



**Medicare
2016 Part C & D
Star Rating
Technical Notes**

First Plan Preview

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Table of Contents

| | |
|--|-----------|
| DOCUMENT CHANGE LOG | 1 |
| INTRODUCTION | 1 |
| Table 1: Contract Year 2016 Organization Types Reported in the 2016 Star Ratings..... | 1 |
| DIFFERENCES BETWEEN THE 2015 STAR RATINGS AND 2016 STAR RATINGS | 1 |
| CONTRACT ENROLLMENT DATA | 2 |
| HANDLING OF BIASED, ERRONEOUS AND/OR NOT REPORTABLE (NR) DATA | 3 |
| HOW THE DATA ARE REPORTED | 3 |
| Table 2: Highest Rating by Contract Type..... | 3 |
| Table 3: Relation of 2016 Organization Types to Contract Types in the 2016 Star Ratings | 4 |
| METHODOLOGY FOR ASSIGNING PART C AND D MEASURE STAR RATINGS | 4 |
| METHODOLOGY FOR CALCULATING STARS FOR INDIVIDUAL MEASURES | 4 |
| A. Relative Distribution and Clustering: | 4 |
| B. Relative Distribution and Significance Testing (CAHPS): | 4 |
| C. Fixed Cut Points | 5 |
| METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL | 5 |
| Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type..... | 5 |
| SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES | 6 |
| METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS | 6 |
| Table 6: Part C and Part D Summary Rating Requirements | 6 |
| METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING | 6 |
| Table 7: Minimum Number of Rated Measures for an Overall Rating | 7 |
| APPLYING THE IMPROVEMENT MEASURE(S) | 7 |
| Table 8: Minimum Number of Measures Required for an Improvement Measure Rating by Contract Type..... | 7 |
| APPLYING THE REWARD FACTOR | 8 |
| Table 9: Performance Summary Thresholds | 9 |
| Table 10: Variance Thresholds | 9 |
| CALCULATION PRECISION | 10 |
| ROUNDING RULES FOR MEASURE SCORES: | 10 |
| ROUNDING RULES FOR SUMMARY AND OVERALL SCORES: | 10 |
| Table 11: Rounding Rules for Summary and Overall Scores | 10 |
| METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON | 11 |
| METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON | 11 |
| Table 12: Example LPI contracts | 11 |
| ADJUSTMENTS FOR CONTRACTS UNDER SANCTION | 11 |
| CAHPS METHODOLOGY | 12 |
| Table 13: CAHPS Star Assignment Rules | 12 |
| Table 14: CAHPS Star Assignment Alternate Representation | 13 |
| RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS | 13 |
| SPECIAL NEEDS PLAN (SNP) DATA | 13 |

STAR RATINGS AND MARKETING..... 13

CONTACT INFORMATION..... 14

PART C DOMAIN AND MEASURE DETAILS 16

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines..... 16

Measure: C01 - Breast Cancer Screening 16

Measure: C02 - Colorectal Cancer Screening 17

Measure: C03 - Annual Flu Vaccine 17

Measure: C04 - Improving or Maintaining Physical Health 18

Measure: C05 - Improving or Maintaining Mental Health 19

Measure: C06 - Monitoring Physical Activity..... 19

Measure: C07 - Adult BMI Assessment 20

Domain: 2 - Managing Chronic (Long Term) Conditions 22

Measure: C08 - Special Needs Plan (SNP) Care Management 22

Measure: C09 - Care for Older Adults – Medication Review 23

Measure: C10 - Care for Older Adults – Functional Status Assessment..... 24

Measure: C11 - Care for Older Adults – Pain Assessment 25

Measure: C12 - Osteoporosis Management in Women who had a Fracture 25

Measure: C13 - Diabetes Care – Eye Exam..... 26

Measure: C14 - Diabetes Care – Kidney Disease Monitoring 27

Measure: C15 - Diabetes Care – Blood Sugar Controlled..... 28

Measure: C16 - Controlling Blood Pressure 29

Measure: C17 - Rheumatoid Arthritis Management 30

Measure: C18 - Reducing the Risk of Falling 31

Measure: C19 - Plan All-Cause Readmissions 32

Domain: 3 - Member Experience with Health Plan 34

Measure: C20 - Getting Needed Care 34

Measure: C21 - Getting Appointments and Care Quickly 35

Measure: C22 - Customer Service..... 36

Measure: C23 - Rating of Health Care Quality 37

Measure: C24 - Rating of Health Plan 38

Measure: C25 - Care Coordination 39

Domain: 4 - Member Complaints and Changes in the Health Plan's Performance 40

Measure: C26 - Complaints about the Health Plan..... 40

Measure: C27 - Members Choosing to Leave the Plan..... 41

Measure: C28 - Beneficiary Access and Performance Problems..... 42

Measure: C29 - Health Plan Quality Improvement 43

Domain: 5 - Health Plan Customer Service..... 45

Measure: C30 - Plan Makes Timely Decisions about Appeals 45

Measure: C31 - Reviewing Appeals Decisions 46

Measure: C32 - Call Center – Foreign Language Interpreter and TTY Availability 47

PART D DOMAIN AND MEASURE DETAILS 48

Domain: 1 - Drug Plan Customer Service 48

Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability 48

Measure: D02 - Appeals Auto-Forward..... 49

Measure: D03 - Appeals Upheld..... 50

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance..... 51

Measure: D04 - Complaints about the Drug Plan 51

Measure: D05 - Members Choosing to Leave the Plan..... 52

Measure: D06 - Beneficiary Access and Performance Problems..... 53

Measure: D07 - Drug Plan Quality Improvement 54

Domain: 3 - Member Experience with the Drug Plan 56

Measure: D08 - Rating of Drug Plan 56

Measure: D09 - Getting Needed Prescription Drugs 57

Domain: 4 - Drug Safety and Accuracy of Drug Pricing 58

Measure: D10 - MPF Price Accuracy..... 58

Measure: D11 - High Risk Medication 59

Measure: D12 - Medication Adherence for Diabetes Medications..... 60

Measure: D13 - Medication Adherence for Hypertension (RAS antagonists) 62

Measure: D14 - Medication Adherence for Cholesterol (Statins) 64

Measure: D15 - MTM Program Completion Rate for CMR 65

ATTACHMENT A: CAHPS CASE-MIX ADJUSTMENT 68

 Table A-1: Part C CAHPS Measures 68

 Table A-2: Part D CAHPS Measures 69

ATTACHMENT B: COMPLAINTS TRACKING MODULE EXCLUSION LIST..... 70

 Table B-1: Exclusions since September 25, 2010 70

 Table B-2: Exclusions prior to September 25, 2010 71

ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES 72

 Table C-1: National Averages for Part C Measures 72

 Table C-2: National Averages for Part D Measures 73

ATTACHMENT D: PART C AND D DATA TIME FRAMES..... 74

 Table D-1: Part C Measure Data Time Frames 74

 Table D-2: Part D Measure Data Time Frames 75

ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES 76

 A. Medicare Part C Reporting Requirements Measure (C08: SNP Care Management) 76

 B. NCQA HEDIS Measures - (C09 - C11: Care for Older Adults) 77

ATTACHMENT F: CALCULATING MEASURE C19: PLAN ALL-CAUSE READMISSIONS 78

ATTACHMENT G: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES 79

 Table G-1: Part C Measure Weights 79

 Table G-2: Part D Measure Weights 80

ATTACHMENT H: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES 81

ATTACHMENT I: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED..... 82

 Calculating the Improvement Measure 82

 General Standard Error Formula..... 83

 Standard Error Numerical Example. 83

 Standard Error Formulas for Specific Measures 83

 Table I-1: Part C Measures Used in the Improvement Measure 85

 Table I-2: Part D Measures Used in the Improvement Measure 86

ATTACHMENT J: STAR RATINGS MEASURE HISTORY 87

 Table J-1: Part C Measure History..... 87

 Table J-2: Part D Measure History..... 90

 Table J-3: Common Part C & Part D Measure History 92

ATTACHMENT K: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS 93

ATTACHMENT L: MEDICATION ADHERENCE MEASURE CALCULATIONS 95

 Days Covered Calculation..... 95

 Example 1: Non-Overlapping Fills of Two Different Drugs 95

 Example 2: Overlapping Fills of the Same Generic Ingredient Across Single and Combination Products 95

 Example 3: Overlapping Fills of the Same and Different Drugs 96

 Days Covered Modification for Inpatient Stays, Hospice Enrollment and Skilled Nursing Facility Stays 97

 Calculating the PDC Adjustment for IP Stays, Hospice Enrollments, and SNF Stays 97

 Example 1 – IP Stay with excess post-IP coverage gap 98

 Figure 1: Drug Coverage Assigned Before Modification in Example 1..... 98

 Figure 2: Drug Coverage Assigned After Modification in Example 1..... 98

 Example 2 – IP stay with post-IP coverage gap < IP length of stay 98

 Figure 3: Drug Coverage Assigned Before Modification in Example 2..... 98

 Figure 4: Drug Coverage Assigned After Modification in Example 2..... 98

 Example 3 – IP stay with no post-IP coverage gap 99

Figure 5: Drug Coverage Assigned Before Modification in Example 3..... 99
 Figure 6: Drug Coverage Assigned After Modification in Example 3..... 99

ATTACHMENT M: METHODOLOGY FOR PRICE ACCURACY MEASURE 100

Contract Selection..... 100
 PF Price Accuracy Index..... 100
 Example of Accuracy Index Calculation..... 101
 Table M-1: Example of Price Accuracy Index Calculation 102

ATTACHMENT N: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES 103

A. Medicare Part D Reporting Requirements Measure (D15: MTM CMR Completion Rate Measure)..... 103

ATTACHMENT O: MISSING DATA MESSAGES 104

Measure level messages 104
 Table O-1: Measure level missing data messages 104
 1. Assignment rules for Part C measure messages..... 104
 2. Assignment rules for Part D measure messages..... 108
 Domain, Summary and Overall level messages 111
 Table O-2: Domain, Summary and Overall level missing data messages 111
 1. Assignment rules for Part C & Part D domain rating level messages..... 111
 2. Assignment rules for Part C & Part D summary rating level messages..... 111
 3. Assignment rules for overall rating level messages..... 111
 Disenrollment Reasons messages..... 112
 Table O-3: Disenrollment Reason missing data messages 112

ATTACHMENT P: GLOSSARY OF TERMS 113

ATTACHMENT Q: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE..... 116

STAR RATINGS..... 116

B. Measure Data page 116
C. Measure Detail page 116
 Table Q-1: Measure Detail page fields 116
D. Measure Detail – Auto-Forward page..... 117
 Table Q-2: Measure Detail – Auto-Forward page fields 117
E. Measure Detail – Upheld page 117
 Table Q-3: Measure Detail – Upheld page fields 117
F. Measure Detail – SNP CM page 117
 Table Q-4: Measure Detail – SNP CM page fields 118
G. Measure Detail – SNP COA page..... 118
 Table Q-6: Measure Detail – SNP COA page fields 118
 Table Q-6: HEDIS 2015 Audit Designations and 2016 Star Ratings 119
H. Measure Detail – CTM page..... 119
 Table Q-7: Measure Detail – CTM page fields..... 119
I. Measure Detail – Disenrollment..... 119
 Table Q-8: Measure Detail – Disenrollment..... 119
J. Measure Detail – DR (Disenrollment Reasons)..... 120
K. Measure Detail – BAPP (Beneficiary Access and Performance Problems) 120
 Table Q-10: Measure Detail – BAPP (Beneficiary Access and Performance Problems) 120
L. Measure Detail – HEDIS LE page..... 121
 Table Q-11: Measure Detail – HEDIS LE page fields 121
M. Measure Detail – C Improvement page 121
 Table Q-12: Part C Measure Improvement Results..... 121
N. Measure Detail – D Improvement page 122
 Table Q-13: Part D Measure Improvement Results..... 122

O. Measure Stars page 122

P. Domain Stars page..... 122

Q. Part C Summary Rating page 122
Table Q-14: Part C Summary Rating View 123

Part D Summary Rating page 123
Table Q-15: Part D Summary Rating View 123

R. Overall Rating page 124
Table Q-16: Overall Rating View 124

S. Low Performing Contract List..... 124
Table Q-17: Low Performing Contract List..... 125

T. High Performing Contract List..... 125
Table Q-18: High Performing Contract List..... 125

U. Technical Notes link 125

V. Medication NDC List – High Risk Medication Measure link..... 125

W. Medication NDC List – Medication Adherence Measure link..... 126

Introduction

This document describes the methodology for creating the Part C and D Star Ratings displayed on the Medicare Plan Finder (MPF) on <http://www.medicare.gov/> and posted on the CMS website at <http://go.cms.gov/partcanddstarratings>.

These ratings are also displayed in the Health Plan Management System (HPMS) for contracts and sponsors. In the HPMS the data can be found by selecting: “Quality and Performance,” then “Performance Metrics,” then “Star Ratings and Display Measures,” then “Star Ratings,” and then select 2016 for the report period.

All of the health/drug plan quality and performance measure data described in this document are reported at the contract level. Table 1 lists the contract year 2016 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2016 Organization Types Reported in the 2016 Star Ratings

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

* Note: These organization types are Medicare Advantage (MA) Organizations

† Note: The numeric data for these organizations will be displayed in HPMS only during the first plan preview and will not be used in processing any Star Ratings.

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

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

Differences between the 2015 Star Ratings and 2016 Star Ratings

There have been several changes between the 2015 Star Ratings and the 2016 Star Ratings. This section provides a synopsis of the significant differences; the reader should examine the entire document for full details about the 2016 Star Ratings. The complete history of measures used in the Star Ratings can be found in [Attachment J](#).

1. Changes
 - a. Part C measure: C12 – Osteoporosis Management in Women who had a Fracture – added an upper age limit, extended the look back period for exclusions due to prior bone mineral testing, removed estrogens from this measure, and removed single-photon absorptiometry and dual-photon absorptiometry tests from the list of eligible bone-density tests.
 - b. Part C measure: C16 – Controlling Blood Pressure – updated to include two different blood pressure thresholds based on age and diagnosis.

- c. Part C measure C19 – Plan All-Cause Readmissions – now excludes planned readmissions from the measure and removes the current exclusion from the denominator for hospitalizations with a discharge date in the 30 days prior to the Index Admission Date.
 - d. Part C measure: C30 – Plan Makes Timely Decisions about Appeals – removed dismissed appeals from the measure.
 - e. Part C & D measures: C26 & D04 – Complaints about the Health/Drug Plan – modified the measurement period from 6 months of the current year to 12 months of the prior year.
 - f. Part D measure: D03 – Appeals Upheld – modified the measurement period to coincide with the 12 month period of the Part D Appeals Auto-forward measure.
 - g. Part D measures: D12 & D13 – both measures adjusted to account for beneficiaries with End-Stage Renal Disease (ESRD).
 - h. Part D measures: D12, D13 & D14 – calculation of the proportion of days now uses the date of death for a member instead of the last day of the month.
 - i. Part D measures: D11 – D14 - Implemented PQA’s 2014 obsolete NDCs methodology.
 - j. Part C & D Consumer Assessment of Healthcare Providers and Systems (CAHPS measures: Implemented CAHPS methodology modifications which permit low-reliability contracts to receive 5 stars or 1 star.
2. Additions
 - a. Part C measure: C01 - Breast Cancer Screening: with a weight of 1.
 - b. Part D measure: D15 – Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews: with a weight of 1.
 - c. Parts C & D measure: C32 & D01 - Call Center – Foreign Language Interpreter and TTY Availability: with a weight of 1.5.
 - d. Parts C & D measures: C28 & D06 - Beneficiary Access and Performance Problems: with a weight of 1.
 3. Transitioned measures (Moved to the display measures which can be found on the CMS website at this address: <http://go.cms.gov/partcanddstarratings>)
 - a. Part C measure: Improving Bladder Control
 4. Retired measures
 - a. Part C measure: Cardiovascular Care - Cholesterol Screening
 - b. Part C measure: Diabetes Care - Cholesterol Screening
 - c. Part C measure: Diabetes Care - Cholesterol Controlled
 - d. Part D measure: Diabetes Treatment

Contract Enrollment Data

The enrollment data used in the Part C and D "Complaints about the Health/Drug Plan" and Part D "Appeals Auto-Forward" measures were pulled from the HPMS. These enrollment files represent the number of beneficiaries the contract was paid for in a specific month. For this measure, twelve months of enrollment files were pulled (January 2014 through December 2014), and the average enrollment from those months was used in the calculations.

Enrollment data are also used to combine plan level data into contract level data in the three Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. This only occurs when the eligible population was not included in the submitted SNP HEDIS data and the submitted rate was NR (see following section). For these measures, twelve months of plan level enrollment files were pulled (January 2014 through December 2014), and the average enrollment in the plan for those months was used in calculating the combined rate.

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

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

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

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

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

How the Data are Reported

For 2016, the Part C and D Star Ratings are reported at five different levels.

- Base:** At the base level, with the most detail, are the individual measures. They are comprised of numeric data for all of the quality and performance measures except for the improvement measures which are explained in the section titled "Applying the Improvement Measure(s)".
- Star:** Each of the base level measure ratings are then scored on a 5-star scale.
- Domain:** Each measure is also grouped with similar measures into a second level called a domain. A domain is assigned a Star Rating.
- Summary:** All of the Part C measures are grouped together to form the Part C summary rating for a contract. There is also a Part D summary rating formed by grouping all of the Part D measures.
- Overall:** All the Part C and Part D measures are grouped together to form the Overall rating for a contract.

Because different organization types offer different benefits, CMS classifies contracts into three contract type categories. The highest level rating differs for each contract type because the set of measures available differ. Table 2 clarifies how CMS classifies contracts for purposes of the Star Ratings and the highest rating per contract type.

Table 2: Highest Rating by Contract Type

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

Table 3 relates the three contract types to the organization types reported on in the 2016 Star Ratings.

Table 3: Relation of 2016 Organization Types to Contract Types in the 2016 Star Ratings

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

For each contract type rating detailed in Table 2, the improvement measure(s) may not be used under certain circumstances, which are explained in the section titled “Applying the Improvement Measure(s)”.

The Star Ratings include up to 9 domains (topic areas) comprised of up to 47 measures.

1. MA-only contracts are measured on 5 domains with up to 32 measures.
2. PDPs are measured on 4 domains with up to 15 measures.
3. MA-PD contracts are measured on all 9 domains with up to 45 unique measures.

Methodology for Assigning Part C and D Measure Star Ratings

CMS develops Part C and Part D Star Ratings in advance of the annual enrollment period each fall. Ratings are calculated at the contract level. The principle for assigning Star Ratings for a measure is based on grouping measure scores so that the variation in measure scores within Star Rating categories is minimized. The trends in Part C & D Star Rating cut points document is posted on the website at <http://go.cms.gov/partcanddstarratings> and is updated after each rating cycle is released.

Methodology for Calculating Stars for Individual Measures

CMS assigns stars for each measure by applying one of two different methods: clustering or relative distribution and significance testing. Each method is described in detail below. [Attachment K](#) explains this process in more detail.

A. Relative Distribution and Clustering:

This method is applied to the majority of CMS’ Star Ratings for star assignments, ranging from operational and process-based measures, to HEDIS and other clinical care measures.

The Star Rating for each of the individual measures using this methodology is determined by applying a clustering algorithm to the individual measure scores. Conceptually, the clustering algorithm identifies the “gaps” in the data and creates four cut points that result in the creation of five categories (one for each Star Rating) such that scores of contracts in the same score category (Star Rating) are as similar as possible, and scores of contracts in different categories are as different as possible.

The variance in measure scores is separated into within-cluster and between-cluster sum of squares components. The clusters reflect the groupings of individual measure scores that minimize the variance of measure scores within the clusters. The five measure Star Ratings levels are assigned to the cluster assignment that minimizes the within-cluster sum of squares. The cut points for star assignments are derived from the range of individual measure Star Ratings per cluster, and the star levels associated with each cluster are determined by ordering the means of each cluster.

B. Relative Distribution and Significance Testing (CAHPS):

This method is applied to determine valid star cut points for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars, a contract’s CAHPS measure score needs to be ranked above the 80th percentile and be statistically significantly higher than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error above the 80th percentile. To obtain 1 star, a contract’s CAHPS measure score needs to be ranked below the 15th percentile and be statistically significantly lower than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error below the 15th percentile.

C. Fixed Cut Points

The Beneficiary Access and Performance Problems measure is unlike all other measures in the Star Ratings. All contracts begin with a starting score (100) which equates to five stars. Set value deductions are then subtracted from the starting score depending on the contracts inclusion in specific measure criteria. This methodology causes the final contracts scores to be either zero or a multiple of 20 (0, 20, 40, 60, 80 or 100).

Since there is no variability in the final contract scores, the two other methods for assigning stars cannot be used. So the Beneficiary Access and Performance Problems measure has the fixed star cut points. Those cut points are shown in table 4.

Table 4: Fixed Cut Points

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

Methodology for Calculating Stars at the Domain Level

The domain rating is the average (unweighted mean) of the individual measure stars. To receive a domain rating, the contract must meet or exceed the minimum number of individual rated measures required for the domain. The minimum number of measures required for a domain rating is determined based on whether the total number of measures in the domain for each contract type is odd or even:

- If the total number of measures that comprise the domain for the contract type is odd, divide the number of measures in the domain by two and round the quotient to the next whole number.
 - Example: If the total number of measures required in a domain for a contract type is 3, the value 3 is divided by 2. The quotient, in this case 1.5, is then rounded to the next whole number. To have a domain rating reported, the contract must have a rating on at least 2 out of 3 required measures.
- If the total number of measures that comprise the domain for the contract type is even, divide the number of measures in the domain by two and then add one to the quotient.
 - Example: If the total number of measures required in a domain for a contract type is 6, the value 6 is divided by 2. In this example, 1 is then added to the quotient of 3. To have a domain rating reported, the contract must have a rating on at least 4 out of 6 required measures

Table 5 details the minimum number of rated measures required for a domain rating by contract type.

Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type

| Part | ID | Domain Name | Contract Type | | | | | |
|------|----|--|----------------|---|--|--------|----------------|------------------|
| | | | 1876 Cost † | Local, E-Local & Regional CCP w/o SNP | Local, E-Local & Regional CCP with SNP | MSA | E-PDP & PDP | E-PFFS & PFFS |
| C | 1 | Staying Healthy: Screenings, Tests and Vaccines | 4 of 7 | 4 of 7 | 4 of 7 | 4 of 7 | N/A | 4 of 7 |
| C | 2 | Managing Chronic (Long Term) Conditions | 4 of 7 | 5 of 8 | 7 of 12 | 5 of 8 | N/A | 5 of 8 |
| C | 3 | Member Experience with Health Plan | 4 of 6 | 4 of 6 | 4 of 6 | 4 of 6 | N/A | 4 of 6 |
| C | 4 | Member Complaints and Changes in the Health Plan's Performance | 3 of 4 | 3 of 4 | 3 of 4 | 3 of 4 | N/A | 3 of 4 |
| C | 5 | Health Plan Customer Service | 2 of 2 | 2 of 3 | 2 of 3 | 2 of 3 | N/A | 2 of 3 |
| D | 1 | Drug Plan Customer Service | 2 of 2* | 2 of 3 | 2 of 3 | N/A | 2 of 3 | 2 of 3 |
| D | 2 | Member Complaints and Changes in the Drug Plan's Performance | 3 of 4* | 3 of 4 | 3 of 4 | N/A | 3 of 4 | 3 of 4 |
| D | 3 | Member Experience with the Drug Plan | 2 of 2* | 2 of 2 | 2 of 2 | N/A | 2 of 2 | 2 of 2 |
| D | 4 | Drug Safety and Accuracy of Drug Pricing | 4 of 6* | 4 of 6 | 4 of 6 | N/A | 4 of 6 | 4 of 6 |

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

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

Summary and Overall Ratings: Weighting of Measures

For the 2016 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by the outcomes and intermediate outcomes measures, then by patient experience/complaints and access measures, and finally the process measures. Process measures are weighted the least. The summary Part C, Part D, and overall MA-PD Star Ratings are calculated as weighted averages of the individual measure ratings. The weights assigned to each measure for summary and overall Star Ratings are shown in [Attachment G](#).

A measure given a weight of 3 counts three times as much as a measure given a weight of 1. For both the summary and overall ratings, the rating for a single contract is calculated as a weighted average of the measures available for that contract. The first step in this calculation is to multiply each individual measure's weight by the measure's Star Rating and then sum all results for all the measures available for each contract. The second step is to divide this result by the sum of the weights for the measures available for the contract.

Methodology for Calculating Part C and Part D Summary Ratings

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

- If the total number of measures required for the organization type in the domain is odd, divide the number by two and round it to a whole number.
 - Example: if there were 15 required Part D measures for the organization, $15 / 2 = 7.5$, when rounded the result is 8. The contract needs at least 8 measures with ratings out of the 15 total measures to receive a Part D summary rating.
- If the total number of measures required for the organization type in the domain is even, divide the number of measures by two.
 - Example: if there were 32 required Part C measures for the organization, $32 / 2 = 16$. The contract needs at least 16 measures with ratings out of the 32 total measures to receive a Part C summary rating.

Table 6 shows the minimum number of measures having a rating needed by each contract type to receive a summary rating.

Table 6: Part C and Part D Summary Rating Requirements

| Rating | 1876 Cost † | Local, E-Local & Regional CCP w/o SNP | Local, E-Local & Regional CCP with SNP | MSA | E-PDP & PDP | E-PFFS & PFFS |
|---------------|-------------|---------------------------------------|--|----------|-------------|---------------|
| Part C Rating | 13 of 25 | 14 of 27 | 16 of 31 | 14 of 27 | N/A | 14 of 27 |
| Part D Rating | 7 of 13 | 7 of 14 | 7 of 14 | N/A | 7 of 14 | 7 of 14 |

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

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

Additionally, to reward consistently high performance, CMS utilizes both the mean and the variance of individual performance ratings to differentiate contracts for the summary score. That is, a measure of individual performance score dispersion, specifically a reward factor, is added to the mean score to reward contracts if they have both high and stable relative performance. Details about the reward factor can be found in the section titled "Applying the Reward Factor".

Methodology for Calculating the Overall MA-PD Rating

For MA-PDs to receive an overall rating, the contract must have stars assigned to both the Part C summary rating and the Part D summary rating. If an MA-PD contract has only one of the two required summary ratings, the overall rating will show as, "Not enough data available".

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

There are a total of 47 measures (32 in Part C, 15 in Part D). The following three measures are contained in both the Part C and D measure lists:

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

These measures share the same data source, so CMS includes the measures only once in the calculation of the overall Star Rating. In addition, the Part C and D improvement measures are not included in the count for the minimum number of measures. Therefore, a total of 42 distinct measures (the Part D CTM, MCLP, and BAPP measures are duplicates of the Part C measures) are used in the calculation of the overall Star Rating.

The minimum number of measures required for an overall MA-PD rating is determined using the same methodology as for the Part C and D summary ratings. Table 7 provides the minimum number of rated measures required for an overall Star Rating by contract type.

Table 7: Minimum Number of Rated Measures for an Overall Rating

| Rating | 1876 Cost † | Local, E-Local & Regional CCP w/o SNP | Local, E-Local & Regional CCP with SNP | MSA | E-PDP & PDP | E-PFFS & PFFS |
|----------------|-------------|---------------------------------------|--|-----|-------------|---------------|
| Overall Rating | 18 of 35* | 19 of 38 | 21 of 42 | N/A | N/A | 19 of 38 |

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

† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 22 out of 44 measures to receive an overall rating.

For the overall Star Rating, half stars are assigned to allow more variation across contracts. The rounding rules are discussed later within this document.

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

Applying the Improvement Measure(s)

The improvement measures (Part C measure C29 and Part D measure D07) compare the underlying numeric data from the 2015 Star Ratings with the data from the 2016 Star Ratings for each contract. The Part C improvement measure uses only data from Part C, and the Part D improvement measure uses only data from Part D. For a measure to be used in the improvement calculation, the measure must exist in both years (current and previous) and not have had a significant specification change.

The measures and formulas for the improvement measures can be found in [Attachment I](#). The result of these calculations is a measure Star Rating; there are no numeric data for the measure for public reporting purposes. To receive a Star Rating in the improvement measure, a contract must have data for both years in at least half of the required measures used for the Part C improvement or Part D improvement. Table 8 shows the minimum number of measures required to receive a rating for the improvement measures.

Table 8: Minimum Number of Measures Required for an Improvement Measure Rating by Contract Type

| Part | 1876 Cost * | Local, E-Local & Regional CCP w/o SNP | Local, E-Local & Regional CCP with SNP | MSA | E-PDP & PDP | E-PFFS & PFFS |
|------|-------------|---------------------------------------|--|----------|-------------|---------------|
| C | 10 of 19 | 10 of 20 | 12 of 24 | 10 of 20 | N/A | 10 of 20 |
| D | 4 of 8 | 4 of 8 | 4 of 8 | N/A | 4 of 8 | 4 of 8 |

* Note: The Part D counts do not apply to MA-only 1876 Cost contracts which do not offer drug benefits.

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

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

MA-PD Contracts

1. There are separate Part C and Part D improvement measures (C29 & D07) for MA-PD contracts.
 - a. C29 is always used in calculating the Part C summary rating of an MA-PD contract.
 - b. D07 is always used in calculating the Part D summary rating for an MA-PD contract.
 - c. Both measures will be used when calculating the overall rating in step 3.
2. Calculate the overall rating for MA-PD contracts without including either improvement measure.
3. Calculate the overall rating for MA-PD contracts with both improvement measures included.
4. If a MA-PD contract in step 2 has 2 or fewer stars, use the overall rating calculated in step 2.
5. If a MA-PD contract in step 2 has 4 or more stars. Compare the two overall ratings calculated in steps 2 & 3. If the rating in step 3 is less than the value in step 2, use the overall rating from step 2, otherwise use the result from step 3.
6. For all other MA-PD contracts, use the overall rating from step 3.

MA-only Contracts

1. Only the Part C improvement measure (C29) is used for MA-only contracts.
2. Calculate the Part C summary rating for MA-only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-only contracts with the Part C improvement measure.
4. If an MA-only contract in step 2 has 2 or fewer stars, use the Part C summary rating calculated in step 2.
5. If an MA-only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2, otherwise use the result from step 3.
6. For all other MA-only contracts, use the Part C summary rating from step 3.

PDP Contracts

1. Only the Part D improvement measure (D07) is used for PDP contracts.
2. Calculate the Part D summary rating for PDP contracts without including the improvement measure.
3. Calculate the Part D summary rating for PDP contracts with the Part D improvement measure.
4. If a PDP contract in step 2 has 2 or fewer stars, use the Part D summary rating calculated in step 2.
5. If a PDP contract in step 2 has 4 or more stars, compare the two Part D summary ratings. If the rating in step 3 is less than the value in step 2, use the Part D summary rating from step 2, otherwise use the result from step 3.
6. For all other PDP contracts, use the Part D summary rating from step 3.

Applying the Reward Factor

The following represents the steps taken to calculate and include the reward factor in the Star Ratings summary and overall ratings. These calculations are performed both with and without the improvement measures included.

- Calculate the mean and the variance of all of the individual quality and performance measure stars at the contract level.
 - The mean is the summary or overall rating before the reward factor is applied, which is calculated as described in the section titled “Weighting of Measures”.

- Using weights in the variance calculation accounts for the relative importance of measures in the reward factor calculation. To incorporate the weights shown in [Attachment G](#) into the variance calculation of the available individual performance measures for a given contract, the steps are as follows:
 - Subtract the summary or overall star from each performance measure’s star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
 - Sum these results; call this ‘SUMWX.’
 - Set n equal to the number of individual performance measures available for the given contract.
 - Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.
 - The weighted variance for the given contract is calculated as: $n \cdot \text{SUMWX} / (W \cdot (n-1))$ (for the complete formula, please see [Attachment H: Calculation of Weighted Star Rating and Variance Estimates](#)).
- Categorize the variance into three categories:
 - low (0 to < 30th percentile),
 - medium (\geq 30th to < 70th percentile) and
 - high (\geq 70th percentile)
- Develop the reward factor as follows:
 - r-Factor = 0.4 (for contract w/ low variability & high mean (mean \geq 85th percentile))
 - r-Factor = 0.3 (for contract w/ medium variability & high mean (mean \geq 85th percentile))
 - r-Factor = 0.2 (for contract w/ low variability & relatively high mean (mean \geq 65th & < 85th percentile))
 - r-Factor = 0.1 (for contract w/ medium variability & relatively high mean (mean \geq 65th & < 85th percentile))
 - r-Factor = 0.0 (for all other contracts)
- Develop final summary score or overall scores using 0.5 as the star scale (create 10 possible overall scores as: 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0).
- Apply rounding to final summary or overall scores such that stars that are within the distance of 0.25 above or below any half-star scale will be rounded to that half-star scale.
- Tables 9 and 10 show the final threshold values used in reward factor calculations for the 2016 Star Ratings:

Table 9: Performance Summary Thresholds

| Improvement | Percentile | Part C Rating | Part D Rating (MA-PD) | Part D Rating (PDP) | Overall Rating |
|-------------|------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| with | 65th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| with | 85th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| without | 65th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| without | 85th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |

Table 10: Variance Thresholds

| Improvement | Percentile | Part C Rating | Part D Rating (MA-PD) | Part D Rating (PDP) | Overall Rating |
|-------------|------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| with | 30th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| with | 70th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| without | 30th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| without | 70th | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |

Calculation Precision

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

The improvement measures, summary and overall ratings are calculated with at least six digits of precision after the decimal whenever the data allow it. With the exception of the Plan All-Cause Readmission measure, the HEDIS measure score input data have two digits of precision after the decimal. All other measures have at least six digits of precision in the improvement calculation.

During plan previews, we display three digits after the decimal in HPMS for easier human readability. We used to only display two digits after the decimal, but there were instances where this artificially rounded value made it appear that values had achieved a boundary when they actually did not. There will still be instances when displaying three digits that values will appear to be at a boundary. When those cases occur, the ratings mailbox may be contacted for higher precision values which were used in the actual calculations.

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

Rounding Rules for Measure Scores:

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure values are rounded using standard round to nearest rules prior to cut point analysis. Raw measure scores that end in 0.49 (0.049, 0.0049) or less are rounded down and raw 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.

Rounding Rules for Summary and Overall Scores:

Summary and overall scores are rounded to the nearest half star (i.e., 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0) using consistent rounding rules. Table 11 summarizes the rounding rules for the Part C and D summary and overall ratings.

Table 11: Rounding Rules for Summary and Overall Scores

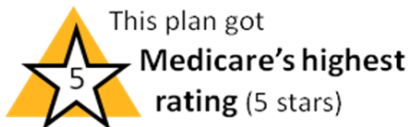
| Raw Summary / Overall Score | Final Summary / Overall Score |
|-----------------------------|-------------------------------|
| ≥ 0.000 and < 0.250 | 0 |
| ≥ 0.250 and < 0.750 | 0.5 |
| ≥ 0.750 and < 1.250 | 1.0 |
| ≥ 1.250 and < 1.750 | 1.5 |
| ≥ 1.750 and < 2.250 | 2.0 |
| ≥ 2.250 and < 2.750 | 2.5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

For example, a summary or overall score of 3.749 rounds down to 3.5, and a measure score of 3.751 rounds up to 4.

Methodology for Calculating the High Performing Icon

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

Figure 1: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary rating. The low performing icon is calculated by evaluating the Part C and Part D summary level ratings for the current year and the past two years (i.e., the 2014, 2015, and 2016 Star Ratings). If the contract had any combination of Part C and/or Part D summary rating of 2.5 or lower in all three years of data, it is marked with a low performing icon (LPI). A contract must have a rating in either Part C and/or Part D for all three years to be considered for this icon.

Table 12 shows example contracts which would receive an LPI.

Table 12: Example LPI contracts

| Contract/Rating | Rated As | 2014 C | 2015 C | 2016 C | 2014 D | 2015 D | 2016 D | LPI Awarded | LPI Reason |
|-----------------|----------|--------|--------|--------|--------|--------|--------|-------------|--------------|
| HAAAA | MA-PD | 2 | 2.5 | 2.5 | 3 | 3 | 3 | Yes | Part C |
| HB BBB | MA-PD | 3 | 3 | 3 | 2.5 | 2 | 2.5 | Yes | Part D |
| HCCCC | MA-PD | 2.5 | 3 | 3 | 3 | 2.5 | 2.5 | Yes | Part C or D |
| HDDDD | MA-PD | 3 | 2.5 | 3 | 2.5 | 3 | 2.5 | Yes | Part C or D |
| HEEEE | MA-PD | 2.5 | 2 | 2.5 | 2 | 2.5 | 2.5 | Yes | Part C and D |
| HFFFF | MA-only | 2.5 | 2 | 2.5 | - | - | - | Yes | Part C |
| SAAAA | PDP | - | - | - | 2.5 | 2.5 | 2 | Yes | Part D |

Figure 2 shows the low performing contract icon used in the MPF:

Figure 2: The Low Performing Icon



Adjustments for Contracts Under Sanction

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

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

CAHPS Methodology

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

The CAHPS star calculations also take into account statistical significance and reliability of the measure. The base groups are assigned prior to taking into account statistical significance and reliability. The percentile cut points for base groups are defined by current-year distribution of case-mix adjusted contract means. Percentile cut points are rounded to the nearest integer on the 0-100 reporting scale, and each base group includes those contracts whose rounded mean score is at or above the lower limit and below the upper limit. To assign final stars, we also examine the difference between a contract's adjusted mean score and the national (overall) mean score. Together with the base group, the statistical significance and direction of the difference, the statistical reliability of the estimate (based on the ratio of sampling variation for each contract mean to between-contract variation), and standard error of the mean score determine the number of stars assigned.

CAHPS reliability calculation details are provided in the document, "[Instructions for Analyzing Data from CAHPS® Surveys: Using the CAHPS Analysis Program Version 4.1](#)".

Tables 13 and 14 contain the rules applied to determine the final CAHPS measure star value.

Table 13: CAHPS Star Assignment Rules

| Star | Criteria for Assigning Star Ratings |
|------|--|
| 1 | A contract is assigned one star if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is lower than the 15th percentile; AND (b) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) below the 15th percentile. |
| 2 | A contract is assigned two stars if it does not meet the one-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is lower than the 30th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is lower than the 15th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score and below the 60th percentile. |
| 3 | A contract is assigned three stars if it meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 30th percentile and lower than the 60th percentile, AND it is not statistically significantly different from the national average CAHPS measure score; OR (b) its average CAHPS measure score is at or above the 15th percentile and lower than the 30th percentile, AND the reliability is low, AND the score is not statistically significantly lower than the national average CAHPS measure score; OR (c) its average CAHPS measure score is at or above the 60th percentile and lower than the 80th percentile, AND the reliability is low, AND the score is not statistically significantly higher than the national average CAHPS measure score. |
| 4 | A contract is assigned four stars if it does not meet the five-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 60th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is at or above the 80th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score and above the 30th percentile. |
| 5 | A contract is assigned five stars if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is at or above the 80th percentile; AND (b) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) above the 80th percentile. |

Table 14: CAHPS Star Assignment Alternate Representation

| Mean Score | | Base Group | Significantly below average | | Not significantly different from average | | Significantly above average | |
|---------------------------|-----------|------------|-----------------------------|---------------------|--|---------------------|-----------------------------|---------------------|
| | | | Low reliability | Not low reliability | Low reliability | Not low reliability | Low reliability | Not low reliability |
| <15th percentile | by > 1 SE | 1 | 1 | 1 | 2 | 2 | 2 | 2 |
| | by ≤ 1 SE | | 2 | 1 | 2 | 2 | 2 | 2 |
| ≥15th to <30th percentile | | 2 | 2 | 2 | 3 | 2 | 3 | 2 |
| ≥30th to <60th percentile | | 3 | 2 | 2 | 3 | 3 | 4 | 4 |
| ≥60th to <80th percentile | | 4 | 3 | 4 | 3 | 4 | 4 | 4 |
| ≥80th percentile | by ≤ 1 SE | 5 | 4 | 4 | 4 | 4 | 4 | 5 |
| | by > 1 SE | | 4 | 4 | 4 | 4 | 5 | 5 |

Note: If reliability is very low (<0.6), the contract does not receive a Star Rating

For example, a contract in base group 4 that was not significantly different from average and was low reliability would receive 3 final stars.

Reliability requirement for low-enrollment contracts

HEDIS measures for contracts whose enrollment as of July 2014 was at least 500 but less than 1,000 will be included in the Star Ratings in 2016 when the contract-specific measure score reliability is equal to or greater than 0.7. The reliability calculations are implemented using SAS PROC MIXED as documented on pages 31-32 of the report, The Reliability of Provider Profiling – A Tutorial, available at <http://www.ncqa.org/HEDISQualityMeasurement/Research.aspx>.

Special Needs Plan (SNP) Data

CMS has included four SNP-specific measures in the 2016 Star Ratings. One measure (C08) is based on data reported by contracts through the Medicare Part C Reporting Requirements. The other three measures (C09, C10, and C11) are based on data from the HEDIS Care for Older Adults measure. The data for all of these measures are reported at the plan benefit package (PBP) level, while the Star Ratings are reported at the contract level.

The methodology used to combine the PBP data to the contract level is different between the two data sources. The Part C Reporting Requirements data are summed into a contract-level rate after excluding PBPs that do not map to any PBP under any contract in the calendar year under which the Reporting Requirements data underwent data validation. The HEDIS data are summed into a contract-level rate as long as the contract will be offering a SNP PBP in the Star Ratings year.

The two methodologies used to combine the PBP data with in a contract for these measures are described further in [Attachment E](#).

Star Ratings and Marketing

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

Contact Information

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

- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

If you have questions or require information about the specific subject areas associated with the Star Ratings please write to those contacts directly and cc the Part C & D Star Ratings mailbox.

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: CallCenterMonitoring@cms.hhs.gov
- Data Integrity: PARTCDQA@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- Part C Plan Reporting: Partcplanreporting@cms.hhs.gov
- Part D Plan Reporting: partd-planreporting@cms.hhs.gov
- Part C & D Plan Reporting Data Validation: PartCandD_Data_Validation@cms.hhs.gov
- Marketing: marketing@cms.hhs.gov
- QBP Ratings and Appeals questions: QBPAppeals@cms.hhs.gov
- QBP Payment or Risk Analysis questions: riskadjustment@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

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

Part C Domain and Measure Details

See [Attachment C](#) for the national averages of individual Part C measures.

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

Measure: C01 - Breast Cancer Screening

Label for Stars: Breast Cancer Screening

Label for Data: Breast Cancer Screening

HEDIS Label: Breast Cancer Screening (BCS)

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 78

Description: Percent of female plan members aged 52-74 who had a mammogram during the past 2 years.

Metric: The percentage of women MA enrollees 50 to 74 years of age (denominator) who had a mammogram to screen for breast cancer (numerator).

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):
 - 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).

