2024
Medicare-Medicaid Plan Performance Data Technical Notes

Updated – March 2024

Table of Contents

Introduction

Under the Medicare-Medicaid Financial Alignment Initiative (FAI) capitated model, the Centers for Medicare & Medicaid Services (CMS) is collecting a variety of measures that examine plan performance and the quality of care provided to enrollees. The Medicare-Medicaid Plan (MMP) performance data published here represent currently available data on MMP performance on certain Medicare Parts C and D quality measures as well as select CMS core measures that MMPs are required to report. The data show MMP performance on quality measures during 2022 and the results of surveys of MMP enrollees conducted in 2022 or 2023.

The scope of the measures displayed here is limited, particularly in the area of long-term services and supports. Consequently, we urge caution in using any of these data for comparative or MMP selection purposes.

In addition, we note that the differences in MMP eligibility across states participating in the FAI, and the differences in the characteristics of enrollees in particular MMPs, may limit the ability to compare MMP performance across demonstrations. For example, enrollment in MMPs in Massachusetts is limited to individuals under the age of 65 at the time of enrollment, while in South Carolina, only individuals aged 65 or older living in the community can enroll. In the New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration, only individuals with IDD can enroll.

Questions about the MMP performance data should be sent to: mmcocapsmodel@cms.hhs.gov.

State Weighted Averages

Within the MMP Performance Data File, state weighted averages are provided for each measure. Depending on the measure type, the averages are weighted by the enrollment of each MMP with valid data for the measure or by the eligible population for the measure as reported for each MMP. More specifically, averages for measures from the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey are weighted using the total number of members enrolled in February 2022 and January 2023, respectively, to align with the timeframe during which each survey's sampling frame was drawn. Averages for the Call Center Foreign Language Interpreter and TTY Availability measures are weighted using the total number of members enrolled in February 2023 to align with the timeframe during which call center monitoring commenced. Averages for all other measures are weighted using each MMP's eligible population for the measure (e.g., the denominator for each MMP).

Differences between the 2023 and 2024 MMP Performance Data File and Technical Notes

There were a few changes between the 2023 and 2024 versions of the MMP Performance Data File and Technical Notes. This section provides a summary of the notable differences.

Revisions:
- Where applicable, measure numbers, measure specifications, and related attachments were updated to comport with the Medicare 2024 Part C & D Star Ratings Technical Notes and Medicare 2024 Part C & D Display Measure Technical Notes.

Additions:
- The following measures were added to the MMP Performance Data File and Technical Notes:
  - Transitions of Care (C17)
  - Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (C18)

Removals:
- The following measure was removed from the MMP Performance Data File and Technical Notes:
  - Diabetes Care – Kidney Disease Monitoring (C10)

Framework and Definitions for the Domain and Measure Details Section

This section 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 measure

Title	Description
Label for Data:	Optional – The label that provides a fuller title for the measure.
Description:	The English language description for the measure.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS-HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS are unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Case-Mix Adjusted:	Indicates if the data are case-mix adjusted.
CMIT #:	The CMS Measure Inventory Tool (CMIT) is the repository of record for information about the measures which CMS uses to promote health care quality and quality improvement.
Data Display:	The format used to the display the numeric data.

Domain 1: Coordination of Care and Long Term Services and Supports

Measure: M21 - Comprehensive Health Risk Assessment

Title	Description
Description:	Percent of members who received a health risk assessment within 90 days of enrollment in the MMP.
Metric:	This measure captures the total number of members with a health risk assessment completed within the first 90 days of enrollment. When calculating the completion rate, the members that were unreachable (after at least three contact attempts) and the members that refused the assessment are subtracted from the denominator.
Primary Data Source:	Measure Core 2.1 from the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements
Data Source Category:	Health and Drug Plans
Exclusions:	Members that were unreachable (after at least three contact attempts) and members that refused the assessment are subtracted from the denominator.
General Notes:	A full description of the measure specifications is available in the [CY 2022 Reporting Requirements](#).
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: M32 - Care Plan Completion

Title	Description
Description:	Percent of members who had a care plan completed within 90 days of enrollment in the MMP.
Metric:	This measure captures the total number of members with a care plan completed within the first 90 days of enrollment. When calculating the completion rate, the members that were unreachable (after at least three contact attempts) and the members that refused the care plan are subtracted from the denominator.
Primary Data Source:	Measure Core 3.2 from the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements
Data Source Category:	Health and Drug Plans
Exclusions:	Members that were unreachable (after at least three contact attempts) and members that refused the care plan are subtracted from the denominator.
General Notes:	A full description of the measure specifications is available in the [CY 2022 Reporting Requirements](#).
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: DMC21 - Care for Older Adults – Functional Status Assessment

Title	Description
Label for Data:	Yearly Assessment of How Well MMP Members Are Able to Do Activities of Daily Living
Description:	Percent of members whose doctor has done a functional status assessment to see how well they are able to do Activities of Daily Living such as dressing, eating, and bathing.
HEDIS Label:	Care for Older Adults (COA) – Functional Status Assessment
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one functional status assessment (Functional Status Assessment Value Set) during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMPs whose enrollment was less than 30 as of the February 2022 Monthly Enrollment by Plan Report were excluded from this measure.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

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

Measure: C06 - Care for Older Adults – Medication Review

Title	Description
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMPs whose enrollment was less than 30 as of the February 2022 Monthly Enrollment by Plan Report were excluded from this measure.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2022 - 12/31/2022
Case-Mix Adjusted:	No

Title	Description
CMIT #:	110
Data Display:	Percentage with no decimal place

Measure: C07 - Care for Older Adults – Pain Assessment

Title	Description
Label for Data:	Yearly Pain Screening or Pain Management Plan
Description:	Percent of plan members who had a pain screening at least once during the year.
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 118
Metric:	The percentage of MMP enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	MMPs whose enrollment was less than 30 as of the February 2022 Monthly Enrollment by Plan Report were excluded from this measure.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 66 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	111
Data Display:	Percentage with no decimal place

Measure: C08 - Osteoporosis Management in Women who had a Fracture

Title	Description
Label for Data:	Osteoporosis Management
Description:	Percent of female members who broke a bone and got screening or treatment for osteoporosis within 6 months.
HEDIS Label:	Osteoporosis Management in Women Who Had a Fracture (OMW)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 228
Metric:	The percentage of woman MMP enrollees 67 – 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD. • Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD. • Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the IESD.

Title	Description
	• Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
	• Members living long-term in an institution any time during the measurement year.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 67 - 85 and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	484
Data Display:	Percentage with no decimal place

Measure: C09 - Diabetes Care – Eye Exam

Title	Description
Label for Data:	Eye Exam to Check for Damage from Diabetes
Description:	Percent of members with diabetes who had an eye exam to check for damage from diabetes during the year.
HEDIS Label:	Eye Exam for Patients with Diabetes (EED)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 203
Metric:	The percentage of diabetic MMP enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
	– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
	– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
	• Members 66 years of age and older as of December 31 of the measurement year with both frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year.
	• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
	(optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, 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.
	If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better

Title	Description
Case-Mix Adjusted:	No
CMIT #:	203
Data Display:	Percentage with no decimal place

Measure: C10 - Diabetes Care – Blood Sugar Controlled

Title	Description
Label for Data:	Members with Diabetes whose Blood Sugar is Under Control
Description:	Percent of members with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MMP enrollees age 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with both frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, 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. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	204
Data Display:	Percentage with no decimal place

Measure: C11 - Controlling Blood Pressure

Title	Description
Label for Data	Controlling High Blood Pressure
Description:	Percent of members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 152
Metric:	The percentage of MMP members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90 mm Hg) (numerator).

