2017 Medicare-Medicaid Plan Performance Data Technical Notes

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Introduction

Under the Medicare-Medicaid Financial Alignment Initiative (FAI) capitated model, the Centers for Medicare & Medicaid Services (CMS) is collecting a variety of measures that examine plan performance and the quality of care provided to enrollees. The Medicare-Medicaid Plan (MMP) performance data published here represent currently available data on MMP performance on certain Medicare Parts C and D quality measures as well as select CMS core and state-specific measures that MMPs are required to report. The data show MMP performance on quality measures during 2015 and the results of surveys of MMP enrollees conducted in early 2016. The measures are organized into six domains that track the potential domains under a future MMP star ratings system described in the Medicare-Medicaid Plan Quality Ratings Strategy published in November 2015.

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

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

We also note that no data on these performance measures is yet available for MMPs participating in either the Rhode Island demonstration or the Fully Integrated Duals Advantage demonstration for individuals with intellectual and developmental disabilities in New York. There are not yet available data based on the Health Outcomes Survey fielded by MMPs and a number of MMPs were too new, or had too limited enrollment to be able to report reliable data for a number of individual measures. Despite these limitations, we are publishing MMP performance data to provide greater transparency on MMP performance during the initial years of the initiative, and as a first step toward equipping the public with a robust set of performance data.

Questions about the MMP performance data published here should be addressed to: mmcocapsmodel@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: The name of the domain to which the measures following this heading belong

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

Title	Description
Label for Data:	Optional: The label that provides a fuller title for the measure.
Description:	The English language description shown for the measure.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS/HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.

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

Title	Description
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS is unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Case Mix Adjusted:	Indicates if the data are case mix adjusted.
NQF #:	The National Quality Framework (NQF) number for the measure or “None” if there is no equivalent measure with NQF endorsement.
Data Display:	The format used to the display the numeric data

Domain: Coordination of Care and Long Term Services and Supports

Measure: Core 2.1- Comprehensive Health Risk Assessment

Title	Description
Description:	Percent of plan members who received a health risk assessment within 90 days of enrollment in the plan.
Metric:	This measure captures the total number of members with a health risk assessment completed within the first 90 days of enrollment. When calculating the completion rate, the members that were unreachable (after at least three contact attempts) and the members that refused the assessment are subtracted from the denominator.
Primary Data Source:	Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements
Data Source Category:	Health and Drug Plans
Exclusions:	Plan members that were unreachable (after at least three contact attempts) and plan members that refused the assessment are subtracted from the denominator.
General Notes:	A full description of the measure specifications is available in the CY 2015 Core Reporting Requirements.
Data Time Frame:	2015 (dates vary by plan depending on demonstration start date)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

Measure: Care Plan Completion

Title	Description
Description:	Percent of plan members who had a care plan completed within the requisite timeframe.
Metric:	This measure captures the total number of members with a care plan completed within the requisite timeframe based on state-specific requirements (e.g. 90 days from enrollment, 30 days from assessment completion). When calculating the completion rate, the members that were unreachable (after the requisite number of contact attempts) and the members that refused the care plan are subtracted from the denominator. See Attachment J for the state-specific requirements for this measure.
Primary Data Source:	Medicare-Medicaid Capitated Financial Alignment Model State-Specific Reporting Requirements
Data Source Category:	Health and Drug Plans
Exclusions:	Plan members that were unreachable (after the requisite number of contact attempts) and plan members that refused the care plan are subtracted from the denominator.
General Notes:	Specifications for the care plan completion measure vary by state, and can be found in the individual State-Specific Reporting Requirements.
Data Time Frame:	2015 (dates vary by plan depending on demonstration start date)
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None

Measure: Care Plan Completion

Title	Description
Data Display:	Percentage with no decimal point

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

Title	Description
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).
HEDIS Label:	Care for Older Adults (COA) – Functional Status Assessment
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 89
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one functional status assessment (Functional Status Assessment Value Set) during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMP benefit packages whose enrollment was less than 30 as of February 2015 Monthly Enrollment Report were excluded from this measure. This measure is not reported for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

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

Measure: DMC14 - Initiation of Alcohol or other Drug Treatment

Title	Description
Description:	The percentage of members who start alcohol or drug treatment within 14 days of being diagnosed as needing treatment.
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 247
Metric:	The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Measure: DMC14 - Initiation of Alcohol or other Drug Treatment

Title	Description
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF #:	0004
Data Display:	Percentage with no decimal place

Measure: DMC15 - Engagement of Alcohol or other Drug Treatment

Title	Description
Description:	The percent of plan members who started drug or alcohol treatment and had two or more services for alcohol or drug treatment within 30 days of their first visit.
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 247
Metric:	The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Exclusions:	None listed.
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF#:	0004
Data Display:	Percentage with no decimal place

Measure: DMC02 - Antidepressant Medication Management (6 months)

Title	Description
Description:	The percent of members with a diagnosis of major depression who received an antidepressant medication for at least 180 days.
HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 160
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (numerator).
Exclusions:	Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population: • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: – AMM Stand Alone Visits Value Set with Major Depression Value Set. – AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set.

