Medicare Health Plan Quality and Performance Ratings
2011 Part C Technical Notes

This document describes the methodology for creating the Part C Plan Ratings displayed in the Medicare Plan Finder tool on Medicare.gov and the Part C Performance Metrics – Part C Report Card Master Table in the Health Plan Management System. All of the Health Plan quality and performance measure data described in this document are reported at the contract level. The following organization types are included in the ratings: Local CCP, MSA, PFFS, 1876 Cost, and Regional CCP.

Contract Enrollment Data

The enrollment data used in the "Complaints about the Health Plan" measure was pulled from the Health Plan Management System (HPMS). These enrollment files represent the number of beneficiaries the contract was paid for in a specific month. For this measure, six months of enrollment files were pulled (January 2010 through June 2010) and the average enrollment from those months was used in the calculations.

Handling of Non-reported (NR) HEDIS Data

For the HEDIS data, NRs are assigned when the individual measure score is materially biased (i.e. the auditor informs the contract it cannot be reported to NCQA/CMS) or the contract decides not to report the data for a particular measure. When NRs have been assigned for a HEDIS measure, because the contract has had materially biased data or the contract has decided not to report the data, the contract receives a “1” star rating for each of these measures and a zero in the measure score with the footnote: “Not reported. There were problems with the plan's data” for material biased or "Measure was not reported by plan" for unreported data.

How the Data are Reported

For 2011, the Part C Plan Ratings are reported using four different levels of detail. At the base level, with the most detail, are the individual measures. They are comprised of numeric data and star ratings for 36 quality and performance measures. Each measure is also grouped with similar measures into a second level called a Domain that is assigned a star rating. All of the Part C measures are also grouped together to form the Summary level star rating for a contract. This year CMS has added an additional level that reports the Overall rating for MA-PD contracts. This overall rating summarizes all of the Part C and D measures for each contract.

Methodology for Assigning Part C Star Ratings

CMS develops Parts C and D Plan Ratings in advance of the annual enrollment period each fall. Ratings are calculated at the plan sponsor contract level. There are a total of 9 topic areas (domains) comprised of 53 individual measures. MA-only plans are measured on 5 topic areas (36 measures). PDPs are measured on 4 topic areas (17 measures). MA-PD plans are measured on both sets of topic areas (53 measures). The principle for assigning star ratings for a measure is based on evaluating the maximum score possible, and testing initial percentile star thresholds with actual scores. Scores are grouped by using statistical techniques to minimize the distance between scores within a grouping (or “cluster”) and maximize the distance between scores in different groupings. Most datasets that are utilized for plan ratings, however, are not normally distributed. This necessitates further adjustments to the star thresholds to account for gaps in the data. CMS does not force the plan ratings data into 5 star categories for every measure. For example, in the health plan measure of Osteoporosis management in women that had a fracture, the 4 star threshold is ≥ 60%. For CY2011, only one contract will receive 4 stars with a score of 66%. No plans will receive 5 stars in this measure. The majority of contracts’ scores fall into the 1 star threshold.

CMS considers whether an absolute regulatory standard has been established for a given measure (such as answering a customer’s call within 2 minutes). Additionally, CMS has set target 4-star thresholds for selected measures in order to define expectations and drive quality improvement. These targeted 4 star thresholds are based on plan performance in prior years; therefore they have not been set for revised measures or for measures with less than 2 years of measurement experience other than the 4 star threshold or 3 star thresholds in the cases where there are standards. The distribution of data is evaluated to assign the other star values. For example, in the call center hold time measure, a plan that has a hold time of 2 minutes or less will receive at least 3 stars. A plan that has a hold time of only 15 seconds will receive 5 stars as they met the CMS standard and were well above the upper limit of all other plans.

When CMS has not set a standard for a measure, the maximum score possible is considered as a first step in setting the initial 5 star thresholds. Again, these thresholds may require adjustments to accommodate the actual distribution of data. After this analysis is complete, the measures' underlying scores, star rating, domain scores, and summary scores are posted on the Medicare Plan Finder tool on www.medicare.gov.

See Attachment A for more details about the methodology.

Methodology for Calculating Stars at the Domain Level

The domain score is a simple average of the star values assigned to each individual measure under the domain. A minimum number of individual measures is needed to produce a domain score.

Domain	Minimum Number of Measures Needed to Calculate a Domain Score
Staying Healthy: Screenings, Tests and Vaccines	6 out of 13
Managing Chronic (Long Term) Conditions	5 out of 10
Ratings of Health Plan Responsiveness and Care	3 out of 6
Health Plan Members' Complaints and Appeals	2 out of 4
Health Plan Telephone Customer Service	2 out of 3

Methodology for Calculating Stars at the Summary Rating for Part C

A summary rating for Part C is calculated by taking an average of the measure level stars. Additionally, to incorporate performance stability into the rating process, CMS has used an approach that utilizes both the mean and the variance of individual performance ratings to differentiate contracts for the summary score. That is, a measure of individual performance score dispersion, specifically an integration factor (i-Factor), has been added to the mean score for rewarding contracts if they have both high and stable relative performance. Details about the integration factor can be found in the section titled Applying the Integration Factor.

For the summary score half scores are also assigned to allow more variation across contracts. To have a summary score, all contracts from organization type other than PFFS and MSA need to have at least 18 of the 36 Part C measures. Note: The colorectal screening measure (C02) is not included in the summary calculation for local and regional PPOs. PFFS and MSA organizations need to have at least 8 of the 15 Part C measures that they are required to report.

Methodology for Calculating the Overall MA-PD Summary Star

The overall summary plan rating for MA-PD contracts is calculated by taking an average of the Part C and D measure level stars. There are 53 measures (36 in Part C, 17 in Part D) total. The Complaints Tracking Module measures for Part C and D share the same data source. Where the Part C and D measures use the same data source, CMS has used the Part C measure (and not the Part D measure) in calculating the overall plan rating. This results in a total of 51 measures (the two Part D CTM measures are equivalent to the one Part C CTM measure). Additionally, CMS is using the same integration factor approach used in calculating the summary level stars for the Part C ratings. Details about the integration factor can be found in the section titled Applying the Integration Factor.

For the overall plan rating, half scores are also assigned to allow more variation across contracts. For MA-PDs to have an overall plan rating, contracts from organization types other than PFFS and MSA need stars for at least 26 of the 51 measures. Note: The colorectal screening measure (C02) is not included in the overall calculation for local and regional PPOs. PFFS and MSA organizations need at least 15 of the 30 measures on which they are required to report.

If a contract does not have a summary rating for Part C or a summary rating for Part D, the overall MA-PD summary rating is not calculated.