Exclusions:	Exclude members who meet any of the following criteria:
	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
	  – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
	  – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
	• Members 81 years of age and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
	• Members 66–80 years of age and older as of December 31 of the measurement year with both frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year.
	• A dispensed dementia medication.
	• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
	
	(optional)
	• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
	• Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
	• Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
	  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
	  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
	  3. Identify the admission date for the stay.

Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	167

Title	Description
Data Display:	Percentage with no decimal place

Measure: C12 - Reducing the Risk of Falling

Title	Description
Label for Data:	Reducing the Risk of Falling
Description:	Percent of members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 39
Metric:	The percentage of members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022).
	HOS Survey Question 44: A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
	HOS Survey Question 45: Did you fall in the past 12 months?
	HOS Survey Question 46: In the past 12 months have you had a problem with balance or walking?
	HOS Survey Question 47: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 44 or Question 47 are excluded from results calculations.
	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." Members with evidence from CMS administrative records of a hospice start date are excluded.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	07/19/2022 - 11/01/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	646
Data Display:	Percentage with no decimal place

Measure: C13 - Improving Bladder Control

Title	Description
Label for Data:	Improving Bladder Control
Description:	Percent of members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.
HEDIS Label:	Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 34
Metric:	The percentage of members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022).
	HOS Survey Question 38: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
	HOS Survey Question 41: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?
	Member choices must be as follows to be included in the denominator:
	• Q39 = "Yes."
	• Q41 = "Yes" or "No."
	The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider.
	Member choice must be as follows to be included in the numerator:
	• Q41 = "Yes."
Data Source Category:	Survey of Enrollees
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." Members with evidence from CMS administrative records of a hospice start date are excluded.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	07/19/2022 - 11/01/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	378
Data Display:	Percentage with no decimal place

Measure: C14 - Medication Reconciliation Post-Discharge

Title	Description
Label for Data:	The MMP Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Description:	This shows the percent of members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care

Title	Description
	professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.
HEDIS Label:	Medication Reconciliation Post-Discharge (MRP)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 330
Metric:	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	441
Data Display:	Percentage with no decimal place

Measure: C15 - Plan All-Cause Readmissions

Title	Description
Label for Data:	Readmission to a Hospital within 30 Days of Being Discharged (lower ratios are better because it means fewer members are being readmitted than would be expected for the MMP's population)
Description:	The ratio of the MMP's observed readmission rate to the MMP's expected readmission rate. The readmission rate is based on the percent of 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 MMPs fair and meaningful.)
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 498
Metric:	The MMP's observed readmission rate (i.e., the percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days), as compared to the readmission rate that the MMP is expected to have given its case mix. This analysis is referred to as the observed-to-expected (O/E) ratio.
	The O/E ratio is calculated as the observed readmission rate divided by the expected readmission rate. To calculate the observed readmission rate and expected readmission rate, the following formulas were used:
	1. The observed readmission rate equals the sum of the count of 30-day readmissions across all age bands divided by the sum of the count of index stays across all age bands.
	2. The expected readmission rate equals the sum of the expected readmissions rates across all age bands, weighted by the percentage of index stays in each age band.
	See Attachment B: Calculating Measure C15: Plan All-Cause Readmissions for the complete formula.

Title	Description
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. As listed in the HEDIS Technical Specifications, CMS has excluded contracts whose denominator (i.e., number of index stays) was 150 or less.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Lower is better
Case-Mix Adjusted:	Yes
CMIT #:	561
Data Display:	Numeric with two decimal places

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description
Label for Data:	The MMP Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Description:	This rating is based on the percent of members with heart disease who get the right type of cholesterol-lowering drugs. MMPs can help make sure their members are prescribed medications that are more effective for them.
HEDIS Label:	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 168
Metric:	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. • In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year. • ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

Title	Description
	– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with both frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the prior year to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits, (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List).
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	700
Data Display:	Percentage with no decimal place

Measure: C17 - Transitions of Care

Title	Description
Label for Data:	After hospital stay, members receive information and care they need.
Description:	This rating is based on the percent of members who got follow-up care after a hospital stay. Follow-up care includes: getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 330
Metric:	The average of the rates for Transitions of Car – Medication Reconciliation Post-Discharge, Transitions of Care – Notification of Inpatient Admission, Transitions of Care – Patient Engagement After Inpatient Discharge, and Transitions of Care – Receipt of Discharge Information.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Members in hospice are excluded from the eligible population. If an MMP reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31

Title	Description
	days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	729
Data Display:	Percentage with no decimal place

Measure: C18 - Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Title	Description
Label for Data:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit.
Description:	This rating is based on the percent of members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 340
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	263
Data Display:	Percentage with no decimal place

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description
Label for Data:	Taking Diabetes Medication as Directed
Description:	Percent of members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
	One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The MMP, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug,* a *sulfonylurea drug,* a *thiazolidinedione drug,* a *DPP-4 inhibitor,* a *GLP-1 receptor agonist,* a *meglitinide drug,* or an *SGLT2 inhibitor.* Members who take insulin are not included.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service 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 are only included in the measure calculation if the first fill of their diabetes 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).
	See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.
	Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period).

Title	Description
	• CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnosis based on ICD-10-CM code, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
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 PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.
	The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
	The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment C: Medication Adherence Measure Calculations for more information about these calculation adjustments.
	When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	436
Data Display:	Percentage with no decimal place

Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	Percent of members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
	One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The MMP, the doctor, and the member can

Title	Description
	work together to do this. ("Blood pressure medication" means an *ACEI (angiotensin converting enzyme inhibitor)*, an *ARB (angiotensin receptor blocker),* or a *direct renin inhibitor* drug.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service 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 are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period.
	The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).
	See the medication list for this measure. The Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.
	Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS).
	• CME is used for enrollment information.
	• EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period).
	• CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available).
	• EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator at any time during the measurement period:

Title	Description
	• Hospice enrollment • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan
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 PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.
	The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
	The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment C: Medication Adherence Measure Calculations for more information about these calculation adjustments.
	When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	437
Data Display:	Percentage with no decimal place

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Data:	Taking Cholesterol Medication as Directed
Description:	Percent of members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
	One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The MMP, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator).

Title	Description
	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 statin 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).
	See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.
	Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates
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 PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.

Title	Description
	The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
	The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment C: Medication Adherence Measure Calculations for more information about these calculation adjustments.
	When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	435
Data Display:	Percentage with no decimal place

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the MMP.
	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.
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period.
	Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period.
	Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. The date of enrollment is counted towards the 60 days but the opt-out date is not.