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts that reported HEDIS 2015, whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0031

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

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

Cut Points: Available in plan preview 2

Measure: C02 - Colorectal Cancer Screening

Label for Stars: Colorectal Cancer Screening

Label for Data: Colorectal Cancer Screening

HEDIS Label: Colorectal Cancer Screening (COL)

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 86

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

Metric: The percentage of MA enrollees aged 50 to 75 (denominator) who had appropriate screenings for colorectal cancer (numerator).

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.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0034

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C03 - Annual Flu Vaccine

Label for Stars: Annual Flu Vaccine

Label for Data: Annual Flu Vaccine

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

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

General Notes: This measure is not case-mix adjusted.

CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

- Have you had a flu shot since July 1, 2014?

CMS Framework Area: Clinical care

NQF #: 0040

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C04 - Improving or Maintaining Physical Health

Label for Stars: Improving or Maintaining Physical Health

Label for Data: Improving or Maintaining Physical Health

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

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

Exclusions: Contracts with less than 30 responses are suppressed.

Data Source: HOS

Data Source Description: 2012-2014 Cohort 15 Performance Measurement Results (2012 Baseline data collection, 2014 Follow-up data collection)

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

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

NQF #: None

Data Time Frame: 04/18/2014 - 07/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C05 - Improving or Maintaining Mental Health

Label for Stars: Improving or Maintaining Mental Health

Label for Data: Improving or Maintaining Mental Health

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

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

Exclusions: Contracts with less than 30 responses are suppressed.

Data Source: HOS

Data Source Description: 2012-2014 Cohort 15 Performance Measurement Results (2012 Baseline data collection, 2014 Follow-up data collection)

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

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

NQF #: None

Data Time Frame: 04/18/2014 - 07/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C06 - Monitoring Physical Activity

Label for Stars: Monitoring Physical Activity

Label for Data: Monitoring Physical Activity

HEDIS Label: Physical Activity in Older Adults (PAO)

Measure Reference: NCQA HEDIS 2014 Specifications for The Medicare Health Outcomes Survey Volume 6, page 32

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

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

Exclusions: Members who responded "I had no visits in the past 12 months" to Question 46 are excluded from results calculations for Question 47. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available".

Data Source: HEDIS / HOS

Data Source Description: Cohort 15 Follow-up Data collection (2014) and Cohort 17 Baseline data collection (2014).

HOS Survey Question 48: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise of physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.

HOS Survey Question 49: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

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

NQF #: 0029

Data Time Frame: 04/18/2014 - 07/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C07 - Adult BMI Assessment

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

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

HEDIS Label: Adult BMI Assessment (ABA)

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 56

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

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

Exclusions: (optional) Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0421

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C08 - Special Needs Plan (SNP) Care Management

Label for Stars: Members Whose Plan Did an Assessment of Their Health Needs and Risks

Label for Data: Members Whose Plan Did an Assessment of Their Health Needs and Risks

Description: The percent of members whose plan did an assessment of their health needs and risks in the past year. The results of this review are used to help the member get the care they need. (Medicare collects this information only from Medicare Special Needs Plans. Medicare does not collect this information from other types of plans.)

Metric: This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new enrollees (Element 13.1) and the number of enrollees eligible for an annual HRA (Element 13.2). The numerator for this measure is the sum of the number of initial HRAs performed on new enrollees (Element 13.3) and the number of annual reassessments performed (Element 13.4). The equation for calculating the SNP Care Management Assessment Rate is:

$$\frac{[\text{Number of initial HRAs performed on new enrollees (Element 13.3)} + \text{Number of annual reassessments performed (Element 13.4)}]}{[\text{Number of new enrollees (Element 13.1)} + \text{Number of enrollees eligible for an annual HRA (Element 13.2)}]}$$

Exclusions: Contracts and PBPs with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2015) are excluded and listed as "No data available".

SNP Care Management Assessment Rates are not provided for contracts that did not score at least 95% on data validation for the SNP Care Management reporting section. Rates are also not provided for contracts that scored 95% or higher on data validation for the SNP Care Management reporting section but that were not compliant with data validation standards/sub-standards for any the following SNP Care Management data elements:

- Number of new enrollees (Element 13.1)
- Number of enrollees eligible for an annual HRA (Element 13.2)
- Number of initial HRAs performed on new enrollees (Element 13.3)
- Number of annual reassessments performed (Element 13.4)

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

Contracts excluded from the SNP Care Management Assessment Rates due to data validation issues are shown as "CMS identified issues with this plan's data".

Additionally, contracts must have 30 or more enrollees in the denominator [Number of new enrollees (Element 13.1) + Number of enrollees eligible for an annual HRA (Element 13.2) \geq 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available."

General Notes: More information about the data used to calculate this measure can be found in [Attachment E](#).

Data Source: Plan Reporting

Data Source Description: Data were reported by contracts to CMS per the Part C Reporting Requirements. Validation of these data was performed during the 2015 Data Validation cycle.

CMS Framework Area: Clinical care

NQF #: None
 Data Time Frame: 01/01/2014 - 12/31/2014
 General Trend: Higher is better
 Statistical Method: Relative Distribution and Clustering
 Improvement Measure: Included
 Weighting Category: Process Measure
 Weighting Value: 1
 Data Display: Percentage with 1 decimal point
 Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C09 - Care for Older Adults – Medication Review

Label for Stars: Yearly Review of All Medications and Supplements Being Taken
 Label for Data: Yearly Review of All Medications and Supplements Being Taken
 HEDIS Label: Care for Older Adults (COA) – Medication Review
 Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 94
 Description: Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (This information about a yearly review of medications is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
 Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (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).
 Exclusions: SNP benefit packages whose enrollment was less than 30 as of February 2014 SNP Comprehensive Report were excluded from this measure.
 General Notes: The formula used to calculate this measure can be found in [Attachment E](#).
 Data Source: HEDIS
 CMS Framework Area: Clinical care
 NQF #: 0553
 Data Time Frame: 01/01/2014 - 12/31/2014
 General Trend: Higher is better
 Statistical Method: Relative Distribution and Clustering
 Improvement Measure: Included
 Weighting Category: Process Measure
 Weighting Value: 1
 Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

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

Label for Stars: Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living

Label for Data: Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living

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

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 94

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

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

Exclusions: SNP benefit packages whose enrollment was less than 30 as of February 2014 SNP Comprehensive Report were excluded from this measure.

General Notes: The formula used to calculate this measure can be found in [Attachment E](#).

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C11 - Care for Older Adults – Pain Assessment

Label for Stars: Yearly Pain Screening or Pain Management Plan

Label for Data: Yearly Pain Screening or Pain Management Plan

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

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 94

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

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).

Exclusions: SNP benefit packages whose enrollment was less than 30 as of February 2014 SNP Comprehensive Report were excluded from this measure.

General Notes: The formula used to calculate this measure can be found in [Attachment E](#).

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

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

Cut Points: Available in plan preview 2

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

Label for Stars: Osteoporosis Management

Label for Data: Osteoporosis Management

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

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 160

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

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).

Exclusions: Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS
 CMS Framework Area: Clinical care
 NQF #: 0053
 Data Time Frame: 01/01/2014 - 12/31/2014
 General Trend: Higher is better
 Statistical Method: Relative Distribution and Clustering
 Improvement Measure: Included
 Weighting Category: Process Measure
 Weighting Value: 1
 Data Display: Percentage with no decimal point

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

Cut Points: Available in plan preview 2

Measure: C13 - Diabetes Care – Eye Exam

Label for Stars: Eye Exam to Check for Damage from Diabetes
 Label for Data: Eye Exam to Check for Damage from Diabetes
 HEDIS Label: Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed
 Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 142
 Description: Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
 Metric: The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).
 Exclusions: (optional) Identify members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:
 • A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member’s history through December 31 of the measurement year.
 • 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.
 Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.
 Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS
 CMS Framework Area: Clinical care
 NQF #: 0055
 Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better
 Statistical Method: Relative Distribution and Clustering
 Improvement Measure: Included
 Weighting Category: Process Measure
 Weighting Value: 1
 Data Display: Percentage with no decimal point
 Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C14 - Diabetes Care – Kidney Disease Monitoring

Label for Stars: Kidney Function Testing for Members with Diabetes
 Label for Data: Kidney Function Testing for Members with Diabetes
 HEDIS Label: Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy
 Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 142
 Description: Percent of plan members with diabetes who had a kidney function test during the year.
 Metric: The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator).
 Exclusions: (optional) Identify members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:
 • A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member's history through December 31 of the measurement year.
 • 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 diabetes care indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator.
 Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.
 Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.
 Data Source: HEDIS
 CMS Framework Area: Clinical care
 NQF #: 0062
 Data Time Frame: 01/01/2014 - 12/31/2014
 General Trend: Higher is better
 Statistical Method: Relative Distribution and Clustering
 Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

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

Cut Points: Available in plan preview 2

Measure: C15 - Diabetes Care – Blood Sugar Controlled

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

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

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

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 142

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

Metric: The percentage of diabetic MA enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.

Exclusions: (optional) Identify members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member's history through December 31 of the measurement year.
- 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 diabetes care indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0059

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C16 - Controlling Blood Pressure

Label for Stars: Controlling Blood Pressure

Label for Data: Controlling Blood Pressure

HEDIS Label: Controlling High Blood Pressure (CBP)

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 132

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

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

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.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0018

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C17 - Rheumatoid Arthritis Management

Label for Stars: Rheumatoid Arthritis Management

Label for Data: Rheumatoid Arthritis Management

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

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 158

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

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

Exclusions: (optional)
 • 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.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2014 enrollment report were excluded from this measure.

Data Source: HEDIS

CMS Framework Area: Clinical care

NQF #: 0054

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C18 - Reducing the Risk of Falling

Label for Stars: Reducing the Risk of Falling

Label for Data: Reducing the Risk of Falling

HEDIS Label: Fall Risk Management (FRM)

Measure Reference: NCQA HEDIS 2014 Specifications for The Medicare Health Outcomes Survey Volume 6, page 34

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

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

Exclusions: Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available".

Data Source: HEDIS / HOS

Data Source Description: Cohort 15 Follow-up Data collection (2014) and Cohort 17 Baseline data collection (2014).

HOS Survey Question 50: A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?

HOS Survey Question 51: Did you fall in the past 12 months?

HOS Survey Question 52: In the past 12 months have you had a problem with balance or walking?

HOS Survey Question 53: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:

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

CMS Framework Area: Clinical care

NQF #: 0035

Data Time Frame: 04/18/2014 - 07/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C19 - Plan All-Cause Readmissions

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

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

HEDIS Label: Plan All-Cause Readmissions (PCR)

Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 318

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

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

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

1. The observed readmission rate for contract A equals the sum of the count of 30-day readmissions across the three age bands (65-74, 75-84 and 85+) divided by the sum of the count of index stays across the three age bands (65-74, 75-84 and 85+).
2. The expected readmission rate for contract A equals the sum of the average adjusted probabilities across the three age bands (65-74, 75-84 and 85+), weighted by the percentage of index stays in each age band.

See [Attachment F](#): Calculating Measure C19: Plan All-Cause Readmissions for the complete formula, example calculation and National Average Observation value used to complete this measure.

Exclusions: Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2014 enrollment report and having measure score reliability less than 0.7 are excluded.

As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was 10 or less.

General Notes: In the 2013, 2014 & 2015 Star Ratings, five 1876 Cost contracts voluntarily reported data in this measure even though they were not required to do so. CMS has rated these five contracts based on their submitted data. We did not use the cost contracts data when calculating the NatAvgObs or when determining the cut points for this measure. This measure is not used in the final Part C summary or overall ratings for 1876 Cost contracts. The data for 1876 Cost contracts will be handled the same way in this measure for the 2016 Star Ratings.

Data Source: HEDIS

CMS Framework Area: Care coordination

NQF #: 1768

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 3 - Member Experience with Health Plan

Measure: C20 - Getting Needed Care

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

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

Description: Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.

Metric: This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

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

NQF #: 0006

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C21 - Getting Appointments and Care Quickly

Label for Stars: Getting Appointments and Care Quickly

Label for Data: Getting Appointments and Care Quickly

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

Metric: This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

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

NQF #: 0006

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C22 - Customer Service

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

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

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

Metric: This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

- In the last 6 months, how often did your health plan’s customer service give you the information or help you needed?
- In the last 6 months, how often did your health plan’s customer service treat you with courtesy and respect?
- In the last 6 months, how often were the forms for your health plan easy to fill out?

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

NQF #: 0006

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients’ Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C23 - Rating of Health Care Quality

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

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

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

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

NQF #: 0006

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C24 - Rating of Health Plan

Label for Stars: Member's Rating of Health Plan

Label for Data: Member's Rating of Health Plan

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

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

NQF #: 0006

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C25 - Care Coordination

Label for Stars: Coordination of Members' Health Care Services

Label for Data: Coordination of Members' Health Care Services

Description: Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they need about members' care and how quickly members got their test results.)

Metric: This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

CMS Framework Area: Care coordination

NQF #: None

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 4 - Member Complaints and Changes in the Health Plan's Performance

Measure: C26 - Complaints about the Health Plan

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

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

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

Metric: Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as:

$$\frac{[(\text{Total number of all complaints logged into the Complaint Tracking Module (CTM)}) / (\text{Average Contract enrollment})] * 1,000 * 30}{(\text{Number of Days in Period} = 365)}$$

- 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.

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 an average enrollment during the measurement period of less than 800 beneficiaries.

Data Source: CTM

Data Source Description: Data were obtained from the CTM based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. 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.

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

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Rate with 2 decimal points

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

Cut Points: Available in plan preview 2

Measure: C27 - Members Choosing to Leave the Plan

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

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

Description: The percent of plan members who chose to leave the plan in 2014. (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, 2014–December 31, 2014 (numerator) divided by all members enrolled in the plan at any time during 2014 (denominator).

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 (Medicare-Medicaid Plan)
- 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 or 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 were not used in the calculation of this measure. The DRS data is presented in each of the systems for information purposes only.

Data Source: Medicare Beneficiary Database Suite of Systems

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

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: C28 - Beneficiary Access and Performance Problems

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

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

Description: Each year, Medicare checks each plan to see if there are problems with the plan. For example, Medicare checks whether:
 Members are having problems getting services, and
 Plan are following all of Medicare's rules.
 Medicare gives the plan a score from 0 to 100. Plans get a lower score when Medicare finds problems. A higher score is better because it means Medicare found fewer problems.

Metric: This measure is based on CMS' sanctions, civil monetary penalties (CMP) as well as Compliance Activity Module (CAM) data (this includes: notices of non-compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity).

- Contracts' scores are based on a scale of 0-100 points.
- The starting score for each contract works as follows:
 - Contracts with an effective date of 1/1/2015 or later are marked as "Plan too new to be measured".
 - All contracts with an effective date prior to 1/1/2015 begin with a score 100.
- Contracts under sanction anytime during the data time frame are reduced to a score of 0. This is separate from the deduction applied at the overall score level for contracts with more recent sanctions.
- The following deductions are taken from contracts whose score is above 0:
 - For each CMP with beneficiary impact related to access: 40 points.
 - Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows:
 - 0 – 2 CAM Score – 0 points
 - 3 – 9 CAM Score – 20 points
 - 10 – 19 CAM Score – 40 points
 - 20 – 29 CAM Score – 60 points
 - ≥ 30 CAM Score – 80 points

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

$$\text{CAM Score} = (\text{NC} * 1) + (\text{woBP} * 3) + (\text{wBP} * 4) + (6 * \text{CAP Severity})$$

Where: NC = Number of Notices of Non-Compliance

woBP = Number of Warning Letters without Business Plan

wBP = Number of Warning Letters with Business Plan

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

- 3 – ad-hoc CAP with beneficiary access impact
- 2 – ad-hoc CAP with beneficiary non-access impact
- 1 – ad-hoc CAP no beneficiary impact

Exclusions: CAM entries with the following characteristics were removed prior to processing the BAPP score:

- Ad-hoc CAPs with a topic of "Star Ratings"
- Notices of Non-Compliance with a topic of "Financial Concerns--Solvency, Reporting, Licensure, Other"

Data Source: CMS Administrative Data

Data Source Description: Ad hoc CAPs and compliance actions that occurred during the 12 month past

performance review period between January 1, 2014 and December 31, 2014. For compliance actions, the date the action was issued is used for pulling the data from HPMS. The "date the action was issued" is the date that the compliance letter was sent to the contract, not the date when the issue occurred.

CMS Framework Area: Population / community health
 NQF #: None
 Data Time Frame: 01/01/2014 - 12/31/2014
 General Trend: Higher is better
 Statistical Method: Fixed Cut Points
 Improvement Measure: Not Included
 Weighting Category: Measures Capturing Access
 Weighting Value: 1
 Data Display: Rate with no decimal point

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

Cut Points: Available in plan preview 2

Measure: C29 - Health Plan Quality Improvement

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

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

Description: This shows how much the health plan's performance has improved or declined from one year to the next year. To calculate the plan's improvement rating, Medicare compares the plan's previous scores to its current scores for all of the topics shown on this website. Then Medicare averages the results to give the plan its improvement rating.

If a plan receives **1 or 2 stars**, it means, on average, the plan's **scores have declined** (gotten worse).

If a plan receives **3 stars**, it means, on average, the plan's scores have **stayed about the same**.

If a plan receives **4 or 5 stars**, it means, on average, the plan's **scores have improved**.

Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.

Metric: The numerator is the net improvement, which is a sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the number of measures eligible for the improvement measure (i.e., the measures that were included in the 2015 and 2016 Star Ratings for this contract and had no specification changes).

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

General Notes: [Attachment 1](#) contains the formulas used to calculate the improvement measure and lists indicating which measures were used.

Data Source: Star Ratings

Data Source Description: 2015 and 2016 Star Ratings

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Improvement Measure

Weighting Value: 5

Data Display: Not Applicable

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 5 - Health Plan Customer Service

Measure: C30 - Plan Makes Timely Decisions about Appeals

Label for Stars: Health Plan Makes Timely Decisions about Appeals

Label for Data: Health Plan Makes Timely Decisions about Appeals

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

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

$$\left(\frac{[\text{Number of Timely Appeals}]}{([\text{Appeals Upheld}] + [\text{Appeals Overturned}] + [\text{Appeals Partially Overturned}])} \right) * 100.$$

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

Exclusions: Dismissed and Withdrawn appeals are excluded from this measure.

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

Data Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE not the date a decision was reached by the IRE.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

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

Cut Points: Available in plan preview 2

Measure: C31 - Reviewing Appeals Decisions

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

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

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

Metric: Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: $(\text{[Appeals Upheld]} / (\text{[Appeals Upheld]} + \text{[Appeals Overturned]} + \text{[Appeals Partially Overturned]})) * 100$.

If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10 , the result is "Not enough data available".

Exclusions: Dismissed and Withdrawn appeals are excluded from this measure.

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

Data Source: IRE

Data Source Description: Data were obtained from the IRE contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year 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 April 1, 2015, the Reopened decision is used in place of the Reconsideration decision. Reopening's decided on or after April 1, 2015 will not be reflected in this 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.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

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

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

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

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

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

Data Source: Call Center

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 03/23/2015 - 06/05/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Part D Domain and Measure Details

See [Attachment C](#) for the national averages of individual Part D measures.

Domain: 1 - Drug Plan Customer Service

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

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

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

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

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

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

Data Source: Call Center

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 03/23/2015 - 06/05/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

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

Cut Points: Available in plan preview 2

Measure: D02 - Appeals Auto-Forward

Label for Stars: Drug Plan Makes Timely Decisions about Appeals

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

Description: Percent of plan members who got a timely response when they made an appeal request to the drug plan about a decision to refuse payment or coverage. 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: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000. There is no minimum number of cases required to receive a rating.

Exclusions: 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 Source: IRE

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

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate with 1 decimal point

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

Cut Points: Available in plan preview 2

Measure: D03 - Appeals Upheld

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

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

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

Metric: This measure is defined as the percent of IRE confirmations of upholding the plans’ decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100. Total number of cases reviewed is defined all cases received by the IRE during the timeframe and receiving a decision before April 1, 2015. 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. Only for the 2016 Star Ratings, appeal cases for beneficiaries enrolled in hospice at any point during the measurement period (2014) will be excluded. 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 April 1, 2015, the Reopened decision is used in place of the Reconsideration decision. Reopening's decided on or after April 1, 2015 will not be reflected in this 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.

Exclusions: Contracts with fewer than 10 cases reviewed by the IRE.

Data Source: IRE, Medicare Beneficiary Database

Data Source Description: Data were obtained from the IRE contracted by CMS for Part D reconsiderations. The appeals used in this measure are based on the date they were received by the IRE, not the date a decision was reached by the IRE.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance

Measure: D04 - Complaints about the Drug Plan

- Label for Stars: Complaints about the Drug Plan (more stars are better because it means fewer complaints)
- Label for Data: Complaints about the Drug Plan (for every 1,000 members) (lower numbers are better because it means fewer complaints)
- Description: How many complaints Medicare received about the drug plan.
- Metric: Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as:

$$\frac{[(\text{Total number of all complaints logged into the Complaint Tracking Module (CTM)}) / (\text{Average Contract enrollment})] * 1,000 * 30}{(\text{Number of Days in Period})}$$
 - Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data.
 - Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.
 - A contract's failure to follow CMS' CTM Standard Operating Procedures will not result in CMS' adjustment of the data used for these measures.
- Exclusions: Some complaints that cannot be clearly attributed to the plan are excluded, please see [Attachment B](#): Complaints Tracking Module Exclusion List.

Complaint rates are not calculated for contracts with an average enrollment less than 800 enrollees during the measurement period.

Data Source: CTM

Data Source Description: Data were obtained from the CTM based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. 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.

