



Medicare 2016 Part C & D Star Rating Technical Notes

Updated – 04/05/2016

Document Change Log

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-	Release of the final 2016 Part C & D Star Ratings Technical Notes	09/30/2015
09/30/2015	Updated Table 1 to show optional Part D coverage for PFFS organizations	04/05/2015
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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	Technical Note Abbreviation	Medicare Advantage (MA)	Part C Ratings	Part D Ratings
1876 Cost	1876 Cost	No	Yes	Yes (if drugs offered)
Chronic Care	Chronic Care	No	No	No
Demonstration (Medicare-Medicaid Plan) †	MMP	No	No	No
Employer/Union Only Direct Contract Local Coordinated Care Plan (CCP)	E-CCP	Yes	Yes	Yes
Employer/Union Only Direct Contract Prescription Drug Plan (PDP)	E-PDP	No	No	Yes
Employer/Union Only Direct Contract Private Fee-for-Service (PFFS)	E-PFFS	Yes	Yes	Yes (if drugs offered)
HCPP 1833 Cost	HCPP	No	No	No
Local Coordinated Care Plan (CCP)	Local CCP	Yes	Yes	Yes
Regional Coordinated Care Plan (CCP)	Regional CCP	Yes	Yes	Yes
Medical Savings Account (MSA)	MSA	Yes	Yes	No
National PACE	PACE	No	No	No
Medicare Prescription Drug Plan (PDP)	PDP	No	No	Yes
Private Fee-for-Service (PFFS)	PFFS	Yes	Yes	Yes (if drugs offered)

† 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 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 of the care they 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 –excluded planned readmissions from the measure and removed 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.
- k. Eliminated pre-determined 4 star thresholds.
- l. Included data in HEDIS measures for contracts with 500-999 enrolled in July of the measurement year.

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. Part C & D measures: 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 enrolled 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 rates.

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. Note there is no minimum number of cases required for a contract's data to be subject to data integrity reviews.

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 "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 types. The highest level rating differs for each contract type because the set of required measures differs by contract type. 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 presents the relation between the three contract types and the organization types.

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

Organization Type	1876 Cost (no drugs)	1876 Cost (offers drugs)	E-CCP, Local CCP & Regional CCP	MSA	E-PDP & PDP	E-PFFS & PFFS (no drugs)	E-PFFS & PFFS (offers drugs)
Rated As	MA-only	MA-PD	MA-PD	MA-only	PDP	MA-only	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 “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 44 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 three different methods: clustering, relative distribution and significance testing or fixed cut points. Each method is described below. [Attachment K](#) explains the clustering method in more detail.

A. 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 based on the distribution that results in the creation of five categories (one for each Star Rating). The scores of contracts in the same score category (Star Rating) are as similar as possible; the scores of contracts in different categories are as different as possible. Star Rating categories 1 through 5 are assigned based on contract scores, with 1 being the worst and 5 being the best for measures when the general trend is “Higher is better”.

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. Each contract begins with a starting score of 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 contract 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 scores between contracts, 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	40	60	80	100

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	Domain Name (Identifier)	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	Staying Healthy: Screenings, Tests and Vaccines (HD1)	4 of 7	4 of 7	4 of 7	4 of 7	N/A	4 of 7
C	Managing Chronic (Long Term) Conditions (HD2)	4 of 7	5 of 8	7 of 12	5 of 8	N/A	5 of 8
C	Member Experience with Health Plan (HD3)	4 of 6	4 of 6	4 of 6	4 of 6	N/A	4 of 6
C	Member Complaints and Changes in the Health Plan's Performance (HD4)	3 of 4	3 of 4	3 of 4	3 of 4	N/A	3 of 4
C	Health Plan Customer Service (HD5)	2 of 2	2 of 3	2 of 3	2 of 3	N/A	2 of 3
D	Drug Plan Customer Service (DD1)	2 of 2*	2 of 3	2 of 3	N/A	2 of 3	2 of 3*
D	Member Complaints and Changes in the Drug Plan's Performance (DD2)	3 of 4*	3 of 4	3 of 4	N/A	3 of 4	3 of 4*
D	Member Experience with the Drug Plan (DD3)	2 of 2*	2 of 2	2 of 2	N/A	2 of 2	2 of 2*
D	Drug Safety and Accuracy of Drug Pricing (DD4)	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 and PFFS 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 assigned the lowest weight. 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 use in calculating the 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 the summary and overall ratings, a rating for a 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 Parts C and D, respectively. To receive a Part C and/or Part D summary rating, a contract must meet the minimum number of individual measures with assigned Star Ratings. The Parts 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: Does not apply to MA-only 1876 Cost and PFFS contracts which do not offer drug benefits.

† 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 summary rating.