Measure: DMC02 - Antidepressant Medication Management (6 months)

Title	Description
	• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set). • An acute or nonacute inpatient discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. For a direct transfer, use the discharge date from the last discharge.
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF#:	0105
Data Display:	Percentage with no decimal place

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

Title	Description
Description:	The percent of plan members who were hospitalized for certain mental health disorders who received follow-up care within 30 days of leaving the hospital.
HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 169
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator).
Exclusions:	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. Organizations must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

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

Title	Description
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case Mix Adjusted:	No
NQF#:	0576
Data Display:	Percentage with no decimal place

Measure: C09 - Care for Older Adults – Medication Review

Title	Description
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of 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.
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 89
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMP benefit packages whose enrollment was less than 30 as of February 2015 Monthly Enrollment Report were excluded from this measure. This measure is not reported for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2015 - 12/31/2015
Case-mix adjusted:	No
NQF #:	0553
Data Display:	Percentage with no decimal point

Measure: C11 - Care for Older Adults – Pain Assessment

Title	Description
Label for Data:	Yearly Pain Screening or Pain Management Plan
Description:	Percent of plan members who had a pain screening or pain management plan at least once during the year.
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 89

Measure: C11 - Care for Older Adults – Pain Assessment

Title	Description
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMP benefit packages whose enrollment was less than 30 as of February 2015 Monthly Enrollment Report were excluded from this measure. This measure is not reported for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

Measure: C19 - Plan All-Cause Readmissions

Title	Description
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)
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.)
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 326
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned 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+).

Measure: C19 - Plan All-Cause Readmissions

Title	Description
	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 C: Calculating Measure C19: Plan All-Cause Readmissions for the complete formula, example calculation and National Average Observation value used to complete this measure.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was 10 or less.
General Notes:	This measure is not reported for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Lower is better
Case-mix adjusted:	Yes
NQF #:	1768
Data Display:	Percentage with no decimal point

Measure: C13 - Diabetes Care – Eye Exam

Title	Description
Label for Data:	Eye Exam to Check for Damage from Diabetes
Description:	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 132
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).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator.

Measure: C13 - Diabetes Care – Eye Exam

Title	Description
	If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0055
Data Display:	Percentage with no decimal point

Measure: C14 - Diabetes Care – Kidney Disease Monitoring

Title	Description
Label for Data:	Kidney Function Testing for Members with Diabetes
Description:	Percent of plan members with diabetes who had a kidney function test during the year.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 132
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).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0062
Data Display:	Percentage with no decimal point

Measure: C15 - Diabetes Care – Blood Sugar Controlled

Title	Description
Label for Data:	Plan Members with Diabetes whose Blood Sugar is Under Control
Description:	Percent of plan members with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 132
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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0059
Data Display:	Percentage with no decimal point

Measure: C16 - Controlling Blood Pressure

Title	Description
Label for Data:	Controlling Blood Pressure
Description:	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 116
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) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year (numerator).
Primary Data Source:	HEDIS

Measure: C16 - Controlling Blood Pressure

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) • Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis. • Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. • Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the discharge date for the stay.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0018
Data Display:	Percentage with no decimal point

Measure: D12 - Medication Adherence for Diabetes Medications

Title	Description
Label for Data:	Taking Diabetes Medication as Directed
Description:	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. One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The plan, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug,* a *sulfonylurea drug,* a *thiazolidinedione drug*, a *DPP-IV inhibitor,* an *incretin mimetic drug,* a *meglitinide drug,* or an *SGLT2 inhibitor*. Plan members who take insulin are not included.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of medication(s) across any of the drug classes during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or medications in its therapeutic category. Beneficiaries

Measure: D12 - Medication Adherence for Diabetes Medications

Title	Description
	with one or more fills for insulin or with ESRD coverage dates anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The PDC Adherence measures are also endorsed by the National Quality Forum (NQF). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list is posted along with these technical notes. NDCs with obsolete dates are included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2015-December 31, 2015 by June 30, 2016. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation are not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (using the ESRD indicator). • CWF is used to identify inpatient stays for PDPs and MA-PDs, and skilled nursing facility stays for PDPs.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled 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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the Medi-Span

Measure: D12 - Medication Adherence for Diabetes Medications

Title	Description
	generic ingredient name. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, hospice enrollments, and stays in skilled nursing facilities (SNFs). The SNF adjustment only applies to PDPs because SNF data are not currently available for MA-PDs. Please see Attachment D: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0541
Data Display:	Percentage with no decimal point

Measure: D13 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	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. One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this. ("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 and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of either the same medication or medications in the drug class during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries with ESRD coverage dates or that received one or more prescriptions for sacubitril/valsartan anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The PDC Adherence measures are also endorsed by the National Quality Forum (NQF).

Measure: D13 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
	See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list is posted along with these technical notes. NDCs with obsolete dates are included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2015-December 31, 2015 by June 30, 2016. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation are not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (using the ESRD indicator). • CWF is used to identify inpatient stays for PDPs and MA-PDs, and skilled nursing facility stays for PDPs.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled 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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (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, hospice enrollments, and stays in skilled nursing facilities (SNFs). The SNF adjustment only applies to PDPs because SNF data are not currently available for MA-PDs. Please see Attachment D: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better

Measure: D13 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Case-mix adjusted:	No
NQF #:	0541
Data Display:	Percentage with no decimal point

Measure: D14 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Data:	Taking Cholesterol Medication as Directed
Description:	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. One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of either the same medication or medication in the drug class during the measurement period (denominator). The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The PDC Adherence measures are also endorsed by the National Quality Forum (NQF). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list is posted along with these technical notes. NDCs with obsolete dates are included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2015-December 31, 2015 by June 30, 2016. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin drug(s). PDE adjustments made post-reconciliation are not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF). • CME is used for enrollment information.