Applying the Integration Factor

The following represents the steps taken to calculate and include the i-Factor in the Plan Ratings Summary and Overall Ratings:

- Calculate the mean and the variance of all of the individual performance measure stars at the contract level
- Categorize the variance into three categories
  - low (0 to 30th percentile),
  - medium (30th to 70th percentile) and
  - high (70th percentile and above)
- Develop the i-Factor as follows:
  - i-Factor = 0.4 (for contract w/low-variability high-mean (mean >= 85th percentile)
  - i-Factor = 0.3 (for contract w/medium-variability high-mean (mean >= 85th percentile)
  - i-Factor = 0.2 (for contract w/low-variability relatively high-mean (mean >= 65th < 85th percentile)
  - i-Factor = 0.1 (for contract w/medium-variability relatively high-mean (mean >= 65th < 85th percentile)
  - i-Factor = 0.0 (for other types of contracts)
- Add i-Factor to the mean overall score by contract to develop final summary score using 0.5:
  - 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0
- Apply rounding to final summary score such that stars that are within the distance of .25 above or below any half star scale will be rounded to that half star scale.

Methodology for Calculating the Low Performing Contract Indicator

The low performing contract indicator is calculated by evaluating the Part C summary star rating for the current year and the past two years (i.e., the 2009, 2010 and 2011 plan ratings). If the contract has had a Part C summary rating of 2.5 or lower for all three years of data, they are marked as a low performing contract. Each contract must have a Part C summary star rating for all three years to be considered for this indicator.

CAHPS Methodology

The table below contains the actual cut point values used in processing each CAHPS measure and the rules applied to the actual data to produce the final star rating in these measures. The values are case-mix adjusted for measures C24 – C29. See Attachment B for the case-mix adjusters.

Measure	2 Star Cut point (15 %tile)	3 Star Cut Point (30 %tile)	4 Star Threshold	5 Star Cut Point (80 %tile)
C07 - Annual Flu Vaccine	56.1767	60.9714	70.6329	72.7475
C08 - Pneumonia Vaccine	54.5539	62.7547	69.8590	75.7560
C24 - Getting Needed Care	80.3339	82.9673	85.0912	87.4859
C25 - Doctors who Communicate Well	87.4397	88.5353	90.1535	91.0142
C26 - Getting Appointments and Care Quickly	69.8424	71.7555	75.3601	77.4666
C27 - Customer Service	83.8092	85.4459	88.4232	91.2952
C28 - Overall Rating of Health Care Quality	81.0850	82.9058	85.1088	86.4981
C29 - Overall Rating of Plan	77.6961	80.3273	85.0271	87.1360

The base stars are the number of stars assigned prior to taking into account statistical significance and reliability. Both statistical significance and reliability are taken into account in the final assignment of stars.

These are the rules applied to the base star values to arrive at the final CAHPS measure star value:
5 base stars: If significance is NOT above average OR reliability is low, the Final Star value equals 4.
4 base stars: Always stays 4 Final Stars.
3 base stars: If significance is below average, the Final Star value equals 2.
2 base stars: If significance is NOT below average AND reliability is low, the Final Star value equals 3.
1 base star: If significance is NOT below average AND reliability is low, the Final Star value equals 3 or
If significance is below average and reliability is low, the Final Stars Value equals 2 or
If significance is not below average and reliability is not low, the Final Stars Value equals 2.

Domain and Measure details

See Attachment C for the national averages of each individual measure.

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

Measure: C01 - Breast Cancer Screening

Label for Stars: Breast Cancer Screening
Label for Data: Breast Cancer Screening
HEDIS Label: Breast Cancer Screening (BCS)
Description: Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.
Metric: Percent of female MA enrollees ages 40 to 69 (denominator) who had a mammogram during the measurement year or the year prior to the measurement year (numerator).
Data Source: HEDIS
Data Time Frame: 1/1/2009 - 12/31/2009
Statistical Method: Relative Distribution with Clustering
General Trend: Higher is better
Data Display: Percentage with no decimal point
PFFS & MSA Reporting: Voluntary
4 Star Threshold: ≥ 74%
All other Orgs Reporting: Required
Cut Points:
1 Star: < 59%
2 Stars: ≥ 59% and < 69%
3 Stars: ≥ 69% and < 74%
4 Stars: ≥ 74% and < 82%
5 Stars: ≥ 82%

Measure: C02 - Colorectal Cancer Screening

Label for Stars: Colorectal Cancer Screening
Label for Data: Colorectal Cancer Screening
HEDIS Label: Colorectal Cancer Screening (COL)
Description: Percent of plan members aged 50-75 who had appropriate screening for colon cancer.
Metric: Percent of MA enrollees aged 50 to 75 (denominator) who had appropriate screening for colorectal cancer (numerator).
Data Source: HEDIS
Data Time Frame: 1/1/2009 - 12/31/2009
Statistical Method: Relative Distribution with Clustering
General Trend: Higher is better
Data Display: Percentage with no decimal point
PFFS & MSA Reporting: Voluntary
4 Star Threshold: ≥ 58%
All other Orgs Reporting: Required
Cut Points:
1 Star: < 36%
2 Stars: ≥ 36% and < 48%
3 Stars: ≥ 48% and < 58%
4 Stars: ≥ 58% and < 70%
5 Stars: ≥ 70%

Measure: C03 - Cardiovascular Care - Cholesterol Screening

Label for Stars: Cholesterol Screening for Patients with Heart Disease

Label for Data: Cholesterol Screening for Patients with Heart Disease

HEDIS Label: Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

Description: Percent of plan members with heart disease who have had a test for “bad” (LDL) cholesterol within the past year.

Metric: Percent of MA enrollees age 18-75 with ischemic vascular disease, AMI, coronary bypass Graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) (denominator) who had LDL-C test performed during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 85%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 72%

2 Stars: ≥ 72% and < 79%

3 Stars: ≥ 79% and < 85%

4 Stars: ≥ 85% and < 93%

5 Stars: ≥ 93%

Measure: C04 - Diabetes Care - Cholesterol Screening

Label for Stars: Cholesterol Screening for Patients with Diabetes

Label for Data: Cholesterol Screening for Patients with Diabetes

HEDIS Label: Comprehensive Diabetes Care (CDC) – LDL-C Screening

Description: Percent of plan members with diabetes who have had a test for “bad” (LDL) cholesterol within the past year.

