Medicare 2018 Part C & D Display Measure Technical Notes

Updated – 04/03/2018

Document Change Log:

Previous Version	Description of Change	Revision Date
-	Release of the Display Measure Technical Notes	12/21/2017
12/21/2017	DMD15: Corrected language in the Metric and Data Source Description sections	04/03/2018

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General

This document describes the metric, data source, and reporting time period for each Medicare Part C or Part D Display Measure. All data are reported at the contract level. The data do not reflect information for National PACE, 1833 Cost contracts, Continuing Care Retirement Community demonstrations (CCRCs), End Stage Renal Disease Networks (ESRDs), and Demonstration contracts. All other organization types are included.

These display measures are not part of the Star Ratings. Display measures may have been transitioned from the Star Ratings. These can also be new measures being tested before inclusion into the Star Ratings. Lastly, some measures are displayed for informational purposes only. As indicated in the 2018 Call Letter, CMS will give advance notice if display measures are being considered for inclusion to the Star Ratings. Data for display page measures will continue to be collected and monitored, and poor scores on display measures are subject to compliance actions by CMS.

For 2018, CMS is

- Introducing three measures to display:
    a. High Risk Medication (Part D)
    b. Formulary Administration Analysis (Part D)
    c. Antipsychotic Use in Persons with Dementia (Part D)
- Removing eleven display measures
    a. Reminders for Appointments (Part C)
    b. Reminders for Immunizations (Part C)
    c. Reminders for Screening Tests (Part C)
    d. Computer Used during Office Visits (Part C)
    e. Computer Use by Doctor Helpful (Part C)
    f. Computer Use Made Talking with Doctor Easier (Part C)
    g. Improving Bladder Control (Part C)
    h. Medication Reconciliation Post Discharge (Part C)
    i. Medication Management for People With Asthma (Part C)
    j. Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes (Part D)
    k. Getting Information from Drug Plan (Part D)

Contact Information

The contact below can assist you with various aspects of the Display Measures.

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

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

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: CallCenterMonitoring@cms.hhs.gov
- Disenrollment Reasons Survey: DisenrollSurvey@cms.hhs.gov
- Formulary Administration Analysis: naseem.tarmohamed@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- HPMS Access issues: CMSHPMS_Access@cms.hhs.gov
- HPMS Help Desk (all other HPMS issues): HPMS@cms.hhs.gov
- Part C Plan Reporting: Partcplanreporting@cms.hhs.gov
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- Part C & D Plan Reporting Data Validation: PartCandD_Data_Validation@cms.hhs.gov

Part C Display Measure Details

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

Title	Description
HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 171
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator).
Exclusions:	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. Organizations must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC02 - Antidepressant Medication Management (6 months)

Title	Description
HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 162
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (numerator).
Exclusions:	Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population: • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: – AMM Stand Alone Visits Value Set with Major Depression Value Set. – AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set. • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

Title	Description
	• 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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC03 - Continuous Beta Blocker Treatment

Title	Description
HEDIS Label:	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 122
Metric:	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI (denominator) and who received persistent beta-blocker treatment for six months after discharge (numerator).
Exclusions:	(optional) Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member's history through the end of the continuous enrollment period meet criteria: • Asthma (Asthma Value Set). • COPD (COPD Value Set). • Obstructive chronic bronchitis (Obstructive Chronic Bronchitis Value Set). • Chronic respiratory conditions due to fumes and vapors (Chronic Respiratory Conditions Due to Fumes/Vapors Value Set). • Hypotension, heart block >1 degree or sinus bradycardia (Beta-Blocker Contraindications Value Set). • A medication dispensing event indicative of a history of asthma (Table PBH-D). • Intolerance or allergy to beta-blocker therapy.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC04 - Appropriate Monitoring of Patients Taking Long-term Medications

Title	Description
HEDIS Label:	Annual Monitoring for Patients on Persistent Medication (MPM)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 198
Metric:	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (denominator) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year (numerator).

Title	Description
Exclusions:	(optional) Exclude members from each eligible population who had an acute inpatient encounter (Acute Inpatient Value Set) or nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC05 - Osteoporosis Testing

Title	Description
HEDIS Label:	Osteoporosis Testing in Older Women (OTO)
Measure Reference:	NCQA HEDIS 2016 Specifications for The Medicare Health Outcomes Survey Volume 6, page 39
Metric:	The percentage of Medicare women 65 years of age and older (denominator) who report ever having received a bone density test to check for osteoporosis (numerator).
Exclusions:	None listed.
Primary Data Source:	HEDIS / HOS
Data Source Description:	Cohort 17 Follow-up Data collection (2016) and Cohort 19 Baseline data collection (2016). HOS Survey Question 52: Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger.
Data Source Category:	Survey of Enrollees
Data Time Frame:	04/18/2016 – 07/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC06 - Testing to Confirm Chronic Obstructive Pulmonary Disease

