Medicare Health & Drug Plan 2013 Part C & Part D Display Measure Technical Notes

Updated – 01/31/2013

Document Change Log:

Previous Version	Description of Change	Revision Date
-	Initial Release of the draft Display Measure Technical Notes	12/13/2012
12/13/2012	Removed “per month” from the end of the first sentence in the metric for DMC13 and DMD11	01/31/2013

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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.

Proposed Display Measure Concepts

CMS evaluated the use of validated plan-reported data for public reporting as new 2013 Display Measures. Please refer to (DMD12) Medication Therapy Management Completion Rate for Comprehensive Medication Reviews, and (DMC 13 and DMD11) Grievance Rates for more information. CMS also evaluated potential measures of effective plans' appeals decisions, the rate of Serious Reportable Adverse Events (SRAE), and Hospital Inpatient Quality Reporting data.

Plans' Appeals Decisions

Using the data collected from the Part C reporting section "Organization Determinations/Reconsiderations" for 2011, and validated retrospectively during the 2012 Data Validation cycle, CMS evaluated three metrics.

1. **Percent of Adverse Organization Determinations Appealed for Reconsideration,** where the numerator is the total number of reconsiderations and the denominator is the number of adverse organization determinations:

   *[(Number of Fully Favorable Reconsiderations + Number of Partially Favorable Reconsiderations + Number of Adverse Reconsiderations) / (Number of Partially Favorable Organization Determinations + Number of Adverse Organization Determinations)] * 100*

2. **Percent of Fully Favorable Organization Determinations or Reconsiderations**, where the numerator is the sum of the fully favorable determinations and reconsiderations and the denominator is the total number of determinations:

   *[(Number of Fully Favorable Organization Determinations + Number of Fully Favorable Reconsiderations) / (Number of Fully Favorable Organization Determinations + Number of Partially Favorable Organization Determinations + Number of Adverse Organization Determinations) * 100*

3. **Percent of Adverse** Reconsiderations, where the numerator is the sum of the adverse and partially favorable reconsiderations and the denominator is the total number of reconsiderations:

   *[(Number of Adverse Reconsiderations + Number of Partially Favorable Reconsiderations) / (Number of Fully Favorable Reconsiderations + Number of Partially Favorable Reconsiderations + Number of Adverse Reconsiderations)] * 100*

Similar metrics were evaluated using the data collected from the Part D reporting sections "Coverage Determinations/Exceptions" and "Redeterminations".

1. **Percent of Adverse Coverage Determinations Appealed for Redetermination**, where the numerator is the total number of redeterminations and the denominator is the number of adverse coverage determinations: **

   {(Number of Redeterminations) / [(Number of Prior Authorizations Requested - Number of Prior Authorizations Approved) + (Number of Exceptions to UM Tools Requested - Number of Exceptions to UM Tools Approved) + (Number of Tier Exceptions Requested - Number of Tier

*Exceptions Approved) + (Number of Non-Formulary Exceptions Requested - Number of Non-Formulary Exceptions Approved)]} * 100*

2. **Percent of Fully Favorable Coverage Determinations or Redeterminations**, where the numerator is the sum of the fully favorable coverage determinations and redeterminations and the denominator is the total number of coverage determinations requested:

   *[(Number of Prior Authorizations Approved + Number of Exceptions to UM Tools Approved + Number of Tier Exceptions Approved + Number of Non-Formulary Exceptions Approved + Number of Redeterminations Resulting in a Full Reversal of Original Coverage Determinations) / (Number of Prior Authorizations Requested + Number of Exceptions to UM Tools Requested + Number of Tier Exceptions Requested + Number of Non-Formulary Exceptions Requested)] * 100*

3. **Percent of Adverse Redeterminations,** where the numerator is the number of redeterminations that do not result in a full reversal of the original determination and the denominator is the total number of redeterminations:

   *[(Number of Redeterminations - Number of Redeterminations Resulting in Full Reversal of Original Coverage Determination) / (Number of Redeterminations)] * 100*

   ****** Because the Part D data are collected via two separate reporting sections, there are concerns that this metric is not accurate, compared to Part C's data. That is, exception requests reported by a sponsor may not correlate directly to the redetermination requests reported during the same quarter.