Metric: Percent of diabetic MA enrollees 18-75 with diabetes type I and II (denominator) who had an LDL-C test performed during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 85%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 73%

2 Stars: ≥ 73% and < 81%

3 Stars: ≥ 81% and < 85%

4 Stars: ≥ 85% and < 89%

5 Stars: ≥ 89%

Measure: C05 - Glaucoma Testing

Label for Stars: Glaucoma Testing

Label for Data: Glaucoma Testing

HEDIS Label: Glaucoma Screening in Older Adults (GSO)

Description: Percent of senior plan members who got a glaucoma eye exam for early detection.

Metric: Percent of MA enrollees aged 65 or older without a prior diagnosis of glaucoma (denominator) who had at least one glaucoma exam by an eye doctor during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 70%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 51%

2 Stars: ≥ 51% and < 57%

3 Stars: ≥ 57% and < 70%

4 Stars: ≥ 70% and < 76%

5 Stars: ≥ 76%

Measure: C06 - Appropriate Monitoring for Patients Taking Long Term Medications

Label for Stars: Monitoring of Patients Taking Long-term Medications

Label for Data: Monitoring of Patients Taking Long-term Medications

HEDIS Label: Annual Monitoring for Patients on Persistent Medications (MPM)

Description: Percent of plan members who got a 6 month (or longer) prescription for a drug known to have possibly harmful side effects among seniors if used long-term, and who had at least one appropriate follow-up visit during the year to monitor these medications: Angiotensin Converting Enzyme (ACE) inhibitors, Angiotensin Receptor Blockers (ARB), digoxin, diuretics and anticonvulsants.

Metric: Percent of MA enrollees 18 or older who received at least a 180 day supply of ambulatory medication therapy for a select therapeutic agent (denominator), and who received at least one monitoring event appropriate for the specific therapeutic agent during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 90%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 70%

2 Stars: ≥ 70% and < 78%

3 Stars: ≥ 78% and < 90%

4 Stars: ≥ 90% and < 92%

5 Stars: ≥ 92%

Measure: C07 - Annual Flu Vaccine

Label for Stars: Annual Flu Vaccine

Label for Data: Annual Flu Vaccine

Description: Percent of plan members aged 65+ who got a vaccine (flu shot) prior to flu season.

Metric: Percent of sampled Medicare enrollees (denominator) who received an influenza vaccination between September – December during the measurement year (numerator).
• Have you had a flu shot since September 2009?

Data Source: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 70.6329%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C08 - Pneumonia Vaccine

Label for Stars: Pneumonia Vaccine

Label for Data: Pneumonia Vaccine

Description: Percent of plan members aged 65+ who ever got a vaccine (shot) to prevent pneumonia.

Metric: Percent of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator).
• Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu.

Data Source: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 69.8590%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C09 - Improving or Maintaining Physical Health

Label for Stars: Improving or Maintaining Physical Health

Label for Data: Improving or Maintaining Physical Health

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

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

Data Source: HOS

Data Time Frame: Apr - Aug 2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 60%

All other Orgs Reporting: Required

Cut Points:

1 Star: Not Applicable

2 Stars: < 57%

3 Stars: ≥ 57% and < 60%

4 Stars: ≥ 60% and < 68%

5 Stars: ≥ 68%

Measure: C10 - Improving or Maintaining Mental Health

Label for Stars: Improving or Maintaining Mental Health

Label for Data: Improving or Maintaining Mental Health

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

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

Data Source: HOS

Data Time Frame: Apr - Aug 2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 85%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 76%

2 Stars: ≥ 76 and < 81%

3 Stars: ≥ 81 and < 85%

4 Stars: ≥ 85% and < 95%

5 Stars: ≥ 95%

Measure: C11 - Osteoporosis Testing

Label for Stars: Osteoporosis Testing

Label for Data: Osteoporosis Testing

HEDIS Label: Osteoporosis Testing in Older Women (OTO)

Description: Percent of female, senior plan members who had a bone density test to check for osteoporosis (fragile bones).

Metric: Percent of sampled Medicare female enrollees 65 years of age or older (denominator) who report ever having received a bone density test to check for osteoporosis (numerator).

Data Source: HEDIS / HOS

Data Time Frame: Apr - Aug 2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 73%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 57%

2 Stars: ≥ 57% and < 62%

3 Stars: ≥ 62% and < 73%

4 Stars: ≥ 73% and < 79%

5 Stars: ≥ 79%

Measure: C12 - Monitoring Physical Activity

Label for Stars: Monitoring Physical Activity

Label for Data: Monitoring Physical Activity

HEDIS Label: Physical Activity in Older Adults (PAO)

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

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

Data Source: HEDIS / HOS

Data Time Frame: Apr - Aug 2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 60%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 46%

2 Stars: ≥ 46% and < 51%

3 Stars: ≥ 51% and < 60%

4 Stars: ≥ 60% and < 85%

5 Stars: ≥ 85%

Measure: C13 - Access to Primary Care Doctor Visits

Label for Stars: At Least One Primary Care Doctor Visit in the Last Year

Label for Data: At Least One Primary Care Doctor Visit in the Last Year

HEDIS Label: Adults' Access to Preventive/Ambulatory Health Services (AAP)

Description: Percent of all plan members who saw their primary care doctor during the year.

Metric: Percent of MA enrollees age 20 and older (denominator) who had an ambulatory or preventive care visits during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 85%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 74%

2 Stars: ≥ 74% and < 81%

3 Stars: ≥ 81% and < 85%

4 Stars: ≥ 85% and < 94%

5 Stars: ≥ 94%

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C14 - Osteoporosis Management in Women who had a Fracture

Label for Stars: Osteoporosis Management

Label for Data: Osteoporosis Management

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

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

Metric: Percent of female MA enrollees 67 and older who suffered a fracture during the measurement year (denominator), and who subsequently had either a bone mineral density test or were prescribed a drug to treat or prevent osteoporosis in the six months after the fracture (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 60%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 23%

2 Stars: ≥ 23% and < 41%

3 Stars: ≥ 41% and < 60%

4 Stars: ≥ 60% and < 85%

5 Stars: ≥ 85%

Measure: C15 - Diabetes Care – Eye Exam

Label for Stars: Eye exam to check for damage from diabetes

Label for Data: Eye exam to check for damage from diabetes

HEDIS Label: Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed

Description: Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year

Metric: Percent of diabetic MA enrollees (denominator) who had a retinal or dilated eye exam by an eye care professional during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 64%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 45%

2 Stars: ≥ 45% and < 54%

3 Stars: ≥ 54% and < 64%

4 Stars: ≥ 64% and < 75%

5 Stars: ≥ 75%

Measure: C16 - Diabetes Care – Kidney Disease Monitoring

Label for Stars: Kidney function testing for members with diabetes

Label for Data: Kidney function testing for members with diabetes

HEDIS Label: Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy

Description: Percent of plan members with diabetes who had a kidney function test during the year

Metric: Percent of diabetic MA enrollees (denominator) who either had a urine microalbumin test during the measurement year, or who had received medical attention for nephropathy during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 85%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 79%

2 Stars: ≥ 79% and < 83%

3 Stars: ≥ 83% and < 85%

4 Stars: ≥ 85% and < 90%

5 Stars: ≥ 90%

Measure: C17 - Diabetes Care – Blood Sugar Controlled

Label for Stars: Plan Members with Diabetes whose blood sugar is under control

Label for Data: Plan Members with Diabetes whose blood sugar is under control

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

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

Metric: Percent of diabetic MA enrollees whose most recent HbA1c level is greater than 9 (denominator), or who were not tested during the measurement year (numerator). (This measure for public reporting is reversed score so higher scores are better.)