Measure: D14 - Medication Adherence for Cholesterol (Statins)

Title	Description
	• EDB is used for hospice enrollment. • CWF is used to identify inpatient stays for PDPs and MA-PDs, and skilled nursing facility stays for PDPs.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled 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, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (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, hospice enrollments, and stays in skilled nursing facilities (SNFs). The SNF adjustment only applies to PDPs because SNF data are not currently available for MA-PDs. Please see Attachment D: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0541
Data Display:	Percentage with no decimal point

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

Title	Description
Label for Data:	Osteoporosis Management
Description:	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.
HEDIS Label:	Osteoporosis Management in Women Who Had a Fracture (OMW)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 155

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

Title	Description
Metric:	The percentage of woman MA enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0053
Data Display:	Percentage with no decimal point

Measure: C17 - Rheumatoid Arthritis Management

Title	Description
Label for Data:	Rheumatoid Arthritis Management
Description:	Percent of plan members with rheumatoid arthritis who got one or more prescription(s) for an anti-rheumatic drug.
HEDIS Label:	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 152
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).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) • A diagnosis of HIV (HIV Value Set) any time during the member's history through December 31 of the measurement year. • A diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0054
Data Display:	Percentage with no decimal point

Domain: Member Experience with Integrated Plan and Care Providers

Measure: OHP5-Satisfaction with Care Coordination

Title	Description
Description:	Percent of the plan members who are very satisfied with the help they received coordinating the care from different doctors and health providers.

Measure: OHP5-Satisfaction with Care Coordination

Title	Description
Metric:	The percentage displayed for each measure is the percentage of respondents who answered “Very satisfied” to the measure question on how satisfied the respondent was with the care coordination services provided they received in the last 6 months. Only plans with at least 11 “Yes” answers to the screening question (In the last 6 months, did anyone from your health plan, doctor’s office, or clinic help coordinate your care among these doctors or other health care providers?) and have at least 11 “very satisfied” responses on the measure question have a rate displayed. No case mix adjustment was applied to these measures.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • How satisfied are you with the help you received to coordinate your care in the last 6 months?
Data Source Category:	Survey of Enrollees
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with no decimal point

Measure: CC14-Access to Personal Care

Title	Description
Description:	Percent of plan members who said it was always easy to get personal care help at home.
Metric:	The percentage of survey respondents who answered “Always” to the measure question on how often it was easy to obtain access to personal care or aide assistance at home. Only plans with at least 11 “Yes” answers to the screening question (Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?) and11 “Always” responses on the measure question have a rate displayed. No case mix adjustment was applied to these measures.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • How often was it easy to get personal care or aide assistance at home through your care plan?
Data Source Category:	Survey of Enrollees
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with no decimal point

Measure: CC10: Access to Medical Equipment

Title	Description
Description:	Percent of the plan members who said it was always easy to get or replace medical equipment that they needed.
Metric:	The percentage displayed for each measure is the percentage of respondents who answered “Always” to the measure question on how easy it was to get or replace medical equipment. Only plans with at least 11 “Yes” answers to the screening question (In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, wheelchair or oxygen equipment?) and at least 11 “Always” responses on the measure question have a rate displayed. No case mix adjustment was applied to these measures.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • In the last 6 months, how often was it easy to get or replace the medical equipment you needed through your health plan?
Data Source Category:	Survey of Enrollees
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with no decimal point

Measure: MH3-Access to Mental Health Treatment

Title	Description
Description:	Percent of the plan members who said it was always easy to get treatment or counseling for a personal or family problem.
Metric:	The percentage displayed for each measure is the percentage of respondents who answered “Always” to the measure question on how often it was easy to get the treatment or counseling they needed. Only plans with at least 11 “Yes” answers to the screening question (In the last 6 months, did you need any treatment or counseling for a personal or family problem?) and at least 11 “Always” responses on the measure question have a rate displayed. No case mix adjustment was applied to these measures.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?
Data Source Category:	Survey of Enrollees
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with no decimal point

Measure: C20 - Getting Needed Care

Title	Description
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.
Primary 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?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal point

Measure: C21 - Getting Appointments and Care Quickly

Title	Description
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.
Primary 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

Measure: C21 - Getting Appointments and Care Quickly

Title	Description
	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?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal point

Measure: C22 - Customer Service

Title	Description
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.
Primary 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?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. .These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes

Measure: C22 - Customer Service

Title	Description
NQF #:	0006
Data Display:	Numeric with no decimal point

Measure: C23 - Rating of Health Care Quality

Title	Description
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 members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • 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?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal point

Measure: C24 - Rating of Health Plan

Title	Description
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 members' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type):

Measure: C24 - Rating of Health Plan

Title	Description
	• 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?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	0006
Data Display:	Numeric with no decimal point

Measure: C25 - Care Coordination

Title	Description
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 needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Measure: C25 - Care Coordination

Title	Description
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	None

Measure: D08 - Rating of Drug Plan

Title	Description
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 members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • 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?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	None
Data Display:	Numeric with no decimal point

Measure: D09 - Getting Needed Prescription Drugs

Title	Description
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.
Primary Data Source:	CAHPS

Measure: D09 - Getting Needed Prescription Drugs

Title	Description
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 prescription drug plan to get the medicines your doctor prescribed? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
Case-mix adjusted:	Yes
NQF #:	None
Data Display:	Numeric with no decimal point

