Medicare
2020 Part C & D
Display Measure
Technical Notes

Updated – 10/22/2020

Document Change Log:

Previous Version	Description of Change	Revision Date
12/09/2019	Corrected measure averages for DMD10 and DMD18	10/22/2020

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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. They may be new measures being tested before inclusion into the Star Ratings. Lastly, some measures are displayed for informational purposes only. As indicated in the 2020 Call Letter, CMS will give advance notice if display measures are being considered for inclusion into 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 2020, CMS is

- Introducing four measures to display:
  - Controlling High Blood Pressure (Part C)
  - Transitions of Care (Part C)
  - Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C)
  - Revised MPF Price Accuracy (Part D) – specifications align with Star Ratings regulation
- Changing the specifications for two display measures:
  - Disenrollment Reasons – Problems with Prescription Drug Benefits and Coverage (Part C and D)
  - Disenrollment Reasons – Problems Getting Information and Help from the Plan (Part C and D)
- Removing two display measures:
  - Transition Monitoring (Part D)
  - Formulary Administration Analysis (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
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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 2019 Technical Specifications Volume 2, page 198
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:	01/01/2018 – 12/31/2018
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 2019 Technical Specifications Volume 2, page 188
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:	01/01/2018 – 12/31/2018
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 2019 Technical Specifications Volume 2, page 137
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC04 - Osteoporosis Testing

Title	Description
HEDIS Label:	Osteoporosis Testing in Older Women (OTO)
Measure Reference:	NCQA HEDIS 2017 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

Title	Description
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:	04/18/2018 – 07/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC05 - 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 2019 Technical Specifications Volume 2, page 112
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC06 - 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:	03/2019 – 05/2019
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMC07 - 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 phone number, divided by the number of eligible calls made to the Part C contract beneficiary customer service phone number. 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 phone number.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2019 – 06/2019
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMC08 - 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 number varies depending on survey type): • Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime and these are 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:	03/2019 – 05/2019
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC09 - Access to Primary Care Doctor Visits

Title	Description
HEDIS Label:	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 311

Title	Description
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place
Compliance Standard:	85%

Measure: DMC10 - 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 Medicare Advantage (MA) Plan or Medicare-Medicaid Plan (MMP) 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:	01/2019 – 06/2019
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places
Compliance Standard:	5%

Measure: DMC11 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

Title	Description
HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation (PCE)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 115
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC12 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

Title	Description
HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation (PCE)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 115
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC13 - 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 2019 Technical Specifications Volume 2, page 317
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC14 - 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 2019 Technical Specifications Volume 2, page 317
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:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC15 - Hospitalization for Potentially Preventable Complications

Title	Description
HEDIS Label:	Hospitalization for Potentially Preventable Complications (HPC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 451
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 < 0.2 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 were 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 were 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:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Rate per 1,000 members with no decimal place

Measure: DMC16 - Plan Makes Timely Decisions about Appeals

Title	Description
Metric:	Percent of appeals timely processed by the plan (numerator) out of all the plan‘s appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and dismissed because the plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed/Plan Agreed to Cover]) * 100.
Exclusions:	If the denominator is ≤ 10, the result is “Not enough data available.” Dismissed for reasons other than the plan agreed to cover and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE.

Title	Description
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC17 - Controlling High Blood Pressure

Title	Description
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 130
Metric:	The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year (numerator).
Exclusions:	(Optional) • Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis. • Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. • Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the discharge date for the stay. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2017 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2017 enrollment report are excluded from this measure.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC18 - Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions

Title	Description
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 248
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Exclusions:	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC19 - Transitions of Care - Medication Reconciliation Post-Discharge

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 240
Metric:	The percentage of discharges for members 18 years of age and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date).

Title	Description
	Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC20 - Transitions of Care - Notification of Inpatient Admission

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 240
Metric:	The percentage of discharges for members 18 years of age and older who had documentation of receipt of notification of inpatient admission on the day of admission or the following day.
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC21 - Transitions of Care - Patient Engagement After Inpatient Discharge

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 240
Metric:	The percentage of discharges for members 18 years of age and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
Exclusions:	Members in hospice are excluded from the eligible population. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC22 - Transitions of Care - Receipt of Discharge Information

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 240
Metric:	The percentage of discharges for members 18 years of age and older who had documentation of receipt of discharge information on the day of discharge or the following day.
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last

Title	Description
	discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2018 – 12/31/2018

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC23 - Transitions of Care - Average

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS 2019 Technical Specifications Volume 2, page 240
Metric:	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2018 – 12/31/2018