Title	Description
	A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.
	Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2022 Part D Reporting Requirements (data pulled June 2023). Validation of these data was performed retrospectively during the 2023 data validation cycle (deadline June 30, 2023 and data validation results pulled July 2023). Additionally, the Medicare Enrollment Database (EDB) is used for hospice enrollment (data pulled March 2023).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts that terminated effective December 31, 2022 are excluded from the measure and listed as "Not reportable due to plan termination." Contracts that terminated after December 31, 2022 but before the deadline to submit data validation results to CMS (June 30, 2023) are excluded and listed as "No data available.".
	MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any of the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation: • MBI Number (Element B) • Date of MTM program enrollment (Element H) • Met the specified targeting criteria per CMS – Part D requirements (Element F) • 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) (Element P)
	MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as "CMS identified issues with this plan's data." See Attachment D for more details on the MTM CMR completion rate measure scoring methodology.

Title	Description
	Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select "Monitoring," then "Plan Reporting Data Validation." Select the appropriate contract year. Select the PRDVM Reports. Select "Score Detail Report." Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMS at HPMS_Access@cms.hhs.gov.
	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 "Not enough data available."
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	454
Data Display:	Percentage with no decimal place

Measure: D12 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Data:	The MMP Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of members with diabetes who take the most effective cholesterol-lowering drugs. MMPs can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills on unique dates of service during the measurement period (denominator). Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year or end of the enrollment episode.
	The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA).
	See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022 – December 31, 2022. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2022 PDE submission deadline are used to calculate

Title	Description
	this measure. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify diagnoses based on ICD-10-CM codes.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • Rhabdomyolysis and myopathy • Pregnancy • Lactation and fertility • Cirrhosis • Pre-Diabetes • Polycystic Ovary Syndrome
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 PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	702
Data Display:	Percentage with no decimal place

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

Title	Description
Description:	The percent of members who were hospitalized for certain mental health disorders who received follow-up care within 30 days of leaving the hospital.
HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 256
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who

Title	Description
	had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge (numerator).
Exclusions:	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. Organizations must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the steps above. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	268
Data Display:	Percentage with no decimal place

Measure: DMC02 - Antidepressant Medication Management (6 months)

Title	Description
Description:	The percent of members with a diagnosis of major depression who received an antidepressant medication for at least 180 days.
HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 243
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (numerator).

Exclusions:	Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient of partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:
	• An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
	   - AMM Stand Alone Visits Value Set with Major Depression Value Set.
	   - AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set.

Title	Description
	• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
	• An acute or nonacute inpatient discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:
	1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
	2. Identify the discharge date for the stay.
	For a direct transfer, use the discharge date from the last discharge.
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	63
Data Display:	Percentage with no decimal place

Measure: DMC12 - Initiation of Substance Use Disorder Treatment

Title	Description
Description:	The percent of new substance use disorder (SUD) episodes that have evidence of initiation of treatment within 14 days.
HEDIS Label:	Initiation and Engagement of Substance Use Disorder Treatment (IET)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 433
Metric:	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. (Please note the intake period is November 15 of the year prior to the measurement year through November 14 of the measurement year.)
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	394
Data Display:	Percentage with no decimal place

Measure: DMC13 - Engagement of Substance Use Disorder Treatment

Title	Description
Description:	The percent of new substance use disorder (SUD) episodes that have evidence of engagement of treatment within 34 days of initiation.
HEDIS Label:	Initiation and Engagement of Substance Use Disorder Treatment (IET)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 433
Metric:	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Exclusions:	None listed.

Title	Description
Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	394
Data Display:	Percentage with no decimal place

Domain 3: Member Experience with Integrated Plan and Care Providers

Measure: C19 - Getting Needed Care

Title	Description
Label for Data:	Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how easy it is for members to get needed care, including care from specialists.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): - In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? - In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	293
Data Display:	Numeric with no decimal place

Measure: C20 - Getting Appointments and Care Quickly

Title	Description
Label for Data:	Getting Appointments and Care Quickly (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how quickly members get appointments and care.

Title	Description
Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure. MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	292
Data Display:	Numeric with no decimal place

Measure: C21 - Customer Service

Title	Description
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how easy it is for members to get information and help from the MMP when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.

Title	Description
	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	181
Data Display:	Numeric with no decimal place

Measure: C22 - Rating of Health Care Quality

Title	Description
Label for Data:	Members' Rating of Health Care Quality (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned from members who rated the quality of the health care they received.
Metric:	This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	642
Data Display:	Numeric with no decimal place

Measure: C23 - Rating of Health Plan

Title	Description
Label for Data:	Members' Rating of Health Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned from members who rated the health plan.
Metric:	This case-mix adjusted measure is used to assess member'' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score

Title	Description
	uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	643
Data Display:	Numeric with no decimal place

Measure: C24 - Care Coordination

Title	Description
Label for Data:	Coordination of Members' Health Care Services (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how well the MMP coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Data Source Category:	Survey of Enrollees
Exclusions	MMPs that terminated effective December 31, 2022 are not included in the measure.

Title	Description
General Notes:	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60). CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	106
Data Display:	Numeric with no decimal place

Measure: OHP5 - Satisfaction with Care Coordination

Title	Description
Description:	Percent of members who are very satisfied with the help they received coordinating the care from different doctors and health providers.
Metric:	The percentage of survey respondents who answered "Very satisfied" to the measure question on how satisfied the respondent was with the care coordination services they received in the last 6 months. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • How satisfied are you with the help you received to coordinate your care in the last 6 months?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	Only MMPs with at least 11 "Yes" answers to the screening question (In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?) and have at least 11 "Very satisfied" responses on the measure question have a rate displayed.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: CC10 - Access to Medical Equipment

Title	Description
Description:	Percent of members who said it was always easy to get or replace medical equipment that they needed.
Metric:	The percentage of survey respondents who answered "Always" to the measure question on how easy it was to get or replace medical equipment. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question: • In the last 6 months, how often was it easy to get or replace the medical equipment you needed through your health plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.

Title	Description
	Only MMPs with at least 11 "Yes" answers to the screening question (In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, wheelchair or oxygen equipment?) and at least 11 "Always" responses on the measure question have a rate displayed.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: CC14 - Access to Personal Care

Title	Description
Description:	Percent of members who said it was always easy to get personal care at home.
Metric:	The percentage of survey respondents who answered "Always" to the measure question on how often it was easy to obtain access to personal care or aide assistance at home. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
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 personal care or aide assistance at home through your care plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	Only MMPs with at least 11 "Yes" answers to the screening question (Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?) and at least 11 "Always" responses on the measure question have a rate displayed.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: MH3 - Access to Mental Health Treatment

Title	Description
Description:	Percent of members who said it was always easy to get treatment or counseling for a personal or family problem.
Metric:	The percentage of survey respondents who answered "Always" to the measure question on how often it was easy to get the treatment or counseling they needed. No case-mix adjustment was applied to this measure.
Primary Data Source:	CAHPS Supplemental Question
Data Source Description:	CAHPS Survey Question:
	• In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?
Data Source Category:	Survey of Enrollees

Title	Description
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	Only MMPs with at least 11 "Yes" answers to the screening question (In the last 6 months, did you need any treatment or counseling for a personal or family problem?) and at least 11 "Always" responses on the measure question have a rate displayed.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	Not Applicable
Data Display:	Percentage with no decimal place

Measure: D05 - Rating of Drug Plan

Title	Description
Label for Data:	Members' Rating of Drug Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned from members who rated the prescription drug plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type):
	• Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	641
Data Display:	Numeric with no decimal place

Measure: D06 - Getting Needed Prescription Drugs

Title	Description
Label for Data:	Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the MMP earned on how easy it is for members to get the prescription drugs they need using the MMP.