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 80%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 24%

2 Stars: ≥ 24% and < 49%

3 Stars: ≥ 49% and < 80%

4 Stars: ≥ 80% and < 87%

5 Stars: ≥ 87%

Measure: C18 - Diabetes Care – Cholesterol Controlled

Label for Stars: Plan Members with Diabetes whose Cholesterol Is Under Control

Label for Data: Plan Members with Diabetes whose Cholesterol Is Under Control

HEDIS Label: Comprehensive Diabetes Care (CDC) – LDL-C control (<100 mg/dL)

Description: Percent of plan members with diabetes who had a cholesterol test during the year that showed an acceptable level of “bad” (LDL) cholesterol.

Metric: Percent of diabetic MA enrollees (denominator) whose most recent LDL-C level during the measurement year was 100 or less (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 53%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 30%
2 Stars: ≥ 30% and < 41%
3 Stars: ≥ 41% and < 53%
4 Stars: ≥ 53% and < 61%
5 Stars: ≥ 61%

Measure: C19 - Controlling Blood Pressure

Label for Stars: Controlling Blood Pressure

Label for Data: Controlling Blood Pressure

HEDIS Label: Controlling High Blood Pressure (CBP)

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

Metric: Percent of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) during the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 63%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 26%
2 Stars: ≥ 26% and < 52%
3 Stars: ≥ 52% and < 63%
4 Stars: ≥ 63% and < 74%
5 Stars: ≥ 74%

Measure: C20 - Rheumatoid Arthritis Management

Label for Stars: Rheumatoid Arthritis Management

Label for Data: Rheumatoid Arthritis Management

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

Description: Percent of plan members with Rheumatoid Arthritis who got 1 or more prescription(s) for an anti-rheumatic drug.

Metric: Percent of MA enrollees diagnosed with rheumatoid arthritis during the measurement year (denominator), and who received at least one prescription for a disease modifying anti-rheumatic drug (DMARD) (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 78%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 46%

2 Stars: ≥ 46% and < 70%

3 Stars: ≥ 70% and < 78%

4 Stars: ≥ 78% and < 83%

5 Stars: ≥ 83%

Measure: C21 - Testing to Confirm Chronic Obstructive Pulmonary Disease

Label for Stars: Testing to Confirm Chronic Obstructive Pulmonary Disorder

Label for Data: Testing to Confirm Chronic Obstructive Pulmonary Disorder

HEDIS Label: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Description: Percent of senior plan members with active Chronic Obstructive Pulmonary Disease who got appropriate spirometry testing to confirm the diagnosis.

Metric: Percent of MA enrollees 40 or older with a new diagnosis or newly active Chronic Obstructive Pulmonary Disease (COPD) during the measurement year (denominator), who received appropriate spirometry testing to confirm the diagnosis (numerator).

Data Source: HEDIS

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 60%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 20%

2 Stars: ≥ 20% and < 35%

3 Stars: ≥ 35% and < 60%

4 Stars: ≥ 60% and < 83%

5 Stars: ≥ 83%

Measure: C22 - Improving Bladder Control

Label for Stars: Improving Bladder Control

Label for Data: Improving Bladder Control

HEDIS Label: Management of Urinary Incontinence in Older Adults (MUI)

Description: Percent of members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.

Metric: Percent of Medicare members 65 years of age or older (denominator) who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem (numerator).

Data Source: HEDIS / HOS

Data Time Frame: Apr - Aug 2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 60%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 32%

2 Stars: ≥ 32% and < 39%

3 Stars: ≥ 39% and < 60%

4 Stars: ≥ 60% and < 85%

5 Stars: ≥ 85%

Measure: C23 - Reducing the Risk of Falling

Label for Stars: Reducing the Risk of Falling

Label for Data: Reducing the Risk of Falling

HEDIS Label: Fall Risk Management (FRM)

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

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

Data Source: HEDIS / HOS

Data Time Frame: Apr - Aug 2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Voluntary

4 Star Threshold: ≥ 59%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 51%

2 Stars: ≥ 51% and < 55%

3 Stars: ≥ 55 and < 59

4 Stars: ≥ 59% and < 65%

5 Stars: ≥ 65%

Domain: 3 - Ratings of Health Plan Responsiveness and Care

Measure: C24 - Getting Needed Care

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

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

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

Metric: Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
• In the last 6 months, how often was it easy to get appointments with specialists?
• In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

Data Source: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 85.0912%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average case-mix adjusted CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average case-mix adjusted CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average case-mix adjusted CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C25 - Doctors who Communicate Well

Label for Stars: Doctors Who Communicate Well

Label for Data: Doctors Who Communicate Well

Description: Percent of best possible score the plan earned on how well doctors communicate.

Metric: Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:

- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?
- In the last 6 months, how often did your personal doctor spend enough time with you?

Data Source: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 90.1535%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average case-mix adjusted CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average case-mix adjusted CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average case-mix adjusted CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C26 - Getting Appointments and Care Quickly

Label for Stars: Getting Appointments and Care Quickly

Label for Data: Getting Appointments and Care Quickly

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

Metric: Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
• In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
• In the last 6 months, not counting the times when you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

Data Source: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 75.3601%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average case-mix adjusted CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average case-mix adjusted CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average case-mix adjusted CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C27 - Customer Service

Label for Stars: Customer Service

Label for Data: Customer Service

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

Metric: Mean of CAHPS Composite converted to a scale from 0 to 100 that includes the following questions:
• In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
• In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?
• In the last 6 months, how often were the forms for your health plan easy to fill out?

