: Was the contract enrollment < 500 at time of baseline collection?
    - Yes: Display message: Plan too small to be measured
    - No: Display message: Not enough data available

Improvement (Star Ratings) measure (C33):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Voluntary Disenrollment (MBDSS) measure (C32):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date ≥ 01/01/2013?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

2. Assignment rules for Part D measure messages

Appeals (IRE) measure (D02):

Was the average contract enrollment < 800 in 2012?
- Yes: Display message: Not enough data available
- No: Is the contract effective date > 12/31/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Has CMS identified issues with the contract's data?
    - Yes: Display message: CMS identified issues with this plan's data
    - No: Is there a valid numeric measure rate?
      - Yes: Display numeric measure rate
      - No: Display message: No data available

Appeals (IRE) measure (D03):

Is the contract effective date > 06/30/2013?
- Yes: Display message: Plan too new to be measured
- No: Were fewer than 5 total cases reviewed by the IRE?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric measure percentage?
    - Yes: Display numeric measure percentage
    - No: Display message: No data available

Audit (CMS Administrative Data) measure (D05):

Is there a valid numeric audit score?
- Yes: Display the numeric audit score
- No: Is the contract effective date ≥ 01/01/2013?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

CAHPS measures (D08, D09):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 01/01/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NA?
    - Yes: Display message: No data available
    - No: Display message: Plan too small to be measured

Call Center measure (D01):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date > 05/31/2013?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (D04):

Is the contract effective date > 06/30/2013?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2013?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

Improvement (Star Ratings) measure (D07):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Price Accuracy measure (D10):

Is the contract effective date > 9/30/2012?
- Yes: Display message: Plan too new to be measured
- No: Does contract have at least 30 claims over the measurement period for the price accuracy index
  - Yes: Display the numeric price accuracy rate
  - No: Is the organization type 1876 Cost?
    - Yes: Display message: Plan not required to report measure
    - No: Display message: Not enough data available

Patient Safety measures (D11)

Is the contract effective date > 12/31/2012?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (in the measure denominator)
  - Yes: Display message: Not enough data available
  - No: Has CMS identified issues with the contracts data?
    - Yes: Display message: CMS identified issues with this plan's data
    - No: Display numeric measure percentage

Patient Safety measures (D12, D13, D14, D15)

Is the contract effective date > 12/31/2012?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (in the measure denominator)
  - Yes: Display message: Not enough data available
  - No: Display numeric measure percentage

Voluntary Disenrollment (MBDSS) measure (D06):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective data ≥ 01/01/2013?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Domain, Summary and Overall level messages

Table N-2 contains all of the possible messages that could be assigned to missing data at the domain, summary and overall levels.

Table N-2: Domain, Summary and Overall level missing data messages

Message	Domain Level	Summary & Overall Level
Coming Soon	Used for all domain ratings in MPF between Oct 1 and when the actual data go live	Used for all summary and overall ratings in MPF between Oct 1 and when the actual data go live
Not enough data available	The contract did not have enough rated measures to calculate the domain rating	The contract did not have enough rated measures to calculate the summary or overall rating
Plan too new to be measured	The contract is too new to have submitted measure data for a domain rating to be calculated	The contract is too new to have submitted data to be rated in the summary or overall levels

1. Assignment rules for Part C & Part D domain rating level messages

Part C domain message assignment rules:

Is there a numeric domain star?
- Yes: Display the numeric domain star
- No: Is the contract effective date > 01/01/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Part D domain message assignment rules:

Is there a numeric domain star?
- Yes: Display the numeric domain star
- No: Is the contract effective date > 01/01/2013?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

2. Assignment rules for Part C & Part D summary rating level messages

Part C summary rating message assignment rules:

Is there a numeric Part C summary rating star?
- Yes: Display the numeric Part C summary rating star
- No: Is the contract effective date > 01/01/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Part D summary rating message assignment rules:

Is there a numeric Part D summary rating star?
- Yes: Display the numeric Part D summary rating star
- No: Is the contract effective date > 01/01/2013?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

3. Assignment rules for overall rating level messages

Overall rating message assignment rules:
Is there a numeric overall rating star?
- Yes: Display the numeric overall rating star
- No: Is the contract effective date > 01/01/2012?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Attachment O: 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 either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
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	A Teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.
Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

Attachment P: 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 2014.