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

Title	Description
Data Source Category:	Survey of Enrollees
Exclusions	MMPs that terminated effective December 31, 2022 are not included in the measure.
	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better
Case-Mix Adjusted:	Yes
CMIT #:	294
Data Display:	Numeric with no decimal place

Domain 4: Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening

Title	Description
Label for Data:	Breast Cancer Screening
Description:	Percent of female members aged 52-74 who had a mammogram during the past two years.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 95
Metric:	The percentage of women MMP enrollees 50 to 74 years of age (denominator) as of December 31 of the measurement year who had a mammogram to screen for breast cancer in the past two years (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

Title	Description
	• Members 66 years of age and older as of December 31 of the measurement year with both frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

	(optional) Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:
	• Bilateral mastectomy (Bilateral Mastectomy Value Set).
	• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set).
	• Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15.
	• Both of the following (on the same of different date of service):
	   – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service).
	   – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service).
	• Absence of the left breast (Absence of the Left Brest Value Set) and absence of the right breast (Absence of the Right Breast Value Set) on the same or different date of service.
	• History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
	• Left unilateral mastectomy (History of Bilateral Mastectomy Value Set) and right unilateral mastectomy (Unilateral Mastectomy Value Set) on the same or different date of service.

Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	93
Data Display:	Percentage with no decimal place

Measure: C02 - Colorectal Cancer Screening

Title	Description
Label for Data:	Colorectal Cancer Screening
Description:	Percent of members aged 50-75 who had appropriate screening for colon cancer.
HEDIS Label:	Colorectal Cancer Screening (COL)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Technical Specifications Volume 2, page 105

Title	Description
Metric:	The percentage of MMP enrollees aged 50 to 75 (denominator) as of December 31 of the measurement year who had appropriate screenings for colorectal cancer (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with both frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) *and* advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
	(optional) Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
CMIT #:	139
Data Display:	Percentage with no decimal place

Measure: C03 - Annual Flu Vaccine

Title	Description
Label for Data:	Yearly Flu Vaccine
Description:	Percent of members who got a vaccine (flu shot).
Metric:	The percentage of sampled members (denominator) who received an influenza vaccination (numerator).
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question number varies depending on survey type): • Have you had a flu shot since July 1, 2022?
Data Source Category:	Survey of Enrollees
Exclusions:	MMPs that terminated effective December 31, 2022 are not included in the measure.
	MMPs are excluded if the measure received too few responses to permit reporting (<11) or if the score had very low reliability (<0.60).
General Notes:	This measure is not case-mix adjusted.
	CAHPS Survey results were sent to each contract. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 - 06/2023
General Trend:	Higher is better

Title	Description
Case-Mix Adjusted:	No
CMIT #:	259
Data Display:	Percentage with no decimal place

Measure: C04 - Monitoring Physical Activity

Title	Description
Label for Data:	Monitoring Physical Activity
Description:	Percent of members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
HEDIS Label:	Physical Activity in Older Adults (PAO)
Measure Reference:	NCQA HEDIS Measurement Year 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 37
Metric:	The percentage of sampled members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase or maintain their level exercise or physical activity (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022).
	HOS Survey Question 42: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise for 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 43: 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.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 42 are excluded from results calculations for Question 43. 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." Members with evidence from CMS administrative records of a hospice start date are excluded.
	This measure is not included for Massachusetts MMPs because it is calculated for individuals age 65 and older and only individuals younger than 65 can enroll in Massachusetts MMPs.
Data Time Frame:	07/19/2022 - 11/01/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	540
Data Display:	Percentage with no decimal place

Domain 5: Plan Performance on Administrative Measures

Measure: C25 - Complaints about the Health Plan

Title	Description
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of complaints filed with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • 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's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) 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's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2022 complaints made by June 30, 2023 are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A–- Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Lower is better
Case-Mix Adjusted:	No
CMIT #:	142
Data Display:	Numeric with two decimal places

Measure: C26 - Members Choosing to Leave the Plan

Title	Description
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.

Title	Description
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2022– December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled MMPs that terminated effective December 31, 2022 are not included in the measure. MMPs with less than 1,000 enrollees are also excluded from this measure.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2022 and 12/31/2022 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available".
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Lower is better
Case-Mix Adjusted:	No
CMIT #:	446
Data Display:	Percentage with no decimal place

Measure: C28 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	This rating shows how fast a plan sends information for an independent review.

Title	Description
Metric:	Percent of appeals timely processed by the MMP (numerator) out of all the MMP's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and dismissed because the MMP agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed Because MMP Agreed to Cover])) * 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is "Not enough data available." Dismissed for reasons other than the MMP agreed to cover 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. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed Because MMP Agreed to Cover]) - [Late] Note: When reviewing IRE data from the Maximus appeals website found at http://www.medicareappeal.com/AppealSearch and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

Previous Field Name	Current Field Name
Upheld	Unfavorable
Overturn	Favorable
Partially Overturn	Partially favorable

Title	Description
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	562
Data Display:	Percentage with no decimal place

Measure: C29 - Reviewing Appeals Decisions

Title	Description
Label for Data:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	This rating shows how often an independent reviewer found the health plan's decision to deny coverage to be reasonable.
Metric:	Percent of appeals where an MMP's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the MMP's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as:

Title	Description
	([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2023, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2023 are not reflected in these data, the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2022 - 12/31/2022
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	652
Data Display:	Percentage with no decimal place

Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the MMP's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the MMP's Medicare Part C benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were not collected from MMPs that did not have a phone number accessible to survey callers, MMPs under sanction, and MMPs that terminated effective December 31, 2022.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov

Title	Description
Data Time Frame:	02/2023 - 05/2023
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	96
Data Display:	Percentage with no decimal place

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

Title	Description
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the MMP's Medicare Part D benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the MMP's Medicare Part D benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were not collected from MMPs that did not have a phone number accessible to survey callers, MMPs under sanction, and MMPs that terminated effective December 31, 2022.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 - 05/2023
General Trend:	Higher is better
Case-Mix Adjusted:	No
CMIT #:	96
Data Display:	Percentage with no decimal place

Attachment A: CAHPS Case-Mix Adjustment

Most Part C and D CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include administrative age, dual eligibility status, low-income subsidy (LIS) indicator, use of Asian language survey, self-reported education, general health status, mental health status, and proxy usage status. The tables below include the case-mix variables and show the case-mix coefficients for each of the Part C and D CAHPS measures included in the MMP Performance Data File. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to otherwise similar people with the baseline value for that characteristic (e.g., reference group), on the original scale of the item or composite, as presented in plan reports. The reference group for each characteristic will have a coefficient value of zero.