Domain: Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening

Title	Description
Label for Data:	Breast Cancer Screening
Description:	Percent of female plan members aged 52-74 who had a mammogram during the past 2 years.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 77
Metric:	The percentage of women MA enrollees 50 to 74 years of age (denominator) who had a mammogram to screen for breast cancer (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: • Bilateral mastectomy (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set). • Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. • Both of the following (on the same or a different date of service):

Measure: C01 - Breast Cancer Screening

Title	Description
	– Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service). • Absence of the left breast (Absence of Left Breast Value Set) and absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service. • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0031
Data Display:	Percentage with no decimal point

Measure: C02 - Colorectal Cancer Screening

Title	Description
Label for Data:	Colorectal Cancer Screening
Description:	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.
HEDIS Label:	Colorectal Cancer Screening (COL)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 83
Metric:	The percentage of MA enrollees aged 50 to 75 (denominator) who had appropriate screenings for colorectal cancer (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member’s history through December 31 of the measurement year.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
NQF #:	0034
Data Display:	Percentage with no decimal point

Measure: C03 - Annual Flu Vaccine

Title	Description
Label for Data:	Annual Flu Vaccine
Description:	Percent of plan members who got a vaccine (flu shot) prior to flu season.

Measure: C03 - Annual Flu Vaccine

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who received an influenza vaccination during the measurement year (numerator).
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question number varies depending on survey type): • Have you had a flu shot since July 1, 2015?
Data Source Category:	Survey of Enrollees
General Notes:	This measure is not case-mix adjusted. CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	02/2016 – 08/2016
General Trend:	Higher is better
CMS Framework Area:	Clinical care
NQF #:	0040
Data Display:	Numeric with no decimal point

Measure: C07 - Adult BMI Assessment

Title	Description
Label for Data:	Checking to See if Members Are at a Healthy Weight
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.
HEDIS Label:	Adult BMI Assessment (ABA)
Measure Reference:	NCQA HEDIS 2016 Technical Specifications Volume 2, page 56
Metric:	The percentage of MA enrollees 18-74 years of age (denominator) who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(optional) Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	0421
Data Display:	Percentage with no decimal point

Domain: Safety of Care Provided

Measure: D11 - High Risk Medication

Title	Description
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:	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 is defined as the percentage of Medicare Part D beneficiaries 65 years and 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 the number of member-years of enrolled beneficiaries 65 years and older who received two or more prescription fills for the same HRM during the period measured (numerator) divided by the number of member-years of enrolled beneficiaries 65 years and older during the period measured (denominator). Beneficiaries enrolled in hospice at any point during the measurement year are excluded. 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 list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year. 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 HRM measure rate includes additional PQA specifications for identifying HRM medications based on the calculation of cumulative days supply (nitrofurantoin and nonbenzodiazepine hypnotics) and average daily dose (reserpine, digoxin, and doxepin). Refer to the High Risk Medication Measures Report User Guide posted on the Patient Safety Analysis website for more information.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2015-December 31, 2015 by June 30, 2016. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members 65 years and older, and for those Part D covered drugs identified to have high risk of serious side effects in patients 65 years of age and older. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME) and the Medicare Enrollment Database (EDB). • CME is used for enrollment information. • EDB is used for hospice enrollment.
Data Source Category:	Health and Drug Plans

Measure: D11 - High Risk Medication

Title	Description
Exclusions:	Contracts with 30 or fewer enrolled 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. A subject beneficiary must be enrolled and age 65 or older in at least one month of the period measured. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within 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 Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Lower is better
Case-mix adjusted:	No
NQF #:	22
Data Display:	Percentage with no decimal point

Measure: D15 - MTM Program Completion Rate for CMR

Title	Description
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications. ***Note:*** If you would like more information about your plan's Medication Therapy Management program, including whether you might be eligible for the program: Return to Star Ratings information page, scroll up to the top of the page, and then click on the "Manage Drugs" tab.
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded.

Measure: D15 - MTM Program Completion Rate for CMR

Title	Description
	A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	Additional data sources used to calculate the measure: Medicare Enrollment Database (EDB) File. Data were reported by contracts to CMS per the Part D Reporting Requirements. Validation of these data was performed retrospectively during the 2016 Data Validation cycle.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2016) are excluded and listed as "No data available." MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any the following Medication Therapy Management Program data elements: • HICN or RRB Number (Element B) • Met the specified targeting criteria per CMS – Part D requirements (Element G) • Date of MTM program enrollment (Element I) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element K) • Received annual CMR with written summary in CMS standardized format (Element O) • Date(s) of CMR(s) with written summary in CMS standardized format (Element Q) MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as "CMS identified issues with this plan's data." Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov.

Measure: D15 - MTM Program Completion Rate for CMR

Title	Description
	Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "No data available."
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with 1 decimal point

Domain: Plan Performance on Administrative Measures

Measure: C26 - Complaints about the Health Plan

Title	Description
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 = 365). • 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.
Primary Data Source:	Complaints Tracking Module (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. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS' CTM Standard Operating Procedures. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
Data Source Category:	CMS Administrative Data
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 contracts with average enrollment of less than 800 enrollees during the measurement period.