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 P-1 below explains each of the columns displayed on this page.

Table P-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 P-2 below explains each of the columns displayed on this page.

Table P-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 2012 (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 P-3: HEDIS 2013 Audit Designations and 2014 Star 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 P-3: HEDIS 2013 Audit Designations and 2014 Star 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 P-3: HEDIS 2013 Audit Designations and 2014 Star Ratings below)

Table P-3: HEDIS 2013 Audit Designations and 2014 Star 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
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”
OS	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 P-4 below explains each of the columns displayed on this page.

Table P-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
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 and the Measures Used".

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 P-5 below.

Table P-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
Held Harmless	The contract had 5 stars in this measure last year and this year

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 P-6 below explains each of the columns contained on this page.

Table P-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)
2014 Part C Summary Rating	The final rounded 2014 Part C Summary Rating
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 P-7 below explains each of the columns contained on this page.

Table P-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
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
2014 Part C Summary Rating	The 2014 Part C Summary Rating
2014 Part D Summary Rating	The 2014 Part D Summary Rating
Improvement Measure Usage	Were the improvement measures (C33 & D07) used to produce the final Overall Rating? (Yes/No)
2014 Overall Rating	The final 2014 Overall Rating
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. Low Performing Contract List

The Low Performing Contract List page displays the contracts that received a Low Performing Icon and the data used to calculate the assignment. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a Low Performing Icon. Table P-8 below explains each of the columns contained on this page.

Table P-8: Low Performing Contract List

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
Rated As	The type of rating for this contract, valid values are “MA-Only”, “MA-PD” and “PDP”
2012 C Summary	The 2012 Part C Summary Rating earned by the contract
2012 D Summary	The 2012 Part D Summary Rating earned by the contract
2013 C Summary	The 2013 Part C Summary Rating earned by the contract
2013 D Summary	The 2013 Part D Summary Rating earned by the contract
2014 C Summary	The 2014 Part C Summary Rating earned by the contract
2014 D Summary	The 2014 Part D Summary Rating earned by the contract
Reason for LPI	The combination of ratings that met the Low Performing Icon rules. Valid values are “Part C”, “Part D”, “Part C and D” & “Part C or D”. See the section titled “Methodology for Calculating the Low Performing Icon for details”.

K. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table P-9 below explains each of the columns contained on this page.

Table P-9: High Performing Contract List

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
Rated As	The type of rating for this contract, valid values are “MA-Only”, “MA-PD” and “PDP”
Highest Rating	The highest level of rating that can be achieved for this organization, valid values are “Part C Summary”, “Part D Summary”, “Overall Rating”
Rating	The star value attained in the highest rating for the organization type

L. Technical Notes link

The Technical Notes link provides the user with a copy of the 2014 Star 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 to the technical if errors are identified outside of the plan preview periods and after MPF data release.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2014 Star 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 2014.

M. 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 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 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, domain name, and the data time frame. All subsequent rows contain the data associated with an individual contract.

N. Measure Detail page

The Measure Detail page contains the underlying data used for the Part D Appeals (D02 & D03) and Complaints measures (D04). This page is available during the first plan preview. Table P-10 below explains each of the columns displayed on this page.

Table P-10: Measure Detail page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
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)
2012 part D enrollment	The average 2012 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

O. Measure Detail – CTM page

The Measure Detail – CTM page contains the case-level data of the non-excluded cases used in producing the Part D Complaints measure (D04). This page is available during the first plan preview. Table P-11 below explains each of the columns displayed on this page.