Title	Description
HEDIS Label:	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 98
Metric:	The percentage of members 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).
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC07 - Doctors who Communicate Well

Title	Description
Metric:	This case-mix adjusted composite measure is used to assess how well doctors communicate. 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. CAHPS Survey Questions (question numbers vary depending on survey type): • 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 listen carefully to you? • 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?
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2017 – 06/2017
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMC08 - Call Center – Beneficiary Hold Time

Title	Description
Metric:	This measure is defined as the average time spent on hold by the call surveyor following the navigation of the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and prior to reaching a live person for the "Customer Service for Current Members – Part C" phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part C contract beneficiary customer service call center, divided by the number of eligible calls made to the Part C contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the "hold" queue.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call Center
Data Source Description:	Call Center surveillance monitoring data collected by CMS. The "Customer Service for Current Members – Part C" phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	02/13/2017 – 06/02/2017
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMC09 - Pneumonia Vaccine

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator). CAHPS Survey Question (question numbers vary depending on survey type): • 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 a flu shot. It is also called the pneumococcal vaccine.
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2017 – 06/2017
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC10 - Access to Primary Care Doctor Visits

Title	Description
HEDIS Label:	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 251
Metric:	The percentage of members 20 years and older (denominator) who had an ambulatory or preventive care visit during the measurement year (numerator).
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place
Compliance Standard:	85%

Measure: DMC11 - Call Center - Calls Disconnected When Customer Calls Health Plan

Title	Description
Metric:	This measure is defined as the number of calls unexpectedly dropped by the sponsor divided by the total number of calls made to the phone number associated with the contract.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call Center
Data Source Description:	Call Center surveillance monitoring data collected by CMS. The "Customer Service for Current Members – Part C" phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	02/13/2017 – 06/02/2017
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places
Compliance Standard:	5%

Measure: DMC12 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

Title	Description
HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation (PCE)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 101
Metric:	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed a systemic corticosteroid within 14 days of the event.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC13 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

Title	Description
HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation (PCE)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 101
Metric:	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC14 - Initiation of Alcohol or other Drug Treatment

Title	Description
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 257
Metric:	The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC15 - Engagement of Alcohol or other Drug Treatment

Title	Description
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 257
Metric:	The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC16 - Hospitalization for Potentially Preventable Complications

Title	Description
HEDIS Label:	Hospitalization for Potentially Preventable Complications (HPC)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 354
Metric:	For members 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.
Exclusions:	CMS and NCQA have developed the following rules for removing outlier data which cause distorted results. 1) Data for contracts whose Observed / Expected ratio is either ≤0.02 or ≥ 5.0 have been excluded. 2) Data for contracts with <200 in the denominator have been excluded. Formulas to implement the above rules as well calculate the measure are contained in Attachment B. Contracts whose data was dropped because of these rules will be marked with the message "Insufficient data".
General Notes:	1876 Cost contracts, Demonstration MMP contracts and contracts whose data was dropped due to the exclusion rules were not included in the calculation of the National Observed Average.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Rate per 1,000 members with no decimal place

Measure: DMC17 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description
HEDIS Label:	Statin Therapy for Patients With Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 125
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

Title	Description
	cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
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 (Table SPC-A) 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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC18 - Asthma Medication Ratio

Title	Description
HEDIS Label:	Asthma Medication Ratio (AMR)
Measure Reference:	NCQA HEDIS 2017 Technical Specifications Volume 2, page 111
Metric:	The percentage of members 18–85 years of age who were identified as having persistent asthma (denominator) and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year (numerator).
Exclusions:	Exclude members who met any of the following criteria: • Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year: – Emphysema Value Set. – Other Emphysema Value Set. – COPD Value Set. – Obstructive Chronic Bronchitis Value Set. – Chronic Respiratory Conditions Due to Fumes/Vapors Value Set. – Cystic Fibrosis Value Set. – Acute Respiratory Failure Value Set. • Members who had no asthma medications (controller or reliever) dispensed (Table AMR-A) during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Part D Display Measure Details

Measure: DMD01 - Timely Receipt of Case Files for Appeals

Title	Description
Metric:	This measure is defined as the percent of case files that were requested by the IRE that were received timely from the plan. (Timely is defined as files being received from the plan within 48 hours for Standard appeals, and within 24 hours for Expedited appeals.) Numerator = The number of case files requested that were received in the required time frame. Denominator = The number of case files requested by the IRE. This is calculated as: [(The number of case files received in the required timeframe) / (The number of case files requested by the IRE)] * 100.
Exclusions:	None
Primary Data Source:	IRE
Data Source Description:	Data were obtained from the IRE contracted by CMS for Part D reconsiderations. These data are limited to appeal cases requested by beneficiaries and the IRE requests files from the plans. Cases auto-forwarded to the IRE are excluded.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD02 - Timely Effectuation of Appeals