Measure: C26 - Complaints about the Health Plan

Title	Description
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Lower is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with 2 decimal points

Measure: C27 - Members Choosing to Leave the Plan

Title	Description
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because it means fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan. (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, 2015–December 31, 2015 (numerator) divided by all members enrolled in the plan at any time during 2015 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their plan due to circumstances beyond their control are removed from the final numerator, specifically: • Members who moved out of the service area • Members affected by a contract service area reduction • Members affected by PBP termination • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members in PBPs that were granted special enrollment exceptions • Members who were passively enrolled into a Demonstration (MMP) • SNPs disproportionate share members who do not meet the SNP criteria • Contracts with less than 1,000 enrollees
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 99 - Other (not supplied by beneficiary). The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview, as part of Medicare Plan Finder and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Lower is better

Measure: C27 - Members Choosing to Leave the Plan

Title	Description
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

Measure: C30 - Plan Makes Timely Decisions about Appeals

Title	Description
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 and partially overturned appeals) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) * 100. If the denominator is ≤ 10, the result is —"Not enough data available."
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to May 1, 2016, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2016 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with no decimal point

Measure: C31 - Reviewing Appeals Decisions

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

Measure: C31 - Reviewing Appeals Decisions

Title	Description
Description:	This 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."
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to May 1, 2016, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2016 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

Measure: D02 - Appeals Auto–Forward

Title	Description
Label for Data:	Drug Plan Fails to Make Timely Decisions about Appeals (for every 10,000 members)
Description:	Percent of plan members who failed to get a timely response when they made an appeal request to the drug plan about a decision to refuse payment or coverage. If you would like more information about Medicare appeals, click on http://www.medicare.gov/claims-and-appeals/index.html
Metric:	This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because the plan exceeded decision timeframes for coverage determinations or redeterminations. This is calculated as:

Measure: D02 - Appeals Auto–Forward

Title	Description
	[(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.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Rates are not calculated for contracts with average enrollment less than 800 enrollees during the measurement period. Cases the IRE remands back to the plan are not included in these data.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Lower is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Numeric with 1 decimal point

Measure: D03 - Appeals Upheld

Title	Description
Label for Data:	Fairness of Drug Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	How often an 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 before May 1, 2016. The denominator is equal to the number of cases upheld, fully reversed, and partially reversed. Dismissed, remanded, and withdrawn cases are not included in the denominator. Auto-forwarded cases are included, as these are considered to be adverse decisions per Subpart M rules. If a Reopening occurs and is decided prior to May 1, 2016, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after May 1, 2016 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data. Contracts with no IRE cases reviewed will not receive a score in this measure.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part D reconsiderations. The appeals used in this measure are based on the date they were received by the IRE, not the date a decision was reached by the IRE.

Measure: D03 - Appeals Upheld

Title	Description
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Contracts with fewer than 10 cases reviewed by the IRE.
Data Time Frame:	01/01/2015 - 12/31/2015
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

Measure: C32 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by 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 and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part C benefit.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/18/2016 - 06/03/2016
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

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

Title	Description
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by 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 and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part D benefit.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/18/2016 - 06/03/2016
General Trend:	Higher is better
Case-mix adjusted:	No
NQF #:	None
Data Display:	Percentage with no decimal point

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 Star Ratings. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to others with the baseline value for that characteristic, on the 0-100 scale used in consumer reports.

For example, for the measure "Getting Needed Care," the coefficient for "age 80-84" is +0.01981, indicating that respondents in that age range tend to score their plans 0.01981 point higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligible beneficiaries tend to respond -0.04851 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 on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are dual eligible beneficiaries will be adjusted upwards on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. In the tables we report the average of the coefficients for these several items, for each of the categories (rows) of the table, as a summary of the adjustment for the composite. Note: The measures derived from the supplemental questions on the MMP CAHPS survey (OHP5: Satisfaction with Care Coordination, CC14: Access to Personal Care, CC10: Access to Medical Equipment and MH3: Access to Mental Health Treatment) are not case-mix adjusted.

Table A-1: Part C CAHPS Measures

Predictor	C03: Annual Flu Vaccine	C20: Getting Needed Care (Comp)	C21: Getting Appointments and Care Quickly (Comp)	C22: Customer Service (Comp)	C23: Rating of Health Care Quality	C24: Rating of Health Plan	C25: Care Coordination (Comp)
Age: 64 or under	N/A	-0.06578	-0.02325	-0.03938	-0.17422	-0.23044	-0.02052
Age: 65 - 69	N/A	0.02681	-0.00735	-0.01398	-0.01875	-0.04524	-0.00771
Age: 75 - 79	N/A	-0.00077	0.01679	-0.00516	0.06576	0.07395	-0.01673
Age: 80 - 84	N/A	0.01981	0.01068	0.01641	0.08601	0.12252	-0.01073
Age: 85 and older	N/A	0.00795	0.01965	0.00800	0.10873	0.19082	-0.04819
Less than an 8th grade education	N/A	0.06608	-0.00950	0.02536	0.05944	0.17079	0.03275
Some high school	N/A	0.00388	-0.01735	-0.01691	0.04845	0.13634	0.01237
Some college	N/A	-0.05811	-0.00695	-0.05239	-0.07413	-0.20580	-0.01708
College graduate	N/A	-0.07714	-0.02070	-0.04485	-0.18943	-0.24973	-0.05268
More than a bachelor's degree	N/A	-0.09723	0.00934	-0.08799	-0.20722	-0.35177	-0.01692
General health rating: excellent	N/A	0.06977	0.04362	0.06420	0.39167	0.34982	0.01861
General health rating: very good	N/A	0.05110	0.03878	0.03097	0.25460	0.22071	0.02660
General health rating: fair	N/A	-0.05850	-0.03825	-0.01015	-0.20037	-0.09609	-0.01362
General health rating: poor	N/A	-0.10608	-0.03876	-0.06759	-0.44555	-0.26483	-0.02675
Mental health rating: excellent	N/A	0.15143	0.12798	0.07152	0.51309	0.34293	0.13565
Mental health rating: very good	N/A	0.07691	0.06783	0.03355	0.23984	0.14657	0.07210
Mental health rating: fair	N/A	-0.07843	-0.03536	-0.05105	-0.16960	-0.18627	-0.05122
Mental health rating: poor	N/A	-0.17530	-0.11081	-0.21117	-0.54104	-0.48376	-0.10682
Proxy helped	N/A	0.00218	-0.04383	-0.03625	-0.08993	-0.06614	0.02356
Proxy answered	N/A	-0.01587	0.03219	-0.02592	-0.00134	-0.00815	0.02373
Medicaid dual eligible	N/A	-0.04851	-0.00408	0.00706	-0.06071	0.21234	-0.01415
Low-income subsidy (LIS)	N/A	0.02839	-0.08787	0.04764	-0.08275	0.05071	0.00955
Chinese Language	N/A	0.02772	0.05809	-0.15994	0.22584	-0.09093	0.00005
Supplemental sample	-0.059749	-0.06371	0.05024	0.03227	-0.11010	0.18672	0.02077