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

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Rate with 2 decimal points

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

Cut Points: Available in plan preview 2

Measure: D05 - Members Choosing to Leave the Plan

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

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

Description: The percent of plan members who chose to leave the plan in 2014. (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, 2014– December 31, 2014 (numerator) divided by all members enrolled in the plan at any time during 2014 (denominator).

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 (Medicare-Medicaid Plan)
- 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 or 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 were not used in the calculation of this measure. The DRS data is presented in each of the systems for information purposes only.

Data Source: Medicare Beneficiary Database Suite of Systems

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

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Patients’ Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: D06 - Beneficiary Access and Performance Problems

- Label for Stars: Problems Medicare Found in the Plan's Performance (more stars are better because it means fewer serious problems)
- Label for Data: Problems Medicare Found in the Plan's Performance (on a scale from 0 to 100, higher numbers are better because it means fewer serious problems)
- Description: Each year, Medicare checks each plan to see if there are problems with the plan. For example, Medicare checks whether:
 Members are having problems getting services, and
 Plans are following all of Medicare's rules.
 Medicare gives the plan a score from 0 to 100. Plans get a lower score when Medicare finds problems, they are more serious, more numerous, or they affect more members directly. A higher score is better, because it means Medicare found fewer problems.
- Metric: This measure is based on CMS' sanctions, civil monetary penalties (CMP) as well as Compliance Activity Module (CAM) data (this includes: notices of non-compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity).
- Contracts' scores are based on a scale of 0-100 points.
 - The starting score for each contract works as follows:
 - Contracts with an effective date of 1/1/2015 or later are marked as "Plan too new to be measured".
 - All contracts with an effective date prior to 1/1/2015 begin with a score 100.
 - Contracts under sanction anytime during the data time frame are reduced to a score of 0. This is separate from the deduction applied at the overall score level for contracts with more recent sanctions.
 - The following deductions are taken from contracts whose score is above 0:
 - For each CMP with beneficiary impact related to access: 40 points.
 - Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows:
 - 0 – 2 CAM Score – 0 points
 - 3 – 9 CAM Score – 20 points
 - 10 – 19 CAM Score – 40 points
 - 20 – 29 CAM Score – 60 points
 - ≥ 30 CAM Score – 80 points
- Calculation of the CAM Score combines the notices of non-compliance, warning letters (with or without business plan) and ad-hoc CAPs and their severity. The formula used is as follows:

$$\text{CAM Score} = (\text{NC} * 1) + (\text{woBP} * 3) + (\text{wBP} * 4) + (6 * \text{CAP Severity})$$
 Where: NC = Number of Notices of Non-Compliance
 woBP = Number of Warning Letters without Business Plan
 wBP = Number of Warning Letters with Business Plan
 CAP Severity = Sum of the severity of each individual ad-hoc CAP given to a contract during the measurement period. Each CAP is rated as one of the following:
 - 3 – ad-hoc CAP with beneficiary access impact
 - 2 – ad-hoc CAP with beneficiary non-access impact
 - 1 – ad-hoc CAP no beneficiary impact
- Exclusions: CAM entries with the following characteristics were removed prior to processing the BAPP score:
 - Ad-hoc CAPs with a topic of "Star Ratings"
 - Notices of Non-Compliance with a topic of "Financial Concerns--Solvency, Reporting, Licensure, Other"
- Data Source: CMS Administrative Data

Data Source Description: Ad hoc CAPs and compliance actions that occurred during the 12 month past performance review period between January 1, 2014 and December 31, 2014. For compliance actions, the date the action was issued is used for pulling the data from HPMS. The "date the action was issued" is the date that the compliance letter was sent to the contract, not the date when the issue occurred.

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Fixed Cut Points

Improvement Measure: Not Included

Weighting Category: Measures Capturing Access

Weighting Value: 1

Data Display: Rate with no decimal point

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

Cut Points: Available in plan preview 2

Measure: D07 - Drug Plan Quality Improvement

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

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

Description: This shows how much the drug plan's performance has improved or declined from one year to the next year. To calculate the plan's improvement rating, Medicare compares the plan's previous scores to its current scores for all of the topics shown on this website. Then Medicare averages the results to give the plan its improvement rating.

If a plan receives **1 or 2 stars**, it means, on average, the plan's **scores have declined** (gotten worse).

If a plan receives **3 stars**, it means, on average, the plan's scores have **stayed about the same**.

If a plan receives **4 or 5 stars**, it means, on average, the plan's **scores have improved**.

Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.

Metric: The numerator is the net improvement, which is a sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the number of measures eligible for the improvement measure (i.e., the measures that were included in the 2015 and 2016 Star Ratings for this contract and had no specification changes).

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

General Notes: [Attachment 1](#) contains the formulas used to calculate the improvement measure and lists indicating which measures were used.

Data Source: Star Ratings

Data Source Description: 2015 and 2016 Star Ratings

CMS Framework Area: Population / community health

NQF #: None

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Improvement Measure

Weighting Value: 5

Data Display: Not Applicable

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 3 - Member Experience with the Drug Plan

Measure: D08 - Rating of Drug Plan

Label for Stars: Members' Rating of Drug Plan

Label for Data: Members' Rating of Drug Plan

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

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

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

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

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

NQF #: None

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: D09 - Getting Needed Prescription Drugs

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

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

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

Metric: This case-mix adjusted measure is used to assess member satisfaction related to the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in early August 2015. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Source: CAHPS

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

- In the last 6 months, how often was it easy to use your 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?

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

NQF #: None

Data Time Frame: 02/15/2015 - 05/31/2015

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 1.5

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D10 - MPF Price Accuracy

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

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

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

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

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

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

The index is computed as:

$(\text{Total amount that PDE is higher than PF} + \text{Total PDE cost}) / (\text{Total PDE cost})$.

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

A contract's score is computed using its accuracy index as:

$100 - ((\text{accuracy index} - 1) \times 100)$.

Exclusions: A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria:

- Pharmacy number on PDE must appear in MPF pharmacy cost file as either a retail-only pharmacy or a retail and limited access-only pharmacy (PDE with pharmacy numbers reported as non-retail pharmacy types or both retail and mail order/HI/LTC are excluded)
- Drug must appear in formulary file and in MPF pricing file
- PDE must be a 30 day supply
- Date of service must occur at a time that data are not suppressed for the plan on MPF
- PDE must not be a compound claim
- PDE must not be a non-covered drug

General Notes: Please see [Attachment M](#): Methodology for Price Accuracy Measure for more information about this measure.

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

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

CMS Framework Area: Efficiency and cost reduction

NQF #: None

Data Time Frame: 01/01/2014 - 09/30/2014

| | |
|-------------------------|--------------------------------------|
| General Trend: | Higher is better |
| Statistical Method: | Relative Distribution and Clustering |
| Improvement Measure: | Not Included |
| Weighting Category: | Process Measure |
| Weighting Value: | 1 |
| Data Display: | Rate with no decimal point |
| Reporting Requirements: | |

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

Cut Points: Available in plan preview 2

Measure: D11 - High Risk Medication

| | |
|------------------|--|
| Label for Stars: | Plan Members 65 and Older Who Received Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May Be Safer Drug Choices |
| Label for Data: | Plan Members 65 and Older Who Received Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May Be Safer Drug Choices |
| Description: | The percent of plan members who got prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices. |
| Metric: | This measure is defined as the percentage of Medicare Part D beneficiaries 65 years or older who received two or more prescription fills for the same HRM drug with a high risk of serious side effects in the elderly. This percentage is calculated as the number of member-years of enrolled beneficiaries 65 years or older who received two or more prescription fills for the same HRM during the period measured (numerator) divided by the number of member-years of enrolled beneficiaries 65 years and older during the period measured (denominator). |

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 2014 methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. For the 2016 Star Ratings, NDCs with obsolete dates will be included in the measure calculation if its 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 updated PQA HRM measure drug list based upon the American Geriatrics Society (AGS) recommendations is used to calculate the 2016 Star Rating.

| | |
|----------------|--|
| 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. Beneficiaries must be enrolled and age 65 or older in at least one month of the period measured. Also, member-years of enrollment is the adjustment made by CMS to account for 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 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, 2014-December 31, 2014 by June 30, 2015. Only final action PDE claims are used to calculate the patient safety measures. PDE claims are limited to members over 65 years of age, and for those Part D covered drugs identified to have high risk of serious side effects in patients 65 years of age or older. PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Safety

NQF #: 0022

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: D12 - Medication Adherence for Diabetes Medications

Label for Stars: Taking Diabetes Medication as Directed

Label for Data: Taking Diabetes Medication as Directed

Description: One of the most important ways you can manage your health is by taking your medication as directed. The plan, the doctor, and the member can work together to find ways to help the member take their medication as directed. Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. (“Diabetes medication” means a *biguanide drug*, a *sulfonylurea drug*, a *thiazolidinedione drug*, a *DPP-IV inhibitor*, an *incretin mimetic drug*, a *meglitinide drug* or a *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 or older that 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 or older with a proportion of days covered (PDC) at 80 percent or over across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years or older with at least two fills of medication(s) across any of the drug classes during the measurement period (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 with one of more fills for insulin or with ESRD coverage dates, as

reported in the Medicare Enrollment Database (EDB), anytime during the measurement period are excluded. Patients are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure 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 2014 methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. For the 2016 Star Ratings, NDCs with obsolete dates will be included in the measure calculation if their 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.

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

Please see [Attachment L](#): Medication Adherence Measure Calculations for more information about these calculations.

- Data Source: Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF); Common Medicare Environment (CME)
- Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2014-December 31, 2014 by June 30, 2015. Only final action PDE claims are used to calculate the patient safety measures. PDE claims are limited to members who received at least two prescriptions for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.
- CMS Framework Area: Clinical care
- NQF #: 0541
- Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better
 Statistical Method: Relative Distribution and Clustering
 Improvement Measure: Included
 Weighting Category: Intermediate Outcome Measure
 Weighting Value: 3
 Data Display: Percentage with no decimal point
 Reporting Requirements:

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

Cut Points: Available in plan preview 2

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

Label for Stars: Taking Blood Pressure Medication as Directed

Label for Data: Taking Blood Pressure Medication as Directed

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

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years or older that 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 over for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years or older with at least two fills of either the same medication or medications in the drug class during the measurement period (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, as reported in the Medicare Enrollment Database (EDB), anytime during the measurement period are excluded. Patients are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure 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 Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date 2014 methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. For the 2016 Star Ratings, NDCs with obsolete dates will be included in the measure calculation if their 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.

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

Please see [Attachment L](#): Medication Adherence Measure Calculations for more information about these calculations.

- Data Source: Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF); Common Medicare Environment (CME)
- Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2014-December 31, 2014 by June 30, 2015. Only final action PDE claims are used to calculate the patient safety measures. PDE claims are limited to members who received at least two prescriptions for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.
- CMS Framework Area: Clinical care
- NQF #: 0541
- Data Time Frame: 01/01/2014 - 12/31/2014
- General Trend: Higher is better
- Statistical Method: Relative Distribution and Clustering
- Improvement Measure: Included
- Weighting Category: Intermediate Outcome Measure
- Weighting Value: 3
- Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: D14 - Medication Adherence for Cholesterol (Statins)

Label for Stars: Taking Cholesterol Medication as Directed

Label for Data: Taking Cholesterol Medication as Directed

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

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years or older that 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 of older with a proportion of days covered (PDC) at 80 percent or over for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years or older with at least two fills of either the same medication or medication in the drug class during the measurement period (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. Patients are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure 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 2014 methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. For the 2015 Star Ratings, NDCs with obsolete dates will be included in the measure calculation if their 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.

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

Please see [Attachment L](#): Medication Adherence Measure Calculations for more information about these calculations.

Data Source: Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF); Common Medicare Environment (CME)

Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2014-December 31, 2014 by June 30, 2015. PDE claims are limited to members who received at least two prescriptions for a statin drug(s). PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Clinical care

NQF #: 0541

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Data Display: Percentage with no decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

Measure: D15 - MTM Program Completion Rate for CMR

Label for Stars: Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications

Label for Data: Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications

Description: Some members of the plan are in a program (called a “medication therapy management program”) to help them manage their drugs. The topic 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 the 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 that 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 that were in hospice at any point during the reporting period are excluded.

A beneficiary's MTM eligibility, receipt of CMRs, etc. are 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 that 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.

MTM eligibility rates are also provided as an attachment to these technical notes as additional information.

Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2015) 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. Rates are also not provided for contracts that scored 95% or higher on data validation for the Medication Therapy Management Program reporting section but that 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)

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

Contracts excluded from the MTM CMR Rates due to data validation issues are shown as "CMS identified issues with this plan's data".

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 Source: Part D Plan Reporting, Medicare Enrollment Database (EDB) File

Data Source Description: Data were reported by contracts to CMS per the Part D Reporting Requirements. Validation of these data was performed retrospectively during the 2015 Data Validation cycle.

CMS Framework Area: Clinical care

NQF #: None

Data Time Frame: 01/01/2014 - 12/31/2014

General Trend: Higher is better

Statistical Method: Relative Distribution and Clustering

Improvement Measure: Not Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage with 1 decimal point

Reporting Requirements:

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

Cut Points: Available in plan preview 2

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 +0.021, indicating that respondents in that age range tend to score their plans 0.021 point higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligibles tend to respond -0.044 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 80-84 age range will be adjusted downwards to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are dual eligibles will be adjusted upwards to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures.

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

Table A-1: Part C CAHPS Measures

| Predictor | 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 | -0.068 | -0.061 | -0.003 | -0.199 | -0.205 | -0.002 |
| Age: 65 - 69 | -0.004 | -0.028 | 0.016 | -0.098 | -0.055 | -0.002 |
| Age: 75 - 79 | 0.010 | -0.003 | 0.032 | 0.033 | 0.106 | 0.008 |
| Age: 80 - 84 | 0.021 | 0.001 | 0.034 | 0.066 | 0.213 | -0.015 |
| Age: 85 and older | 0.027 | 0.013 | 0.041 | 0.142 | 0.276 | -0.018 |
| Less than an 8th grade education | -0.016 | -0.041 | 0.017 | -0.021 | 0.126 | -0.012 |
| Some high school | 0.004 | -0.006 | 0.017 | 0.026 | 0.135 | 0.015 |
| Some college | -0.041 | -0.014 | -0.045 | -0.131 | -0.226 | -0.039 |
| College graduate | -0.032 | -0.013 | -0.049 | -0.192 | -0.276 | -0.066 |
| More than a bachelor's degree | -0.060 | -0.012 | -0.083 | -0.236 | -0.362 | -0.042 |
| General health rating: excellent | 0.079 | 0.111 | 0.038 | 0.378 | 0.333 | 0.050 |
| General health rating: very good | 0.058 | 0.051 | 0.025 | 0.232 | 0.161 | 0.030 |
| General health rating: fair | -0.065 | -0.035 | -0.060 | -0.260 | -0.175 | -0.039 |
| General health rating: poor | -0.156 | -0.061 | -0.146 | -0.724 | -0.540 | -0.081 |
| Mental health rating: excellent | 0.149 | 0.116 | 0.093 | 0.494 | 0.368 | 0.112 |
| Mental health rating: very good | 0.069 | 0.045 | 0.051 | 0.230 | 0.175 | 0.049 |
| Mental health rating: fair | -0.039 | -0.040 | 0.011 | -0.070 | -0.035 | -0.031 |
| Mental health rating: poor | -0.122 | -0.077 | -0.055 | -0.490 | -0.328 | -0.088 |
| Proxy helped | -0.018 | -0.034 | -0.077 | -0.145 | -0.150 | 0.006 |
| Proxy answered | 0.021 | 0.002 | -0.019 | 0.024 | 0.043 | 0.017 |
| Dual eligible | -0.044 | -0.013 | 0.031 | -0.007 | 0.287 | -0.018 |
| Low-income subsidy (LIS) | 0.015 | -0.012 | 0.026 | -0.103 | 0.054 | -0.018 |
| Chinese language survey | 0.052 | -0.012 | -0.026 | 0.071 | -0.248 | -0.114 |

Table A-2: Part D CAHPS Measures

| Predictor | MA-PD | | PDP | |
|----------------------------------|--------------------------|---|--------------------------|---|
| | D08: Rating of Drug Plan | D09: Getting Needed Prescription Drugs (Comp) | D08: Rating of Drug Plan | D09: Getting Needed Prescription Drugs (Comp) |
| Age: 64 or under | -0.263 | -0.071 | -0.190 | -0.078 |
| Age: 65 - 69 | -0.108 | -0.018 | -0.055 | -0.030 |
| Age: 75 - 79 | 0.134 | 0.021 | 0.251 | 0.015 |
| Age: 80 - 84 | 0.270 | 0.034 | 0.373 | 0.023 |
| Age: 85 and older | 0.404 | 0.031 | 0.528 | 0.015 |
| Less than an 8th grade education | 0.064 | -0.056 | 0.003 | -0.054 |
| Some high school | 0.100 | -0.006 | 0.079 | 0.035 |
| Some college | -0.270 | -0.025 | -0.252 | -0.048 |
| College graduate | -0.333 | -0.040 | -0.439 | -0.086 |
| More than a bachelor's degree | -0.451 | -0.066 | -0.415 | -0.066 |
| General health rating: excellent | 0.370 | 0.032 | 0.028 | 0.032 |
| General health rating: very good | 0.192 | 0.033 | 0.023 | 0.041 |
| General health rating: fair | -0.172 | -0.042 | -0.153 | -0.055 |
| General health rating: poor | -0.332 | -0.099 | -0.487 | -0.170 |
| Mental health rating: excellent | 0.336 | 0.086 | 0.224 | 0.048 |
| Mental health rating: very good | 0.188 | 0.063 | 0.167 | 0.036 |
| Mental health rating: fair | -0.062 | -0.013 | 0.040 | -0.025 |
| Mental health rating: poor | -0.416 | -0.059 | 0.009 | 0.009 |
| Proxy helped | -0.225 | -0.009 | -0.319 | -0.066 |
| Proxy answered | -0.107 | 0.011 | -0.227 | 0.019 |
| Dual eligible | 0.681 | 0.049 | 0.880 | 0.058 |
| Low-income subsidy (LIS) | 0.563 | 0.051 | 0.653 | 0.063 |
| Chinese language survey | -0.253 | -0.046 | 0.000 | 0.000 |

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 | December 16, 2011 |
| | | 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 | |
| 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 | |
| 49 | Contractor/Partner Performance | 90 | Other Contractor/Partner Performance | |
| | | | | 90 |
| 50 | Contractor/Partner Performance | 90 | Other Contractor/Partner Performance | |
| 03 | Enrollment/ Disenrollment | 11 | Disenrollment Due to Loss of Entitlement | June 1, 2013 |
| 11 | Enrollment/ Disenrollment | 24 | Disenrollment Due to Loss of Entitlement | |

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

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

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

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

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

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of the numeric and star values for each measure reported in the 2016 Star Ratings.