For the Parts C and D summary ratings, half stars are assigned to allow 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 and PFFS 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: Does not apply to MA-only 1876 Cost and PFFS 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	3.684	4.077	3.754	3.788
with	85th	3.960	4.344	4.148	4.034
without	65th	3.718	4.083	3.622	3.805
without	85th	3.987	4.353	4.000	4.074

Table 10: Variance Thresholds

Improvement	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
with	30th	.982	.781	.966	.983
with	70th	1.378	1.236	1.564	1.371
without	30th	.966	.800	.898	.986
without	70th	1.368	1.262	1.538	1.364

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 inspection. Previously, we only displayed 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 publicly-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 Parts 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 ratings 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
HBBBB	MA-PD	3	3	3	2.5	2	2.5	Yes	Part D
HCCCC	MA-PD	2.5	3	3	3	2.5	2.5	Yes	Part C or D
HDDDD	MA-PD	3	2.5	3	2.5	3	2.5	Yes	Part C or D
HEEEE	MA-PD	2.5	2	2.5	2	2.5	2.5	Yes	Part C and D
HFFFF	MA-only	2.5	2	2.5	-	-	-	Yes	Part C
SAAAA	PDP	-	-	-	2.5	2.5	2	Yes	Part D

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

Figure 2: The Low Performing Icon



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 within a contract for these measures are described further in [Attachment E](#).

CAHPS Methodology

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

The 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. The number of stars assigned is determined by the position of the contract mean score relative to percentile cutoffs from the distribution of contract-weighted mean scores from all contracts (which determines the base group), statistical significance of the difference of the contract mean from the national mean along with the 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 the standard error of the mean score. All statistical tests, including comparisons involving standard errors, are computed using unrounded scores.

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	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
< 15 th percentile by > 1 SE	1	1	1	2	2	2	2
< 15 th percentile 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
≥ 80th percentile by > 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (<0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. The SE is considered when the measure score is below the 15th percentile (in base group 1; at least 1 SE below the base group 2 cut point), significantly below average, and has low reliability. Similarly, the SE is considered when the measure score is at or above the 80th percentile (in base group 5; at least 1 SE above the base group 4 cut point), significantly above average, and has low reliability.

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>.

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
- Disenrollment Reasons Survey: DisenrollSurvey@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
- Demonstration (Medicare-Medicaid Plan) Ratings: mmcocapsmodel@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

Title	Description
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.
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 entitled “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 weighting category of this measure.
Weighting Value:	The numeric weight used for this measure in the summary and overall rating calculations.
Data Display:	The format 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 for the base group 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

Title	Description				
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:					
<ul style="list-style-type: none"> • 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): <ul style="list-style-type: none"> – 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: 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

Title	Description				
Cut Points:	1 Star	2 Star	3 Star	4 Star	5 Star
	< 39%	≥ 39% to < 63%	≥ 63% to < 74%	≥ 74% to < 80%	≥ 80%

Measure: C02 - Colorectal Cancer Screening

Title	Description
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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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 51%	≥ 51% to < 63%	≥ 63% to < 71%	≥ 71% to < 78%	≥ 78%

Measure: C03 - Annual Flu Vaccine

Title	Description
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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).

Title	Description
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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

Base Group Cut Points:	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
	< 64	≥ 64 to < 69	≥ 69 to < 75	≥ 75 to < 78	≥ 78

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: C04 - Improving or Maintaining Physical Health

Title	Description
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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: Clustering

Title	Description					
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:	1 Star	2 Star	3 Star	4 Star	5 Star	
	< 63%	≥ 63% to < 67%	≥ 67% to < 69%	≥ 69% to < 72%	≥ 72%	

Measure: C05 - Improving or Maintaining Mental Health

Title	Description					
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:	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:	1 Star	2 Star	3 Star	4 Star	5 Star	
	< 75%	≥ 75% to < 77%	≥ 77% to < 80%	≥ 80% to < 82%	≥ 82%	

Measure: C06 - Monitoring Physical Activity

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

HOS Survey Question 47: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

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

NQF #: 0029

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

General Trend: Higher is better

Statistical Method: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 44%	≥ 44% to < 49%	≥ 49% to < 55%	≥ 55% to < 62%	≥ 62%

Measure: C07 - Adult BMI Assessment

Title	Description
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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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 70%	≥ 70% to < 81%	≥ 81% to < 90%	≥ 90% to < 96%	≥ 96%

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

Title	Description
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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. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov.

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) ≥ 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.

Title	Description
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CMS Framework Area: Clinical care

NQF #: None

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Weighting Value: 1

Data Display: Percentage 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
No	No	Yes	No	No	No

Cut Points:	1 Star	2 Star	3 Star	4 Star	5 Star
	< 35.8%	≥ 35.8% to < 51.9%	≥ 51.9% to < 74.0%	≥ 74.0% to < 93.9%	≥ 93.9%

Measure: C09 - Care for Older Adults – Medication Review

Title	Description
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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: Clustering

Improvement Measure: Included

Title	Description					
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:	1 Star	2 Star	3 Star	4 Star	5 Star	
	< 47%	≥ 47% to < 60%	≥ 60% to < 77%	≥ 77% to < 87%	≥ 87%	

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

Title	Description					
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:	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:	1 Star	2 Star	3 Star	4 Star	5 Star	
	< 24%	≥ 24% to < 54%	≥ 54% to < 67%	≥ 67% to < 86%	≥ 86%	

Measure: C11 - Care for Older Adults – Pain Assessment

Title	Description
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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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 30%	≥ 30% to < 62%	≥ 62% to < 78%	≥ 78% to < 95%	≥ 95%

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

Title	Description
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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

Title	Description
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osteoporosis in the six months after the fracture (numerator).