Title	Description
Metric:	This measure is defined as the percent of appeals that required effectuation that the plan effectuated in a timely manner (Timely is defined as within one day of decision notification for Expedited appeals, or three days of decision notification for Standard appeals.). Numerator = The number of appeals that were effectuated timely. Denominator = The number of the dispositions which required effectuation. Appeals with a disposition of “Fully Reverse Plan” or “Partially Reverse Plan” require effectuation. This measure looks at the most recent proceeding where effectuation is required in the event of ALJ’s or Reopenings. This is calculated as: [(The number of appeals that were effectuated timely) / (The number of dispositions that required effectuation)] * 100.
Exclusions:	None. These data are based on the report generation date. If the IRE does not receive a notice of effectuation before the timeframe has elapsed, the IRE will count the appeal as non-timely. Discrepancies may occur if the IRE receives the effectuation notice late, despite the actual effectuation occurring timely. Re-openings and ALJ decisions may also negate the need for effectuation.
Primary Data Source:	IRE
Data Source Description:	Data were obtained from the IRE contracted by CMS for Part D reconsiderations. Timely is defined as within one day of decision notification for Expedited appeals, or

Title	Description
	three days of decision notification for Standard appeals. For appeals involving plans making payments, timely is defined as payment being made within 30 calendar days of decision notification.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with 2 decimal places

Measure: DMD03 - Call Center - Calls Disconnected When Customer Calls Drug Plan

Title	Description
Metric:	This measure is defined as the number of calls unexpectedly dropped by the sponsor divided by the total number of calls made to the phone number associated with the contract.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call Center
Data Source Description:	Call Center surveillance monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	02/13/2017 – 06/02/2017
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places
Compliance Standard:	5%

Measure: DMD04 - Call Center – Beneficiary Hold Time

Title	Description
Metric:	This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and prior to reaching a live person for the “Customer Service for Current Members – Part D” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract beneficiary customer service call center divided by the number of eligible calls made to the Part D contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored.

Title	Description
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	02/13/2017 – 06/02/2017
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMD05 - Drug-Drug Interactions

Title	Description
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries who received a prescription for a target medication during the measurement period and who were dispensed a prescription for a contraindicated medication with or subsequent to the initial target medication prescription. Numerator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication with at least one day overlap with a contraindicated medication. Denominator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication. This is calculated as: [(Number of member-years of beneficiaries in the denominator dispensed a target medication with at least one day overlap with a contraindicated medication) / (Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication within the measurement period]*100.
Exclusions:	Contracts with 30 or fewer beneficiary member years (in the denominator).
Primary Data Source:	PDE data
Data Source Description:	The Drug-Drug Interaction (DDI) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2016-December 31, 2016, and processed by June 30, 2017. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year. The complete NDC lists will be posted along with these technical notes. Common Medicare Environment (CME) enrollment information.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMD06 - Diabetes Medication Dosing

Title	Description
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years or older who were dispensed a dose higher than the daily recommended dose for the following diabetes treatment therapeutic categories of oral hypoglycemics: biguanides, sulfonlyureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV inhibitors. Numerator = Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose. Denominator = Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed at least one prescription of an oral hypoglycemic. This is calculated as: [(Number of member-years of beneficiaries in the denominator who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose) / (Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed at least one prescription of an oral hypoglycemic during the measurement period)]*100. Dose calculation of a given oral hypoglycemic PDE record: Dose = (quantity * strength) / days supply
Exclusions:	Contracts with 30 or fewer beneficiary member years (in the denominator).
Primary Data Source:	PDE data
Data Source Description:	The Diabetes Medication Dosing (DMD) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2016-December 31, 2016, and processed by June 30, 2017. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year. Common Medicare Environment (CME) – used for enrollment information.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

Measure: DMD07 - Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website

Title	Description
Metric:	This measure is defined as percent of pricing/formulary data file submissions that do not result in suppression of pricing data on www.medicare.gov. Numerator = Number of pricing data file submissions that do not result in suppression of pricing data on www.medicare.gov Denominator = Total number of pricing data submissions

Title	Description

This is calculated as: [(Number of pricing data file submissions that do not result in suppression of pricing data on www.medicare.gov) / (Total number of pricing data submissions)]*100.

Exclusions: None.

Primary Data Source: CMS Administrative Data

Data Source Category: Data Collected by CMS Contractors

Data Time Frame: 10/01/2016 – 09/30/2017

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMD08 - MPF – Stability

Title	Description

Metric: This measure evaluates stability in a plan's point of sale prices.

The stability price index uses final prescription drug event (PDE) data to assess changes in prices over the contract year. It is defined as the average change in price of a specified basket of drugs each quarter. A basket of drugs defined by quarter 1 PDEs is priced using quarter 1 average prices for each drug first. The same basket is then priced using quarter 2 average prices. The stability price index from quarter 1 to quarter 2 is calculated as the total price of the basket using the quarter 2 average prices divided by the total price of same basket using quarter 1 average prices. This same process is repeated using a quarter 2 basket of drugs to compute the quarter 2 to quarter 3 price index and a quarter 3 basket of drugs to compute the quarter 3 to quarter 4 price index. The overall stability price index is the average of the price index from quarter 1 to 2, quarter 2 to 3, and quarter 3 to 4. A price index of 1 indicates a plan had no increase in prices from the beginning to the end of the year. A stability index smaller than 1 indicates that prices decreased, while an index greater than 1 indicates that prices increased.