Table C-1: National Averages for Part C Measures

| Measure ID | Measure Name | Numeric Average | Star Average |
|------------|---|-----------------------------|-----------------------------|
| C01 | Breast Cancer Screening | Available in plan preview 2 | Available in plan preview 2 |
| C02 | Colorectal Cancer Screening | Available in plan preview 2 | Available in plan preview 2 |
| C03 | Annual Flu Vaccine | Available in plan preview 2 | Available in plan preview 2 |
| C04 | Improving or Maintaining Physical Health | Available in plan preview 2 | Available in plan preview 2 |
| C05 | Improving or Maintaining Mental Health | Available in plan preview 2 | Available in plan preview 2 |
| C06 | Monitoring Physical Activity | Available in plan preview 2 | Available in plan preview 2 |
| C07 | Adult BMI Assessment | Available in plan preview 2 | Available in plan preview 2 |
| C08 | Special Needs Plan (SNP) Care Management | Available in plan preview 2 | Available in plan preview 2 |
| C09 | Care for Older Adults – Medication Review | Available in plan preview 2 | Available in plan preview 2 |
| C10 | Care for Older Adults – Functional Status Assessment | Available in plan preview 2 | Available in plan preview 2 |
| C11 | Care for Older Adults – Pain Assessment | Available in plan preview 2 | Available in plan preview 2 |
| C12 | Osteoporosis Management in Women who had a Fracture | Available in plan preview 2 | Available in plan preview 2 |
| C13 | Diabetes Care – Eye Exam | Available in plan preview 2 | Available in plan preview 2 |
| C14 | Diabetes Care – Kidney Disease Monitoring | Available in plan preview 2 | Available in plan preview 2 |
| C15 | Diabetes Care – Blood Sugar Controlled | Available in plan preview 2 | Available in plan preview 2 |
| C16 | Controlling Blood Pressure | Available in plan preview 2 | Available in plan preview 2 |
| C17 | Rheumatoid Arthritis Management | Available in plan preview 2 | Available in plan preview 2 |
| C18 | Reducing the Risk of Falling | Available in plan preview 2 | Available in plan preview 2 |
| C19 | Plan All-Cause Readmissions | Available in plan preview 2 | Available in plan preview 2 |
| C20 | Getting Needed Care | Available in plan preview 2 | Available in plan preview 2 |
| C21 | Getting Appointments and Care Quickly | Available in plan preview 2 | Available in plan preview 2 |
| C22 | Customer Service | Available in plan preview 2 | Available in plan preview 2 |
| C23 | Rating of Health Care Quality | Available in plan preview 2 | Available in plan preview 2 |
| C24 | Rating of Health Plan | Available in plan preview 2 | Available in plan preview 2 |
| C25 | Care Coordination | Available in plan preview 2 | Available in plan preview 2 |
| C26 | Complaints about the Health Plan | Available in plan preview 2 | Available in plan preview 2 |
| C27 | Members Choosing to Leave the Plan | Available in plan preview 2 | Available in plan preview 2 |
| C28 | Beneficiary Access and Performance Problems | Available in plan preview 2 | Available in plan preview 2 |
| C29 | Health Plan Quality Improvement | Available in plan preview 2 | Available in plan preview 2 |
| C30 | Plan Makes Timely Decisions about Appeals | Available in plan preview 2 | Available in plan preview 2 |
| C31 | Reviewing Appeals Decisions | Available in plan preview 2 | Available in plan preview 2 |
| C32 | Call Center – Foreign Language Interpreter and TTY Availability | Available in plan preview 2 | Available in plan preview 2 |

Table C-2: National Averages for Part D Measures

| Measure ID | Measure Name | MA-PD Numeric Average | MA-PD Star Average | PDP Numeric Average | PDP Star Average |
|------------|---|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| D01 | Call Center – Foreign Language Interpreter and TTY Availability | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D02 | Appeals Auto-Forward | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D03 | Appeals Upheld | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D04 | Complaints about the Drug Plan | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D05 | Members Choosing to Leave the Plan | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D06 | Beneficiary Access and Performance Problems | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D07 | Drug Plan Quality Improvement | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D08 | Rating of Drug Plan | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D09 | Getting Needed Prescription Drugs | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D10 | MPF Price Accuracy | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D11 | High Risk Medication | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D12 | Medication Adherence for Diabetes Medications | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D13 | Medication Adherence for Hypertension (RAS antagonists) | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D14 | Medication Adherence for Cholesterol (Statins) | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |
| D15 | MTM Program Completion Rate for CMR | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 | Available in plan preview 2 |

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

| Measure ID | Measure Name | Data Time Frame |
|------------|---|-------------------------|
| C01 | Breast Cancer Screening | 01/01/2014 - 12/31/2014 |
| C02 | Colorectal Cancer Screening | 01/01/2014 - 12/31/2014 |
| C03 | Annual Flu Vaccine | 02/15/2015 - 05/31/2015 |
| C04 | Improving or Maintaining Physical Health | 04/18/2014 - 07/31/2014 |
| C05 | Improving or Maintaining Mental Health | 04/18/2014 - 07/31/2014 |
| C06 | Monitoring Physical Activity | 04/18/2014 - 07/31/2014 |
| C07 | Adult BMI Assessment | 01/01/2014 - 12/31/2014 |
| C08 | Special Needs Plan (SNP) Care Management | 01/01/2014 - 12/31/2014 |
| C09 | Care for Older Adults – Medication Review | 01/01/2014 - 12/31/2014 |
| C10 | Care for Older Adults – Functional Status Assessment | 01/01/2014 - 12/31/2014 |
| C11 | Care for Older Adults – Pain Assessment | 01/01/2014 - 12/31/2014 |
| C12 | Osteoporosis Management in Women who had a Fracture | 01/01/2014 - 12/31/2014 |
| C13 | Diabetes Care – Eye Exam | 01/01/2014 - 12/31/2014 |
| C14 | Diabetes Care – Kidney Disease Monitoring | 01/01/2014 - 12/31/2014 |
| C15 | Diabetes Care – Blood Sugar Controlled | 01/01/2014 - 12/31/2014 |
| C16 | Controlling Blood Pressure | 01/01/2014 - 12/31/2014 |
| C17 | Rheumatoid Arthritis Management | 01/01/2014 - 12/31/2014 |
| C18 | Reducing the Risk of Falling | 04/18/2014 - 07/31/2014 |
| C19 | Plan All-Cause Readmissions | 01/01/2014 - 12/31/2014 |
| C20 | Getting Needed Care | 02/15/2015 - 05/31/2015 |
| C21 | Getting Appointments and Care Quickly | 02/15/2015 - 05/31/2015 |
| C22 | Customer Service | 02/15/2015 - 05/31/2015 |
| C23 | Rating of Health Care Quality | 02/15/2015 - 05/31/2015 |
| C24 | Rating of Health Plan | 02/15/2015 - 05/31/2015 |
| C25 | Care Coordination | 02/15/2015 - 05/31/2015 |
| C26 | Complaints about the Health Plan | 01/01/2014 - 12/31/2014 |
| C27 | Members Choosing to Leave the Plan | 01/01/2014 - 12/31/2014 |
| C28 | Beneficiary Access and Performance Problems | 01/01/2014 - 12/31/2014 |
| C29 | Health Plan Quality Improvement | Not Applicable |
| C30 | Plan Makes Timely Decisions about Appeals | 01/01/2014 - 12/31/2014 |
| C31 | Reviewing Appeals Decisions | 01/01/2014 - 12/31/2014 |
| C32 | Call Center – Foreign Language Interpreter and TTY Availability | 03/23/2015 - 06/05/2015 |

Table D-2: Part D Measure Data Time Frames

| Measure ID | Measure Name | Data Time Frame |
|------------|---|-------------------------|
| D01 | Call Center – Foreign Language Interpreter and TTY Availability | 03/23/2015 - 06/05/2015 |
| D02 | Appeals Auto-Forward | 01/01/2014 - 12/31/2014 |
| D03 | Appeals Upheld | 01/01/2014 - 12/31/2014 |
| D04 | Complaints about the Drug Plan | 01/01/2014 - 12/31/2014 |
| D05 | Members Choosing to Leave the Plan | 01/01/2014 - 12/31/2014 |
| D06 | Beneficiary Access and Performance Problems | 01/01/2014 - 12/31/2014 |
| D07 | Drug Plan Quality Improvement | Not Applicable |
| D08 | Rating of Drug Plan | 02/15/2015 - 05/31/2015 |
| D09 | Getting Needed Prescription Drugs | 02/15/2015 - 05/31/2015 |
| D10 | MPF Price Accuracy | 01/01/2014 - 09/30/2014 |
| D11 | High Risk Medication | 01/01/2014 - 12/31/2014 |
| D12 | Medication Adherence for Diabetes Medications | 01/01/2014 - 12/31/2014 |
| D13 | Medication Adherence for Hypertension (RAS antagonists) | 01/01/2014 - 12/31/2014 |
| D14 | Medication Adherence for Cholesterol (Statins) | 01/01/2014 - 12/31/2014 |
| D15 | MTM Program Completion Rate for CMR | 01/01/2014 - 12/31/2014 |

Attachment E: SNP Measure Scoring Methodologies

A. Medicare Part C Reporting Requirements Measure (C08: SNP Care Management)

Step 1: Start with all contracts that offer at least one SNP plan that was active at any point during contract year 2014.

Step 2: Exclude any PBP that is not required to report data for the contract year 2014 Part C SNP Care Reporting Requirements, based on terminations on or before the end of the contract year. This exclusion is consistent with the statement from page 4 of the CY 2014 Medicare Part C Plan Reporting Requirements Technical Specifications Document: “If a plan terminates before or at the end of its contract year (CY), it is not required to report and/or have its data validated for that CY.” This **excludes**:

- PBPs that terminate in transition from CY 2014 to CY 2015 according to the plan crosswalk
- Contracts that terminate on or before 12/31/2014 according to the Contract Info extract

We then also **exclude** those that are **not required to undergo data validation (DV)** for the contract year 2014 Part C SNP Care Reporting Requirements, based on terminations on or before the deadline for submission of DV results to CMS. This exclusion is consistent with the following statement from page 5 of the Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual:

“A sponsoring organization that terminates its contract(s) to offer Medicare Part C and/or Part D benefits, or that is subject to a CMS termination of its contract(s), is not required to undergo a DV review for the final contract year’s reported data. Similarly, for reporting sections that are reported at the plan benefit package (PBP) level, PBPs that terminate are not required to undergo a DV review for the final year’s reported data.”

This excludes: Contracts and PBP with an effective termination data that occurs between 1/1/2015 and 6/30/2015 according to the Contract Info extract

Step 3: After removing contract/PBP data excluded above, suppress contract rates based on the following rules:

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2014 SNP Care Reporting Requirements data are listed as “Data Issues Found”.

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2014 SNP Care Reporting Requirements data but that failed at least one of the four data elements are listed as “Data Issues Found”.

Small size: Contracts that have not yet been suppressed and have a SNP Care Assessment rate denominator [Number of New Enrollees (Element 13.1) + Number of enrollees eligible for an annual HRA (Element 13.2)] of fewer than 30 are listed as “No 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 contract/PBPs using the formula:

$$\frac{[\text{Number of initial HRAs performed on new enrollees (Element 13.3)} + \text{Number of annual reassessments performed (Element 13.4)}]}{[\text{Number of new enrollees (Element 13.1)} + \text{Number of enrollees eligible for an annual HRA (Element 13.2)}]}$$

B. NCQA HEDIS Measures - (C09 - C11: Care for Older Adults)

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

Rates are produced for any contract offering a SNP in the ratings year which provided SNP HEDIS data in the measurement year.

Definitions

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

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

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

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

Setup Calculations

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

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

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

Pooled Analysis

The pooled result from the two rates (means) is calculated as: $P_{\text{pooled}} = W_1 * P_1 + W_2 * P_2$

NOTES:

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

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

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

Attachment F: Calculating Measure C19: Plan All-Cause Readmissions

All data come from the HEDIS 2015 M15_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 |

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

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

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

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

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 |

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

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

$$\text{NatAvgObs} = 0.13924$$

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

$$\text{Expected Contract 1} =$$

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

$$\text{Expected Contract 1} = (0.058 + 0.037 + 0.046) = 0.142$$

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

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

The actual calculated NatAvgObs value used in the 2016 Star Ratings was 0.129878176067651

Attachment G: Weights Assigned to Individual Performance Measures

Table G-1: Part C Measure Weights

| Measure ID | Measure Name | Weighting Category | Part C Summary | MA-PD Overall |
|------------|---|---|----------------|---------------|
| C01 | Breast Cancer Screening | Process Measure | 1 | 1 |
| C02 | Colorectal Cancer Screening | Process Measure | 1 | 1 |
| C03 | Annual Flu Vaccine | Process Measure | 1 | 1 |
| C04 | Improving or Maintaining Physical Health | Outcome Measure | 3 | 3 |
| C05 | Improving or Maintaining Mental Health | Outcome Measure | 3 | 3 |
| C06 | Monitoring Physical Activity | Process Measure | 1 | 1 |
| C07 | Adult BMI Assessment | Process Measure | 1 | 1 |
| C08 | Special Needs Plan (SNP) Care Management | Process Measure | 1 | 1 |
| C09 | Care for Older Adults – Medication Review | Process Measure | 1 | 1 |
| C10 | Care for Older Adults – Functional Status Assessment | Process Measure | 1 | 1 |
| C11 | Care for Older Adults – Pain Assessment | Process Measure | 1 | 1 |
| C12 | Osteoporosis Management in Women who had a Fracture | Process Measure | 1 | 1 |
| C13 | Diabetes Care – Eye Exam | Process Measure | 1 | 1 |
| C14 | Diabetes Care – Kidney Disease Monitoring | Process Measure | 1 | 1 |
| C15 | Diabetes Care – Blood Sugar Controlled | Intermediate Outcome Measure | 3 | 3 |
| C16 | Controlling Blood Pressure | Intermediate Outcome Measure | 3 | 3 |
| C17 | Rheumatoid Arthritis Management | Process Measure | 1 | 1 |
| C18 | Reducing the Risk of Falling | Process Measure | 1 | 1 |
| C19 | Plan All-Cause Readmissions | Outcome Measure | 3 | 3 |
| C20 | Getting Needed Care | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C21 | Getting Appointments and Care Quickly | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C22 | Customer Service | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C23 | Rating of Health Care Quality | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C24 | Rating of Health Plan | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C25 | Care Coordination | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C26 | Complaints about the Health Plan | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C27 | Members Choosing to Leave the Plan | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| C28 | Beneficiary Access and Performance Problems | Measures Capturing Access | 1 | 1 |
| C29 | Health Plan Quality Improvement | Improvement Measure | 5 | 5 |
| C30 | Plan Makes Timely Decisions about Appeals | Measures Capturing Access | 1.5 | 1.5 |
| C31 | Reviewing Appeals Decisions | Measures Capturing Access | 1.5 | 1.5 |
| C32 | Call Center – Foreign Language Interpreter and TTY Availability | Measures Capturing Access | 1.5 | 1.5 |

Table G-2: Part D Measure Weights

| Measure ID | Measure Name | Weighting Category | Part D Summary | MA-PD Overall |
|------------|---|---|----------------|---------------|
| D01 | Call Center – Foreign Language Interpreter and TTY Availability | Measures Capturing Access | 1.5 | 1.5 |
| D02 | Appeals Auto–Forward | Measures Capturing Access | 1.5 | 1.5 |
| D03 | Appeals Upheld | Measures Capturing Access | 1.5 | 1.5 |
| D04 | Complaints about the Drug Plan | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| D05 | Members Choosing to Leave the Plan | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| D06 | Beneficiary Access and Performance Problems | Measures Capturing Access | 1 | 1 |
| D07 | Drug Plan Quality Improvement | Improvement Measure | 5 | 5 |
| D08 | Rating of Drug Plan | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| D09 | Getting Needed Prescription Drugs | Patients' Experience and Complaints Measure | 1.5 | 1.5 |
| D10 | MPF Price Accuracy | Process Measure | 1 | 1 |
| D11 | High Risk Medication | Intermediate Outcome Measure | 3 | 3 |
| D12 | Medication Adherence for Diabetes Medications | Intermediate Outcome Measure | 3 | 3 |
| D13 | Medication Adherence for Hypertension (RAS antagonists) | Intermediate Outcome Measure | 3 | 3 |
| D14 | Medication Adherence for Cholesterol (Statins) | Intermediate Outcome Measure | 3 | 3 |
| D15 | MTM Program Completion Rate for CMR | Process Measure | 1 | 1 |

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) Star Rating for contract j is estimated as:

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

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

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

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

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

Contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measure to be eligible to receive a rating in that improvement measure.

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2015 and 2016:

$$\text{Improvement Change Score} = \text{Score in 2016} - \text{Score in 2015}.$$

An eligible measure was defined as a measure for which a contract was scored in both the 2015 and 2016 Star Ratings and there were no significant specification changes.

For each measure, significant improvement or decline between Star Ratings years 2015 and 2016 was determined by a t-test at the 95% significance level:

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

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

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

Net improvement was calculated for each class of measures (e.g., outcome, access, and process) by subtracting the number of significantly declined measures from the number of significantly improved measures.

$$\text{Net Improvement} = \# \text{ of significantly improved measures} - \# \text{ of significantly declined measures}$$

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

Measures were weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience measure: Weight of 1.5

Process measure: Weight of 1

When the weight of an individual measure changes over the two years of data used, the lower weight value will be used in the improvement calculation.

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

Net_Imp_Process = Net improvement for process measures

Net_Imp_PtExp = Net improvement for patient experience and access measures

Net_Imp_Outcome = Net improvement for outcome and intermediate outcome measures

Elig_Process = Number of eligible process measures

Elig_PtExp = Number of eligible patient experience and access measures

Elig_Outcome = Number of eligible outcome and intermediate outcome measures

The improvement measure score is converted into a Star Rating using the relative distribution method. Improvement scores of 0 (equivalent to no net change on the attainment measures included in the

improvement measure calculation) will be centered at 3 stars when assigning the improvement measure Star Rating.

Contracts with 2 or fewer stars for their highest rating when calculated without improvement will not have their data calculated with the improvement measure included.

Hold Harmless Provision: Contracts with 4 or more stars for their highest rating that would have had their overall rating decreased with the addition of the improvement measures were held harmless. That is, the highest Star Rating would not be decreased from 4 or more stars when the improvement measures were added to the overall Star Rating calculation. In addition, the reward factor is recalculated without the improvement measures included.

General Standard Error Formula

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

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

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

$se(Y_{i2})$ Represents the 2016 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2015 standard error for contract i on measure C01

Y_{i2} Represents the 2016 rate for contract i on measure C01

Y_{i1} Represents the 2015 rate for contract i on measure C01

cov Represents the covariance between Y_{i2} and Y_{i1} computed using the correlation across all contracts observed at both time points (2016 and 2015). In other words:

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

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

Standard Error Numerical Example.

For measure C04, contract A:

$$se(Y_{i2}) = 2.805$$

$$se(Y_{i1}) = 3.000$$

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

$$\text{Standard error for measure C04 for contract A} = \sqrt{(2.805^2 + 3.000^2 - 2 * 0.901 * 2.805 * 3.000)} = 1.305$$

Standard Error Formulas for Specific Measures

The following formulas are used for calculating the standard error for specific measures in the 2016 Star Ratings. These are modifications to the general standard error formula provide above to account for the specific type of data in the measure.

Standard Error Formula for Measures C01, C02, C06 – C08, C12 – C18, C27, C30, C31, D03, D05, D11 – D14

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

for y = 2015, 2016

Denominator_y is as defined in the Measure Details section for each measure

Standard Error Formula for Measures C09 – C11

These measures are rolled up from the plan level to the contract level following the formula outlined in “[Attachment E: NCQA HEDIS Measures](#)”. The standard error at the contract level is calculated as shown below. The specifications are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

The plan level standard error is calculated as:

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

for y = 2015, 2016 and j = Plan 1, Plan 2

The contract level standard error is then calculated as:

Let Wy1 = The weight assigned to the first PBP results (estimated, auditable) for year y, where y = 2015, 2016. This result is estimated by the formula $Wy1 = Ny1 / (Ny1 + Ny2)$

Let Wy2 = The weight assigned to the second PBP results (estimated, auditable) for year y, where y = 2015, 2016. This result is estimated by the formula $Wy2 = Ny2 / (Ny1 + Ny2)$

$$SE_{yi} = \sqrt{(Wy1)^2 * (SE_{y1})^2 + (Wy2)^2 * (SE_{y2})^2}$$

for y = Contract Year 2015, Contract Year 2016 and i = Contract i

Standard Error Formula for C19

$$SE_y = 100 * NatAvgObs * \sqrt{\frac{Observed\ Count\ of\ Readmissions_y}{(Expected\ Count\ of\ Readmissions_y)^2}}$$

for y = 2015, 2016

The calculation of NatAvgObs is explained in “[Attachment F: Calculating Measure C19: Plan All-Cause Readmissions](#)”. The observed count of readmissions is calculated as D+E+F, where D, E, and F are formula values in [Attachment F](#). The expected count of readmissions is calculated using the formula A*G + B*H + C*I, and A, B, C, G, H, and I are formula values in [Attachment F](#).

Standard Error Formula for Measures C03, C20 – C25, and D08 – D09

The CAHPS measure standard errors for 2015 and 2016 were provided to CMS by the CAHPS contractor. The actual values used for each contract can be provided by the Star Ratings or CAHPS mailboxes, send your request to: PartCandDStarRatings@cms.hhs.gov or MP-CAHPS@cms.hhs.gov.

Standard Error Formula for Measure D02

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

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

| Measure ID | Measure Name | Measure Usage | Correlation |
|------------|---|---------------|-----------------------------|
| C01 | Breast Cancer Screening | Not Included | - |
| C02 | Colorectal Cancer Screening | Included | Available in plan preview 2 |
| C03 | Annual Flu Vaccine | Included | Available in plan preview 2 |
| C04 | Improving or Maintaining Physical Health | Not Included | - |
| C05 | Improving or Maintaining Mental Health | Not Included | - |
| C06 | Monitoring Physical Activity | Included | Available in plan preview 2 |
| C07 | Adult BMI Assessment | Included | Available in plan preview 2 |
| C08 | Special Needs Plan (SNP) Care Management | Included | Available in plan preview 2 |
| C09 | Care for Older Adults – Medication Review | Included | Available in plan preview 2 |
| C10 | Care for Older Adults – Functional Status Assessment | Included | Available in plan preview 2 |
| C11 | Care for Older Adults – Pain Assessment | Included | Available in plan preview 2 |
| C12 | Osteoporosis Management in Women who had a Fracture | Included | Available in plan preview 2 |
| C13 | Diabetes Care – Eye Exam | Included | Available in plan preview 2 |
| C14 | Diabetes Care – Kidney Disease Monitoring | Included | Available in plan preview 2 |
| C15 | Diabetes Care – Blood Sugar Controlled | Included | Available in plan preview 2 |
| C16 | Controlling Blood Pressure | Included | Available in plan preview 2 |
| C17 | Rheumatoid Arthritis Management | Included | Available in plan preview 2 |
| C18 | Reducing the Risk of Falling | Included | Available in plan preview 2 |
| C19 | Plan All-Cause Readmissions | Included | Available in plan preview 2 |
| C20 | Getting Needed Care | Included | Available in plan preview 2 |
| C21 | Getting Appointments and Care Quickly | Included | Available in plan preview 2 |
| C22 | Customer Service | Included | Available in plan preview 2 |
| C23 | Rating of Health Care Quality | Included | Available in plan preview 2 |
| C24 | Rating of Health Plan | Included | Available in plan preview 2 |
| C25 | Care Coordination | Included | Available in plan preview 2 |
| C26 | Complaints about the Health Plan | Not Included | - |
| C27 | Members Choosing to Leave the Plan | Included | Available in plan preview 2 |
| C28 | Beneficiary Access and Performance Problems | Not Included | - |
| C29 | Health Plan Quality Improvement | Not Included | - |
| C30 | Plan Makes Timely Decisions about Appeals | Not Included | - |
| C31 | Reviewing Appeals Decisions | Included | Available in plan preview 2 |
| C32 | Call Center – Foreign Language Interpreter and TTY Availability | Not Included | - |

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

| Measure ID | Measure Name | Measure Usage | Correlation |
|------------|---|---------------|-----------------------------|
| D01 | Call Center – Foreign Language Interpreter and TTY Availability | Not Included | - |
| D02 | Appeals Auto-Forward | Included | Available in plan preview 2 |
| D03 | Appeals Upheld | Not Included | - |
| D04 | Complaints about the Drug Plan | Not Included | - |
| D05 | Members Choosing to Leave the Plan | Included | Available in plan preview 2 |
| D06 | Beneficiary Access and Performance Problems | Not Included | - |
| D07 | Drug Plan Quality Improvement | Not Included | - |
| D08 | Rating of Drug Plan | Included | Available in plan preview 2 |
| D09 | Getting Needed Prescription Drugs | Included | Available in plan preview 2 |
| D10 | MPF Price Accuracy | Not Included | - |
| D11 | High Risk Medication | Included | Available in plan preview 2 |
| D12 | Medication Adherence for Diabetes Medications | Included | Available in plan preview 2 |
| D13 | Medication Adherence for Hypertension (RAS antagonists) | Included | Available in plan preview 2 |
| D14 | Medication Adherence for Cholesterol (Statins) | Included | Available in plan preview 2 |
| D15 | MTM Program Completion Rate for CMR | Not Included | - |

Attachment J: Star Ratings Measure History

The tables below cross reference the measures code in each of the Star Ratings releases over the past nine years. Measure codes that begin with DM are display measures which are posted on CMS.gov on this page: <http://go.cms.gov/partcanddstarratings>.