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.

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: 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:	1 Star	2 Star	3 Star	4 Star	5 Star
	< 20%	≥ 20% to < 32%	≥ 32% to < 51%	≥ 51% to < 75%	≥ 75%

Measure: C13 - Diabetes Care – Eye Exam

Title	Description
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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

Title	Description
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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: 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:	1 Star	2 Star	3 Star	4 Star	5 Star
	< 53%	≥ 53% to < 65%	≥ 65% to < 75%	≥ 75% to < 82%	≥ 82%

Measure: C14 - Diabetes Care – Kidney Disease Monitoring

Title	Description
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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

Title	Description
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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: 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:	1 Star	2 Star	3 Star	4 Star	5 Star
	< 85%	≥ 85% to < 89%	≥ 89% to < 93%	≥ 93% to < 97%	≥ 97%

Measure: C15 - Diabetes Care – Blood Sugar Controlled

Title	Description
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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.

Title	Description
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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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 49%	≥ 49% to < 60%	≥ 60% to < 71%	≥ 71% to < 84%	≥ 84%

Measure: C16 - Controlling Blood Pressure

Title	Description
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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

Title	Description
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CMS Framework Area: Clinical care

NQF #: 0018

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

General Trend: Higher is better

Statistical Method: 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:	1 Star	2 Star	3 Star	4 Star	5 Star
	< 47%	≥ 47% to < 62%	≥ 62% to < 75%	≥ 75% to < 82%	≥ 82%

Measure: C17 - Rheumatoid Arthritis Management

Title	Description
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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: Clustering

Improvement Measure: Included

Weighting Category: Process Measure

Title	Description					
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:	1 Star	2 Star	3 Star	4 Star	5 Star	
	< 64%	≥ 64% to < 75%	≥ 75% to < 82%	≥ 82% to < 86%	≥ 86%	

Measure: C18 - Reducing the Risk of Falling

Title	Description
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 48: A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?
	HOS Survey Question 49: Did you fall in the past 12 months?
	HOS Survey Question 50: In the past 12 months have you had a problem with balance or walking?
	HOS Survey Question 51: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: <ul style="list-style-type: none"> • 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

Title	Description					
Statistical Method:	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:	1 Star	2 Star	3 Star	4 Star	5 Star	
	< 53%	≥ 53% to < 60%	≥ 60% to < 67%	≥ 67% to < 73%	≥ 73%	

Measure: C19 - Plan All-Cause Readmissions

Title	Description
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.

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

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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
> 17%	> 11% to ≤ 17%	> 9% to ≤ 11%	> 6% to ≤ 9%	≤ 6%

Domain: 3 - Member Experience with Health Plan

Measure: C20 - Getting Needed Care

Title	Description
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

Base Group Cut Points:	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
	< 79	≥ 79 to < 81	≥ 81 to < 84	≥ 84 to < 86	≥ 86

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: C21 - Getting Appointments and Care Quickly

Title	Description
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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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 71	≥ 71 to < 74	≥ 74 to < 77	≥ 77 to < 79	≥ 79

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: C22 - Customer Service

Title	Description
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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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 83	≥ 83 to < 85	≥ 85 to < 88	≥ 88 to < 90	≥ 90

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: C23 - Rating of Health Care Quality

Title	Description
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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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 83	≥ 83 to < 84	≥ 84 to < 86	≥ 86 to < 87	≥ 87

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: C24 - Rating of Health Plan

Title	Description
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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

Base Group Cut Points:	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
	< 80	≥ 80 to < 83	≥ 83 to < 85	≥ 85 to < 87	≥ 87

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: C25 - Care Coordination

Title	Description
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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):

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 82	≥ 82 to < 84	≥ 84 to < 86	≥ 86 to < 87	≥ 87

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

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

Measure: C26 - Complaints about the Health Plan

Title	Description
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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 average enrollment of 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: 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:	1 Star	2 Star	3 Star	4 Star	5 Star
	> 0.98	> 0.50 to ≤ 0.98	> 0.21 to ≤ 0.50	> 0.08 to ≤ 0.21	≤ 0.08

Measure: C27 - Members Choosing to Leave the Plan

Title	Description
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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: 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

Title	Description				
Cut Points:	1 Star	2 Star	3 Star	4 Star	5 Star
	> 31%	> 23% to ≤ 31%	> 16% to ≤ 23%	> 10% to ≤ 16%	≤ 10%

Measure: C28 - Beneficiary Access and Performance Problems

Title	Description
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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 lower score (from 0 to 100) if there are problems. The score combines how serious the problems are, how many there are, and how directly they affect members. A higher score is better because it means Medicare found less serious or fewer problems, or they affected fewer members directly.