Table P-11: 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 parent organization of the contract
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

P. Measure Detail – Auto-Forward page

The Measure Detail – Auto-Forward page contains the case-level data of the non-excluded cases used in producing the Part D Appeals Auto-Forward measure (D02). This page is available during the first plan preview. Table P-12 below explains each of the columns displayed on this page.

Table P-12: Measure Detail – Auto-Forward 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 parent organization of the contract
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

Q. Measure Detail – Upheld page

The Measure Detail – Upheld page contains the case-level data of the non-excluded cases used in producing the Part D Appeals Upheld measure (D03). This page is available during the first plan preview. Table P-13 below explains each of the columns displayed on this page.

Table P-13: Measure Detail – Upheld 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 parent organization of the contract
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

R. 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 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 and the Measures Used".

The two rows immediately above this measure information contain the domain id, 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 P-14 below.

Table P-14: 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
Held Harmless	The contract had 5 stars in this measure last year and this year

S. 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 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 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, domain name, and the data time frame. All subsequent rows contain the stars associated with an individual contract.

T. 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 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 D domains. The domain columns are identified by the domain name. All subsequent rows contain the stars associated with an individual contract.

U. 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 P-15 below explains each of the columns contained on this page.

Table P-15: Part D Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Contract Name	The name the contract is known by in HPMS
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Contract Type	The contract plan type used to compute the ratings
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 (D07) used in the final Part D Summary Rating? (Yes/No)
2014 Part D Summary Rating	The final rounded 2014 Part D Summary Rating
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

V. Low Performing Contract List

The Low Performing Contract List page displays the contracts that received a Low Performing Icon and the data used to calculate the assignment. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a Low Performing Icon. Table P-16 below explains each of the columns contained on this page.

Table P-16: Low Performing Contract List

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
Rated As	The type of organization, valid values are “MA-Only”, “MA-PD” and “PDP”
2012 C Summary	The 2012 Part C Summary Rating earned by the contract
2012 D Summary	The 2012 Part D Summary Rating earned by the contract
2013 C Summary	The 2013 Part C Summary Rating earned by the contract
2013 D Summary	The 2013 Part D Summary Rating earned by the contract
2014 C Summary	The 2014 Part C Summary Rating earned by the contract
2014 D Summary	The 2014 Part D Summary Rating earned by the contract
Reason for LPI	The combination of ratings that met the Low Performing Icon rules. Valid values are “Part C”, “Part D”, “Part C and D” & “Part C or D”. See the section titled Methodology for Calculating the Low Performing Icon for details.

W. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table P-17 below explains each of the columns contained on this page.

Table P-17: High Performing Contract List

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
Rated As	The type of rating for this contract, valid values are “MA-Only”, “MA-PD” and “PDP”
Highest Rating	The highest level of rating that can be achieved for this organization, valid values are “Part C Summary”, “Part D Summary”, “Overall Rating”
Rating	The star value attained in the highest rating for the organization type

X. Technical Notes link

The Technical Notes link provides the user with a copy of the 2014 Star 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 to the technical if errors are identified outside of the plan preview periods and after MPF data release.

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Y. Medication NDC List – High Risk Medication Measure link

The Medication NDC List – High Risk Medication Measure link provides the user a means to download a copy of the medication list used for the High Risk Medication measure (D11). This downloadable file is in Excel format.

Z. Medication NDC List – Diabetes Treatment Measure link

The Medication NDC List – Diabetes Treatment Measure link provides the user a means to download a copy of the medication list used for the Diabetes Treatment measure (D12). This downloadable file is in Excel format.

AA. Medication NDC List – Medication Adherence Measure link

The Medication NDC List – Medication Adherence Measure link provides the user a means to download a copy of the medication list used for the Medication Adherence measures (D13, D14 & D15). This downloadable file is in Excel format.