Each of the six metrics was thoroughly evaluated for the clarity between the measure direction and its reflection on plan performance, as well as its correlation with existing performance metrics. As a result, contract-level metrics will not be released at this time as these metrics are conceptually unclear, and do not correlate well with existing Plan Ratings. Aggregate data for the Parts C and D program are provided below.

Contracts are grouped by type (MA Only, PDP, or MA-PD), and an aggregate calculation for each contract type is calculated by combining the individual contract's values and weighting by contract enrollment.

Part C Plan-reported Data

Metric	MA Only		MA-PD	
	Number of Contracts	Value	Number of Contracts	Value
Percent of Adverse Organization Determinations Appealed for Reconsideration	7	19.06%	446	4.42%
Percent of Fully Favorable Organization Determinations or Reconsiderations	7	98.91%	469	97.65%
Percent of Adverse Reconsiderations	6	32.66%	400	27.85%

Part D Plan-reported Data

Metric	PDP		MA-PD	
	Number of Contracts	Value	Number of Contracts	Value
Percent of Adverse Coverage Determinations Appealed for Redetermination	62	30.78%	394	10.90%
Percent of Fully Favorable Coverage Determinations or Redeterminations	64	68.00%	415	70.68%
Percent of Adverse Redeterminations	63	24.03%	345	30.78%

Exclusions: Data were not included for contracts that did not score at least 70% on data validation for the associated Part C or D reporting section(s), or whose data elements were not compliant with data validation standards/sub-standards. Additionally, contracts were not included in the aggregate analysis per the following exclusions:

1. For the Percent of Adverse Organization Determinations Appealed for Reconsideration (Part C) or for Adverse Coverage Determinations Appealed for Redetermination (Part D), contracts must have at least 10 adverse determinations to have a percent calculated.

2. For the Percent of Fully Favorable Organization Determinations or Reconsiderations (Part C) or Percent of Fully Favorable Coverage Determinations or Redeterminations, contracts must have at least 10 total determinations to have a percent calculated.

3. For the Percent of Adverse Reconsiderations (Part C) or Redeterminations (Part D), contracts must have at least 10 reconsiderations/redeterminations to have a percent calculated.

Serious Reportable Adverse Events

Using the data collected from the Part C reporting section "Serious Reportable Adverse Events (SRAE)" for CY-2010, and validated during the 2012 Data Validation cycle, CMS evaluated the following 20 metrics for public reporting:

Part C Data Element #	Description
3.2	Surgeries on Wrong Body Part
3.3	Surgeries on Wrong Patient
3.4	Wrong Procedure Performed
3.5	Post-Operative Death in Normal Healthy Patient
3.6	Foreign Body Left in Patient
3.7	Air Embolisms
3.8	Blood Incompatibility
3.9	Stage III or IV Pressure Ulcers
3.10	Fractures
3.11	Dislocations
3.12	Intracranial Injuries
3.13	Crushing Injuries
3.14	Burns
3.15	Vascular Catheter Infections
3.16	Catheter-Associated UTIs
3.17	Poor Glycemic Control
3.18	SSI following CABG
3.19	SSI following Orthopedic Procedure
3.20	SSI Following Bariatric Surgery
3.21	DVT and Pulmonary Embolism Following Orthopedic Procedure

CMS compared the frequencies of the plan-reported events with comparable CMS data reported for the period of October 2008 through June 2009 (Federal Register /Vol. 75, No.85/Tuesday, May 4, 2010/ Proposed Rules, pp. 23852-24322). Data were excluded from contracts that did not score at least 70% on data validation on SRAEs. It was expected that CMS' data would have higher frequencies of SRAE, as they pertained to all Medicare hospitalizations, and not just those occurring to beneficiaries enrolled in Part C.

- CMS data were not available for the first four data elements—surgeries on wrong body part, surgeries on the wrong patient, wrong procedure performed, and post-operative death in normal

healthy patients. Therefore, no assessment could be made of the reliability/validity of plan-reporting for these data elements.

- Comparable data were available only for data elements 3.6 – 3.21.
- The data reported under Part C reporting requirements appeared to be reasonably in line with the CMS data for the following data elements: foreign body left in patient and air embolisms.
- For vascular catheter infections and catheter-associated UTIs, CMS could not rule out that the data elements were reported accurately for Part C, although they were a bit higher in value than expected.
- For all the remaining data elements, Part C data had much higher than expected values.