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

Title	Description
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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:	1 Star	2 Star	3 Star	4 Star	5 Star
	≤ 20	40	60	80	100

Measure: C29 - Health Plan Quality Improvement

Title	Description
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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

Title	Description
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and had no specification changes).

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

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

Data Source: Star Ratings

Data Source Description: 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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< -0.250	≥ -0.250 to < 0.000	≥ 0.000 to < 0.197	≥ 0.197 to < 0.317	≥ 0.317

Measure: C30 - Plan Makes Timely Decisions about Appeals

Title	Description
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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:

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

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. If a Reopening occurs and is decided prior to April 1, 2015, the Reopened decision is used in place of the Reconsideration decision. Reopenings 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: 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	Yes	No	Yes

Cut Points:

1 Star	2 Star	3 Star	4 Star	5 Star
< 53%	≥ 53% to < 76%	≥ 76% to < 91%	≥ 91% to < 98%	≥ 98%

Measure: C31 - Reviewing Appeals Decisions

Title	Description
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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. Reopenings 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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 73%	≥ 73% to < 85%	≥ 85% to < 89%	≥ 89% to < 94%	≥ 94%

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

Title	Description
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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.

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

General Notes: Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov

Data 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: 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:

1 Star	2 Star	3 Star	4 Star	5 Star
< 47%	≥ 47% to < 70%	≥ 70% to < 85%	≥ 85% to < 93%	≥ 93%

Part D Domain and Measure Details

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

Domain: 1 - Drug Plan Customer Service

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

Title	Description
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.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
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:	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:	Type	1 Star	2 Star	3 Star	4 Star	5 Star
	MA-PD	< 55%	≥ 55% to < 76%	≥ 76% to < 89%	≥ 89% to < 94%	≥ 94%
	PDP	< 72%	≥ 72% to < 82%	≥ 82% to < 90%	≥ 90% to < 95%	≥ 95%

Measure: D02 - Appeals Auto-Forward

Title	Description
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Label for Stars: Drug Plan Fails to Make Timely Decisions about Appeals

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

Description: Percent of plan members who failed to get a timely response when they made an appeal request to the drug plan about a decision to refuse payment or coverage. If you would like more information about Medicare appeals, click on <http://www.medicare.gov/claims-and-appeals/index.html>

Metric: This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because the plan exceeded decision timeframes for coverage determinations or redeterminations. This is calculated as: [(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: Clustering

Improvement Measure: Included

Weighting Category: Measures Capturing Access

Weighting Value: 1.5

Data Display: Rate 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	> 60.3	> 38.5 to ≤ 60.3	> 14.2 to ≤ 38.5	> 5.0 to ≤ 14.2	≤ 5.0
PDP	> 66.8	> 38.6 to ≤ 66.8	> 18.0 to ≤ 38.6	> 5.3 to ≤ 18.0	≤ 5.3

Measure: D03 - Appeals Upheld

Title	Description
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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. Reopenings 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: 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 42%	≥ 42% to < 60%	≥ 60% to < 73%	≥ 73% to < 88%	≥ 88%
PDP	< 54%	≥ 54% to < 65%	≥ 65% to < 76%	≥ 76% to < 91%	≥ 91%

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

Measure: D04 - Complaints about the Drug Plan

Title	Description
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 (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 drug plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: $\frac{[(\text{Total number of all complaints logged into the Complaint Tracking Module (CTM)}) / (\text{Average Contract enrollment})] * 1,000 * 30}{(\text{Number of Days in Period} = 365)}$ <ul style="list-style-type: none"> 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 average enrollment of 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:	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:	Type	1 Star	2 Star	3 Star	4 Star	5 Star
	MA-PD	> 0.98	> 0.50 to ≤ 0.98	> 0.21 to ≤ 0.50	> 0.08 to ≤ 0.21	≤ 0.08
	PDP	> 0.29	> 0.17 to ≤ 0.29	> 0.07 to ≤ 0.17	> 0.01 to ≤ 0.07	≤ 0.01

Measure: D05 - Members Choosing to Leave the Plan

Title	Description
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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: 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

Title	Description					
Cut Points:	Type	1 Star	2 Star	3 Star	4 Star	5 Star
	MA-PD	> 31%	> 23% to ≤ 31%	> 16% to ≤ 23%	> 10% to ≤ 16%	≤ 10%
	PDP	> 23%	> 13% to ≤ 23%	> 9% to ≤ 13%	> 5% to ≤ 9%	≤ 5%

Measure: D06 - Beneficiary Access and Performance Problems

Title	Description
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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 lower score (from 0 to 100) if there are problems. The score combines how serious the problems are, how many there are, and how directly they affect members. A higher score is better because it means Medicare found less serious or fewer problems, or they affected fewer members directly.