Table A-2: Part D CAHPS Measures

Predictor	MA-PD D08: Rating of Drug Plan	MA-PD D09: Getting Needed Prescription Drugs (Comp)	PDP D08: Rating of Drug Plan	PDP D09: Getting Needed Prescription Drugs (Comp)
Age: 64 or under	-0.27569	-0.06454	0.06211	-0.02891
Age: 65 - 69	-0.19440	-0.03037	-0.08983	-0.02822
Age: 75 - 79	0.07233	0.00378	0.24711	0.02864
Age: 80 - 84	0.21853	0.01595	0.47427	0.03152
Age: 85 and older	0.33341	0.01583	0.67113	0.10747
Less than an 8th grade education	0.08252	-0.03436	0.00931	-0.11294

Predictor	MA-PD D08: Rating of Drug Plan	MA-PD D09: Getting Needed Prescription Drugs (Comp)	PDP D08: Rating of Drug Plan	PDP D09: Getting Needed Prescription Drugs (Comp)
Some high school	0.11874	0.00096	0.30042	-0.02304
Some college	-0.21490	-0.01862	-0.32058	-0.07855
College graduate	-0.24904	-0.02611	-0.37643	-0.10954
More than a bachelor's degree	-0.40747	-0.03288	-0.51899	-0.12881
General health rating: excellent	0.35712	-0.01633	0.23756	0.06252
General health rating: very good	0.20741	0.02448	0.18783	0.01657
General health rating: fair	-0.14385	-0.03628	-0.25042	-0.07071
General health rating: poor	-0.32451	-0.06472	-0.63890	-0.20834
Mental health rating: excellent	0.28843	0.09477	0.12897	0.08428
Mental health rating: very good	0.13911	0.05275	0.03531	0.05432
Mental health rating: fair	-0.10406	-0.02567	-0.08717	0.03976
Mental health rating: poor	-0.42811	-0.08262	-0.39533	-0.00522
Proxy helped	-0.00781	0.00945	-0.29024	-0.04416
Proxy answered	-0.02595	0.05698	-0.06049	0.07667
Medicaid dual eligible	0.59949	0.01851	0.89267	0.00984
Low-income subsidy (LIS)	0.45558	0.01937	0.47135	0.00984
Chinese Language	-0.25143	-0.02937	N/A	N/A
Supplemental sample	0.24165	-0.05079	0.25967	-0.05065

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: Calculating Measure C19: Plan All-Cause Readmissions

All data come from the HEDIS 2016 M16_PCRb data file. The CMS MA HEDIS Public Use File (PUF) data can be found on this page: Medicare Advantage/Part D Contract and Enrollment Data

Formula Value	PCRb Field	Field Description	PUF Field
A	is6574	Count of Index Stays (Denominator) 65-74	UOS524-0010
D	r6574	Count of 30-Day readmissions (numerator) 65-74	UOS524-0020
G	ap6574	Average Adjusted Probability 65-74	UOS524-0030
B	is7584	Count of Index Stays (Denominator) 75-84	UOS524-0040
E	r7584	Count of 30-Day readmissions (numerator) 75-84	UOS524-0050
H	ap7584	Average Adjusted Probability 75-84	UOS524-0060
C	is85	Count of Index Stays (Denominator) 85+	UOS524-0070
F	r85	Count of 30-Day readmissions (numerator) 85+	UOS524-0080
I	ap85	Average Adjusted Probability 85+	UOS524-0090

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

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

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

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

Example: Calculating the final rate for Contract 1

Formula Value	PCR Field	Contract 1	Contract 2	Contract 3	Contract 4
A	is6574	2,217	1,196	4,157	221
D	r6574	287	135	496	30
G	ap6574	0.126216947	0.141087156	0.122390927	0.129711036
B	is7584	1,229	2,483	3,201	180
E	r7584	151	333	434	27
H	ap7584	0.143395345	0.141574415	0.168403941	0.165909069
C	is85	1,346	1,082	1,271	132
F	r85	203	220	196	22
I	ap85	0.165292297	0.175702614	0.182608065	0.145632638

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

NatAvgObs = Average $((0.13376)+ (0.14451)+ (0.13049)+ (0.14822))$

NatAvgObs = 0.13924

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

Expected Contract 1 = $\left(\left(\left(\frac{2217}{2217+1229+1346}\right)\times\ 0.126216947\right)+\left(\left(\frac{1229}{2217+1229+1346}\right)\times\ 0.143395345\right)+\left(\left(\frac{1346}{2217+1229+1346}\right)\times\ 0.165292297\right)\right)$