As a result of these comparisons, CMS will not consider these data for public reporting.

Hospital Inpatient Quality Reporting Data

The use of Hospital Inpatient Quality Reporting (IQR) clinical process of care performance measures to score MA contracts on the inpatient quality of care delivered to their enrollees was explored. Twenty-eight Hospital IQR measures covering acute myocardial infarction, heart failure, pneumonia, and surgical care were used in our analysis. The results of the analysis using these 28 measures did not yield reliable estimates of contract performance.

The results were not reliable due to not having sufficient variation in measure scores to distinguish inpatient performance and sample size issues. Eighteen of the 28 measures have average rates greater than 95%; only one measure fell below 90%. Results from the analysis found that there were not enough data for individual clinical process measures, with median sample sizes among contracts for each measure ranging from a low of 1 to a high of 16. The limited variation in measure performance made it difficult to distinguish differences in performance across contracts. While rolling the individual measures up to a composite measure improved the sample size issue, the composite could not improve the problem of limited variation across contracts. Alternative sources for developing an inpatient quality of care measure for Plan Ratings are being explored, such as data from the Hospital Value-Based Purchasing Program. Once analysis of these data is completed to determine the feasibility of developing a measure, we will make those available to plans.

Contact Information

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

- Part C Plan Ratings: PartCRatings@cms.hhs.gov
- Part D Plan Ratings: PartDMetrics@cms.hhs.gov

Part C Display Measure Details

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

HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 186
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).
Data Source:	HEDIS
Data Time Frame:	01/01/2011 - 12/31/2011
General Trend:	Higher is better

Measure: DMC02 - Call Answer Timeliness

HEDIS Label:	Call Answer Timeliness (CAT)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 250
Metric:	The percentage of calls received by the organization's member services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.
Data Source:	HEDIS
Data Time Frame:	01/01/2011 - 12/31/2011
General Trend:	Higher is better

Measure: DMC03 - Antidepressant Medication Management (6 months)

HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 176
Metric:	The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression (denominator), treated with antidepressant medication, and who remained on an antidepressant medication treatment (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2011 - 12/31/2011
General Trend:	Higher is better

Measure: DMC04 - Continuous Beta Blocker Treatment

HEDIS Label:	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 141
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).
Data Source:	HEDIS
Data Time Frame:	01/01/2011 - 12/31/2011
General Trend:	Higher is better

Measure: DMC05 - Appropriate Monitoring for Patients Taking Long Term Medications

HEDIS Label:	Annual Monitoring for Patients on Persistent Medication (MPM)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 190
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:	01/01/2011 - 12/31/2011
General Trend:	Higher is better

Measure: DMC06 - Osteoporosis Testing

HEDIS Label:	Osteoporosis Testing in Older Women (OTO)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 213
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:	04/18/2012 - 07/31/2012
General Trend:	Higher is better

Measure: DMC07 - Testing to Confirm Chronic Obstructive Pulmonary Disease

HEDIS Label:	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Measure Reference:	NCQA HEDIS 2012 Technical Specifications Volume 2, page 115
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:	01/01/2011 - 12/31/2011
General Trend:	Higher is better

Measure: DMC08 - Doctors who Communicate Well

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:	02/15/2012 - 05/31//2012
General Trend:	Higher is better

Measure: DMC09 - Call Center – Beneficiary Hold Time

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) or Automatic Call Distributor (ACD) system 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 not collected from contracts that cover U.S territories, 1876 Cost, Demo, 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.

Data Source: 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 Time Frame: 01/09/2012 - 02/03/2012, 03/26/2012 - 04/20/2012 (Monday - Friday)

General Trend: Lower is better

Compliance Standard: 2:00

Measure: DMC10 - Call Center – Information Accuracy

Metric: This measure is defined as the percent of the time Customer Service Representatives (CSR) answered questions correctly. The calculation of this measure is the number of times the CSR answered the questions correctly divided by the number of questions asked.

Exclusions: Data were not collected from contracts that cover U.S territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, MA-PDs and PDPs under sanction, organizations that did not have a phone number accessible to survey callers, or phone lines that only cover SNP plans.