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

Title	Description
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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

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

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	≤ 20	40	60	80	100
PDP	≤ 20	40	60	80	100

Measure: D07 - Drug Plan Quality Improvement

Title	Description
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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.,

Title	Description
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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 I](#) 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: 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< -0.250	≥ -0.250 to < 0.000	≥ 0.000 to < 0.333	≥ 0.333 to < 0.545	≥ 0.545
PDP	< -0.273	≥ -0.273 to < 0.000	≥ 0.000 to < 0.333	≥ 0.333 to < 0.545	≥ 0.545

Domain: 3 - Member Experience with the Drug Plan

Measure: D08 - Rating of Drug Plan

Title	Description
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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

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	< 80	≥ 80 to < 82	≥ 82 to < 84	≥ 84 to < 86	≥ 86
PDP	< 80	≥ 80 to < 81	≥ 81 to < 82	≥ 82 to < 86	≥ 86

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Measure: D09 - Getting Needed Prescription Drugs

Title	Description
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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

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	< 87	≥ 87 to < 89	≥ 89 to < 91	≥ 91 to < 92	≥ 92
PDP	< 87	≥ 87 to < 88	≥ 88 to < 90	≥ 90 to < 91	≥ 91

These technical notes show the base group cut points for CAHPS measures; please see the CAHPS Methodology section for final star assignment rules.

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D10 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the prices members actually pay for their drugs to the drug prices the plan provided for this Website (Medicare's Plan Finder Website). (Higher scores are better because they mean the plan provided more accurate prices.)
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index. The accuracy price index compares point-of-sale PDE prices to plan-reported MPF prices and determines the magnitude of differences found. Using each PDE's date of service, the price displayed on MPF is compared to the PDE price. The accuracy index considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF—that is, the reported price is higher than the actual price—will not count against a plan's accuracy score. The index is computed as: (Total amount that PDE is higher than PF + Total PDE cost) / (Total PDE cost). The best possible accuracy index is 1. An index of 1 indicates that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index as: $100 - ((\text{accuracy index} - 1) \times 100)$.
Exclusions:	A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria: <ul style="list-style-type: none">• 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

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

General Trend: Higher is better

Statistical Method: 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 94	≥ 94 to < 97	≥ 97 to < 99	≥ 99 to < 100	≥ 100
PDP	NA	NA	NA	≥ 98 to < 99	≥ 99

Measure: D11 - High Risk Medication

Title	Description
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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 and older who received two or more prescription fills for the same HRM drug with a high risk of serious side effects in the elderly. This percentage is calculated as the number of member-years of enrolled beneficiaries 65 years and older who received two or more prescription fills for the same HRM during the period measured (numerator) divided by the number of member-years of enrolled beneficiaries 65 years and older during the period measured (denominator).

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

Title	Description
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be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. A subject beneficiary must be enrolled and age 65 or older in at least one month of the period measured. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.

Data 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 65 years and older, and for those Part D covered drugs identified to have high risk of serious side effects in patients 65 years of age and older. PDE adjustments made post-reconciliation were not reflected in this measure.

CMS Framework Area: Safety

NQF #: 0022

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

General Trend: Lower is better

Statistical Method: Clustering

Improvement Measure: Included

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

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	No	Yes	Yes

Cut Points:	Type	1 Star	2 Star	3 Star	4 Star	5 Star
	MA-PD	> 20%	> 12% to ≤ 20%	> 8% to ≤ 12%	> 6% to ≤ 8%	≤ 6%
	PDP	> 14%	> 12% to ≤ 14%	> 10% to ≤ 12%	> 6% to ≤ 10%	≤ 6%

Measure: D12 - Medication Adherence for Diabetes Medications

Title	Description
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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 and 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

Title	Description
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(SGLT) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or over across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of medication(s) across any of the drug classes during the measurement period (denominator).

The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or medications in its therapeutic category. Beneficiaries with one or more fills for insulin or with ESRD coverage dates, as reported in the Medicare Enrollment Database (EDB), anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The PDC Adherence measures are also endorsed by the National Quality Forum (NQF).

See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date 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, the member-years of enrollment 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

Title	Description
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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: 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 60%	≥ 60% to < 69%	≥ 69% to < 75%	≥ 75% to < 82%	≥ 82%
PDP	< 75%	≥ 75% to < 80%	≥ 80% to < 83%	≥ 83% to < 95%	≥ 95%

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

Title	Description
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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 and 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 and older with at least two fills of either the same medication or medications in the drug class during the measurement period (denominator).

The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries with ESRD coverage dates, as reported in the Medicare Enrollment Database (EDB), anytime during the measurement period are excluded. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before

Title	Description
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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, the member-years of enrollment adjustment is 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: Clustering

Improvement Measure: Included

Title	Description
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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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 58%	≥ 58% to < 73%	≥ 73% to < 77%	≥ 77% to < 81%	≥ 81%
PDP	< 76%	≥ 76% to < 78%	≥ 78% to < 82%	≥ 82% to < 85%	≥ 85%

Measure: D14 - Medication Adherence for Cholesterol (Statins)

Title	Description
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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 and 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 and 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 and older with at least two fills of either the same medication or medication in the drug class during the measurement period (denominator).

The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The PDC Adherence measures are also endorsed by the National Quality Forum (NQF).