To convert the index into the stability score, we use the formula below. The score is rounded to the nearest whole number.

100 – ((stability index – 1) x 100).

Exclusions: A contract must have at least one drug with at least 10 claims in each quarter for the price stability index. PDEs must also meet the following criteria:
- Pharmacy number on PDE must appear in MPF pharmacy cost file
- PDE must be for retail pharmacy
- Date of service must occur at a time that data are not suppressed for the plan on MPF
- PDE must not be a compound claim
- PDE must not be a non-covered drug

Primary Data Source: PDE data, MPF Pricing Files

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

Data Source Category: Data Collected by CMS Contractors

Data Time Frame: 01/01/2016 – 12/31/2016

General Trend: Higher is better

Data Display: Numeric with no decimal place

Measure: DMD09 - Call Center – Pharmacy Hold Time

Title	Description
Metric:	This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and prior to reaching a live person for the “Pharmacy Technical Help Desk” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract pharmacy technical help desk divided by the number of eligible calls made to the Part D contract pharmacy technical help desk. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call Center
Data Source Description:	Call center data collected by CMS. The Pharmacy Technical Help Desk phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	02/13/2017 – 06/02/2017
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMD10 - Plan Submitted Higher Prices for Display on MPF

Title	Description
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract’s score is based on the accuracy index. The accuracy price index compares point-of-sale PDE prices to plan-reported MPF prices and determines the magnitude of differences found. Using each PDE’s date of service, the price displayed on MPF is compared to the PDE price. The accuracy index considers both ingredient cost and dispensing fee and measures the amount that the MPF price is higher than the PDE price. Therefore, prices that are understated on MPF—that is, the reported price is lower than the actual price—will not count against a plan’s accuracy score. The index is computed as: (Total amount that PF is higher than PDE + Total PDE cost) / (Total PDE cost). The best possible accuracy index is 1. An index of 1 indicates that a plan did not have PDE prices less than MPF prices. A contract’s score is computed using its accuracy index as: 100 – ((accuracy index - 1) x 100).
Exclusions:	A contract must have at least 30 claims over the measurement period for the price accuracy index. PDEs must also meet the following criteria:

Title	Description
	• Pharmacy number on PDE must appear in MPF pharmacy cost file • Drug must appear in formulary file and in MPF pricing file • PDE must be for retail and/or specialty pharmacy • PDE must be a 30 day supply • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug • PDE must be for retail pharmacy (pharmacies marked retail and mail order/HI/LTC are excluded)
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	HPMS approved formulary extracts, and data from First DataBank and Medi-span
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2016 – 09/30/2016
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMD11 - Transition monitoring - failure rate for drugs within classes of clinical concern

Title	Description
Metric:	The numbers of failures (numerator) were divided by the number of claims sampled (denominator) to calculate an overall compliance score. If the number of failures resulted in more than a 10% failure rate, CMS determined that an overall compliance failure occurred for this area.
Exclusions:	Contracts with fewer than 15 claims sampled; Contracts not listed in active status in HPMS; MMPs that did not have a start date on or before January 2016; Contracts that are involved in other transition oversight activities; Contracts that do not offer Part D coverage or did not utilize a formulary.
Primary Data Source:	Part D Sponsor
Data Source Description:	Data was obtained from the Part D Sponsor, PDE data, CME data and HPMS approved formulary extracts.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	January 4 – 24, 2017
General Trend:	Lower is better
Data Display:	Percentage with 1 decimal place
Compliance Standard:	>10%

Measure: DMD12 - Transition monitoring - failure rate for all other drugs

Title	Description
Metric:	The numbers of failures (numerator) were divided by the number of claims sampled (denominator) to calculate an overall compliance score. If the number of failures resulted in more than a 20% failure rate, CMS determined that an overall compliance failure occurred for this area.
Exclusions:	Contracts with fewer than 15 claims sampled; Contracts not listed in active status in HPMS; MMPs that did not have a start date on or before January 2016; Contracts that are involved in other transition oversight activities; Contracts that do not offer Part D coverage or did not utilize a formulary.