For example, for the measure "Rating of Health Care Quality" the model coefficient for "age 75-79" is 0.0521, indicating that respondents in that age range tend to score their plans 0.0521 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, dual eligible beneficiaries tend to respond 0.0322 points lower on this item than otherwise similar non-duals. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who are dual eligible beneficiaries will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. Item-level coefficients are presented below separately for each composite. For more detailed information on the application of CAHPS case-mix adjustment, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Note: The measures derived from the supplemental questions on the MMP CAHPS survey (OHP5: Satisfaction with Care Coordination, CC10: Access to Medical Equipment, CC14: Access to Personal Care, and MH3: Access to Mental Health Treatment) are not case-mix adjusted.

Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items

Predictor	Getting appointment with specialist	Easy to get care
Age: 64 or under	0.0414	-0.0138
Age: 65 - 69	0.0069	-0.0144
Age: 70 - 74	0.0000	0.0000
Age: 75 - 79	0.0241	-0.0047
Age: 80 - 84	0.0101	0.0030
Age: 85 and older	0.0122	-0.0184
Less than an 8th grade education	0.0147	-0.0513
Some high school	0.0152	0.0390
High school graduate	0.0000	0.0000
Some college	-0.0174	-0.0368
College graduate	-0.0451	-0.0436
More than a bachelor's degree	-0.0861	-0.0641
General health rating: excellent	0.1082	0.0313
General health rating: very good	0.0623	0.0552
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0744	-0.0488
General health rating: poor	-0.0956	-0.1716
Mental health rating: excellent	0.1989	0.2116
Mental health rating: very good	0.0973	0.1005

Predictor	Getting appointment with specialist	Easy to get care
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0560	-0.0609
Mental health rating: poor	-0.0956	-0.1199
Proxy helped	0.0318	0.0089
Proxy answered	0.0170	0.0893
Medicaid dual eligible	0.0019	-0.0222
Low-income subsidy (LIS)	0.0088	-0.0506
Asian Language	0.0527	-0.1072

Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items

Predictor	Getting needed care as soon as wanted	Getting routine care as soon as wanted	Wait <15 minutes
Age: 64 or under	-0.0044	0.0542	-0.0653
Age: 65 - 69	0.0333	0.0009	-0.0177
Age: 70 - 74	0.0000	0.0000	0.0000
Age: 75 - 79	0.0401	0.0218	0.0122
Age: 80 - 84	0.0326	0.0389	-0.0077
Age: 85 and older	0.0710	0.0243	0.0141
Less than an 8th grade education	0.0230	-0.0306	-0.0526
Some high school	0.0125	-0.0357	0.0548
High school graduate	0.0000	0.0000	0.0000
Some college	0.0023	-0.0203	0.0344
College graduate	0.0086	-0.0511	0.0225
More than a bachelor's degree	-0.0137	-0.0717	0.0122
General health rating: excellent	0.1011	0.0186	0.2354
General health rating: very good	0.0425	0.0092	0.0974
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0476	-0.0439	-0.0891
General health rating: poor	-0.0857	-0.0784	-0.1452
Mental health rating: excellent	0.1801	0.1525	0.1130
Mental health rating: very good	0.0698	0.0749	0.0421
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0306	-0.0406	-0.0215
Mental health rating: poor	-0.0917	-0.0721	0.0829
Proxy helped	0.0512	-0.0061	-0.0675
Proxy answered	0.0764	0.0762	-0.0235
Medicaid dual eligible	-0.0436	-0.0336	-0.0196
Low-income subsidy (LIS)	0.0031	-0.0299	0.0143
Asian Language	-0.2210	-0.2959	-0.0893

Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items

Predictor	Paperwork easy	Plan customer service gives information	Plan customer service courtesy and respect
Age: 64 or under	0.0170	0.0369	-0.0096

Predictor	Paperwork easy	Plan customer service gives information	Plan customer service courtesy and respect
Age: 65 - 69	0.0067	0.0112	-0.0096
Age: 70 - 74	0.0000	0.0000	0.0000
Age: 75 - 79	-0.0082	0.0074	-0.0132
Age: 80 - 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian Language	-0.1493	-0.0986	-0.1499

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	C03: Annual Flu Vaccine	C22: Rating of Health Care Quality	C23: Rating of Health Plan
Age: 64 or under	N/A	-0.0536	-0.1125
Age: 65 - 69	N/A	-0.0663	-0.0893
Age: 70 - 74	N/A	0.0000	0.0000
Age: 75 - 79	N/A	0.0521	0.0367
Age: 80 - 84	N/A	0.0086	0.0312
Age: 85 and older	N/A	0.0271	0.1218
Less than an 8th grade education	N/A	0.0259	0.1073
Some high school	N/A	0.0652	0.1057
High school graduate	N/A	0.0000	0.0000
Some college	N/A	-0.1052	-0.1775
College graduate	N/A	-0.1670	-0.2669
More than a bachelor's degree	N/A	-0.2532	-0.3808
General health rating: excellent	N/A	0.3099	0.1928
General health rating: very good	N/A	0.2091	0.1455

Predictor	C03: Annual Flu Vaccine	C22: Rating of Health Care Quality	C23: Rating of Health Plan
General health rating: good	N/A	0.0000	0.0000
General health rating: fair	N/A	-0.2432	-0.1138
General health rating: poor	N/A	-0.6785	-0.3463
Mental health rating: excellent	N/A	0.5034	0.4300
Mental health rating: very good	N/A	0.2076	0.1654
Mental health rating: good	N/A	0.0000	0.0000
Mental health rating: fair	N/A	-0.2119	-0.1309
Mental health rating: poor	N/A	-0.4494	-0.3638
Proxy helped	N/A	-0.1395	-0.1019
Proxy answered	N/A	0.1199	-0.0091
Medicaid dual eligible	N/A	-0.0322	0.2307
Low-income subsidy (LIS)	N/A	-0.0496	0.1633
Asian Language	N/A	0.0513	-0.1899

Table A-5: Coefficients of Part C Care Coordination (C24) CAHPS Measure Composite Items

Predictor	MD/office help to manage care	MD informed about specialist	MD follows up about test results and gives results as soon as needed	Talk with MD about medicines	MD has medical records about care
Age: 64 or under	0.0046	-0.0114	-0.0013	0.0402	-0.0265
Age: 65 - 69	-0.0528	-0.0120	-0.0077	0.0376	-0.0073
Age: 70 - 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 - 79	-0.0282	0.0151	-0.0080	-0.0344	0.0022
Age: 80 - 84	-0.0190	0.0006	0.0066	-0.1098	-0.0094
Age: 85 and older	-0.0895	-0.0232	-0.0263	-0.1662	-0.0021
Less than an 8th grade education	0.0260	0.1001	-0.0047	0.0194	-0.0268
Some high school	-0.0135	0.0669	0.0250	-0.0074	-0.0330
High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Some college	-0.0034	-0.0245	-0.0377	-0.0035	-0.0055
College graduate	-0.0332	-0.0389	-0.0417	-0.0222	-0.0205
More than a bachelor's degree	-0.0216	-0.0856	-0.0365	-0.0587	-0.0065
General health rating: excellent	-0.0008	-0.0270	0.0860	0.1207	-0.0079
General health rating: very good	-0.0111	-0.0040	0.0423	0.0601	0.0247
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0650	-0.0502	-0.0635	-0.0435	-0.0308
General health rating: poor	-0.1020	-0.1222	-0.1524	-0.1039	-0.0726
Mental health rating: excellent	0.1224	0.1946	0.1645	0.1768	0.0931
Mental health rating: very good	0.0304	0.0808	0.0931	0.0867	0.0571
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0391	-0.1002	-0.0407	-0.0597	-0.0274
Mental health rating: poor	-0.0342	-0.1422	-0.0559	-0.0531	-0.0843
Proxy helped	0.0196	-0.0021	-0.0019	0.0816	-0.0079
Proxy answered	-0.0020	-0.0433	0.0655	0.0710	0.0457
Medicaid dual eligible	-0.0061	0.0613	-0.0082	0.0014	-0.0122