Data Source: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 88.4232%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average case-mix adjusted CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average case-mix adjusted CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average case-mix adjusted CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C28 - Overall Rating of Health Care Quality

Label for Stars: Overall Rating of Health Care Quality

Label for Data: Overall Rating of Health Care Quality

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

Metric: Mean of CAHPS Rating converted to a scale from 0 to 100 for the following question:
• 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: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 85.1088%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average case-mix adjusted CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average case-mix adjusted CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average case-mix adjusted CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Measure: C29 - Overall Rating of Plan

Label for Stars: Members' Overall Rating of Health Plan

Label for Data: Members' Overall Rating of Health Plan

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

Metric: Mean of CAHPS Rating converted to a scale from 0 to 100 for the following question:
• 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: CAHPS

Data Time Frame: Feb - June 2010

Statistical Method: Relative Distribution and Significance Testing

General Trend: Higher is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 85.0271%

All other Orgs Reporting: Required

Cut Points:

1 Star: A contract is assigned 1 star if the contract's average case-mix adjusted CAHPS measure score is ranked below the 15th percentile and the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

2 Stars: A contract is assigned 2 stars if it does not meet the 1 star criteria and meets at least one of these two criteria: (a) the contract's average case-mix adjusted CAHPS measure score is lower than the 30th percentile OR (b) the contract's average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

3 Stars: A contract is assigned 3 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 30th percentile (inclusive) and the contract's average CAHPS measure score is below the cutoff defined for 4 stars.

4 Stars: A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average case-mix adjusted CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure.

5 Stars: A contract is assigned 5 stars if the contract's average case-mix adjusted CAHPS measure score is ranked above the 80th percentile and the contract's average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score.

Domain: 4 - Health Plan Members' Complaints and Appeals

Measure: C30 - Complaints about the Health Plan

Label for Stars: Complaints about the Health Plan

Label for Data: Complaints about the Health Plan (number of complaints for every 1,000 members)

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

Metric: Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).

• Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract.
• A contract's failure to follow CMS' CTM Standard Operating Procedures will not result in CMS' adjustment of the data used for these measures.
• Data Exclusions: Some complaints that cannot be clearly attributed to the plan are excluded. These complaints include the following complaint types: complaints regarding 1-800-MEDICARE, websites, State Health Insurance Programs (SHIPs), Social Security Administration (SSA), or Medicare Drug Integrity Contractors (MEDICs); enrollment reconciliation issues, facilitated enrollment issues; beneficiary loss of LIS status/eligibility; enrollment exceptions; complaints identified as a CMS issue; or Part D premium overcharge issues.
• Exclusions: Complaint rates are not calculated for plans with enrollment less than 800 beneficiaries.

Data Source: CTM

Data Time Frame: 1/1/2010 - 06/30/2010

Statistical Method: Relative Distribution with Clustering

General Trend: Lower is better

Data Display: Rate with 2 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: Not Predetermined

All other Orgs Reporting: Required

Cut Points:
1 Star: > 1.51
2 Stars: > 1.1 and ≤ 1.51
3 Stars: > 0.75 and ≤ 1.1
4 Stars: > 0.23 and ≤ 0.75
5 Stars: ≤ 0.23

Measure: C31 - Plan Makes Timely Decisions about Appeals

Label for Stars: Health Plan Makes Timely Decisions about Appeals

Label for Data: Health Plan Makes Timely Decisions about Appeals

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

Metric: Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals cases decided by the IRE (includes only Upheld, Overturned and Partially Overturned cases) (denominator). If the denominator is <=10, the result is "Not enough data available to calculate the measure".

Data Source: IRE Maximus

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 85%

All other Orgs Reporting: Required

Cut Points:
1 Star: < 55%
2 Stars: ≥ 55% and < 70%
3 Stars: ≥ 70% and < 85%
4 Stars: ≥ 85% and < 91%
5 Stars: ≥ 91%

Measure: C32 - Reviewing Appeals Decisions

Label for Stars: Fairness of Health Plan's Denials to Member Appeals, Based on an Independent reviewer

Label for Data: Fairness of Health Plan's Denials to Member Appeals, Based on an Independent reviewer

Description: How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.

Metric: Percent of appeals cases where a plan's decision was "upheld" by the IRE (numerator) out of all the plan's appeals cases ("upheld", "overturned" and "partially overturned" cases only) that the IRE reviewed (denominator). If the minimum number of cases is (upheld + overturned + partially overturned) <=10, the result is "Not enough data available to calculate the measure".

Appeals can be filed on behalf of the beneficiary so this measure includes both beneficiary and provider appeals. A contract provider (i.e., a health plan network provider) can file an appeal on behalf of an MA member. However, appeals can also be filed by non-contract providers under certain circumstances (i.e., when the non-contract provider completes a waiver of liability form, agreeing to file an appeal on his/her own behalf and waiving financial liability of the MA member except for the member's cost sharing responsibility).

Data Source: IRE Maximus

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Required

4 Star Threshold: ≥ 87%

All other Orgs Reporting: Required

Cut Points:

1 Star: < 64%

2 Stars: ≥ 64% and < 74%

3 Stars: ≥ 74% and < 87%

4 Stars: ≥ 87% and < 92%

5 Stars: ≥ 92%

Measure: C33 - Corrective Action Plans

Label for Stars: Beneficiary Access Problems Medicare Found During an Audit of the Health Plan (more stars are better because they mean fewer serious problems)

Label for Data: Beneficiary Access Problems Medicare Found During an Audit of the Health Plan (on a scale from 0 to 100; lower numbers are better because they mean fewer serious problems)

Description: Medicare oversees the operations of health plans by auditing. Some plans are selected at random for an audit. Other plans are audited because Medicare thinks there could be a problem. Not every plan is audited every year, so “not audited” is neither good nor bad.

Medicare gives the plan a rating from 0 to 100 beneficiary access problems found during an audit. The rating combines how severe the problems were, how many there were, and how much they affect plan members directly.

Metric: 1. This score is based on CMS' audit findings of health and drug plans. A health or drug plan may be audited as part of CMS' routine monitoring and oversight activities, or as an ad-hoc activity due to CMS identifying an issue or concern. Standardized CMS audit guides are used to review many different areas of a contract’s operations. Only those elements from CMS' audit guides representing potential harm to beneficiaries either through financial impact or access to services or medications are included.

• Each element in CMS' audit guides were categorized by the potential harm to beneficiaries either through financial impact or access to services or medications, or if a contract did not meet CMS standards. Each category was then assigned a point value. The following points were assigned to each category:

i. No beneficiary harm, with no risk of financial impact – 1 point*
ii. No beneficiary harm, with financial impact – 3 points*
iii. Beneficiary harm, with no risk of financial impact - 5 points
iv. Beneficiary harm, with risk of financial impact – 7 points
v. Beneficiary harm, with risk of impact to access to services or medications – 10 points
vi. For each failed ad-hoc audit – additional 10 points

* As of 8/19/10, this category is excluded from this measure’s calculation.