Title	Description
Primary Data Source:	Part D Sponsor
Data Source Description:	Data was obtained from the Part D Sponsor, PDE data, CME data, and HPMS approved formulary extracts.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	January 4 – 24, 2017
General Trend:	Lower is better
Data Display:	Percentage with 1 decimal place
Compliance Standard:	>20%

Measure: DMD13 - Reminders to Fill prescriptions

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about filling or refilling a prescription (numerator). CAHPS Survey Question (question numbers vary depending on survey type): • In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2017 – 06/2017
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD14 - Reminders to Take Medications

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about taking medications as directed (numerator). CAHPS Survey Question (question numbers vary depending on survey type): • In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you were taking medications as directed?
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2017 – 06/2017
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD15 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Metric:	This measure is defined as the percentage of Medicare Part D beneficiaries 40-75 years old dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period. Numerator = Number of member-years of enrolled beneficiaries in the denominator who received a statin medication fill during the measurement period. Denominator = Number of member-years of enrolled beneficiaries, ages, 40-75 years

Title	Description
	old, with at least two diabetes medication fills and not enrolled in hospice during the measurement period. This is calculated as: [(Number of member-years of beneficiaries in the denominator who received a statin medication fill during the measurement period) / (Number of member-years of beneficiaries 40-75 years old not enrolled in hospice with at least two diabetes medication fills during the measurement period)]*100.
Exclusions:	Contracts with 30 or fewer beneficiary member years (in the denominator).
Primary Data Source:	PDE data
Data Source Description:	The Statin Use in Persons with Diabetes (SUPD) measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2016-December 31, 2016, and processed by June 30, 2017. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.Common Medicare Environment (CME) – used for enrollment information and Medicare Enrollment Database (EDB) – used for hospice information.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD16 - High Risk Medication

Title	Description
Metric:	This measure is defined as the percentage of Medicare Part D beneficiaries 65 years and older who received two or more prescription fills for the same HRM drug with a high risk of serious side effects in the elderly. This percentage is calculated as the number of member-years of enrolled beneficiaries 65 years and older who received two or more prescription fills for the same HRM during the period measured (numerator) divided by the number of member-years of enrolled beneficiaries 65 years and older during the period measured (denominator). Beneficiaries enrolled in hospice at any point during the measurement year are excluded. Numerator = Number of member-years of enrolled beneficiaries in the denominator with at least two fills of the same HRM. Denominator = Number of member-years of enrolled beneficiaries 65 years or older. The HRM measure rate includes additional PQA specifications for identifying HRM medications based on the calculation of cumulative days supply (nitrofurantoin and nonbenzodiazepine hypnotics) and average daily dose (reserpine, digoxin, and doxepin). Refer to the High Risk Medication Measures Report User Guide posted on the Patient Safety Analysis website for more information. This is calculated as: [(Number of member-years of beneficiaries in the denominator

Title	Description
	with at least two fills of the same HRM in the measurement period) (Number of member-years of beneficiaries 65 years or older not enrolled in hospice during the measurement period)]*100.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator)
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included
Primary Data Source:	PDE data
Data Source Description:	This measure, also named the High Risk Medication measure (HRM), was first developed by the National Committee for Quality Assurance (NCQA), through its Healthcare Effectiveness Data and Information Set (HEDIS), and then adapted and endorsed by the Pharmacy Quality Alliance (PQA). This measure is also endorsed by the National Quality Forum (NQF).The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2016-December 31, 2016 by June 30, 2017. Only final action PDE claims are used to calculate this measure. PDE claims are limited to members 65 years and older, and for those Part D covered drugs identified to have high risk of serious side effects in patients 65 years of age and older. PDE adjustments made post-reconciliation were not reflected in this measure. See the medication list for this measure. The HRM rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year. The same HRM is defined at the active ingredient level. The active ingredient is identified using the active ingredient flags in the PQA's NDC list. Common Medicare Environment (CME) – used for enrollment information and Medicare Enrollment Database (EDB) for hospice enrollment.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMD17 - Formulary Administration Analysis

Title	Description
Metric:	The numbers of failures (numerator) were divided by the number of claims sampled (denominator) to calculate an overall compliance score. If the number of failures resulted in more than a 20% failure rate, CMS determined that an overall compliance failure occurred for this area.
Exclusions:	• Contracts with fewer than 15 claims sampled • Contracts not listed in active status in HPMS • Contracts that are involved in other formulary oversight activities • Contracts that do not offer Part D coverage or did not utilize a formulary.
General Notes:	Data are collected from larger plans (≥20,000 enrollees)- 05/01/2016-05/14/2016 / smaller plans (<20,000 enrollees)- 05/01/2016-05/31/2016
Primary Data Source:	Part D Sponsor

Title	Description
Data Source Description:	Data was obtained from the Part D Sponsor, PDE data, CME data, and HPMS approved formulary extracts.
Data Source Category:	Health and Drug Plans
Data Time Frame:	05/01/2016 - 05/31/2016
General Trend:	Lower is better
Data Display:	Percentage with 1 decimal place
Compliance Standard:	>20%