Predictor	MD/office help to manage care	MD informed about specialist	MD follows up about test results and gives results as soon as needed	Talk with MD about medicines	MD has medical records about care
Low-income subsidy (LIS)	-0.0318	0.1438	0.0131	-0.0131	0.0067
Asian Language	0.1027	-0.1596	0.1903	-0.1308	-0.1026

Table A-6: Coefficients of Part D CAHPS Stand-alone Measures

Predictor	MA-PD D05: Rating of Drug Plan	PDP D05: Rating of Drug Plan
Age: 64 or under	-0.1891	-0.3770
Age: 65 - 69	-0.1095	-0.1195
Age: 70 - 74	0.0000	0.0000
Age: 75 - 79	0.1042	0.1631
Age: 80 - 84	0.1505	0.2597
Age: 85 and older	0.1974	0.5198
Less than an 8th grade education	0.0703	-0.1769
Some high school	0.0425	0.0060
High school graduate	0.0000	0.0000
Some college	-0.2087	-0.3485
College graduate	-0.3306	-0.1539
More than a bachelor's degree	-0.4426	-0.5077
General health rating: excellent	0.2238	0.1233
General health rating: very good	0.1922	0.0239
General health rating: good	0.0000	0.0000
General health rating: fair	-0.1861	-0.2132
General health rating: poor	-0.4147	-0.3450
Mental health rating: excellent	0.3268	0.1120
Mental health rating: very good	0.1035	0.0617
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1101	-0.2242
Mental health rating: poor	-0.1847	-0.9212
Proxy helped	0.1628	-0.2064
Proxy answered	-0.0284	0.2563
Medicaid dual eligible	0.3942	0.8442
Low-income subsidy (LIS)	0.3567	0.5929
Asian Language	-0.3631	0.0000

Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items

Predictor	MA-PD: Getting needed prescription drugs	MA-PD: Get prescription drugs form mail or pharmacy	PDP: Getting needed prescription drugs	PDP: Get prescription drugs form mail or pharmacy
Age: 64 or under	-0.0603	-0.0276	-0.1955	-0.1288
Age: 65 - 69	-0.0152	-0.0062	-0.0411	-0.0108
Age: 70 - 74	0.0000	0.0000	0.0000	0.0000
Age: 75 - 79	0.0204	0.0136	0.0322	0.0381
Age: 80 - 84	0.0462	0.0168	0.0365	0.0418

Predictor	MA-PD: Getting needed prescription drugs	MA-PD: Get prescription drugs form mail or pharmacy	PDP: Getting needed prescription drugs	PDP: Get prescription drugs form mail or pharmacy
Age: 85 and older	0.0138	-0.0005	0.0134	-0.0303
Less than an 8th grade education	-0.0556	-0.0378	-0.0470	-0.0335
Some high school	-0.0062	-0.0187	-0.1264	-0.1132
High school graduate	0.0000	0.0000	0.0000	0.0000
Some college	-0.0375	-0.0425	-0.0692	-0.0427
College graduate	-0.0481	-0.0536	-0.0365	-0.0826
More than a bachelor's degree	-0.0618	-0.0857	-0.1088	-0.1149
General health rating: excellent	0.0306	0.0514	0.0839	0.0712
General health rating: very good	0.0473	0.0425	0.0331	0.0552
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0529	-0.0442	-0.1217	-0.0595
General health rating: poor	-0.1323	-0.1428	-0.2777	-0.1987
Mental health rating: excellent	0.0988	0.1109	-0.0206	0.0334
Mental health rating: very good	0.0502	0.0555	-0.0026	0.0256
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0506	-0.0467	-0.1631	-0.0679
Mental health rating: poor	-0.0532	-0.0254	-0.3480	-0.2465
Proxy helped	-0.0094	0.0049	-0.0014	-0.0612
Proxy answered	0.0294	0.0411	0.1625	0.0613
Medicaid dual eligible	0.0413	0.0149	0.0288	0.0656
Low-income subsidy (LIS)	0.0669	0.0170	0.1885	0.1608
Asian Language	-0.0583	0.0220	0.0000	0.0000

Attachment B: Calculating Measure C15: Plan All-Cause Readmissions

The following fields and formulas were used to calculate each MMP's performance rate for the Plan All-Cause Readmissions (PCR) measure. For MMPs in demonstrations that target populations either over or under age 65, the formulas were modified to use only the applicable age bands.

Formula Value	PCR Field	Field Description
A	is1844	Count of Index Stays (Denominator) Age 18-44
G	r1844	Count of 30-Day Readmissions (Numerator) Age 18-44
M	err1844	Expected Readmissions Rate (Expected Readmissions/Den) 18-44
B	is4554	Count of Index Stays (Denominator) Age 45-54
H	r4554	Count of 30-Day Readmissions (Numerator) Age 45-54
N	err4554	Expected Readmissions Rate (Expected Readmissions/Den) 45-54
C	is5564	Count of Index Stays (Denominator) Age 55-64
I	r5564	Count of 30-Day Readmissions (Numerator) Age 55-64
O	err5564	Expected Readmissions Rate (Expected Readmissions/Den) 55-64
D	is6574	Count of Index Stays (Denominator) Age 65-74
J	r6574	Count of 30-Day Readmissions (Numerator) Age 65-74
P	err6574	Expected Readmissions Rate (Expected Readmissions/Den) 65-74
E	is7584	Count of Index Stays (Denominator) Age 75-84
K	r7584	Count of 30-Day Readmissions (Numerator) Age 75-84
Q	err7584	Expected Readmissions Rate (Expected Readmission/Den) 75-84
F	is85	Count of Index Stays (Denominator) Age 85+
L	r85	Count of 30-Day readmissions (Numerator) Age 85+
R	err85	Expected Readmissions Rate (Expected Readmission/Den) 85+

$$\text{Observed} = \frac{G+H+I+J+K+L}{A+B+C+D+E+F}$$

$$\text{Expected} = \left(\frac{A}{A+B+C+D+E+F}\right) \times M\right) + \left(\left(\frac{B}{A+B+C+D+E+F}\right) \times N\right) + \left(\left(\frac{C}{A+B+C+D+E+F}\right) \times O\right) + \left(\left(\frac{D}{A+B+C+D+E+F}\right) \times P\right) +$$
$$\left(\left(\frac{E}{A+B+C+D+E+F}\right) \times Q\right) + \left(\left(\frac{F}{A+B+C+D+E+F}\right) \times R\right)$$

$$\text{Final Rate} = \frac{\text{Observed}}{\text{Expected}}$$

Attachment C: Medication Adherence Measure Calculations

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal 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 A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the measurement period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Calculating the PDC Adjustment for IP Stays and SNF Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