Data Source: Call Center surveillance monitoring data collected by CMS. The "Customer Service for Prospective Members – Part C" phone number associated with each contract was monitored. This measure is based on calls to the prospective enrollee call center.

Data Time Frame: 01/30/2012 - 05/18/2012 (Monday - Friday)

General Trend: Higher is better

Compliance Standard: 75%

Measure: DMC11 - Pneumonia Vaccine

Metric: The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator). CAHPS Survey Question (question number varies 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.

Data Source: CAHPS

Data Time Frame: 02/15/2012 - 05/31/2012

General Trend: Higher is better

Measure: DMC12 - Access to Primary Care Doctor Visits

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

Measure Reference: NCQA HEDIS 2012 Technical Specifications Volume 2, page 224

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

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Compliance Standard: 85%

Measure: DMC13 - Grievance Rate

Metric: This measure is defined as the number of grievances filed with the health plan per 1,000 enrollees.

Numerator = Sum of the grievances reported by the contract during the measurement period

Denominator = Average monthly enrollment for the contract during the reporting period

As grievances are reported quarterly and by category, the number of grievances is a sum of grievances reported for all four quarters and across grievance categories for the contract.

The is calculated as:{[(Quarter 1 Total Grievances + Quarter 2 Total Grievances + Quarter 3 Total Grievances + Quarter 4 Total Grievances)/ Average contract enrollment] * 1,000 * 30} / Number of days in period.
For MA-PDs, the grievances reported under the Part C Reporting Requirements and the Part D Reporting Requirements are combined in order to report a contract-level grievance rate.

Exclusions: A contract must have a minimum of 800 enrollees to have a grievance rate calculated. Contracts with fewer than 800 enrollees will be listed as "No Data Available." Grievance rates are also not calculated for contracts that did not score at least 70% on data validation for the Grievances reporting sections, or whose Grievance data elements were not compliant with data validation standards/sub-standards. These contracts will be shown as "Data issues found".

Data Source: Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2012 Data Validation cycle.

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Measure: DMC14 - Special Needs Plan (SNP) Care Management

Metric:	This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new SNP enrollees for the contract and the number of SNP enrollees eligible for an annual reassessment for the contract. The numerator for this measure is the sum of the number of initial assessments performed on new SNP enrollees during the reporting period and the number of annual reassessments performed on SNP enrollees eligible for a reassessment. The equation for calculating the SNP health risk assessment rate is: [(Number of initial assessments performed on new SNP enrollees during reporting period + Number of annual reassessments performed on SNP enrollees eligible for a reassessment) / (Number of new SNP enrollees + Number of SNP enrollees eligible for an annual reassessment)]
Exclusions:	A contract must have a minimum of 30 SNP enrollees eligible to have a SNP assessment rate calculated. Contracts with fewer than 30 eligible enrollees will be listed as "No Data Available." SNP assessment rates are also not calculated for contracts that did not score at least 70% on data validation for the SNP Care Management reporting measure, or whose SNP Care Management data elements were not compliant with data validation standards/sub-standards. These contracts will be shown as "Data issues found".
Data Source:	Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2012 Data Validation cycle.
Data Time Frame:	01/01/2010 - 12/31/2010
General Trend:	Higher is better

Measure: DMC15 - Calls Disconnected When Customer Calls Health Plan

Metric:	This measure is defined as the number of calls unexpectedly dropped by the sponsor while the call surveyor was navigating the IVR or connected with a customer service representative (CSR) divided by the total number of calls made to the phone number associated with the contract.
Exclusions:	Data were not collected from contracts that cover U.S territories, 1876 Cost, Demo, 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.
Data Source:	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 Time Frame:	01/09/2012 - 02/03/2012, 03/26/2012 - 04/20/2012 (Monday - Friday)
General Trend:	Lower is better
Compliance Standard:	5%

Part D Display Measure Details

Measure: DMD01 - Timely Receipt of Case Files for Appeals

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

Data Source: 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 Time Frame: 01/01/2012 - 06/30/2012

General Trend: Higher is better

Measure: DMD02 - Timely Effectuation of Appeals

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.

Data Source: 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 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 Time Frame: 01/01/2012 - 06/30/2012

General Trend: Higher is better

Measure: DMD03 - Calls Disconnected When Customer Calls Drug Plan

Metric: This measure is defined as the number of calls unexpectedly dropped by the sponsor while the call surveyor was navigating the IVR or connected with a customer service representative (CSR) divided by the total number of calls made to the phone number associated with the contract.