Measure: DMD18 - Antipsychotic Use in Persons with Dementia

Title	Description
Metric:	This measure is defined as the percentage of Part D beneficiaries 65 years or older with a diagnosis of or prescriptions for dementia, who received at least one prescription and greater than 30 days supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome. This percentage is calculated as the number of member-years of enrolled beneficiaries 65 years and older who received at least one prescription and greater than 30 days supply for any antipsychotic medication (numerator) divided by the number of member-years of enrolled beneficiaries 65 years and older who had either (i) a dementia diagnosis and/or (ii) two or more prescription claims and total days supply > 60 for a dementia drug during the period measured (denominator). Age of 65 years and older is determined as of the first day of the measurement year and the dementia diagnosis can occur anytime during the measurement year. See the medication list for this measure. The APD rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. NDCs with obsolete dates will be included in the measure calculation if the obsolete dates as reported by PQA are within the period of measurement (measurement year) or within six months prior to the beginning of the measurement year.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator)
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included
Primary Data Source:	PDE data
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2016-December 31, 2016 by June 30, 2017. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME) and the Medicare Enrollment Database (EDB). • CME is used for enrollment information. • RAPS RxHCC for dementia and CWF ICD-10-CM codes are used for diagnoses.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Common Part C & D Display Measure Details

Measure: DME01 - Enrollment Timeliness

Title	Description
Metric:	Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date Denominator = The total number of plan generated enrollment transactions submitted to CMS Calculation = [(The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date) / (The total number of plan generated enrollment transactions submitted to CMS)] * 100
Exclusions:	1. Contracts with 25 or fewer enrollment submissions during the measurement period, when summed. 2. Election Types: ICEP, IEP, IEP2 and AEP. 3. Employer/Union enrollments. 4. 1876 Cost contracts. 5. Special Needs Plans. 6. Transaction Reply Codes 1-5 (TRC1, TRC2, TRC3, TRC4, TRC5) equal to any of the below: TRC's: ('001', '002', '003', '004', '006', '007', '008', '009', '019', '020', '032', '033', '034', '035', '036', '037', '038', '039', '042', '044', '045', '048', '056', '060', '062', '102', '103', '104', '105', '106', '107', '108', '109', '110', '114', '116', '122', '123', '124', '126', '127', '128', '129', '130', '133', '139', '156', '157', '162', '166', '169', '176', '184', '196', '200', '201', '202', '203', '211', '220', '257', '258', '263', '600', '601', '602', '603', '605', '611') TRCs are defined in the Plan Communication Users Guide Appendix Table I-2.
Primary Data Source:	Medicare Advantage and Prescription Drug System (MARx)
Data Source Description:	The data timeframe is the monthly enrollment files for January - June, 2017, which represents submission dates of 01/01/2017 - 06/30/2017.
Data Source Category:	CMS Administrative Data
Data Time Frame:	01/01/2017 – 06/30/2017
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DME02 - Grievance Rate

Title	Description
Metric:	This measure is defined as the number of grievances filed with the health plan per 1,000 enrollees per month. Numerator = (Quarter 1 Total Grievances + Quarter 2 Grievances + Quarter 3 Grievances + Quarter 4 Grievances) * 1,000 * 30 Denominator = Average Enrollment * Number of days in period For MAOs, Total Grievances includes grievances reported per the Part C Reporting Requirements. For PDPs, Total Grievances includes grievances reported per the Part D Reporting Requirements. For MA-PDs, Part C and Part D grievances are combined in order to report a single contract-level rate. For both Part C and Part D, grievances are summed by category. Contracts that indicate there is no data to report for a quarter are assumed to have 0 grievances in that quarter.
Exclusions:	Part C grievances reported in the "CMS issues" category (Element 5.19: CMS issues grievances) are excluded from the Total Grievances count. Part D grievances reported in the "CMS issues" category (Element T: CMS issues grievances) are excluded from the Total Grievances count.

Title	Description

A contract must have an average enrollment of 800 or more enrollees to have a rate calculated. Contracts with fewer than 800 enrollees are listed as "Plan too small to be measured."

Contracts and plans with an effective terminate date on or before the deadline to submit data validation results to CMS (June 30, 2016) are listed as “Plan not required to report measure.”

Rates are not calculated for contracts that did not score at least 95% on data validation for the Grievances reporting section(s). Rates are also not calculated for contracts that scored 95% or higher on data validation for Grievance section(s) but that were not compliant with data validation standards/sub-standards for at least one of the following Grievance data elements:

Part C (MA only and MA-PDs)
• Enrollment/disenrollment grievances (Element 5.5)
• Benefit package grievances (Element 5.7)
• Access grievances (Element 5.9)
• Marketing grievances (Element 5.11)
• Customer service grievances (Element 5.13)
• Organization determination and reconsideration process grievances (Element 5.15)
• Quality of care grievances (Element 5.17)
• Other grievances (Element 5.21)

Part D (PDPs and MA-PDs)
• Enrollment/disenrollment grievances (Element F)
• Benefit package grievances (Element H)
• Pharmacy access grievances (Element J)
• Marketing grievances (Element L)
• Customer service grievances (Element N)
• Coverage determination and redetermination process grievances (Element P)
• Quality of care grievances (Element R)
• Other grievances (Element V)

These contracts excluded from the measure due to data validation issues are shown as “Data issues found.”