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

Table C-1: No Adjustment

Drug	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Benazepril	15	16	15	13		
Captopril					15	16

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

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

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

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

Table C-2: Before Overlap Adjustment

Drug	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

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

Table C-3: After Overlap Adjustment

Drug	January		February		March	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
Lisinopril	15	16				
Lisinopril & HCTZ			15	13	3	
Benazepril & HCTZ			15	13		

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

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

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

Table C-4: Before Overlap Adjustment

Drug	January		February		March		April	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

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

Table C-5: After Overlap Adjustment

Drug	January		February		March		April	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

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

PDC Adjustment for Inpatient and Skilled Nursing Facility Stays Examples

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

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

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. 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 from the CWF have been used to adjust the SNF PDC adjustments for PDPs. Starting in the 2019 measurement year, when available for MA-PDs in the CWF, adjust the SNF PDC adjustments. Additionally, starting in 2019 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries. Additionally, starting in 2020 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries.

Note: Hospice enrollment is no longer a PDC adjustment but rather an exclusion starting with the 2020 Star Ratings (2018 YOS).

Calculating the PDC Adjustment for IP Stays and SNF Stays

The PDC modification for IP stays and SNF stays is based on two assumptions: 1) a beneficiary receives their medications through the facility during the IP or SNF stay, and 2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay 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 for beneficiaries included in adherence measures. The discharge date is included in the PDC adjustment.
    o Use IP claims from the CWF to identify IP stays, and when available for MA-PDs.
    o Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount with Medicare utilization days to identify Medicare Part A covered SNF dates. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 and/or a no payment reason code.
    o Use IP and SNF stay encounter data when available for MA-PD beneficiaries. Additionally, if IP and SNF stay claims for MA-PD enrolled beneficiaries are reported in the CWF, the CWF will remain as an additional data source.

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 or subsequent fills for the same drug class to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

If SNF and IP stays cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

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

Example 1: Gap in Coverage after IP Stay

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

Table C-6: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1	X1				X2	X2	X2	X2
Inpatient Stay					+	+									

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

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

Table C-7: After Adjustment

Day	1	2	3	4	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	+	+		X2	X2	X2	X2
Inpatient Stay													

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

Example 2: Gap in Coverage before IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different days of service. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and 13, as illustrated in Table C-8.

Table C-8: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2	X2	X2
Inpatient Stay												+	+		

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

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

Table C-9: After Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2
Inpatient Stay													

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

Example 3: Gap in Coverage Before and After IP Stay

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

Table C-10: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			X2	X2	X2	X2			X3	X3	X3	X3
Inpatient Stay						+	+	+	+						

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

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

Table C-11: After Adjustment

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			+	+	X2	X2	X3	X3
Inpatient Stay											

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

Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 fills on different dates of service. This beneficiary had drug coverage from days 1-4, and 7-11 for the same drug class, and an IP stay on days 2-4, as illustrated in Table C-12.

Table C-12: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1			X2	X2	X2	X 2	X 2				

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

PDC Calculation:
Covered Days: 9
Measurement Period: 15
PDC: 9/15 = 60%

With the adjustment for the IP stay, days 2-4 are deleted from the measurement period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days supply of the subsequent fill are shifted. In this example, the days supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes 1 days supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12. This is illustrated in Table C-13.

Table C-13: After Adjustment

Day	1	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	+	+	+	X2	X2	X2	X2	X2			
Inpatient Stay												

PDC Calculation:
Covered Days: 9
Measurement Period: 12
PDC: 9/12 = 75%

Attachment D: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2022. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.

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 2022.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), 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 MMP 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. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation.

- MBI Number (Element B)
- Date of MTM program enrollment (Element H)
- Met the specified targeting criteria per CMS – Part D requirements (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) (Element P)

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

File DV failure: Contracts that failed to submit the CY 2022 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2022 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2022 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

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

Organizations can view their own MMP 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. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe.

CMS uses a standard set of messages in the MMP Performance Data File when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages.

Measure level messages

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

Table E-1: Measure level missing data messages

Message	Measure Level
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules.
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report.
Plan too new to be measured	The contract is too new to have submitted measure data.
No data available	There were no data for the contract included in the source data for the measure.
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules.
Plan not required to report measure	The contract was not required to report the measure due to low plan enrollment.
Not reportable due to plan termination	The contract was excluded from the measure due to plan termination effective December 31, 2022.
N/A based on demonstration's target population (Massachusetts MMPs only)[1]	Massachusetts MMPs are excluded because the age range for the measure does not align with the demonstration's target population (only individuals younger than 65 can enroll in Massachusetts MMPs).
Data consolidated with another plan	Data for the contract were reported under another contract due to plan consolidation.

Assignment rules for Part C measure messages

Appeals (IRE) measures (C28 & C29):

    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 > 01/01/2022?
                Yes: Display message: Plan too new to be measured
                No: Display message: Not enough data available

CAHPS measures (C03, C19, C20, C21, C22, C23, & C24):

    Is the contract still active as of 01/01/2023?
        Yes: Is there a valid numeric CAHPS measure rate?
            Yes: Display the numeric CAHPS measure rate
            No: Is the contract effective date > 07/01/2022?
                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
        No: Display message: Not reportable due to plan termination

Call Center – Foreign Language Interpreter and TTY Availability measure (C30):

    Is the contract still active as of 01/01/2023?
        Yes: Is there a valid call center numeric rate?
            Yes: Display the call center numeric rate
            No: Is the contract effective date > 01/01/2023?

---

[1] For Massachusetts MMPs, this missing data message applies to the following measures: C04, C06, C07, C08, C12, C13, and DMC21.

Yes: Display message: Plan too new to be measured
No: Display message: Not enough data available
No: Display message: Not reportable due to plan termination

Complaints (CTM) measure (C25):
   Is the contract effective date > 01/01/2022?
         Yes: Display message: Plan too new to be measured
         No: Was the average contract enrollment < 800 in 2022?
                  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 except PCR and TRC (C01, C02, C08 – C11, C14, C16, C18, DMC01, DMC02, DMC12, & DMC13):
   Was the contract required to report HEDIS?
         Yes: What is the HEDIS measure audit designation?
                  BD: Display message: CMS identified issues with this plan's data
                  BR: Display message: CMS identified issues with this plan's data
                  NA: Display message: Not enough data available
                  NB: Display message: Benefit not offered by plan
                  NR: Display message: CMS identified issues with this plan's data
                  NQ: Display message: Plan not required to report measure
                  R: Was a valid patient level detail file 1 submitted and the measure data usable?
                           Yes: Is the status NA?
                                    Yes: Display message: Not enough data available
                                    No: Display message: Display the HEDIS measure numeric rate
                           No: Display message: CMS identified issues with this plan's data
         No: Is the contract effective date > 01/01/2022?
                  Yes: Display message: Plan too new to be measured
                  No: Display message: Plan not required to report measure