See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date 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

Title	Description
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the medication or NDC lists, are excluded from CMS analyses. Also, the member-years of adjustment adjustment is 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 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: 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 50%	≥ 50% to < 61%	≥ 61% to < 73%	≥ 73% to < 79%	≥ 79%
PDP	< 68%	≥ 68% to < 73%	≥ 73% to < 78%	≥ 78% to < 83%	≥ 83%

Measure: D15 - MTM Program Completion Rate for CMR

Title	Description
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.

Exclusions: 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”.

Title	Description
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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. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov.

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: 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:

Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	< 13.6%	≥ 13.6% to < 36.2%	≥ 36.2% to < 48.6%	≥ 48.6% to < 76.0%	≥ 76.0%
PDP	< 8.5%	≥ 8.5% to < 16.6%	≥ 16.6% to < 27.2%	≥ 27.2% to < 36.7%	≥ 36.7%

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 -0.050 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	-0.071	-0.062	0.001	-0.220	-0.206	0.002
Age: 65 – 69	0.003	-0.029	0.018	-0.091	-0.046	0.006
Age: 75 - 79	0.005	-0.007	0.021	0.036	0.092	0.009
Age: 80 - 84	0.021	-0.009	0.018	0.057	0.174	-0.007
Age: 85 and older	0.028	0.007	0.033	0.128	0.253	-0.006
Less than an 8th grade education	-0.023	-0.027	0.017	0.014	0.152	-0.010
Some high school	0.016	-0.003	0.012	0.021	0.126	0.022
Some college	-0.040	-0.003	-0.041	-0.107	-0.204	-0.031
College graduate	-0.035	-0.005	-0.060	-0.172	-0.301	-0.066
More than a bachelor's degree	-0.052	-0.004	-0.065	-0.235	-0.368	-0.037
General health rating: excellent	0.094	0.102	0.050	0.396	0.357	0.045
General health rating: very good	0.055	0.042	0.025	0.218	0.169	0.029
General health rating: fair	-0.065	-0.044	-0.065	-0.274	-0.172	-0.044
General health rating: poor	-0.155	-0.068	-0.128	-0.688	-0.488	-0.075
Mental health rating: excellent	0.152	0.119	0.085	0.512	0.381	0.115
Mental health rating: very good	0.071	0.050	0.047	0.254	0.182	0.057
Mental health rating: fair	-0.031	-0.034	-0.001	-0.063	-0.032	-0.030
Mental health rating: poor	-0.147	-0.069	-0.059	-0.494	-0.318	-0.108
Proxy helped	-0.008	-0.045	-0.073	-0.147	-0.145	0.000
Proxy answered	0.021	-0.004	-0.024	0.015	0.014	0.015
Dual eligible	-0.050	-0.027	0.033	-0.018	0.277	-0.021
Low-income subsidy (LIS)	0.002	-0.026	0.018	-0.100	0.045	-0.026
Chinese language survey	0.033	-0.070	-0.064	-0.131	-0.334	-0.133

Table A-2: Part D CAHPS Measures

Predictor	MA-PD D08: Rating of Drug Plan	MA-PD D09: Getting Needed Prescription Drugs (Comp)	PDP D08: Rating of Drug Plan	PDP D09: Getting Needed Prescription Drugs (Comp)
Age: 64 or under	-0.268	-0.060	-0.158	-0.073
Age: 65 - 69	-0.070	-0.009	-0.031	-0.033
Age: 75 - 79	0.144	0.016	0.289	0.024
Age: 80 - 84	0.253	0.031	0.405	0.023
Age: 85 and older	0.383	0.024	0.541	0.007
Less than an 8th grade education	0.069	-0.053	0.001	-0.042
Some high school	0.064	-0.010	0.076	0.051
Some college	-0.268	-0.024	-0.232	-0.036
College graduate	-0.377	-0.041	-0.473	-0.058
More than a bachelor's degree	-0.481	-0.063	-0.406	-0.067
General health rating: excellent	0.417	0.030	0.018	0.013
General health rating: very good	0.202	0.034	-0.001	0.030
General health rating: fair	-0.142	-0.037	-0.162	-0.058
General health rating: poor	-0.300	-0.089	-0.547	-0.165
Mental health rating: excellent	0.326	0.084	0.253	0.050
Mental health rating: very good	0.172	0.061	0.174	0.031
Mental health rating: fair	-0.084	-0.018	0.102	-0.012
Mental health rating: poor	-0.373	-0.029	0.058	-0.020
Proxy helped	-0.208	-0.003	-0.339	-0.051
Proxy answered	-0.130	0.010	-0.227	0.014
Dual eligible	0.687	0.043	0.783	0.049
Low-income subsidy (LIS)	0.535	0.045	0.584	0.062
Chinese language survey	-0.389	-0.093	N/A	N/A