• For contracts audited in the measurement time period, a score was calculated using the formula: contract score = ((Sum of points for failed elements)/ Sum of points for audited elements))*100) + (Points from failed ad-hoc audits). The maximum score that could be received by a contract was 100.

• Contracts that were neither audited in the measurement time period nor had an ad hoc finding are displayed as, "No data available”. A footnote also states, “No information is shown because Medicare did not audit this plan during the previous year. This is neither good nor bad, because Medicare does not always audit plans every year.”

2. Exclusions: Contracts with 3 or fewer reviewed elements or that were not audited in the measurement period are not assigned a score.

Data Source: HPMS Audit Modules

Data Time Frame: 1/1/2009 - 12/31/2009

Statistical Method: Relative Distribution with Clustering

General Trend: Lower is better

Data Display: Rate with 0 decimal points

PFFS & MSA Reporting: Required

4 Star Threshold: Not Predetermined

All other Orgs Reporting: Required

Cut Points:

1 Star: > 70
2 Stars: > 52 and ≤ 70
3 Stars: > 33 and ≤ 52
4 Stars: > 7 and ≤ 33
5 Stars: ≤ 7

Domain: 5 - Health Plan Telephone Customer Service

Measure: C34 - Call Center - Hold Time

Label for Stars: Time on Hold When Customer Calls Health Plan

Label for Data: Time on Hold When Customer Calls Health Plan (minutes: seconds)

Description: How long members wait on hold when they call the health plan's customer service number.

Metric: Hold time - Average number of seconds between IVR or message pickup and response by a CSR.

Data Source: Call Center

Data Time Frame: 1/1/2010 - 06/30/2010

Statistical Method: CMS Standard, Relative Distribution and Clustering

General Trend: Lower is better

Data Display: Time

PFFS & MSA Reporting: Required

3 Star Threshold: ≤ 135 Seconds

All other Orgs Reporting: Required

Cut Points:

1 Star: > 201 seconds

2 Stars: > 135 and ≤ 201 seconds

3 Stars: > 89 and ≤ 135 seconds

4 Stars: > 50 and ≤ 89 seconds

5 Stars: ≤ 50 seconds

Measure: C35 - Call Center - Information Accuracy

Label for Stars: Accuracy of Information Members Get When They Call the Health Plan

Label for Data: Accuracy of Information Members Get When They Call the Health Plan

Description: Percent of the time members are given correct information by the health plan's customer service representative.

Metric: Information accuracy - Percent of the time CSRs answered questions correctly.

Data Source: Call Center

Data Time Frame: 1/1/2010 - 06/30/2010

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Required

4 Star Threshold: Not Predetermined

All other Orgs Reporting: Required

Cut Points:

1 Star: < 80%

2 Stars: ≥ 80% and < 86%

3 Stars: ≥ 86% and < 90%

4 Stars: ≥ 90% and < 92%

5 Stars: ≥ 92%

Measure: C36 - Call Center - Foreign Language interpreter and TTY/TDD availability

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

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

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

Metric: Foreign Language interpreter and TTY/TDD availability - Percent of the time a foreign language interpreter or TTY/TDD service was available to callers who spoke a foreign language or were hearing impaired.

Data Source: Call Center

Data Time Frame: 1/1/2010 - 06/30/2010

Statistical Method: Relative Distribution with Clustering

General Trend: Higher is better

Data Display: Percentage with no decimal point

PFFS & MSA Reporting: Required

4 Star Threshold: Not Predetermined

All other Orgs Reporting: Required

Cut Points:

1 Star: < 31%

2 Stars: ≥ 31% and < 56%

3 Stars: ≥ 56% and < 72%

4 Stars: ≥ 72% and < 80%

5 Stars: ≥ 80%

Methodology for Calculating Star Ratings

CMS will release Parts C and D Plan Ratings for the CY2011 annual enrollment period this fall. There are a total of 9 topic areas (domains) comprised of 53 individual measures. MA only plans are measured on 5 topic areas (36 measures). PDPs are measured on 4 topic areas (17 measures). MA-PD plans are measured on both sets of topic areas (53 measures).

For each individual measure, CMS assigns a star-rating based on a 5 star scale. CMS also assigns a star-rating for each of the 9 topic areas and an overall summary rating for each contract.

Calculating Individual Measure Scores:
CMS assigns stars for each measure by applying one of three different methods: relative distribution and clustering; relative distribution and significance testing; and CMS standard, relative distribution, and clustering. Each method is described in detail below.

A. Relative Distribution and Clustering:

This method is applied to the majority of CMS' plan ratings for star assignments, ranging from operational and process-based measures, as well as HEDIS and other clinical care measures. The following sequential statistical steps are taken to derive thresholds based on the relative distribution of the data. The first step is to assign initial thresholds using an adjusted percentile approach and a two-stage clustering analysis method. These methods jointly produce initial thresholds to account for gaps in the data and the relative number of contracts with an observed star value. The adjusted percentile approach adjusts the initial percentile breakpoints created by any regular percentile approach to account for gaps in the data.

Detailed description:

1. By using Euclidean metric (defined in Attachment D), scale the raw measures to comparable metrics, and group them into clusters. Clusters are defined as contracts with similar Euclidean distances between their data value to the center data value. Six different clustering scenarios are tested, where the smallest number of clusters is 10, and the largest number of clusters is 35. The results from each of these clustering scenarios are evaluated for potential star thresholds. The formula for scaling a contract's raw measure value (X) for a measure (M) is the following, where $Scale_{\min} = 0.025$ and $Scale_{\max} = 0.975$:

   Scaled measure value = $(Scale_{\max} - Scale_{\min}) * \frac{(X - M_{\min})}{(M_{\max} - M_{\min})} + Scale_{\min}$

2. Determine up to five star groupings and their corresponding thresholds from the means of each cluster derived in the Step 1.

In applying these two steps, goodness of fit analysis using an empirical distribution function test in an iterative process is performed as needed to test the properties of the

raw measure data distribution in contrast to various types of continuous distributions. Additional sub-tests are also applied and include: Kolmogorov- Smirnov statistic, Cramer-von Mises statistic, and Anderson-Darling statistic. See Appendix 1 for definitions of these tests.

Following these steps, the estimates of thresholds for star assignments derived from the adjusted percentile and clustering analyses are combined to produce final individual measure star ratings.

B. Relative Distribution and Significance Testing:

This method is applied to determine valid star thresholds for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars a contract's CAHPS measure score needs to be ranked above the 80th percentile and be statistically significantly higher than the national average CAHPS measure score. A contract is assigned 4 stars if it does not meet the 5 star criteria, but the contract's average CAHPS measure score exceeds a cutoff defined by the 60th percentile of plan means in 2009 CAHPS reports for the same measure. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and the contract's CAHPS measure score is statistically significantly lower than the national average CAHPS measure score.