HEDIS PCR measure (C15):
   Was the contract required to report HEDIS?
         Yes: What is the HEDIS measure audit designation?
                  BD: Display message: CMS identified issues with this plan's data
                  BR: Display message: CMS identified issues with this plan's data
                  NA: Display message: Not enough data available
                  NB: Display message: Benefit not offered by plan
                  NR: Display message: CMS identified issues with this plan's data
                  NQ: Display message: Plan not required to report measure
                  R: Was a valid patient level detail file 2 submitted and the measure data usable?
                           Yes: Did the contract report more than 150 index stays?
                                    Yes: Display the HEDIS measure numeric rate
                                    No: Display message: Not enough data available
                           No: Display message: CMS identified issues with this plan's data
         No: Is the contract effective date > 01/01/2022?
                  Yes: Display message: Plan too new to be measured
                  No: Display message: Plan not required to report measure

 HEDIS TRC average (C17):
   Was the contract required to report HEDIS?
         Yes: Is the audit designation for all four TRC measures R?
                  No: Is the audit designation for any of the four TRC measures DB, BR, or NR?
                           Yes: Display message: CMS identified issues with this plan's data

No: Is the audit designation for any of the four TRC measures NB?
    Yes: Display message: Benefit not offered by plan
    No: The audit designation for one of the four TRC measures is NQ.
        Display message: Plan not required to report measure
Yes: Was a valid patient level detail file 1 submitted and the measure data usable?
    Yes: Is the status for any component of the TRC average measure NA?
        Yes: Display message: Not enough data available
        No: Display the HEDIS measure numeric rate
    No: Display message: CMS identified issues with this plan's data

No: Is the contract effective date > 01/01/2022?
    Yes: Display message: Plan too new to be measured
    No: Display message: Plan not required to report measure

HEDIS SNP measures (DMC21, C06, & C07):

Does the contract have < 30 members enrolled as of 02/01/2022?
    Yes: Display message: Plan not required to report measure
    No: Is the contract effective date > 01/01/2022?
        Yes: Display message: Plan too new to be measured
        No: What is the HEDIS measure audit designation?
            BD: Display message: CMS identified issues with this plan's data
            BR: Display message: CMS identified issues with this plan's data
            NA: Display message: Not enough data available
            NB: Display message: Benefit not offered by plan
            NR: Display message: CMS identified issues with this plan's data
            NQ: Display message: Plan not required to report measure
            R: Is there a valid HEDIS measure numeric rate?
                Yes: Display the HEDIS measure numeric rate
                No: Display message: No data available

HEDIS-HOS measures (C04, C12, & C13):

Is there a valid HEDIS-HOS numeric rate?
    Yes: Display the HEDIS-HOS numeric rate
    No: Is the contract effective date > 01/01/2021?
        Yes: Display message: Plan too new to be measured
        No: Is the February 2022 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

Members Choosing to Leave the Plan (C26):

Is the contract active as of 01/01/2023?
    Yes: Is there a valid numeric voluntary disenrollment rate?
        Yes: Display the numeric voluntary disenrollment rate
        No: Is the contract effective date > 01/01/2023?
            Yes: Display message: Plan too new to be measured
            No: Display message: Not enough data available
    No: Display message: Not reportable due to plan termination

Assignment rules for Part D measure messages

CAHPS measures (D05, D06):

Is the contract still active as of 01/01/2023?

Yes: Is there a valid numeric CAHPS measure rate?
       Yes: Display the numeric CAHPS measure rate
      No: Is the contract effective date > 07/01/2023?
            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
No: Display message: Not reportable due to plan termination

Call Center – Foreign Language Interpreter and TTY Availability measure (D01):

Is the contract still active as of 01/01/2023?
      Yes: Is there a valid call center numeric rate?
           Yes: Display the call center numeric rate
          No: Is the contract effective date > 01/01/2023?
               Yes: Display message: Plan too new to be measured
               No: Display message: Not enough data available
No: Display message: Not reportable due to plan termination

Patient Safety measures – Adherence (D08 – D10) & SUPD (D12):

Is the contract effective date > 12/31/2022?
      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 percentage

Patient Safety measure – MTM CMR (D11):

Is the contract still active as of 01/01/2023?
      Yes: Is the contract effective date > 12/31/2022?
           Yes: Display message: Plan too new to be measured
          No: Is Part D offered?
               Yes: Is there a numeric rate?

                      Yes: Display numeric measure percentage
                      No: Is there a Reason(s) for Display Message?
                           Yes: Display appropriate message per table E-2
           No: Display message: Plan not required to report measure
No: Display message: Not reportable due to plan termination

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

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

Assignment rules for MMP measure messages

Comprehensive Health Risk Assessment and Care Plan Completion (M21 & M32):

Did the contract enroll new members during the measurement year?
      Yes: Has CMS identified issues with the contract's data?
            Yes: Display message: CMS identified issues with this plan's data
            No: Display the numeric measure rate
      No: Display message: No data available

Supplemental CAHPS measures (CC10, CC14, MH3, & OHP5):

Is the contract still active as of 01/01/2023?
      Yes: Is there a valid numeric CAHPS measure rate?
            Yes: Display the numeric CAHPS measure rate
            No: Is the contract effective date > 07/01/2022?
                  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
      No: Display message: Not reportable due to plan termination

Attachment F: Contract Enrollment Data

The enrollment data used in the Part C "Complaints about the Health Plan" measure are pulled from 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 are pulled (January 2022 through December 2022) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the three Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor, there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2022 through December 2022), and the average enrollment in the plan across those months is used in calculating the combined rate.

Attachment G: Rounding Rules for Measure Scores

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using traditional rounding rules. These are standard "round to nearest" rules. To obtain a value with the specified level of precision, the single digit following the level of precision will be rounded. If the digit to be rounded is 0, 1, 2, 3 or 4, the value is rounded down, with no adjustment to the preceding digit. If the digit to be rounded is 5, 6, 7, 8 or 9, the value is rounded up, and a value of one is added to the preceding digit. After rounding, all digits after the specified level of precision are removed. If rounding to a whole number, the digit to be rounded is in the first decimal place. If the digit in the first decimal place is below 5, then after rounding the whole number remains unchanged and fractional parts of the number are deleted. If the digit in the first decimal place is 5 or greater, then the whole number is rounded up by adding a value of 1 and fractional parts of the number are deleted. For example, a measure listed with a Data Display of "Percentage with no decimal place" that has a value of 83.499999 rounds down to 83, while a value of 83.500000 rounds up to 84.

Attachment H: Glossary of Terms

CAHPS

The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.

Cohort

A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.

Disability Status

Based on the original reason for entitlement for Medicare. (Disability insurance benefits or both Disability insurance benefits and End-Stage Renal Disease).

Dual eligibles

Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

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.

I-SNP

Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to institutionalized special needs individuals defined in 42 CFR 422.2.

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.

LIS

The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.

LIS/DE

Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.

MA

A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who 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.
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.
Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality ("signal") rather than random variation ("noise"). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
SNP	A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP).
Sponsor	An entity that sponsors a health or drug plan.
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.