Exclusions: Data were not collected from contracts that cover U.S territories, 1876 Cost, Demo, 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.

Data Source: 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 Time Frame: 01/09/2012 - 02/03/2012, 03/26/2012 - 04/20/2012 (Monday - Friday)

General Trend: Lower is better

Compliance Standard: 5%

Measure: DMD04 - Call Center – Beneficiary Hold Time

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) or Automatic Call Distributor (ACD) system 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 not collected from contracts that cover U.S territories, 1876 Cost, Demo, 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.

Data Source: Call center monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored.

Data Time Frame: 01/09/2012 - 02/03/2012, 03/26/2012 - 04/20/2012 (Monday - Friday)

General Trend: Lower is better

Compliance Standard: 2:00

Measure: DMD05 - Call Center – Information Accuracy

Metric: This measure is defined as the percent of the time CSRs answered questions correctly. The calculation of this measure is the number of times the CSR answered the questions correctly divided by the number of questions asked.

Exclusions: Contracts that cover U.S territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, MA-PDs and PDPs under sanction, organizations that did not have a phone number.

Data Source: Call Center surveillance monitoring data collected by CMS. The "Customer Service for Prospective Members – Part D" phone number associated with each contract was monitored. This measure is based on calls to the prospective enrollee call center.

Data Time Frame: 01/30/2012 - 05/18/2012

General Trend: Higher is better

Compliance Standard: 75%

Measure: DMD06 - Drug-Drug Interactions

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 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 enrolled during the measurement period who were 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)]*100.

Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).

Data Source: 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, 2011-December 31, 2011, and processed by June 30, 2012. 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.

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Measure: DMD07 - Diabetes Medication Dosing

Metric: This measure is defined as the percent of Medicare Part D beneficiaries who were dispensed a dose higher than the daily recommended dose for the following diabetes treatment therapeutic categories of oral hypoglycemics: biguanides, sulfonlyureas and thiazolidinediones.

Numerator = Number of member-years of beneficiaries 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 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 enrolled during the measurement period who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose) / (Number of member-years of beneficiaries enrolled during the measurement period who were dispensed at least one prescription of an oral hypoglycemic)]*100.

Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).

Data Source: 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, 2011-December 31, 2011, and processed by June 30, 2012. 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.

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Measure: DMD08 - Completeness of the Drug Plan's Information on Members Who Need Extra Help

Metric: For each contract, this percentage calculation is based on the following: Beneficiary-weighted monthly average of the Low-Income Subsidy (LIS) matching rate: Each month's LIS match rate used in the average is calculated as follows: (Number of LIS beneficiaries on CMS enrollment file that have matching enrollment and benefit records (or more favorable benefits) on plan sponsors' enrollment files) / (Number of LIS beneficiaries on CMS enrollment file). For a given LIS beneficiary to be considered a match, the plan sponsor must have the beneficiary enrolled, must indicate that the beneficiary is eligible for a LIS, and must have premium and co-payment levels that match (or are more favorable than) CMS records. If two or more monthly LIS match rates cannot be calculated due to a sponsor not submitting enrollment data or not submitting a valid file format, the lowest match rate of the reporting period will be substituted in the weighted monthly average calculation. Note: the first incidence of a non-submission or non-validation will be dismissed.

Exclusions: Any contract that exclusively services U.S. territories is excluded from the match rate analysis. Also, sponsors that did not have any LIS beneficiaries enrolled in their plan during the analysis period did not have match rates available.

Data Source: Data on the LIS match rates are obtained from a CMS contractor based on enrollment data supplied by Part D sponsors compared to enrollment data based on CMS records.

Data Time Frame: 02/01/2012 - 06/30/2012

General Trend: Higher is better

Compliance Standard: 95%

Measure: DMD09 - Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website

Metric: This measure is defined as percent of pricing 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

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.

Data Source: CMS Administrative Data

Data Time Frame: 10/01/2011 - 09/30/2012

General Trend: Higher is better

Measure: DMD10 - MPF - Stability

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

Data Source: 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 Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Measure: DMD11 - Grievance Rate

Metric: This measure is defined as the number of grievances filed with the drug plan per 1,000 enrollees.