Primary Data Source: Part C & D Plan Reporting

Data Source Description: Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2016 Data Validation cycle.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2016 – 12/31/2016

General Trend: Lower is better

Data Display: Numeric with 2 decimal places

Measure: DME03 - Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only)

Title	Description
Metric:	"Problems Getting Needed Care, Coverage, and Cost Information" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because you were frustrated by the plan's approval process for care, tests, or treatment? (b) Did you leave the plan because you had problems getting the care, tests, or treatment you needed? (c) Did you leave the plan because you had problems getting the plan to pay a claim? (d) Did you leave the plan because it was hard to get information from the plan -- like which health care services were covered or how much a specific test or treatment would cost? Each of these questions asked about a reason for disenrollment that was related to the beneficiary's experiences with getting needed health care services and cost information and getting claims paid for these services. Scores range from 0 to 100 and a lower mean indicates that problems getting needed care, coverage and cost information reasons were endorsed less frequently by disenrollees from your contract.
Exclusions:	Contracts with less than 30 responses are excluded.
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME04 - Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)

Title	Description
Metric:	"Problems with Coverage of Doctors and Hospitals" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan? (b) Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan? Each of these questions asked about a reason for disenrollment that was related to the coverage of doctors and hospitals by the plan. Scores range from 0 to 100 and a lower mean indicates that problems with coverage of doctors and hospitals reasons were endorsed less frequently by disenrollees from your contract.
Exclusions:	Contracts with less than 30 responses are excluded.
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).

Title	Description
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME05 - Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)

Title	Description
Metric:	"Financial Reasons for Disenrollment" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because the monthly fee that the health plan charges to provide coverage for health care and prescription medicines went up? (b) Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up? (c) Did you leave the plan because you found a health plan that costs less? (d) Did you leave the plan because a change in your personal finances meant you could no longer afford the plan? Each of these questions asked about a reason for disenrollment that was related to the cost or affordability of services. Scores range from 0 to 100 and a lower mean indicates that financial reasons were endorsed less frequently by disenrollees from your contract.
Exclusions:	Contracts with less than 30 responses are excluded.
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME06 - Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)

Title	Description
Metric:	"Problems with Prescription Drug Benefits and Coverage" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because they changed the list of prescription medicines they cover? (b) Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed? (c) Did you leave the plan because you had problems getting the medicines your doctor prescribed? (d) Did you leave the plan because it was difficult to get brand name medicines? (e) Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers? Each of these questions asked about a reason for disenrollment that was related to

Title	Description
	prescription drug benefits and coverage. Scores range from 0 to 100 and a lower mean indicates that problems with prescription drug benefits and coverage reasons were endorsed less frequently by disenrollees from your contract.
Exclusions:	Contracts with less than 30 responses are excluded.
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME07 - Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP)

Title	Description
Metric:	"Problems Getting Information about Prescription Drugs" a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription? (b) Did you leave the plan because it was hard to get information from the plan -- like which prescription medicines were covered or how much a specific medicine would cost? (c) Did you leave the plan because you were unhappy with how the plan handled a question or complaint? (d) Did you leave the plan because you could not get the information or help you needed from the plan? (e) Did you leave the plan because their customer service staff did not treat you with courtesy and respect? Each of these questions asked about a reason for disenrollment that was related to the beneficiary's experiences with getting information about prescription drugs. Scores range from 0 to 100 and a lower mean indicates that problems with getting information about prescription drug reasons were endorsed less frequently by disenrollees from your contract.
Exclusions:	Contracts with less than 30 responses are excluded.
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2016 – 12/31/2016
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Attachment A: National Averages for Part C and D Display Measures

The tables below contain the average of the numeric values for each measure reported in the 2017 Display measures.[1]

Table A-1: National Averages for Part C Display Measures

Measure ID	Measure Name	Average
DMC01	Follow-up Visit after Hospital Stay for Mental Illness (within 30 days of discharge)	53%
DMC02	Antidepressant Medication Management (6 months)	58%
DMC03	Continuous Beta Blocker Treatment	89%
DMC04	Appropriate Monitoring of Patients Taking Long-term Medications	92%
DMC05	Osteoporosis Testing	74%
DMC06	Testing to Confirm Chronic Obstructive Pulmonary Disease	34%
DMC07	Doctors who Communicate Well	91
DMC08	Call Center – Beneficiary Hold Time	0:31
DMC09	Pneumonia Vaccine	69%
DMC10	Access to Primary Care Doctor Visits	95%
DMC11	Call Center - Calls Disconnected When Customer Calls Health Plan	0.55%
DMC12	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	67%
DMC13	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	77%
DMC14	Initiation of Alcohol or other Drug Treatment	34%
DMC15	Engagement of Alcohol or other Drug Treatment	3%
DMC16	Hospitalization for Potentially Preventable Complications	43
DMC17	Statin Therapy for Patients with Cardiovascular Disease	77%
DMC18	Asthma Medication Ratio	74%