Table J-1: Part C Measure History

| Part | Measure Name | Data Source | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | Notes |
|------|--|---------------------|-------|-------|-------|-------|-------|-------|-------|------|------|-------|
| c | Access to Primary Care Doctor Visits | HEDIS | DMC12 | DMC10 | DMC12 | DMC12 | C11 | C13 | C12 | C13 | C09 | |
| c | Adult BMI Assessment | HEDIS | C07 | C08 | C10 | C10 | C12 | DMC05 | | | | |
| c | Annual Flu Vaccine | CAHPS | C03 | C04 | C06 | C06 | C06 | C07 | C06 | C07 | C07 | |
| c | Antidepressant Medication Management (6 months) | HEDIS | DMC03 | DMC03 | DMC03 | DMC03 | DMC03 | DMC03 | DMC04 | C28 | C23 | |
| c | Appropriate Monitoring of Patients Taking Long-term Medications | HEDIS | DMC05 | DMC05 | DMC05 | DMC05 | DMC05 | C06 | C05 | C06 | C06 | |
| c | Beneficiary Access and Performance Problems | Administrative Data | C28 | DME08 | C31 | C31 | C32 | C33 | C30 | | | |
| c | Breast Cancer Screening | HEDIS | C01 | DMC22 | C01 | C01 | C01 | C01 | C01 | C01 | C01 | |
| c | Call Answer Timeliness | HEDIS | DMC02 | DMC02 | DMC02 | DMC02 | DMC02 | DMC02 | DMC01 | C20 | C16 | |
| c | Call Center – Beneficiary Hold Time | Call Center | DMC09 | | DMC09 | DMC09 | DMC09 | C34 | C31 | | | |
| c | Call Center - Calls Disconnected When Customer Calls Health Plan | Call Center | DMC13 | | DMC15 | DMC15 | | | | | | |
| c | Call Center – CSR Understandability | Call Center | | | | | | | DMC02 | | | |
| c | Call Center – Foreign Language Interpreter and TTY Availability | Call Center | C32 | | C36 | C36 | C36 | C36 | C33 | | | |
| c | Call Center – Information Accuracy | Call Center | DMC10 | | DMC10 | DMC10 | DMC10 | C35 | C32 | | | |
| c | Cardiovascular Care – Cholesterol Screening | HEDIS | | C02 | C03 | C03 | C03 | C03 | | C03 | C03 | A |
| c | Care Coordination | CAHPS | C25 | C28 | C29 | C29 | | | | | | |
| c | Care for Older Adults – Functional Status Assessment | HEDIS | C10 | C11 | C12 | C12 | C14 | | | | | |
| c | Care for Older Adults – Medication Review | HEDIS | C09 | C10 | C11 | C11 | C13 | | | | | |
| c | Care for Older Adults – Pain Assessment | HEDIS | C11 | C12 | C13 | C13 | C15 | | | | | |
| c | Cholesterol Screening | HEDIS | | | | | | | C03 | | | B |
| c | Colorectal Cancer Screening | HEDIS | C02 | C01 | C02 | C02 | C02 | C02 | C02 | C02 | C02 | |
| c | Complaints about the Health Plan | CTM | C26 | C29 | C30 | C30 | C31 | C30 | C26 | | | |
| c | Computer use by provider helpful | CAHPS | DMC22 | DMC20 | | | | | | | | |
| c | Computer use made talking to provider easier | CAHPS | DMC23 | DMC21 | | | | | | | | |
| c | Computer used during office visits | CAHPS | DMC21 | DMC19 | | | | | | | | |
| c | Continuous Beta Blocker Treatment | HEDIS | DMC04 | DMC04 | DMC04 | DMC04 | DMC04 | DMC04 | DMC05 | C32 | C27 | |
| c | Controlling Blood Pressure | HEDIS | C16 | C18 | C19 | C19 | C21 | C19 | C15 | C29 | C24 | |
| c | Customer Service | CAHPS | C22 | C25 | C26 | C26 | C28 | C27 | C23 | C22 | | |
| c | Diabetes Care | HEDIS | | | | | | | C14 | | | C |

| Part | Measure Name | Data Source | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | Notes |
|------|--|---------------|-------|-------|-------|-------|-------|-------|-------|------|------|-------|
| c | Diabetes Care – Blood Sugar Controlled | HEDIS | C15 | C16 | C17 | C17 | C19 | C17 | | C26 | C21 | D |
| c | Diabetes Care – Cholesterol Controlled | HEDIS | | C17 | C18 | C18 | C20 | C18 | | C27 | C22 | D |
| c | Diabetes Care – Cholesterol Screening | HEDIS | | C03 | C04 | C04 | C04 | C04 | | C04 | C04 | A |
| c | Diabetes Care – Eye Exam | HEDIS | C13 | C14 | C15 | C15 | C17 | C15 | | C24 | C19 | D |
| c | Diabetes Care – Kidney Disease Monitoring | HEDIS | C14 | C15 | C16 | C16 | C18 | C16 | | C25 | C20 | D |
| c | Doctor Follow up for Depression | HEDIS | | | | | | | | C15 | C11 | |
| c | Doctors who Communicate Well | CAHPS | DMC08 | DMC08 | DMC08 | DMC08 | DMC08 | C25 | C21 | C21 | C17 | |
| c | Engagement of Alcohol or other Drug Treatment | HEDIS | DMC17 | DMC15 | DMC19 | | | | | | | |
| c | Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge) | HEDIS | DMC01 | DMC01 | DMC01 | DMC01 | DMC01 | DMC01 | DMC03 | C14 | C10 | |
| c | Getting Appointments and Care Quickly | CAHPS | C21 | C24 | C25 | C25 | C27 | C26 | C22 | C17 | C13 | |
| c | Getting Needed Care | CAHPS | C20 | C23 | C24 | C24 | C26 | C24 | C20 | C16 | C12 | |
| c | Glaucoma Testing | HEDIS | | | C05 | C05 | C05 | C05 | C04 | C05 | C05 | |
| c | Health Plan Quality Improvement | Star Ratings | C29 | C31 | C33 | C33 | | | | | | |
| c | Improving Bladder Control | HEDIS / HOS | | C20 | C21 | C21 | C23 | C22 | C18 | C33 | | |
| c | Improving or Maintaining Mental Health | HOS | C05 | C06 | C08 | C08 | C09 | C10 | C09 | C10 | | |
| c | Improving or Maintaining Physical Health | HOS | C04 | C05 | C07 | C07 | C08 | C09 | C08 | C09 | | |
| c | Initiation of Alcohol or other Drug Treatment | HEDIS | DMC16 | DMC14 | DMC18 | | | | | | | |
| c | Members Choosing to Leave the Plan | MBDSS | C27 | C30 | C32 | C32 | C33 | DMC06 | C29 | | | |
| c | Monitoring Physical Activity | HEDIS / HOS | C06 | C07 | C09 | C09 | C10 | C12 | C11 | C12 | | |
| c | Osteoporosis Management in Women who had a Fracture | HEDIS | C12 | C13 | C14 | C14 | C16 | C14 | C13 | C23 | C18 | |
| c | Osteoporosis Testing | HEDIS / HOS | DMC06 | DMC06 | DMC06 | DMC06 | DMC06 | C11 | C10 | C11 | | |
| c | Pharmacotherapy Management of COPD Exacerbation – Bronchodilator | HEDIS | DMC15 | DMC13 | DMC17 | | | | | | | |
| c | Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid | HEDIS | DMC14 | DMC12 | DMC16 | | | | | | | |
| c | Plan All-Cause Readmissions | HEDIS | C19 | C22 | C23 | C23 | C25 | | | | | |
| c | Plan Makes Timely Decisions about Appeals | IRE / Maximus | C30 | C32 | C34 | C34 | C34 | C31 | C27 | C35 | C28 | |
| c | Pneumonia Vaccine | CAHPS | DMC11 | DMC09 | DMC11 | DMC11 | C07 | C08 | C07 | C08 | C08 | |
| c | Rating of Health Care Quality | CAHPS | C23 | C26 | C27 | C27 | C29 | C28 | C24 | C18 | C14 | |
| c | Rating of Health Plan | CAHPS | C24 | C27 | C28 | C28 | C30 | C29 | C25 | C19 | C15 | |
| c | Reducing the Risk of Falling | HEDIS / HOS | C18 | C21 | C22 | C22 | C24 | C23 | C19 | C34 | | |
| c | Reminders for appointments | CAHPS | DMC18 | DMC16 | | | | | | | | |
| c | Reminders for immunizations | CAHPS | DMC19 | DMC17 | | | | | | | | |
| c | Reminders for screening tests | CAHPS | DMC20 | DMC18 | | | | | | | | |
| c | Reviewing Appeals Decisions | IRE / Maximus | C31 | C33 | C35 | C35 | C35 | C32 | C28 | C36 | C29 | |

| Part | Measure Name | Data Source | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | Notes |
|------|--|----------------|-------|-----------|-------|-------|-------|------|------|------|------|-------|
| c | Rheumatoid Arthritis Management | HEDIS | C17 | C19 | C20 | C20 | C22 | C20 | C16 | C30 | C25 | |
| c | Special Needs Plan (SNP) Care Management | Plan Reporting | C08 | C09/DMC11 | DMC14 | DMC14 | | | | | | |
| c | Testing to Confirm Chronic Obstructive Pulmonary Disease | HEDIS | DMC07 | DMC07 | DMC07 | DMC07 | DMC07 | C21 | C17 | C31 | C26 | |

Notes:

A: Part of composite measure Cholesterol Screening in 2010

B: Composite Measure - combined Cardiovascular Care – Cholesterol Screening and Diabetes Care – Cholesterol Screening measures

C: Composite Measure - combined Diabetes Care – Blood Sugar Controlled, Diabetes Care – Cholesterol Controlled, Diabetes Care – Eye Exam and Diabetes Care – Kidney Disease Monitoring measures

D: Part of composite measure Diabetes Care in 2010

Table J-2: Part D Measure History

| Part | Measure Name | Data Source | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | Notes |
|------|--|-------------------------------|-------|-------|-------|-------|-------|-------|-------|------|------|-------|
| D | 4Rx Timeliness | Acumen/OIS (4Rx) | | | | | DMD03 | D07 | D07 | | D09 | |
| D | Adherence - Proportion of Days Covered | Prescription Drug Event (PDE) | | | | | | DMD07 | | | | |
| D | Appeals Auto-Forward | IRE / Maximus | D02 | D01 | D02 | D03 | D03 | D05 | D05 | D05 | D13 | |
| D | Appeals Upheld | IRE / Maximus | D03 | D02 | D03 | D04 | D04 | D06 | D06 | D06 | D14 | |
| D | Beneficiary Access and Performance Problems | Administrative Data | D06 | DME08 | D05 | D07 | D07 | D10 | D11 | | | |
| D | Call Center – Beneficiary Hold Time | Call Center | DMD04 | | DMD04 | DMD04 | DMD05 | D01 | D01 | D01 | D01 | |
| D | Call Center – Calls Disconnected - Pharmacist | Call Center | | | | | | | DMD05 | D04 | D04 | |
| D | Call Center - Calls Disconnected When Customer Calls Drug Plan | Call Center | DMD03 | | DMD03 | DMD03 | DMD04 | DMD04 | DMD04 | D02 | D02 | |
| D | Call Center – CSR Understandability | Call Center | | | | | | | DMD06 | | | |
| D | Call Center – Foreign Language Interpreter and TTY Availability | Call Center | D01 | | D01 | D02 | D02 | D04 | D04 | | | |
| D | Call Center – Information Accuracy | Call Center | DMD05 | | DMD05 | DMD05 | DMD06 | D03 | D03 | | | |
| D | Call Center – Pharmacy Hold Time | Call Center | DMD12 | | DMD15 | D01 | D01 | D02 | D02 | D03 | D03 | |
| D | Complaint Resolution | CTM | | | | | | | DMD07 | | | |
| D | Complaints - Benefits | CTM | | | | | | | | D07 | D11 | |
| D | Complaints - Enrollment | CTM | | | | | | D08 | D08 | D08 | D12 | |
| D | Complaints - Other | CTM | | | | | | D09 | D09 | D10 | | |
| D | Complaints - Pricing | CTM | | | | | | | | D09 | D17 | |
| D | Complaints about the Drug Plan | CTM | D04 | D03 | D04 | D06 | D06 | | | | D05 | |
| D | Diabetes Medication Dosing | Prescription Drug Event (PDE) | DMD07 | DMD04 | DMD07 | DMD07 | DMD08 | DMD06 | DMD09 | | | |
| D | Diabetes Treatment | Prescription Drug Event (PDE) | | D10 | D12 | D15 | D14 | D17 | D19 | | | |
| D | Drug Plan Provides Current Information on Costs and Coverage for Medicare’s Website | Acumen/OIS (LIS Match Rates) | DMD08 | DMD05 | DMD08 | DMD08 | DMD09 | D14 | D15 | D15 | D10 | |
| D | Drug Plan Quality Improvement | Star Ratings | D07 | D05 | D07 | D09 | | | | | | |
| D | Drug-Drug Interactions | Prescription Drug Event (PDE) | DMD06 | DMD03 | DMD06 | DMD06 | DMD07 | DMD05 | DMD08 | | | |
| D | Enrollment Timeliness | MARx | | | DME01 | D05 | D05 | DMD03 | DMD03 | | | |
| D | Getting Information From Drug Plan | CAHPS | DMD11 | DMD09 | DMD14 | D10 | D09 | D11 | D12 | D12 | D06 | |
| D | Getting Needed Prescription Drugs | CAHPS | D09 | D07 | D09 | D12 | D11 | D13 | D14 | D14 | D08 | |
| D | High Risk Medication | Prescription Drug Event (PDE) | D11 | D09 | D11 | D14 | D13 | D16 | D18 | D19 | | |
| D | Medication Adherence for Cholesterol (Statins) | Prescription Drug Event (PDE) | D14 | D13 | D15 | D18 | D17 | | | | | |
| D | Medication Adherence for Diabetes Medications | Prescription Drug Event (PDE) | D12 | D11 | D13 | D16 | D15 | | | | | |
| D | Medication Adherence for Hypertension (RAS antagonists) | Prescription Drug Event (PDE) | D13 | D12 | D14 | D17 | D16 | | | | | |
| D | Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews | Prescription Drug Event (PDE) | D15 | DMD07 | DMD12 | DMD12 | | | | | | |
| D | Member Retention | MBDSS | | | | | | | | D11 | | |

| Part | Measure Name | Data Source | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | Notes |
|------|--|--|-------|-------|-------|-------|-------|-------|-------|------|------|-------|
| D | Members Choosing to Leave the Plan | MBDSS | D05 | D04 | D06 | D08 | D08 | DMD09 | D10 | | | |
| D | MPF - Composite | Plan Finder Data | | | | | D12 | D15 | | | | B |
| D | MPF – Stability | Plan Finder Data | DMD09 | DMD06 | DMD10 | DMD10 | | | D16 | D17 | D16 | A |
| D | MPF – Updates | Plan Finder Data | | | DMD09 | DMD09 | DMD10 | DMD08 | DMD10 | D16 | D15 | |
| D | MPF Price Accuracy | Plan Finder Data | D10 | D08 | D10 | D13 | | | D17 | D18 | | A |
| D | Plan Submitted Higher Prices for Display on MPF | Plan Finder Data | DMD13 | DMD10 | DMD16 | | | | | | | |
| D | Plan Submitted Higher Prices for Display on MPF | Plan Finder Data | DMD13 | | | | | | | | | |
| D | Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes | Fu Associates | DMD10 | DMD08 | DMD13 | DMD13 | | | | | | |
| D | Rating of Drug Plan | CAHPS | D08 | D06 | D08 | D11 | D10 | D12 | D13 | D13 | D07 | |
| D | Reminders to fill prescriptions | CAHPS | DMD16 | DMD13 | | | | | | | | |
| D | Reminders to take medications | CAHPS | DMD17 | DMD14 | | | | | | | | |
| D | Timely Effectuation of Appeals | IRE / Maximus | DMD02 | DMD02 | DMD02 | DMD02 | DMD02 | DMD02 | DMD02 | | | |
| D | Timely Receipt of Case Files for Appeals | IRE / Maximus | DMD01 | DMD01 | DMD01 | DMD01 | DMD01 | DMD01 | DMD01 | | | |
| D | Transition monitoring - failure rate for all other drugs | Transition Monitoring Program Analysis | DMD15 | DMD12 | | | | | | | | |
| D | Transition monitoring - failure rate for drugs within classes of clinical concern | Transition Monitoring Program Analysis | DMD14 | DMD11 | | | | | | | | |

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012

B: Composite measure - combined MPF - Accuracy and MPF Stability

Table J-3: Common Part C & Part D Measure History

| Part | Measure Name | Data Source | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 |
|------|---|------------------------------|-------|-------|-------------|-------------|------|-------|-------|------|------|
| E | Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP) | Disenrollment Reasons Survey | DME05 | DME05 | | | | | | | |
| E | Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP) | Disenrollment Reasons Survey | DME07 | DME07 | | | | | | | |
| E | Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only) | Disenrollment Reasons Survey | DME03 | DME03 | | | | | | | |
| E | Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only) | Disenrollment Reasons Survey | DME04 | DME04 | | | | | | | |
| E | Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP) | Disenrollment Reasons Survey | DME06 | DME06 | | | | | | | |
| E | Enrollment Timeliness | MARx | DME01 | DME01 | DME01 | C37/D05 | D05 | DMD03 | DMD03 | | |
| E | Grievance Rate | Plan Reporting | DME02 | DME02 | DMC13/DMD11 | DMC13/DMD11 | | | | | |

Attachment K: Individual Measure Star Assignment Process

This attachment illustrates detailed steps of the clustering method to develop individual measure stars. For each measure, the clustering method does the following:

1. Produces the individual measure distance matrix.
2. Groups the measure scores into an initial set of clusters.
3. Selects the final set of clusters.

1. Produce the individual measure distance matrix.

For each pair of contracts j and k ($j \geq k$) among the n contracts with measure score data, compute the Euclidian distance of their measure scores (e.g., the absolute value of the difference between the two measure scores). Enter this distance in row j and column k of a distance matrix with n rows and n columns. This matrix can be produced using the DISTANCE procedure in SAS as follows:

```
proc distance data=inclusterdat out=distancedat method=Euclid;
    var interval(measure_score);
    id contract_id;
run;
```

In the above code, the input data set, *inclusterdat*, is the list of contracts without missing, flagged, or voluntary contract scores for a particular measure. Each record has a unique contract identifier, *contract_id*. The option *method=Euclid* specifies that distances between contract measure scores should be based on Euclidean distance. The input data contain a variable called *measure_score* that is formatted to the display criteria outlined in the Technical Notes. In the *var* call, the parentheses around *measure_score* indicate that *measure_score* is considered to be an interval or numeric variable. The distances computed by this code are stored to an output data set called *distancedat*.

2. Create a tree of cluster assignments.

The distance matrix calculated in Step 1 is the input to the clustering procedure. The stored distance algorithm is implemented to compute cluster assignments. The following process is implemented by using the CLUSTER procedure in SAS:

- a. The input measure score distances are squared.
- b. The clusters are initialized by assigning each contract to its own cluster.
- c. In order to determine which pair of clusters to merge, Ward's minimum variance method is used to separate the variance of the measure scores into within-cluster and between-cluster sum of squares components.
- d. From the existing clusters, two clusters will be selected for merging to minimize the within-cluster sum of squares over all possible sets of clusters that might result from a merge.
- e. Steps b and c are repeated to reduce the number of clusters by one until a single cluster containing all contracts results.

The result is a data set that contains a tree-like structure of cluster assignments, from which any number of clusters between 1 and the number of contract measure scores could be computed. The SAS code for implementing these steps is:

```
proc cluster data=distancedat method=ward outtree=treedat noprint;
    id contract_id;
run;
```

The *distancedat* data set containing the Euclidian distances was created in Step 1. The option *method=ward* indicates that Ward's minimum variance method should be used to group clusters. The output data set is denoted with the outtree option and is called *treedat*.