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	September 25, 2010
		16	Part D IRMAA	
30	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	01	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	September 25, 2010
		90	Other Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information Issue	
38	Contractor/Partner Performance	90	Other Contractor/Partner Performance	December 16, 2011
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	
90	Other Equitable Relief/Good Cause Request			
49	Contractor/Partner Performance	90	Other Contractor/Partner Performance	
50	Contractor/Partner Performance	90	Other Contractor/Partner Performance	
03	Enrollment/ Disenrollment	11	Disenrollment Due to Loss of Entitlement	June 1, 2013
11	Enrollment/ Disenrollment	24	Disenrollment Due to Loss of Entitlement	

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

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

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

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

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

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of the numeric and star values for each measure reported in the 2016 Star Ratings¹.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	72%	3.6
C02	Colorectal Cancer Screening	67%	3.2
C03	Annual Flu Vaccine	72%	3.3
C04	Improving or Maintaining Physical Health	68%	3.3
C05	Improving or Maintaining Mental Health	79%	3.3
C06	Monitoring Physical Activity	51%	2.9
C07	Adult BMI Assessment	92%	4.1
C08	Special Needs Plan (SNP) Care Management	58.8%	2.5
C09	Care for Older Adults – Medication Review	85%	4.3
C10	Care for Older Adults – Functional Status Assessment	75%	3.9
C11	Care for Older Adults – Pain Assessment	86%	4.0
C12	Osteoporosis Management in Women who had a Fracture	35%	2.5
C13	Diabetes Care – Eye Exam	70%	3.1
C14	Diabetes Care – Kidney Disease Monitoring	92%	3.3
C15	Diabetes Care – Blood Sugar Controlled	76%	3.9
C16	Controlling Blood Pressure	71%	3.4
C17	Rheumatoid Arthritis Management	78%	3.2
C18	Reducing the Risk of Falling	61%	2.7
C19	Plan All-Cause Readmissions	10%	3.3
C20	Getting Needed Care	83%	3.5
C21	Getting Appointments and Care Quickly	76%	3.4
C22	Customer Service	88%	3.5
C23	Rating of Health Care Quality	86%	3.4
C24	Rating of Health Plan	85%	3.3
C25	Care Coordination	85%	3.4
C26	Complaints about the Health Plan	0.06	3.9
C27	Members Choosing to Leave the Plan	11%	4.2
C28	Beneficiary Access and Performance Problems	83	4.2
C29	Health Plan Quality Improvement	Medicare shows only a Star Rating for this topic	3.4
C30	Plan Makes Timely Decisions about Appeals	94%	4.1
C31	Reviewing Appeals Decisions	89%	3.6
C32	Call Center – Foreign Language Interpreter and TTY Availability	89%	4.3

¹ All contracts are weighted equally in these averages. For CAHPS measure calculations we use enrollment-weighted averages.

Table C-2: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD Numeric Average	MA-PD Star Average	PDP Numeric Average	PDP Star Average
D01	Call Center – Foreign Language Interpreter and TTY Availability	89%	4.2	88%	4.0
D02	Appeals Auto-Forward	4.4	4.5	9.9	4.1
D03	Appeals Upheld	75%	3.3	75%	3.1
D04	Complaints about the Drug Plan	0.06	3.9	0.00	3.5
D05	Members Choosing to Leave the Plan	11%	4.2	10%	3.6
D06	Beneficiary Access and Performance Problems	83	4.2	77	3.9
D07	Drug Plan Quality Improvement	Medicare shows only a Star Rating for this topic	3.8	Medicare shows only a Star Rating for this topic	3.8
D08	Rating of Drug Plan	84%	3.3	82%	3.2
D09	Getting Needed Prescription Drugs	90%	3.4	90%	3.6
D10	MPF Price Accuracy	98	3.5	99	4.7
D11	High Risk Medication	7%	4.1	11%	3.1
D12	Medication Adherence for Diabetes Medications	77%	3.9	80%	2.7
D13	Medication Adherence for Hypertension (RAS antagonists)	79%	4.1	82%	3.6
D14	Medication Adherence for Cholesterol (Statins)	75%	4.0	78%	3.5
D15	MTM Program Completion Rate for CMR	30.9%	2.3	15.4%	2.3

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: $P_{pooled} = W_1 * P_1 + W_2 * P_2$

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	
$P_{pooled} = W_1 * P_1 + W_2 * P_2$	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 be counted as showing no significant change. Measures that are held harmless as described here will be considered eligible for the improvement measure.

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 clustering method. Conceptually, the clustering algorithm identifies the “gaps” in the data and creates 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. 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. Then, the remaining contracts are split into two groups and clustered: 1) improvement scores less than zero receive one or two stars on the improvement measure and 2) improvement scores greater than zero receive 4 or 5 stars.