Table A-2: National Averages for Part D Display Measures

Measure ID	Measure Name	Average
DMD01	Timely Receipt of Case Files for Appeals	88%
DMD02	Timely Effectuation of Appeals	96.79%
DMD03	Call Center - Calls Disconnected When Customer Calls Drug Plan	0.52%
DMD04	Call Center – Beneficiary Hold Time	0:31
DMD05	Drug-Drug Interactions	5%
DMD06	Diabetes Medication Dosing	0.46%
DMD07	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	100%
DMD08	MPF – Stability	97
DMD09	Call Center – Pharmacy Hold Time	0:25
DMD10	Plan Submitted Higher Prices for Display on MPF	97
DMD11	Transition monitoring - failure rate for drugs within classes of clinical concern	1.2%
DMD12	Transition monitoring - failure rate for all other drugs	3.8%
DMD13	Reminders to Fill prescriptions	47%
DMD14	Reminders to Take Medications	33%
DMD15	Statin Use in Persons with Diabetes (SUPD)	77%
DMD16	High Risk Medication	6%
DMD17	Formulary Administration Analysis	2.1%
DMD18	Antipsychotic Use in Persons with Dementia	8%

[1] All contracts are weighted equally in these averages.

Table A-3: National Averages for common Part C and D Display Measures

Measure ID	Measure Name	Average
DME01	Enrollment Timeliness	96%
DME02	Grievance Rate	3.11
DME03	Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only)	20%
DME04	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)	27%
DME05	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)	28%
DME06	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	12%
DME07	Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP)	13%

Attachment B: Calculating Measure DMC16: Hospitalization for Potentially Preventable Complications, Total

All data come from the HEDIS 2017 M17_HPC data file. The CMS MA HEDIS Public Use File (PUF) data can be found on this page: Medicare Advantage/Part D Contract and Enrollment Data

Formula Value	HPC Field	Field Description	PUF Field
A	mct6774	Number of Members in the Eligible Population: Total 67-74	UOS530-0010
D	todt6774	Total ACSC 67-74 Total Observed Total ACSC Discharges	UOS530-0160
G	tedt6774	Total ACSC 67-74 Total Expected Total ACSC Discharges	UOS530-0190
B	mct7584	Number of Members in the Eligible Population: Total 75-84	UOS530-0020
E	todt7584	Total ACSC 75-84 Total Observed Total ACSC Discharges	UOS530-0170
H	tedt7584	Total ACSC 75-84 Total Expected Total ACSC Discharges	UOS530-0200
C	mct85	Number of Members in the Eligible Population: Total 85+	UOS530-0030
F	todt85	Total ACSC 85+ Total Observed Total ACSC Discharges	UOS530-0180
I	tedt85	Total ACSC 85+ Total Expected Total ACSC Discharges	UOS530-0210

Observed = D + E + F

Expected = G + H + I

Observed / Expected = $\left(\frac{D + E + F}{G + H + I}\right)$

Denominator = A + B + C

Data Exclusion Rules:

1) Observed / Expected: contracts with values ≤0.2 or ≥ 5.0 are dropped from further calculations.
2) Denominator: contracts with values < 200 are dropped from further calculations.

National Observed Rate = Average $\left(\left(\frac{D_1+E_1+F_1}{A_1+B_1+C_1}\right)+\ldots+\left(\frac{D_n+E_n+F_n}{A_n+B_n+C_n}\right)\right)$

where 1 through n are all remaining contracts with numeric data.

Final Rate = $\left(\left(\frac{\text{Observed Count}}{\text{Expected Count}}\right) \times \text{National Observed Rate}\right) \times 1000$

Example: Calculating the final rate for Contract 1

Formula Value	PCR Field	Contract 1	Contract 2	Contract 3	Contract 4
A	mct6774	2,217	1,196	4,157	221
D	todt6774	287	135	496	30
G	tedt6774	301	149	473	22
B	mct7584	1,229	2,483	3,201	180
E	todt7584	151	333	434	27
H	tedt7584	135	309	422	23
C	mct85	1,346	1,082	1,271	132
F	todt85	203	220	196	22
I	tedt85	206	210	175	28

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

National Observed Rate = Average $\left((0.13376)+(0.14451)+(0.13049)+(0.14822)\right)$

National Observed Rate = .139245

Observed Count Contract 1 = 287 + 151 + 203 = 641

Expected Count Contract 1 = 301 + 135 + 206 = 642

Final Rate Contract 1 = $\left(\left(\frac{641}{642}\right) \times .139245\right) \times 1000 = 139.028$

Final Rate reported in the display measures for Contract 1 = 139

The actual calculated National Observed Rate used in the 2018 Display Measures was 0.0344782610233776