3. Select the final set of clusters from the tree of cluster assignments.

The process outlined in Step 2 will produce a tree of cluster assignments, from which the final number of clusters is selected using the TREE procedure in SAS as follows:

```
proc tree data=treedat ncl=NSTARS horizontal out=outclusterdat noprint;
    id contract_id;
run;
```

The input data set, *treedat*, is created in Step 2 above. The syntax, *ncl=NSTARS*, denotes the desired final number of clusters (or star levels). For most measures, *NSTARS=5*. Since the improvement measures have a constraint that contracts with improvement scores of zero or greater are to be assigned at least a 3-star rating for improvement, the clustering is conducted separately for contract measure scores greater than or equal to zero versus less than zero. Specifically, Steps 1-3 are first applied to contracts with improvement scores that meet or exceed zero, in which case *NSTARS* equals three. The resulting improvement measure stars can take on values of 3, 4, or 5. For those contracts with improvement scores less than zero, Steps 1-3 are applied with *NSTARS=2* and these contracts will either receive 1- or 2-star ratings.

Final Threshold and Star Creation

The cluster assignments produced by the above approach have cluster labels that are unordered. The final step after applying the above steps to all contract measure scores is to order the cluster labels so that the 5-star category reflects the cluster with the best performance and the 1-star category reflects the cluster with the worst performance. With the exception of the lower 3-star threshold of zero for the improvement measures, the measure thresholds are defined by examining the range of measure scores within each of the final clusters.

Attachment L: Medication Adherence Measure Calculations

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

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

Days Covered Calculation

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

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

Example 1: Non-Overlapping Fills of Two Different Drugs

| | January | | February | | March | |
|------------|----------|-----------|----------|-----------|----------|-----------|
| | 1/1/2014 | 1/16/2014 | 2/1/2014 | 2/16/2014 | 3/1/2014 | 3/16/2014 |
| Benazepril | 15 | 16 | 15 | 13 | | |
| Captopril | | | | | 15 | 16 |

Calculation

Covered Days = 90

Measurement Period = 90

PDC = 100%

If a beneficiary fills a drug with the same active generic ingredient prior to the end of the days supply of the first fill, then we adjust the days covered to account for the overlap in days covered.

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

| | January | | February | | March | |
|-------------------|----------|-----------|----------|-----------|----------|-----------|
| | 1/1/2014 | 1/16/2014 | 2/1/2014 | 2/16/2014 | 3/1/2014 | 3/16/2014 |
| Lisinopril | 15 | 16 | | | | |
| Lisinopril & HCTZ | | 16 | 15 | | | |
| Benazepril & HCTZ | | | 15 | 13 | | |

Calculation

Covered Days = 62

Measurement Period = 90

PDC = 69%

This adjustment is only made for fills with the same therapeutic generic ingredient. 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 single drug product. In rows two and three, there is an overlap between two combination drug products, both containing Hydrochlorothiazide. However, Hydrochlorothiazide is not a RAS antagonist, so this overlap is not shifted. The adjustment is applied using the generic ingredient name variable from the Medi-Span database. This variable is consistent with the Generic Drug Name variable listed in the PQA medication list (populated with GPI generic name variable from Medi-Span), without the strength and form of the medication.

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

Example 3: Overlapping Fills of the Same and Different Drugs

| | January | | February | | March | | April | |
|-------------------|----------|-----------|----------|-----------|----------|-----------|----------|-----------|
| | 1/1/2014 | 1/16/2014 | 2/1/2014 | 2/16/2014 | 3/1/2014 | 3/16/2014 | 4/1/2014 | 4/16/2014 |
| Lisinopril | 15 | 16 | | | | | | |
| Lisinopril & HCTZ | | 16 | 15 | | | | | |
| Captopril | | | | | 15 | 16 | | |
| Lisinopril | | | | | | 16 | 15 | |

Calculation

Covered Days = 105

Measurement Period = 120

PDC = 88%

Days Covered Modification for Inpatient Stays, Hospice Enrollment and Skilled Nursing Facility Stays

In response to sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Star Ratings (using 2011 PDE data), to adjust for beneficiary stays in inpatient (IP) facilities, and with the 2016 Star Ratings (using 2014 PDE data) to also adjust for hospice enrollments and beneficiary stays in skilled nursing facilities (SNF). This accounts for periods during which the Part D sponsor would not be responsible for providing prescription fills for relevant 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 2014 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 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.
 - a) Use IP claims from the CWF to identify IP stays.
 - b) Use SNF claims with positive payment amounts from the CWF to identify SNF stays.
 - c) 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 "stockpiles" the Part D prescription fills for later use.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC. The legend below applies to all examples.

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

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

In this simplified example, one assumes the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage, according to our current assignment of days of supply based on fill dates and days of supply reported through PDE claims data, on days 1-8 and 12-15. They also had an IP stay on days 5 and 6. Before the modification, as illustrated in Figure 1 below, the beneficiary’s PDC is equivalent to 12 days covered out of 15, or 80%.

Figure 1: Drug Coverage Assigned Before Modification in Example 1

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

After the modification, as illustrated in Figure 2 below, the beneficiary’s PDC is equivalent to 12 days covered out of 13, or 92.3%. This change in PDC before and after the modification occurs because days 5 and 6 (the days of IP stay) are deleted from the measurement period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received their medication through the hospital on days 5 and 6, then they accumulated two extra days of supply during the inpatient stay. That extra supply is used to cover gaps in Part D drug coverage in days 9 and 10.

Figure 2: Drug Coverage Assigned After Modification in Example 1

| | Days | | | | | | | | | | | | | | |
|-----------------|------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| Drug Coverage | A | A | A | A | D | D | A | A | E | E | B | A | A | A | A |
| Inpatient Stays | B | B | B | B | D | D | B | B | B | B | B | B | B | B | B |

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

In this simplified example, one assumes the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, according to our current assignment of days of supply based on fill dates and days of supply reported through PDE claims data. They also had an IP stay on days 6-9. Before the modification, as illustrated in Figure 3 below, the beneficiary’s PDC is equivalent to 11 days covered out of 15, or 73.3%.

Figure 3: Drug Coverage Assigned Before Modification in Example 2

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

After the modification, as illustrated in Figure 4 below, the beneficiary’s PDC is equivalent to 9 days covered out of 11, or 81.8%. This change in PDC before and after the modification occurs because days 6-9 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days of no supply *after* the IP stay, based on the assumption that the beneficiary received their medication through the hospital on days 6-9. In this case, there are only two days of no supply after the IP stay (days 10 and 11), so two days of supply are “rolled over” to days 10 and 11.

Figure 4: Drug Coverage Assigned After Modification in Example 2

| | Days | | | | | | | | | | | | | | |
|-----------------|------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| Drug Coverage | A | A | A | B | B | D | D | D | D | E | E | A | A | A | A |
| Inpatient Stays | B | B | B | B | B | D | D | D | D | B | B | B | B | B | B |

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

In this simplified example, one assumes the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-7 and 12-15, according to our current assignment of days of supply based on fill dates and days of supply reported through PDE claims data. They also had an IP stay from days 12-13. Before the modification, as illustrated in Figure 5 below, the beneficiary’s PDC is equivalent to 11 days covered out of 15, or 73.3%.

Figure 5: Drug Coverage Assigned Before Modification in Example 3

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

After the modification, as illustrated in Figure 6 below, the beneficiary’s PDC is equivalent to 9 days covered out of 13, or 69.2%. This change in PDC before and after the modification occurs because days 12-13 are deleted from the measurement period (denominator). Additionally, the two days of supply from days 12-13 cannot be applied to any days of no supply *after* the IP stay.

Figure 6: Drug Coverage Assigned After Modification in Example 3

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

Attachment M: Methodology for Price Accuracy Measure

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

Contract Selection

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

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

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

PF Price Accuracy Index

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

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

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

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

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

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

where

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

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

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

$$100 - ((\text{accuracy index} - 1) \times 100)$$

The score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

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

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

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

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

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

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

Table M-1: Example of Price Accuracy Index Calculation

| NDC | Pharmacy Number | PDE Data | | | | Plan Finder Data | | | | Calculated Values | | | |
|-----------------------|-----------------|----------|-----------------|----------------|--------------------|-------------------------|-----------------------------|----------------|---------|-------------------------|------------|-------|-----------------------------------|
| | | DOS | Ingredient Cost | Dispensing Fee | Quantity Dispensed | Biweekly Posting Period | Unit Cost for 30 Day Supply | Dispensing Fee | | Brand or Generic Status | Total Cost | | Amount that PDE is higher than PF |
| | | | | | | | | Brand | Generic | | PDE | PF | |
| A | 111 | 01/08/14 | 3.82 | 2 | 60 | 01/02/14 - 01/15/14 | 0.014 | 2.25 | 2.75 | B | 5.82 | 3.09 | 2.73 |
| B | 222 | 01/24/14 | 0.98 | 2 | 30 | 01/16/14 - 01/29/14 | 0.83 | 1.75 | 2.5 | G | 2.98 | 27.4 | 0 |
| C | 333 | 02/11/14 | 10.48 | 1.5 | 24 | 01/30/14 - 02/12/14 | 0.483 | 2.5 | 2.5 | B | 11.98 | 14.09 | 0 |
| D | 444 | 02/21/14 | 47 | 1.5 | 90 | 02/13/14 - 02/26/14 | 0.48 | 1.5 | 2.25 | G | 48.5 | 45.45 | 3.05 |
| Totals | | | | | | | | | | | 69.28 | | 5.78 |
| Accuracy Index | | | | | | | | | | | | | 1.08343 |
| Accuracy Score | | | | | | | | | | | | | 92 |

Attachment N: MTM CMR Completion Rate Measure Scoring Methodologies**A. 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 2014.

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 2014.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2015), 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:

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2014 MTM Program Reporting Requirements data are listed as "Data Issues Found".

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2014 MTM Program Reporting Requirements data but that failed at least one of the four data elements are listed as "Data Issues Found".

Small size: Contracts that have not yet been suppressed and have fewer than 31 beneficiaries enrolled are listed as "No 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 O: 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 O-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table O-1: Measure level missing data messages

| Message | Measure Level |
|--|---|
| Coming Soon | Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live |
| Medicare shows only a Star Rating for this topic | Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2 |
| Not enough data available | There were data for the contract, but not enough to pass the measure exclusion rules |
| Not enough data to accurately calculate measure | This contract had >500 and <=1,000 enrolled in July of the measurement year and the HEDIS data for this measure did not have a reliability >0.7 |
| CMS identified issues with this plan's data | Data were materially biased, erroneous and/or not reported by a contract required to report |
| Not Applicable | Used in the numeric data for the improvement measures in Plan Preview 1. In the HPMS Measure Star Page when a measure does not apply for a contract. When a Disenrollment Reasons Survey measure does not apply to the contract type. |
| Benefit not offered by plan | The contract was required to report this HEDIS measure but doesn't offer the benefit to members |
| Plan too new to be measured | The contract is too new to have submitted measure data |
| No data available | There were no data for the contract included in the source data for the measure |
| Plan too small to be measured | The contract had data but did not have enough enrollment to pass the measure exclusion rules |
| Plan not required to report measure | The contract was not required to report the measure |

1. Assignment rules for Part C measure messages

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

Appeals (IRE) measures (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 > 01/01/2014?

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

Beneficiary Access and Performance Problems (CMS Administrative Data) measure (C27):

Is there a valid numeric audit score?

Yes: Display the numeric audit score

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 > 07/01/2014?

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 > 05/31/2014?

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 > 01/01/2014?

Yes: Display message: Plan too new to be measured

No: Was the average contract enrollment < 800 in 2014?

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):

Was the contract enrollment < 500 in July 2014?

Yes: Display message: Plan too small to be measured

No: Is there a valid HEDIS numeric rate?

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 numeric rate

No: Display message: Not enough data to accurately calculate measure

No: Display the HEDIS numeric rate

No: Is the HEDIS rate a code?

Yes: Assign message according to value below:

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

NR: Assign message according to audit designation

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

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

OS Display message: Plan not required to report measure

ER Display message: Plan not required to report measure

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

Yes: Display message: Plan too new to be measured

No: Was the contract required to report HEDIS?

Yes: Display message: No data available

No: Display message: Plan not required to report measure

HEDIS PCR measure (C19)

Is there a valid HEDIS numeric rate?

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 numeric rate

No: Display message: Not enough data to accurately calculate measure

No: Display the HEDIS numeric rate

No: Is the HEDIS rate a code?

Yes: Assign message according to value below:

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

NR: Assign message according to audit designation

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

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

OS Display message: Plan not required to report measure

ER Display message: Plan not required to report measure

Else: Display message: Not enough data available

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

Yes: Display message: Plan too new to be measured

No: Display message: No data available

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

Is the organization type (1876 Cost, PFFS, MSA) or SNP offered in 2016 = No?

Yes: Display message: Plan not required to report measure

No: Is there a valid HEDIS numeric rate?

Yes: Display the HEDIS numeric rate

No: Is the HEDIS rate a code?

Yes: Assign message according to value below:

NA: Display message: Not enough data available

NB: Display message: Benefit not offered by plan

NR: Assign message according to audit designation

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

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

OS Display message: Plan not required to report measure

ER Display message: Plan not required to report measure

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

Yes: Display message: Plan too new to be measured

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 > 01/01/2013?

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 > 01/01/2011?

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 ≥ 01/01/2015?

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

Plan Reporting SNP measures (C08):

Is the organization type (1876 Cost, PFFS, MSA) or SNP offered in 2016 = No?

Yes: Display message: Plan not required to report measure

No: Is there a valid Plan Reporting numeric rate?

Yes: Display the Plan Reporting numeric rate

No: Were there Data Issues Found?

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

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

Yes: Display message: Plan too new to be measured

No: Display message: No data available

Improvement (Star Ratings) measure (C29):

Is there a valid improvement measure rate?

Yes: Display message: Medicare shows only a Star Rating for this topic

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

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

2. Assignment rules for Part D measure messages

Appeals 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 2014?

Yes: Display message: Not enough data available

No: Is the contract effective date > 12/31/2014?

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 > 01/01/2014?

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

Beneficiary Access and Performance Problems (CMS Administrative Data) measure (D06):

Is there a valid numeric audit score?

Yes: Display the numeric audit score

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 (D08, D09):

Is there a valid numeric CAHPS measure rate?

Yes: Display the numeric CAHPS measure rate

No: Is the contract effective date > 07/01/2014?

Yes: Display message: Plan too new to be measured

No: Is the CAHPS measure rate NA?

Yes: Display message: No data available

No: Display message: Plan too small to be measured

Call Center – 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 > 05/31/2014?

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 > 01/01/2014?

- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2014?
 - Yes: Display message: Not enough data available
 - No: Is there a valid numeric CTM rate?
 - Yes: Display the numeric CTM rate
 - No: Display message: No data available

Improvement (Star Ratings) measure (D07):

Is there a valid improvement measure rate?

- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date > 01/01/2014?
 - Yes: Display message: Plan too new to be measured
 - No: Display message: Not enough data available

Members Choosing to Leave the Plan (D05):

Is there a valid numeric voluntary disenrollment rate?

- Yes: Display the numeric voluntary disenrollment 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

MPF Price Accuracy measure (D10):

Is the contract effective date > 9/30/2014?

- Yes: Display message: Plan too new to be measured
- No: Does contract have at least 30 claims over the measurement period for the price accuracy index?
 - Yes: Display the numeric price accuracy rate
 - No: Is the organization type 1876 Cost and does not offer Drugs?
 - Yes: Display message: Plan not required to report measure
 - No: Display message: Not enough 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 > 12/31/2014?

- 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: Display numeric measure percentage

Patient Safety measure – MTM CMR (D15)

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 > 12/31/2014?

Yes: Display message: Plan too new to be measured

No: Did the contract have a valid numeric rate?

Yes: Display numeric measure percentage

No: Was the contract too small to report?

Yes: Display message: Plan too small to be measured

No: Was the contract required to report?

Yes: Display message: Not enough data available

No: Display message: "Plan not required to report measure

Domain, Summary and Overall level messages

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

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

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

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

Part C & D domain message assignment rules:

Is there a numeric domain star?

Yes: Display the numeric domain star

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

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

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

Part C & D summary rating message assignment rules:

Is there a numeric summary rating star?

Yes: Is the contract currently under sanction?

Yes: Is this the contract's highest rating?

Yes: Is the contract's summary rating greater than 2.5 stars?

Yes: Set contract's summary rating to 2.5 stars

No: Subtract 1 from the contract's summary rating

No: Display the numeric summary rating star

No: Display the numeric summary rating star

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

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

3. Assignment rules for overall rating level messages

Overall rating message assignment rules:

Is there a numeric overall rating star?

Yes: Is the contract currently under sanction?

Yes: Is this the contract's highest rating?

Yes: Is the contract's overall rating greater than 2.5 stars?

Yes: Set contract's overall rating to 2.5 stars

No: Subtract 1 from the contract's overall rating

No: Display the numeric overall rating star

No: Display the numeric overall rating star

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

Yes: Display message: Plan too new to be measured

No: Display message: Not enough data available

Disenrollment Reasons messages

The 2016 Star Ratings posted to the Medicare Plan Finder includes data collected from the Disenrollment Reasons Survey (DRS). The DRS data was not used at any point in the calculation of the Star Ratings. The data are provided in MPF for beneficiary information only, and are shown in HPMS with the Star Ratings data so organizations can preview them prior to public posting.

Because there are instances where a contract does not have data to display, a set of rules was developed to assign messages where data was missing so the data area would not be left blank.

Table O-3 contains all of the possible messages that could be assigned to missing data in the disenrollment reason data displayed in the Medicare Plan finder and HPMS.

Table O-3: Disenrollment Reason missing data messages

| Message | Meaning |
|-----------------------------|--|
| Coming Soon | Used for all ratings in MPF between Oct 1 and when the actual data go live |
| Not Applicable | Used when the DRS measure does not apply to the contract type |
| Not Available | Used when there is no numeric data available for the DRS measure |
| Plan too new to be measured | The contract is too new for data to be collected for the measure |

Disenrollment Reasons message assignment rules:

Is the contract effective date > 1/1/2014?

Yes: Display message: Plan too new to be measured

No: Is there numeric data for the contract in this DRS measure?

Yes: Display the numeric DRS rate

No: Does the DRS measure apply to the organization type

Yes: Display message: Not Available

No: Display message: Not Applicable

Attachment P: Glossary of Terms

| | |
|--------------------|---|
| AEP | The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part D plan or re-enroll into their existing Medicare Part D Plan or change into another Medicare Part D plan is known as the Annual Election Period (AEP). Beneficiaries can also switch to a Medicare Advantage Plan that has a Prescription Drug Plan (MA-PD). The chosen Medicare Part D plan coverage begins on January 1 st . |
| CAHPS | The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems. |
| CCP | A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS' requirements. |
| Cost Plan | A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost reimbursement contract under §1876(h) of the Act. In the Star Ratings, CMS classifies a Cost Plan not offering Part D as MA-only and a Cost Plan offering Part D as MA-PD. |
| 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. |
| ICEP | The 3 months immediately before beneficiaries are entitled to Medicare Part A and enrolled in Part B are known as the Initial Coverage Election Period (ICEP). Beneficiaries may choose a Medicare health plan during their ICEP and the plan must accept them unless it has reached its limit in the number of members. This limit is approved by CMS. |
| IRE | The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health 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. |
| MA | A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. |
| MA-only | An MA organization that does not offer Medicare prescription drug coverage. |
| MA-PD | An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan. |
| MSA | Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder). |
| Percentage | A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%. |
| Percentile | The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile. |
| PDP | A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage or Medicare Cost Plans that do not offer Medicare prescription drug coverage. |
| PFFS | Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans. |
| Reliability | A measure of the fraction of the variation among the observed measure values that is due to real differences in quality ("signal") rather than random variation ("noise"). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy). |

| | |
|--------------------------|---|
| SNP | A Special Needs Plan (SNP) is an MA coordinated care plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more severe or disabling chronic conditions. |
| Sponsor | An entity that sponsors a health or drug plan. |
| Statistical Significance | Statistical significance assesses how 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 | The sum of the squares of a measure. |
| 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 Q: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS (<https://hpms.cms.gov>) to understand the various pages and fields shown in the HPMS Star Ratings module. This module employs standard HPMS user access rights so that users can only see contracts associated with their user id.

Star Ratings

The HPMS Star Ratings module contains the Part C & Part D data and stars which will be displayed in MPF along with much of the detailed data that went into various calculations. To access the Star Ratings module, on the HPMS home page, select *Quality and Performance*. From the Quality and Performance menu choose Performance Metrics. The Performance Metrics page will be displayed; select *Star Ratings and Display Measures from the left side menu*. The *Star Ratings and Display Measures* home page will be displayed.

On the *Star Ratings and Display Measures* home page, select *Star Ratings* from the left hand menu. You will be presented with a screen that allows you to select a reporting period. The information below describes the HPMS pages for the 2016 Star Ratings.

B. Measure Data page

The Measure Data page displays the numeric data for all Part C and Part D measures. This page is available during the first plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure data which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the data associated with an individual contract.

C. Measure Detail page

The Measure Detail page contains the underlying data used for the Part C and Part D Complaints (C26/D04) and Part C & D Appeals measures (C30, C31, D02 & D03). This page is available during the first plan preview. Table Q-1 below explains each of the columns displayed on this page.