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:

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

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

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

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

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 following the formulas documented in the [CAHPS Macro Manual](#). The actual values used for each contract can be provided by the Star Ratings or CAHPS mailboxes, send your request to: MP-CAHPS@cms.hhs.gov or PartCandDStarRatings@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	0.854461
C03	Annual Flu Vaccine	Included	0.897635
C04	Improving or Maintaining Physical Health	Not Included	-
C05	Improving or Maintaining Mental Health	Not Included	-
C06	Monitoring Physical Activity	Included	0.83644
C07	Adult BMI Assessment	Included	0.677933
C08	Special Needs Plan (SNP) Care Management	Included	0.76784
C09	Care for Older Adults – Medication Review	Included	0.666608
C10	Care for Older Adults – Functional Status Assessment	Included	0.793805
C11	Care for Older Adults – Pain Assessment	Included	0.651893
C12	Osteoporosis Management in Women who had a Fracture	Included	0.796818
C13	Diabetes Care – Eye Exam	Included	0.83471
C14	Diabetes Care – Kidney Disease Monitoring	Included	0.753844
C15	Diabetes Care – Blood Sugar Controlled	Included	0.758475
C16	Controlling Blood Pressure	Included	0.79696
C17	Rheumatoid Arthritis Management	Included	0.808825
C18	Reducing the Risk of Falling	Included	0.844065
C19	Plan All-Cause Readmissions	Included	0.428074
C20	Getting Needed Care	Included	0.732816
C21	Getting Appointments and Care Quickly	Included	0.869789
C22	Customer Service	Included	0.711294
C23	Rating of Health Care Quality	Included	0.783307
C24	Rating of Health Plan	Included	0.831174
C25	Care Coordination	Included	0.7936
C26	Complaints about the Health Plan	Not Included	-
C27	Members Choosing to Leave the Plan	Included	0.643657
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	0.512774
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	0.462121
D03	Appeals Upheld	Not Included	-
D04	Complaints about the Drug Plan	Not Included	-
D05	Members Choosing to Leave the Plan	Included	0.648351
D06	Beneficiary Access and Performance Problems	Not Included	-
D07	Drug Plan Quality Improvement	Not Included	-
D08	Rating of Drug Plan	Included	0.790085
D09	Getting Needed Prescription Drugs	Included	0.625176
D10	MPF Price Accuracy	Not Included	-
D11	High Risk Medication	Included	0.654223
D12	Medication Adherence for Diabetes Medications	Included	0.868033
D13	Medication Adherence for Hypertension (RAS antagonists)	Included	0.907212
D14	Medication Adherence for Cholesterol (Statins)	Included	0.923061
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	DMC11	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	DMC12		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	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	DMC21	DMC20								
C	Computer use made talking to provider easier	CAHPS	DMC22	DMC21								
C	Computer used during office visits	CAHPS	DMC20	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	DMC16	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	DMC15	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	DMC14	DMC13	DMC17							
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC13	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	DMC10	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	DMC17	DMC16								
C	Reminders for immunizations	CAHPS	DMC18	DMC17								
C	Reminders for screening tests	CAHPS	DMC19	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	DMD06	D03	D03			
D	Call Center – Pharmacy Hold Time	Call Center	DMD11		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)	DMD06	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)	DMD07	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)	DMD05	DMD03	DMD06	DMD06	DMD07	DMD05	DMD08			
D	Enrollment Timeliness	MARx			DME01	D05	D05	DMD03	DMD03			
D	Getting Information From Drug Plan	CAHPS	DMD10	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	DMD08	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	DMD12	DMD10	DMD16							
D	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	Fu Associates	DMD09	DMD08	DMD13	DMD13						
D	Rating of Drug Plan	CAHPS	D08	D06	D08	D11	D10	D12	D13	D13	D07	
D	Reminders to fill prescriptions	CAHPS	DMD15	DMD13								
D	Reminders to take medications	CAHPS	DMD16	DMD14								
D	Timely Effectuation of Appeals	IRE / Maximus	DMD02									
D	Timely Receipt of Case Files for Appeals	IRE / Maximus	DMD01									
D	Transition monitoring - failure rate for all other drugs	Transition Monitoring Program Analysis	DMD14	DMD12								
D	Transition monitoring - failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis	DMD13	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 c and d 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.³
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.

³ Because CMS continues to display data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

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.⁴ 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.^{5, 6} 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 lower 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.

⁴ For PDEs with outlying values of reported quantities, we adjust the quantity using drug- and plan-level distributions of price and quantity.

⁵ 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.

⁶ 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 DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PF Data Biweekly Posting Period	PF Data Unit Cost for 30 Day Supply	PF Data Dispensing Fee Brand	PF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost PF	Calculated Value Amount that PDE is higher than PF	
A	111	01/08/2014	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	01/24/2014	0.98	2	30	01/16/14 - 01/29/14	0.83	1.75	2.5	G	2.98	27.40	0	
C	333	02/11/2014	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	02/21/2014	47	1.5	90	02/13/14 - 02/26/14	0.48	1.5	2.25	G	48.5	45.45	3.05	
PDE = Prescription Drug Event PF = Plan Finder											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
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 BAPP score?

Yes: Display the numeric BAPP 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: No data available

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: No data available

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 measure (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 BAPP score?

Yes: Display the numeric BAPP 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: 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: 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
Hospice Exclusion	Was the case on this row excluded for Hospice (Yes = case excluded from final data, No=case included)

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
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
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

R. 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

S. 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

T. 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".

U. 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

V. 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

W. 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.

X. 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.