C. CMS Standard, Relative Distribution, and Clustering:

For measures with a CMS published standard, the CMS standard has been incorporated into star thresholds. Currently, the only measures in which this method applies are the call center hold time measures. Contracts meeting or exceeding the CMS standard are assigned at least 3 stars. To determine the thresholds of the other star ratings (e.g. 1, 2, 4, and 5 stars), the steps outlined above for relative distribution and clustering are applied.

Calculating Summary Scores:
Each contract's summary score is a number in the range of 1.0 to 5.0 that summarizes all of the individual performance measures. A simple average of the star ratings for the individual measures for a contract is computed, and then adjusted to account for low variance and high performance across the individual measures. This adjustment enables CMS to reward contracts for consistently obtaining a high rating for individual measures. Finally, the summary scores are rounded to the nearest half-star scale ranging up to 5.0 stars.

Detailed description of steps:

1. Calculate the mean and the variance of the individual performance measure stars at the contract level.

2. Categorize the variance into three categories of low, medium, and high percentile groupings.

3. Add adjustments for variability and performance to the mean overall score by contract. Example adjustments made for MA-only measures are as follows:
   - 0.4 (for contract w/low-variability and high-mean (mean >= 85th percentile)
   - 0.3 (for contract w/medium-variability and high-mean (mean >= 85th percentile)
   - 0.2 (for contract w/low-variability and relatively high-mean (mean >= 65th & < 85th percentile)
   - 0.1 (for contract w/medium-variability and relatively high-mean (mean >= 65th & < 85th percentile)
   - 0.0 (for other types of contracts)

4. Develop final summary score using 0.5 as the star scale (create 10 possible overall scores as:
   0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0).

5. Apply rounding to final summary score such that stars that are within the distance of .25 above or below any half star scale will be rounded to that half star scale.

CAHPS Case-Mix Adjustment

The CAHPS measures are case-mix adjusted to take into account the mix of enrollees. It includes dual eligibility and education among other variables. The table below includes the case-mix variables and shows the case-mix coefficients for each of the CAHPS measures included in the Medicare Plan Finder tool. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to others with the baseline value for that characteristic, on the 0-100 scale used in consumer reports. For example, for the measure "rating of care", the coefficient for "age 80-84" is +1.00, indicating that respondents in that age range tends to score their plans 1.00 point higher than otherwise similar people in the 70-74 age range, the baseline or reference category. Similarly dual eligibles tend to respond -0.46 points lower on this item than otherwise similar non-duals. Contracts with more-than-average concentrations of respondents who are in the 80-84 age range will be adjusted downwards to compensate for the positive response tendency of their respondents. Similarly, contracts with above-average concentrations of respondents who are dual eligibles will be adjusted upwards to compensate for their respondents negative response tendency. The case-mix patterns are not always consistent across measures.

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

Health Plan CAHPS measures

	Rating of Plan	Rating of Care	Getting Care Quickly Composite	Getting Needed Care Composite	Doctors Who Communicate Well Composite	Health Plan Customer Service Composite
age: 64 and younger	-2.33	-1.72	-1.99	-2.34	0.22	-1.44
age: 65-69	-0.89	-0.70	-0.02	-0.47	0.13	0.17
age: 70-74(reference)	0.00	0.00	0.00	0.00	0.00	0.00
age: 75-79	1.19	0.14	0.00	0.39	-0.39	1.30
age: 80-84	2.32	1.00	0.21	0.82	-0.34	1.34
age: 85 and older	2.48	0.70	0.46	0.08	-0.89	1.10
less than an 8th grade education	1.07	-0.75	-1.94	-0.26	-0.48	-1.37
some high school	1.05	0.06	-0.97	0.40	0.23	-0.02
high school graduate(reference)	0.00	0.00	0.00	0.00	0.00	0.00
some college	-1.79	-1.09	-0.40	-1.57	-0.71	-1.79
college graduate	-3.02	-1.27	-0.32	-2.61	-0.86	-2.39
more than a bachelor's degree	-3.44	-2.01	-0.32	-3.12	-0.87	-3.29
general health rating_excellent	4.07	4.20	3.13	3.44	2.52	1.95
general health rating_very good	2.03	2.20	1.82	1.59	1.57	1.32
general health rating_good(reference)	0.00	0.00	0.00	0.00	0.00	0.00
general health rating_fair	-1.69	-2.44	-1.32	-1.87	-1.29	-1.11
general health rating_poor	-3.60	-3.98	-1.41	-3.11	-2.63	-2.69

Attachment B: Case-Mix Adjusters

	Rating of Plan	Rating of Care	Getting Care Quickly Composite	Getting Needed Care Composite	Doctors Who Communicate Well Composite	Health Plan Customer Service Composite
mental health rating_excellent	3.41	4.69	3.70	4.81	4.33	2.33
mental health rating_very good	1.25	2.02	1.35	2.07	1.61	1.07
mental health rating_good(reference)	0.00	0.00	0.00	0.00	0.00	0.00
mental health rating_fair	-1.47	-1.67	-0.94	-1.71	-1.65	-1.18
mental health rating_poor	-3.35	-2.85	-1.39	-2.49	-1.39	-1.80
proxy_helped	-1.80	-2.08	-1.76	-1.16	-0.34	-1.34
proxy_answered	-1.94	-1.37	0.00	-0.47	-0.51	-1.48
Medicaid dual eligible	2.97	-0.46	-0.61	-0.91	-0.23	0.55
Low Income Subsidy(LIS)	0.75	-0.50	-1.21	-1.54	-0.28	-0.98

Prescription Drug CAHPS Measures

	Rate PD plan	Getting needed prescription drugs	Getting information from PD plan about prescription drugs
age: 64 and younger	-3.26	-2.66	-1.35
age: 65-69	-1.05	-0.36	0.65
age: 70-74(reference)	0.00	0.00	0.00
age: 75-79	1.62	0.16	0.06
age: 80-84	3.35	0.44	0.46
age: 85 and older	4.12	0.07	0.58
less than an 8th grade education	0.94	-2.35	-5.18
some high school	1.21	-0.80	-2.49
high school graduate(reference)	0.00	0.00	0.00
some college	-2.16	-1.01	-0.81
college graduate	-2.94	-1.25	-0.49
more than a bachelor's degree	-3.62	-2.20	-1.32
general health rating_excellent	4.50	1.08	4.18
general health rating_very good	2.12	1.15	2.66
general health rating_good(reference)	0.00	0.00	0.00
general health rating_fair	-1.58	-1.23	-1.39
general health rating_poor	-3.01	-2.75	-4.24
mental health rating_excellent	2.84	2.97	4.02
mental health rating_very good	1.16	1.52	2.04
mental health rating_good(reference)	0.00	0.00	0.00
mental health rating_fair	-1.21	-1.40	-1.99
mental health rating_poor	-3.50	-2.53	-1.77
proxy_helped	-3.29	0.40	1.35
proxy_answered	-2.87	1.55	1.75
Medicaid dual eligible	6.33	0.39	0.18
Low Income Subsidy(LIS)	5.31	-0.02	-2.04