Numerator = Sum of the grievances reported by the contract during the measurement period

Denominator = Average monthly enrollment for the contract during the reporting period

As grievances are reported quarterly and by category, the number of grievances is a sum of grievances reported for all four quarters and across grievance categories for the contract.

The is calculated as:{[(Quarter 1 Total Grievances + Quarter 2 Total Grievances + Quarter 3 Total Grievances + Quarter 4 Total Grievances)/ Average contract enrollment] * 1,000 * 30} / Number of days in period.
For MA-PDs, the grievances reported under the Part C Reporting Requirements and the Part D Reporting Requirements are combined in order to report a contract-level grievance rate.

Exclusions: A contract must have a minimum of 800 enrollees to have a grievance rate calculated. Contracts with fewer than 800 enrollees will be listed as "No Data Available." Grievance rates are also not calculated for contracts that did not score at least 70% on data validation for the Grievances reporting sections, or whose Grievance data elements were not compliant with data validation standards/sub-standards. These contracts will be shown as “Data issues found”.

Data Source: Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2012 Data Validation cycle.

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better

Measure: DMD12 - Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews

Metric: This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR).

Numerator = Number of beneficiaries from the denominator who received a CMR during the reporting period.

Denominator = Number of non-Long Term Care (non-LTC) beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period.

A beneficiary's MTM eligibility, enrollment, and receipt of CMRs, etc. are determined for each contract he/she was enrolled in the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. A beneficiary must meet MTM eligibility criteria for the contract to be included in the contract's CMR rate. A beneficiary that is only enrolled in two contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates.

Exclusions: A contract must have 31 or more non-LTC beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period to have an MTM CMR rate calculated. Contracts with 30 or fewer beneficiaries meeting the denominator criteria will be listed as "No Data Available." MTM CMR rates are also not calculated for contracts that did not score at least 70% on data validation for their plan reporting of the MTM Program section, or whose MTM data elements were not compliant with data validation standards/sub-standards. These contracts will be shown as "Data issues found".

Data Source: Data were reported by contracts to CMS per the Part D Reporting Requirements through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2012 Data Validation cycle.

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Higher is better

Measure: DMD13 - Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 65 years and older who are continuously enrolled in a nursing home and who received atypical antipsychotic (AA) medication fills during the period measured.

Denominator = Number of beneficiaries who meet all of the following:

• Had Long-Term Institutional (LTI) status * for all months of the measurement period or until death,
• Were alive for at least 90 days at the beginning of the measurement period,
• Were enrolled in Part D for all months of the measurement period that they were alive, and
• Whose first reason for Medicare enrollment was aging-in.

Numerator = Number of Part D beneficiaries in the denominator who received at least a 90 days supply of AA medication(s) during the nursing home stay in the measurement period

This rate is calculated using a list of AA National Drug Codes (NDC) maintained by CMS. The complete medication list will be posted along with

these technical notes.

* See Notes under Data Source for definition of LTI

Exclusions: A percentage is not calculated for contracts with 10 or fewer beneficiaries in the denominator and will be shown as “No Data Available.”

Data Source: Data Source: Prescription Drug Event (PDE) data, Enrollment data, Minimum Data Set (MDS) Assessments

Notes: Beneficiaries are defined as LTI for payment purposes under the Medicare Risk Adjustment program. The algorithm that creates monthly flags for each LTI-defined beneficiary is described below.

Monthly LTI flags are created to identify, by month, a beneficiary’s institutional versus community status. The flags are used to determine the appropriate CMS- risk scores for calculating Part C and Part D risk payments, and for resolving risk scores for analysis purposes.

The monthly LTI flags are created based on an analysis of MDS assessments. A nursing home resident (beneficiary) is stepped through their MDS assessments chronologically. For each month, if a quarterly, annual, or significant change assessment is encountered and the nursing home length of stay on the date of that assessment is more than 90 days, then an LTI flag is turned on for the following month. An LTI flag is established for all subsequent months until the beneficiary dies, a discharge assessment with return not anticipated is encountered, or if an assessment is not encountered within 150 days of a prior assessment.

Data Time Frame: 01/01/2011 - 12/31/2011

General Trend: Lower is better