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

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

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

The actual calculated NatAvgObs value used in the 2017 Star Ratings was 0.127865009484439

Attachment D: Medication Adherence Measure Calculations

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

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

Proportion of Days Covered Calculation

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

Example 1: Non-Overlapping Fills of Two Different Drugs

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

Table L-1: No Adjustment

Drug	January		February		March	
	1/1/2015	1/16/2015	2/1/2015	2/16/2015	3/1/2015	3/16/2015
Benazepril	15	16	15	13		
Captopril					15	16

PDC Calculation
Covered Days: 90
Measurement Period: 90
PDC: 90/90 = 100%

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

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

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

Table L-2: Before Overlap Adjustment

Drug	January		February		March	
	1/1/2015	1/16/2015	2/1/2015	2/16/2015	3/1/2015	3/16/2015
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

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

Table L-3: After Overlap Adjustment

Drug	January		February		March	
	1/1/2015	1/16/2015	2/1/2015	2/16/2015	3/1/2015	3/16/2015
	15	16				
Lisinopril & HCTZ			15	13	3	
Benazepril & HCTZ			15	13		

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

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

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

Table L-4: Before Overlap Adjustment

Drug	January		February		March		April	
	1/1/2015	1/16/2015	2/1/2015	2/16/2015	3/1/2015	3/16/2015	4/1/2015	4/16/2015
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

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

Table L-5: After Overlap Adjustment

Drug	January		February		March		April	
	1/1/2015	1/16/2015	2/1/2015	2/16/2015	3/1/2015	3/16/2015	4/1/2015	4/16/2015
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

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

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

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

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

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

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

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

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

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

Example 1: Gap in Coverage after IP Stay

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

Table L-6: Before Adjustment

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

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

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

Table L-7: After Adjustment

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

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

Example 2: Gap in Coverage before IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and13, as illustrated in Table L-8.

Table L-8: Before Adjustment:

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

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

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

Table L-9: After Adjustment

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

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

Example 3: Gap in Coverage Before and After IP Stay

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

Table L-10: Before Adjustment

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

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

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

Table L-11: After Adjustment

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

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

Attachment E: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D15: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2015.

Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2015.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2016), or that were not required to participate in data validation.

Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section and contracts that scored 95% or higher on data validation for the MTM Program section but that were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements:

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

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

File DV failure: Contracts that failed to submit the CY 2015 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2015 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2015 MTM Program Reporting Requirements data but that failed at least one of the four data elements are listed as "CMS identified issues with this plan's data."

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

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

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

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

Attachment F: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no data available for a contract. This attachment provides the rules for assignment of those messages in each level of the Star Ratings.

Measure level messages

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

Table P-1: Measure level missing data messages

Message	Measure Level
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report
Plan too new to be measured	The contract is too new to have submitted measure data
No data available	There were no data for the contract included in the source data for the measure
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules
Plan not required to report measure	The contract was not required to report the measure due to low plan enrollment.

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 (C30 & C31):

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 > 01/01/2015?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C20, C21, C22, C23, C24, & C25):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2015?
  - 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 – Foreign Language Interpreter and TTY Availability measure (C32):

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 > 05/31/2015?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C26):

Is the contract effective date > 01/01/2015?

Yes: Display message: Plan too new to be measured

No: Was the average contract enrollment < 800 in 2015?

Yes: Display message: Not enough data available

No: Is there a valid numeric CTM rate?

Yes: Display the numeric CTM rate

No: Display message: No data available

HEDIS measures (C01, C02, C07, & C12 – C17):

Is the contract effective date > 01/01/2015?

Yes: Display message: Plan too new to be measured

No: Was the contract required to report HEDIS?

Yes:

What is the HEDIS measure audit designation?

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

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

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

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

NQ: Display message: Plan not required to report measure

R: Was a valid patient level detail file 1 submitted and the measure data usable?

Yes: Was contract enrollment at least 500 but less than 1,000?

Yes: Is the measure reliability at least 0.7?

Yes: Display the HEDIS measure numeric rate

No: Display message: No data available

No: Display the HEDIS measure numeric rate

No: Display message: CMS identified issues with this plan's data

No: Display message: Plan not required to report measure

HEDIS PCR measure (C19)

Is the contract effective date > 01/01/2015?

Yes: Display message: Plan too new to be measured

No: Was the contract required to report HEDIS?

Yes:

What is the HEDIS measure audit designation?

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

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

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

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

NQ: Display message: Plan not required to report measure

R: Was a valid patient level detail file 2 submitted and the measure data usable?

Yes:

Was contract enrollment at least 500 but less than 1,000?

Yes: Is the measure reliability at least 0.7?

Yes: Display the HEDIS measure numeric rate

No: Display message: No data available

No: Display the HEDIS measure numeric rate

No: Display message: CMS identified issues with this plan's data

No: Display message: Plan not required to report measure

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

Is the organization type (1876 Cost, PFFS, MSA) or SNP offered in 2017= No?

Yes: Display message: Plan not required to report measure

No: Is the contract effective date > 01/01/2015?

Yes: Display message: Plan too new to be measured

No: What is the HEDIS measure audit designation?

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

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

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

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

NQ: Display message: Plan not required to report measure

R: Is there a valid HEDIS measure numeric rate?