Attachment C: National Averages for Individual Measures

Measure ID	Measure Name	National Average
C01	Breast Cancer Screening	68%
C02	Colorectal Cancer Screening	51%
C03	Cholesterol Screening for Patients with Heart Disease	88%
C04	Cholesterol Screening for Patients with Diabetes	87%
C05	Glaucoma Testing	63%
C06	Monitoring of Patients Taking Long-term Medications	89%
C07	Annual Flu Vaccine	65%
C08	Pneumonia Vaccine	65.64%
C09	Improving or Maintaining Physical Health	66.74%
C10	Improving or Maintaining Mental Health	77%
C11	Osteoporosis Testing	69%
C12	Monitoring Physical Activity	47%
C13	At Least One Primary Care Doctor Visit in the Last Year	96%
C14	Osteoporosis Management	20%
C15	Eye exam to check for damage from diabetes	62%
C16	Kidney function testing for members with diabetes	88%
C17	Plan Members with Diabetes whose blood sugar is under control	68%
C18	Plan Members with Diabetes whose Cholesterol Is Under Control	48%
C19	Controlling Blood Pressure	59%
C20	Rheumatoid Arthritis Management	73%
C21	Testing to Confirm Chronic Obstructive Pulmonary Disorder	28%
C22	Improving Bladder Control	36%
C23	Reducing the Risk of Falling	57%
C24	Ease of Getting Needed Care and Seeing Specialists	84.13%
C25	Doctors Who Communicate Well	89.36%
C26	Getting Appointments and Care Quickly	73.90%
C27	Customer Service	87.48%
C28	Overall Rating of Health Care Quality	84.13%
C29	Overall Rating of Plan	82.79%
C30	Complaints about the Health Plan (number of complaints for every 1,000 members)	0.63
C31	Health Plan Makes Timely Decisions about Appeals	87%
C32	Fairness of Health Plan’s Denials to Member Appeals, Based on an Independent reviewer	75%
C33	Beneficiary Access Problems Medicare Found During an Audit of the Health Plan	40
C34	Time on Hold When Customer Calls Health Plan (minutes : seconds)	0:53
C35	Accuracy of Information Members Get When They Call the Health Plan	89%
C36	Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan	69%

Glossary of Statistical Terms

Euclidean metric is the ordinary distance between two points that one would measure with a ruler.

Kolmogorov-Smirnov test (K–S test) uses a non-parametric technique and determines if two datasets are significantly different. It compares a sample with a reference probability distribution (one-sample K–S test), or compares two samples (two-sample K–S test).

Cramér-von-Mises criteria is used to judge the goodness of fit of a probability distribution, compared to a given empirical distribution function or to compare two empirical distributions.

Anderson–Darling test compares the similarity of an observed cumulative distribution function to an expected cumulative distribution function.

Attachment E: Data Time Frames

Domain ID	Domain	Measure ID	Measure	Data Time Frame
1	Staying Healthy: Screenings, Tests, and Vaccines	C01	Breast Cancer Screening	1/1/2009 - 12/31/2009
		C02	Colorectal Cancer Screening	1/1/2009 - 12/31/2009
		C03	Cardiovascular Care - Cholesterol Screening	1/1/2009 - 12/31/2009
		C04	Diabetes Care - Cholesterol Screening	1/1/2009 - 12/31/2009
		C05	Glaucoma Testing	1/1/2009 - 12/31/2009
		C06	Appropriate Monitoring for Patients Taking Long Term Medications	1/1/2009 - 12/31/2009
		C07	Annual Flu Vaccine	Feb - June 2010
		C08	Pneumonia Vaccine	Feb - June 2010
		C09	Improving or Maintaining Physical Health	Apr - Aug 2009
		C10	Improving or Maintaining Mental Health	Apr - Aug 2009
		C11	Osteoporosis Testing	Apr - Aug 2009
		C12	Monitoring Physical Activity	Apr - Aug 2009
		C13	Access to Primary Care Doctor Visits	1/1/2009 - 12/31/2009
2	Managing Chronic (Long-Lasting) Conditions	C14	Osteoporosis Management in Women who had a Fracture	1/1/2009 - 12/31/2009
		C15	Diabetes Care – Eye Exam	1/1/2009 - 12/31/2009
		C16	Diabetes Care – Kidney Disease Monitoring	1/1/2009 - 12/31/2009
		C17	Diabetes Care – Blood Sugar Controlled	1/1/2009 - 12/31/2009
		C18	Diabetes Care – Cholesterol Controlled	1/1/2009 - 12/31/2009
		C19	Controlling Blood Pressure	1/1/2009 - 12/31/2009
		C20	Rheumatoid Arthritis Management	1/1/2009 - 12/31/2009
		C21	Testing to Confirm Chronic Obstructive Pulmonary Disease	1/1/2009 - 12/31/2009
		C22	Improving Bladder Control	Apr - Aug 2009
		C23	Reducing the Risk of Falling	Apr - Aug 2009
3	Ratings of Health Plan Responsiveness and Care	C24	Getting Needed Care	Feb - June 2010
		C25	Doctors who Communicate Well	Feb - June 2010
		C26	Getting Appointments and Care Quickly	Feb - June 2010
		C27	Customer Service	Feb - June 2010
		C28	Overall Rating of Health Care Quality	Feb - June 2010
		C29	Overall Rating of Plan	Feb - June 2010
4	Health Plan Members' Complaints and Appeals	C30	Complaints about the Health Plan	1/1/2010 - 06/30/2010
		C31	Plan Makes Timely Decisions about Appeals	1/1/2009 - 12/31/2009
		C32	Reviewing Appeals Decisions	1/1/2009 - 12/31/2009
		C33	Corrective Action Plans	1/1/2009 - 12/31/2009
5	Health Plan's Telephone Customer Service	C34	Call Center - Hold Time	1/1/2010 - 06/30/2010
		C35	Call Center - Information Accuracy	1/1/2010 - 06/30/2010
		C36	Call Center - Foreign Language interpreter and TTY/TDD availability	1/1/2010 - 06/30/2010