Table Q-1: Measure Detail page fields

| HPMS Field Label | Field Description |
|--|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Total Number of Complaints | The number of non-excluded complaints for the contract |
| Complaint Average Enrollment | The average enrollment used in the final calculation |
| Complaints Less than 800 Enrolled | Yes / No, Yes = average enrollment < 800, No = average enrollment ≥ 800 |
| Part C Total Appeals Cases | Total number of Part C appeals cases processed by the IRE (Maximus) |
| Part C Number of Appeals Upheld | The number of Part C appeals which were upheld |
| Part C Number of Appeals Overturned | The number of Part C appeals which were overturned |
| Part C Number of Appeals Partly Overturned | The number of Part C appeals which were partially overturned |
| Part C Number of Appeals Dismissed | The number of Part C appeals which were dismissed |
| Part C Number of Appeals Withdrawn | The number of Part C appeals which were withdrawn |
| Part C Number of Late Appeals | The number of Part C appeals which Maximus considered to be late |
| Part C Percent of Timely Appeals | The percent of Part C appeals which were processed in a timely manner |
| Part D Appeals Auto-Forward Cases | The number of Part D appeals that were not processed in a timely manner, and subsequently auto-forwarded to the IRE (Maximus) |

| HPMS Field Label | Field Description |
|-----------------------------------|--|
| Part D 2014 enrollment | The average Part D 2014 monthly enrollment |
| Part D Appeals Upheld Cases | Total number of Part D appeals cases which were upheld |
| Part D Upheld Cases | The number of Part D appeals cases which were upheld |
| Part D Upheld: Fully Reversed | The number of Part D appeals cases which were reversed |
| Part D Upheld: Partially Reversed | The number of Part D appeals cases which were partially reversed |

D. Measure Detail – Auto-Forward page

The Measure Detail – Auto-Forward page contains the case-level data of the non-excluded cases used in producing the Part D Appeals Auto-Forward measure (D02). This page is available during the first plan preview. Table Q-2 below explains each of the columns displayed on this page.

Table Q-2: Measure Detail – Auto-Forward page fields

| HPMS Field Label | Field Description |
|-----------------------------|--|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The parent organization of the contract |
| Appeal Number | The case ID assigned to the appeal request |
| Request Received Date | The date the appeal was received by the IRE |
| Request Type | The type of appeal (auto-forward) |
| Appeal Priority | The priority of the appeal (standard or expedited) |
| Appeal Disposition | The disposition of the IRE (Maximus) |
| Appeal End Date | The end date of the appeal |

E. Measure Detail – Upheld page

The Measure Detail – Upheld page contains the case-level data of the non-excluded cases used in producing the Part D Appeals Upheld measure (D03). This page is available during the first plan preview. Table Q-3 below explains each of the columns displayed on this page.

Table Q-3: Measure Detail – Upheld page fields

| HPMS Field Label | Field Description |
|-----------------------------|--|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The parent organization of the contract |
| Appeal Number | The case ID assigned to the appeal request |
| Request Received Date | The date the appeal was received by the IRE |
| Deadline | The deadline for the decision |
| Appeal Priority | The priority of the appeal (standard or expedited) |
| Appeal Disposition | The disposition of the IRE (Maximus) |
| Appeal End Date | The end date of the appeal |
| Status | The status of the appeal |

F. Measure Detail – SNP CM page

The Measure Detail – SNP CM page contains the underlying data used in calculating the Part C SNP Care Management measure (C08). The formulas used to calculate these SNP measures are detailed in [Attachment E](#). This page is available during the first plan preview. Table Q-4 below explains each of the columns displayed on this page.

Table Q-4: Measure Detail – SNP CM page fields

| HPMS Field Label | Field Description |
|---|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Number of new enrollees | Number of new SNP enrollees eligible for an initial assessment (Element 13.1) |
| Number of enrollees eligible for an annual HRA | Number of SNP enrollees eligible for an annual reassessment (Element 13.2) |
| Number of initial HRAs performed on new enrollees | Number of initial assessments performed on new SNP enrollees (Element 13.3) |
| Number of annual reassessments performed | Number of annual reassessments performed on eligible SNP enrollees (Element 13.4) |
| Total Number of SNP Enrollees Eligible | Final measure numerator (Elements 13.1 + 13.2) |
| Total Number of Assessments Performed | Final measure denominator (Elements 13.3 + 13.4) |
| Percent of Eligible SNP Enrollees Receiving an Assessment | Final measure score |
| Data Validation Score | The data validation score for the contract |
| Reason for Exclusion | Reason (if any) contract submitted data was not used to generate a score |

G. Measure Detail – SNP COA page

The Measure Detail – SNP COA page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adult measures (C09, C10 & C11). The formulas used to calculate these SNP measures are detailed in [Attachment E](#). This page is available during the first plan preview. Table Q-6 below explains each of the columns displayed on this page.

Table Q-6: Measure Detail – SNP COA page fields

| HPMS Field Label | Field Description |
|-----------------------------|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| PBP ID | The Plan Benefit Package number associated with the data |
| Eligible Population – MR | The contract entered COA Eligible population - Medication Review, as entered into the NCQA DSS (Field: eligpopmr) for the associated contract/PBP |
| Eligible Population – FSA | The contract entered COA Eligible population - Functional Status Assessment, as entered into the NCQA DSS (Field: eligpopfsa) for the associated contract/PBP |
| Eligible Population – PA | The contract entered COA Eligible population - Pain Assessment, as entered into the NCQA data submission tool (Field: eligpopps) for the associated contract/PBP |
| Average Plan Enrollment | The average enrollment in the PBP during 2014 (see section Contract Enrollment Data) |
| COA – MR Rate | The contract entered COA Medication Review Rate as entered into the NCQA data submission tool (Field: ratemr) for the associated contract/PBP |
| COA – FSA Rate | The contract entered COA Functional Status Assessment Rate as entered into the NCQA data submission tool (Field: ratefsa) for the associated contract/PBP |
| COA – PA Rate | The contract entered COA Pain Assessment Rate as entered into the NCQA data submission tool (Field: ratesps) for the associated contract/PBP |
| COA - MR Audit Designation | The audit designation for the COA Medication Review Rate for the associated contract/PBP (the codes are defined in Table Q-6: HEDIS 2015 Audit Designations and 2016 Star Ratings below) |
| COA – FSA Audit Designation | The audit designation for the COA Functional Status Assessment Rate for the associated contract/ PBP the codes are defined in Table Q-6: HEDIS 2015 Audit Designations and 2016 Star Ratings below) |
| COA – PA Audit Designation | The audit designation for the COA Pain Assessment Rate for the associated contract/ PBP the codes are defined in Table Q-6: HEDIS 2015 Audit Designations and 2016 Star Ratings below) |

Table Q-6: HEDIS 2015 Audit Designations and 2016 Star Ratings

| Audit Designation | NCQA Description | Resultant Star Rating |
|-------------------|-------------------|---|
| R | Reportable | 1 to 5 stars depending on reported value |
| BR | Biased Rate | 1 star, numeric data set to "CMS identified issues with this plan's data" |
| NA | Small Denominator | "Not enough data available" |
| NB | No Benefit | "Benefit not offered by plan" |
| NR | Not Reported | 1 star, numeric data set to "CMS identified issues with this plan's data" |
| NQ | Not Required | Not possible in HEDIS for Medicare since all measures are required every year |
| OS | Out of Scope | "Plan not required to report measure" (applies only to 1876 Cost in the PCRb measure) |
| UN | Un-Audited | Not possible in Star Ratings measures which only use audited data |

H. Measure Detail – CTM page

The Measure Detail – CTM page contains the case level data of the non-excluded cases used in producing the Part C & Part D Complaints measure (C26/D04). This page is available during the first plan preview. Table Q-7 below explains each of the columns displayed on this page.

Table Q-7: Measure Detail – CTM page fields

| HPMS Field Label | Field Description |
|---|--|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Complaint ID | The case number associated with the complaint in the HPMS CTM module |
| Complaint Category ID | The complaint category identifier associated with this case |
| Category Description | The complaint category description associated with this case |
| Complaint Subcategory ID | The complaint subcategory identifier associated with this case |
| Subcategory Description | The complaint subcategory description associated with this case |
| Contract Assignment / Reassignment Date | The date that complaints are assigned or re-assigned to contracts |

I. Measure Detail – Disenrollment

The Measure Detail – Disenrollment page contains data that are used in calculating the Part C & Part D disenrollment measure (C27/D05). The page shows the denominator, unadjusted numerator and original rate received from the MBDSS annual report. It also contains the adjusted numerator and final rate after all members meeting the measure exclusion criteria described in the measure description have been removed. This page is available during the first plan preview. Table Q-8 below explains each of the columns displayed on this page.

Table Q-8: Measure Detail – Disenrollment

| HPMS Field Label | Field Description |
|-----------------------------|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The parent organization of the contract |
| Number Enrolled | The number of all members in the contract from MBDSS annual report |
| Number Disenrolled | The number disenrolled with a disenrollment reason code of 11, 13, 14 or 99, from the MBDSS annual report |
| Original Rate | The disenrollment rate as calculated by the annual MBDSS report |
| Adjusted Disenrolled | The adjusted numerator when all members who meet the measure exclusion criteria are removed |
| Adjusted Rate | The final adjusted disenrollment rate used in the Star Ratings |
| >1000 Enrolled | Flag indicates contract non-employer group enrollment >1,000 members during the year (True = Yes, False = No) |

J. Measure Detail – DR (Disenrollment Reasons)

The Measure Detail – Disenrollment Reasons page contains the data from the Disenrollment Reasons Survey (DRS) which will be displayed in the Medicare Plan Finder when the user drills down under the Star Ratings Disenrollment measure. The disenrollment reasons data were not used at any point in the calculations of the Star Ratings. The data are provided in MPF for beneficiary information only and in HPMS with the Star Ratings data so organizations can preview them prior to being posted publicly. The data comes from surveys sent to enrollees who disenrolled between 1/1/2014 and 12/31/2014. This page is available during the first plan preview. Table Q-9 below explains each of the columns displayed on this page.

Table Q-9: Measure Detail – Disenrollment Reasons

| HPMS Field Label | Field Description |
|-----------------------------|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The parent organization of the contract |
| DR PGNCCC | Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only) |
| DR PCDH | Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only) |
| DR FRD | Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP) |
| DR PPDBC | Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP) |
| DR PGIPD | Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP) |

K. Measure Detail – BAPP (Beneficiary Access and Performance Problems)

The Measure Detail – BAPP (Beneficiary Access and Performance Problems) page contains data that are used in calculating the Part C & Part D measure (C28/D06). Information on contract Sanctions and Civil Monetary Penalties that occurred during the data timeframe can be viewed on this page: [Part C and Part D Enforcement Actions](#). Information about the Ad-hoc CAPs that occurred during the data timeframe can be downloaded from this page: [Part C and Part D Compliance Actions](#). The notice and warning letter counts come from the Compliance Activity module in HPMS. The CAM score and BAPP score calculation methodology is explained in the measure description section of these technical notes. This page is available during the first plan preview. Table Q-10 below explains each of the columns displayed on this page.

Table Q-10: Measure Detail – BAPP (Beneficiary Access and Performance Problems)

| HPMS Field Label | Field Description |
|-----------------------------|--|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The parent organization of the contract |
| Effective Date | The contract effective date |
| Contract Sanctioned | Was the contract under sanction during the data time frame (Yes/No) |
| Date Sanction Imposed | The date the sanction began (date sanction started if applicable, blank if not) |
| Date Sanction Lifted | The date the sanction ended (date sanction ended if applicable, blank if not) |
| CMP | The count of Civil Monetary Penalties imposed during the data time frame |
| NONC | The count of Notices of Non Compliance issued during the data time frame |
| WLwoBP | The count of Warning Letters without Business Plan issued during the data time frame |
| WLwBP | The count of Warning Letters with Business Plan issued during the data time frame |
| Ad-hoc CAPs | The count of Ad-hoc CAPs issued during the data time frame |
| CAP Severities | The severity of each individual Ad-hoc CAP issued during the data time frame |
| Total Severity | The total severity of all the Ad-hoc CAPs issued during the data time frame |
| CAM Score | The final calculated CAM score |
| BAPP Score | The final calculated measure score |

L. Measure Detail – HEDIS LE page

The Measure Detail – HEDIS LE page contains the data used to calculate the reliability of the HEDIS measures (C01, C02, C07, C13 – C17 & C19) data for contracts with ≥ 500 and $< 1,000$ members enrolled in July of the measurement year (July 01, 2014). This page is available during the second plan preview. Table Q-11 below explains each of the columns displayed on this page.

Table Q-11: Measure Detail – HEDIS LE page fields

| HPMS Field Label | Field Description |
|------------------|--|
| Contract Number | The contract number associated with the data |
| Measure ID | The Star Ratings measure that the other data on this row is associated with |
| Rate | The submitted HEDIS rate |
| Score | The rounded value used for the measure in the Star Ratings |
| Enrollment | The contract enrollment for July 2014 |
| Reliability | The computed reliability for the contract measure |
| Usable | The computed reliability ≥ 0.7 and rate is used = True, reliability < 0.7 and rate was not used = False |

M. Measure Detail – C Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part C measures. There is one column for each Part C measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part C measure columns which contain the final numeric Part C improvement score. This numeric result from step 4 is described in [Attachment I](#): “Calculating the Improvement Measure and the Measures Used”.

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract.

The possible results for Part C measure calculations are shown in Table Q-12 below.

Table Q-12: Part C Measure Improvement Results

| Improvement Measure Result | Description |
|------------------------------------|---|
| No significant change | There was no significant change in the values between the two years |
| Significant improvement | There was a significant improvement from last year to this year |
| Significant decline | There was a significant decline from last year to this year |
| Not included in calculation | There was only one year of data available so the calculation could not be completed |
| Not Applicable | The measure is not an improvement measure |
| Not Eligible | The contract did not have data in more than half of the improvement measures or was too new |
| Held Harmless | The contract had 5 stars in this measure last year and this year |
| Low reliability and low enrollment | The low-enrollment contract measure score did not have sufficiently high reliability |

N. Measure Detail – D Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part D measures. There is one column for each Part D measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part D measure columns which contain the final numeric Part D improvement score. This numeric result from step 4 is described in [Attachment I](#): “Calculating the Improvement Measure and the Measures Used”.

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract.

The possible results for Part D measure calculations are shown in Table Q-13 below.

Table Q-13: Part D Measure Improvement Results

| Improvement Measure Result | Description |
|-----------------------------------|---|
| No significant change | There was no significant change in the values between the two years |
| Significant improvement | There was a significant improvement from last year to this year |
| Significant decline | There was a significant decline from last year to this year |
| Not included in calculation | There was only one year of data available so the calculation could not be completed |
| Not Applicable | The measure is not an improvement measure |
| Not Eligible | The contract did not have data in more than half of the improvement measures or was too new |
| Held Harmless | The contract had 5 stars in this measure last year and this year |

O. Measure Stars page

The Measure Stars page displays the Star Rating for each Part C and Part D measure. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure stars which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the stars associated with an individual contract.

P. Domain Stars page

The Domain Stars page displays the Star Rating for each Part C and Part D domain. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part C and Part D domains. The domain columns are identified by the domain id and domain name. All subsequent rows contain the stars associated with an individual contract.

Q. Part C Summary Rating page

The Part C Summary Rating page displays the Part C rating and data associated with calculating the final Part C summary rating. This page is available during the second plan preview. Table Q-14 below explains each of the columns contained on this page.

Table Q-14: Part C Summary Rating View

| HPMS Field Label | Field Description |
|----------------------------------|--|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Contract Type | The contract plan type used to compute the ratings |
| SNP Plans | Does the contract offer a SNP (Yes/No) |
| Number Measures Required | The minimum number of measures required to calculate a rating out all required for the contract type. |
| Number Missing Measures | The number of measures that were missing stars |
| Number Rated Measures | The number of measures that were assigned stars |
| Calculated Summary Mean | Contains the mean of the stars for rated measures |
| Calculated Variance | The variance of the calculated summary mean |
| Variance Category | The reward factor variance category for the contract (low, medium or high) |
| Reward Factor | The calculated reward factor for the contract (0, 0.1, 0.2, 0.3 or 0.4) |
| Final Summary | Contains the sum of the Calculated Summary Mean and the Reward Factor |
| Improvement Measure Usage | Was the improvement measure (C29) used in the final Part C Summary Rating? (Yes/No) |
| 2016 Part C Summary Rating | The final rounded 2016 Part C Summary Rating |
| Sanction Deduction | Did this contract receive an adjustment to the Part C Summary rating for contracts under sanction (Yes/No) |
| Calculated Score Percentile Rank | Percentile ranking of Calculated Summary Mean |
| Variance Percentile Rank | Percentile ranking of Calculated Variance |

Part D Summary Rating page

The Part D Summary Rating page displays the Part D rating and data associated with calculating the final Part D summary rating. This page is available during the second plan preview. Table Q-15 below explains each of the columns contained on this page.

Table Q-15: Part D Summary Rating View

| HPMS Field Label | Field Description |
|----------------------------------|--|
| Contract Number | The contract number associated with the data |
| Contract Name | The name the contract is known by in HPMS |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Contract Type | The contract plan type used to compute the ratings |
| Number Measures Required | The minimum number of measures required to calculate a rating out all required for the contract type. |
| Number Missing Measures | The number of measures that were missing stars |
| Number Rated Measures | The number of measures that were assigned stars |
| Calculated Summary Mean | Contains the mean of the stars for rated measures |
| Calculated Variance | The variance of the calculated summary mean |
| Variance Category | The reward factor variance category for the contract (low, medium or high) |
| Reward Factor | The calculated reward factor for the contract (0, 0.1, 0.2, 0.3 or 0.4) |
| Final Summary | Contains the sum of the Calculated Summary Mean and the Reward Factor |
| Improvement Measure Usage | Was the improvement measure (D05) used in the final Part D Summary Rating? (Yes/No) |
| 2016 Part D Summary Rating | The final rounded 2016 Part D Summary Rating |
| Sanction Deduction | Did this contract receive an adjustment to the Part D Summary rating for contracts under sanction (Yes/No) |
| Calculated Score Percentile Rank | Percentile ranking of Calculated Summary Mean |
| Variance Percentile Rank | Percentile ranking of Calculated Variance |

R. Overall Rating page

The Overall Rating page displays the overall rating for MA-PD contracts and data associated with calculating the final overall rating. This page is available during the second plan preview. Table Q-16 below explains each of the columns contained on this page.

Table Q-16: Overall Rating View

| HPMS Field Label | Field Description |
|----------------------------------|--|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Contract Type | The contract plan type used to compute the ratings |
| SNP Plans | Does the contract offer a SNP (Yes/No) |
| Number Measures Required | The minimum number of measures required to calculate a final rating out of the number of measures required for this contract type. |
| Number Missing Measures | The number of measures that were missing stars |
| Number Rated Measures | The number of measures that were assigned stars |
| Calculated Summary Mean | Contains the weighted mean of the stars for rated measures |
| Calculated Variance | The variance of the calculated summary mean |
| Variance Category | The reward factor variance category for the contract (low, medium or high) |
| Reward Factor | The calculated reward factor for the contract (0, 0.1, 0.2, 0.3 or 0.4) |
| Final Summary | Contains the sum of the Calculated Summary Mean and the Reward Factor |
| 2016 Part C Summary Rating | The 2016 Part C Summary Rating |
| 2016 Part D Summary Rating | The 2016 Part D Summary Rating |
| Improvement Measure Usage | Were the improvement measures (C29 & D07) used to produce the final Overall Rating? (Yes/No) |
| 2016 Overall Rating | The final 2016 Overall Rating |
| Sanction Deduction | Did this contract receive an adjustment to the Overall rating for contracts under sanction (Yes/No) |
| Calculated Score Percentile Rank | Percentile ranking of Calculated Summary Mean |
| Variance Percentile Rank | Percentile ranking of Calculated Variance |

S. Low Performing Contract List

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

Table Q-17: Low Performing Contract List

| HPMS Field Label | Field Description |
|-----------------------------|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Rated As | The type of rating for this contract, valid values are "MA-only", "MA-PD" and "PDP" |
| 2014 C Summary | The 2014 Part C Summary Rating earned by the contract |
| 2014 D Summary | The 2014 Part D Summary Rating earned by the contract |
| 2015 C Summary | The 2015 Part C Summary Rating earned by the contract |
| 2015 D Summary | The 2015 Part D Summary Rating earned by the contract |
| 2016 C Summary | The 2016 Part C Summary Rating earned by the contract |
| 2016 D Summary | The 2016 Part D Summary Rating earned by the contract |
| Reason for LPI | The combination of ratings that met the Low Performing Icon rules. Valid values are "Part C", "Part D", "Part C and D" & "Part C or D". See the section titled "Methodology for Calculating the Low Performing Icon for details". |

T. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table Q-18 below explains each of the columns contained on this page.

Table Q-18: High Performing Contract List

| HPMS Field Label | Field Description |
|-----------------------------|---|
| Contract Number | The contract number associated with the data |
| Organization Marketing Name | The name the contract markets to members |
| Contract Name | The name the contract is known by in HPMS |
| Parent Organization | The name of the parent organization for the contract |
| Rated As | The type of rating for this contract, valid values are "MA-only", "MA-PD" and "PDP" |
| Highest Rating | The highest level of rating that can be achieved for this organization, valid values are "Part C Summary", "Part D Summary", "Overall Rating" |
| Rating | The star value attained in the highest rating for the organization type |

U. Technical Notes link

The Technical Notes link provides the user with a copy of the 2016 Star Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur to the technical if errors are identified outside of the plan preview periods and after MPF data release.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2016 Star Ratings Technical Notes. Right clicking on the Technical Notes link will pop up a context menu which contains Save Target As...; clicking on this will allow the user to download and save a copy of the PDF document

V. Medication NDC List – High Risk Medication Measure link

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

W. Medication NDC List – Medication Adherence Measure link

The Medication NDC List – Medication Adherence Measure link provides the user a means to download a copy of the medication lists used for the Medication Adherence measures (D12, D13 & D14). This downloadable file is in Excel format.