Yes: Display the HEDIS measure numeric rate

No: Display message: No data available

HEDIS / HOS measures (C06, C18):

Is there a valid HEDIS / HOS numeric rate?

Yes: Display the HEDIS / HOS numeric rate

No: Is the contract effective date > 01/01/2014?

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 (C04 & C05):

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 > 01/01/2012?

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

Members Choosing to Leave the Plan (C27):

Is there a valid numeric voluntary disenrollment rate?

Yes: Display the numeric voluntary disenrollment rate

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

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

Assignment rules for Part D measure messages

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

Has CMS identified issues with the contract's data?

Yes: Display message: CMS identified issues with this plan’s data
No: Was the average contract enrollment < 800 in 2015?
Yes: Display message: Not enough data available
No: Is the contract effective date > 12/31/2015?
Yes: Display message: Plan too new to be measured
No: Is there a valid numeric measure rate?
Yes: Display numeric measure rate
No: Display message: No data available

Appeals Upheld (IRE) measure (D03):

Has CMS identified issues with the contract’s data?

Yes: Display message: CMS identified issues with this plan’s data
No: Is the contract effective date > 01/01/2015?
Yes: Display message: Plan too new to be measured
No: Were fewer than 10 cases reviewed by the IRE?
Yes: Display message: Not enough data available
No: Is there a valid numeric measure percentage?
Yes: Display numeric measure percentage
No: Display message: No data available

CAHPS measures (D08, D09):

Is there a valid numeric CAHPS measure rate?
Yes: Display the numeric CAHPS measure rate
No: Is the contract effective date > 07/01/2015?
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 – Foreign Language Interpreter and TTY Availability 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 > 05/31/2015?
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 > 01/01/2015?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2015?
  - 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

Patient Safety measure – HRM (D11):

Is the contract effective date > 12/31/2014?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (measure denominator)?
  - Yes: Display message: Not enough data available
  - No: 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 – Adherence (D12 - D14):

Is the contract effective date > 12/31/2015?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (measure denominator)?
  - Yes: Display message: Not enough data available
  - No: Display numeric measure percentage

Patient Safety measure – MTM CMR (D15)

Is the contract effective date > 12/31/2015?
- Yes: Display message: Plan too new to be measured
- No: Is Part D Offered=False?
  - Yes: Display message: Plan not required to report measure
  - No: Is there a numeric rate?
    - Yes: Display numeric measure percentage
    - No: Is there a Reason(s) for Display Message?
    - Yes: Display appropriate message per table O-2

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

Reason(s) for Display Message	Star Ratings Message
Contract failed to submit file and pass system validation by the reporting deadline	CMS identified issues with this plan's data
Contract did not pass element-level DV for at least one element	CMS identified issues with this plan's data
Contract had missing DV score for MTM	CMS identified issues with this plan's data
Contract scored less than 95% on MTM section DV	CMS identified issues with this plan's data
Contract had all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
Contract not required to submit MTM program	Not required to report

Attachment G: Contract Enrollment Data

The enrollment data used in the Part C and Part D "Complaints about the Health/Drug Plan" and Part D "Appeals Auto–Forward" measures are pulled from the HPMS. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2015 through December 2015) and the average enrollment across those months is used in the calculations.

Attachment H: Rounding Rules for Measure Scores

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

Attachment I: Glossary of Terms

CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Disability Status	Based on the original reason for entitlement for Medicare.
Dual eligible	are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
Euclidean distance	The absolute value of the difference between two points, x-y.
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. Note: No MMP performance data is yet available based on the Medicare HOS.

Attachment I: Glossary of Terms

IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
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.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.
Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality ("signal") rather than random variation ("noise"). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how likely differences observed are 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.
Sum of Squares	Method used to measure variation or deviation from the mean.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.
Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

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

The following table provides information about the state-specific measures that were used to calculate the care plan completion rate. Full specifications for these measures are included in the State-Specific Reporting Requirements documents, which are available on the CMS website at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

State	Measure Number	Measure Name
California*	CA1.2	High risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).
	CA1.4	Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).
Illinois	IL3.1	Members with care plans within 90 days of enrollment.
Massachusetts	MA1.1	Members with care plans within 90 days of enrollment.
Michigan	MI2.1	Members with an Individual Integrated Care and Supports Plan (IICSP) within 90 days of enrollment.
New York FIDA**	NY2.1 (Q1-Q3)	Participants with Person-Centered Service Plans (PCSPs) completed within 30 days of initial assessment and each re-assessment.
	NY2.1 (Q4)	Participants with Person-Centered Service Plans (PCSPs) completed within 90 days of enrollment and PCSPs updated within 30 days of a trigger event or reassessment.
Ohio	OH1.1	Members with care plans within 90 days of enrollment.
South Carolina	SC2.1	Low, moderate, and high-risk members with an Individualized Care Plan (ICP) completed within 90 days of enrollment.
Texas	TX1.1	Members with Plans of Care within 90 days of enrollment.
Virginia	VA2.1	Community Well members, vulnerable subpopulation members, EDCD members, and nursing facility members with a Plan of Care (POC) completed within 90 days of enrollment.

* For California MMPs, the care plan completion rate was calculated using both CA1.2 and CA1.4. Corresponding data elements for each measure were summed across 2015 quarterly reporting periods in order to calculate the annual rate.

** For New York FIDA MMPs, the care plan measure specifications were revised as of Q4 2015 to align with updates to New York's Interdisciplinary Team (IDT) Policy.