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:	Independent Review Entity (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:	01/01/2018 – 12/31/2018
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:	Independent Review Entity (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:	01/01/2018 – 12/31/2018
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 phone number.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2019 – 06/2019
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 phone number divided by the number of eligible calls made to the Part D contract beneficiary customer service phone number. 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:	01/2019 – 06/2019
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 precipitant medication with or subsequent to the initial prescription. The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator enrolled during the measurement period who were dispensed a precipitant medication with at least one day overlap with a different, target medication / divided by (the number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication (denominator))] * 100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Drug-Drug Interaction (DDI) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer beneficiary member-years (in the denominator).
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or the National Drug Code (NDC) lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.
Primary Data Source:	PDE data
Data Source Description:	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, 2018-December 31, 2018, and processed by June 30, 2019. 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 DDI measure rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data used is the Common Medicare Environment (CME) for enrollment information.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
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 who were dispensed a dose higher than the maximum daily adult recommended dose for the following diabetes treatment therapeutic categories of oral hypoglycemics: biguanides, sulfonlyureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV inhibitors. The percentage is calculated as: [(The 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 maximum adult daily recommended dose (numerator)) / divided by (the 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 (denominator))] * 100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is at least 18 years of age and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Diabetes Medication Dosing (DMD) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer beneficiary member years (in the denominator)
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or the National Drug Code (NDC) lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.
Primary Data Source:	PDE data
Data Source Description:	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, 2018-December 31, 2018, and processed by June 30, 2019. 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 DMD measure rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources used is the Common Medicare Environment (CME) for enrollment information.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
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 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:	10/01/2018 – 09/30/2019
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

Title	Description
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:	01/01/2018 – 12/31/2018
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:	01/2019 – 06/2019
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

Title	Description
	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: • 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:	01/01/2018 – 09/30/2018
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMD11 - 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:	03/2019 – 05/2019
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD12 - 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:	03/2019 – 05/2019
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD13 - High Risk Medication

Title	Description
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 65 years and older who received two or more prescription fills for the same high risk medication (HRM) drug with a high risk of serious side effects in the elderly. The 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 on unique dates of service during the period measured (numerator)) / divided by (the number of member-years of enrolled beneficiaries 65 years and older during the period measured (denominator))]*100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. This measure, also named the 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 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 HRM Measure Report User Guide posted on the Patient Safety Analysis website for more information.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator) Beneficiaries enrolled in hospice at any point during the measurement year are excluded.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or the National Drug Code (NDC) lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.
Primary Data Source:	PDE data

Title	Description
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2018-December 31, 2018 by June 30, 2019. 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. The HRM measure rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. 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. Additional data sources include the Common Medicare Environment (CME) used for enrollment information, and the Medicare Enrollment Database (EDB) used for hospice enrollment.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMD14 - Antipsychotic Use in Persons with Dementia

Title	Description
Metric:	This measure is defined as the percent 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. The 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 greater than 60 for a dementia drug during the period measured (denominator))]*100. The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Antipsychotic Use in Persons with Dementia (APD) is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with a dementia diagnosis and an exclusion diagnosis (schizophrenia, bipolar disorders, Huntington's Disease, and Tourette Syndrome) are excluded from the numerator.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or National Drug Code (NDC) lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.

Title	Description
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, 2018–December 31, 2018 by June 30, 2019. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The APD measure rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources include Common Medicare Environment (CME) used for enrollment information, the Risk Adjustment Processing System (RAPS) RxHCC data for diagnosis information, and the Common Working File (CWF) ICD-10-CM codes used to identify diagnoses.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMD15 - Antipsychotic Use in Persons with Dementia - for Community-Only Residents

Title	Description
Metric:	This measure is defined as the percent 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 AND beneficiaries who spent zero days in a nursing home during the measurement period. The percentage is calculated as: [(The number of member-years of enrolled community-only resident 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 greater than 60 for a dementia drug during the period measured and spent zero days in a nursing home resident during the period measured (denominator))]*100. The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Antipsychotic Use in Persons with Dementia for Community-Only Residents (APD-COMM) is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with a dementia diagnosis and an exclusion diagnosis (schizophrenia, bipolar disorders, Huntington's Disease, and Tourette Syndrome) are excluded from the numerator.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or the National Drug Code (NDC) lists, are excluded from CMS

Title	Description
	analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.
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, 2018-December 31, 2018 by June 30, 2019. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The APD-COMM measure rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources include the Common Medicare Environment (CME) for enrollment information, the Minimum Data Set (MDS) for nursing home information, the Risk Adjustment Processing System (RAPS) RxHCC data for diagnosis information, and the Common Working File (CWF) ICD-10-CM codes used to identify diagnoses.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMD16 - Antipsychotic Use in Persons with Dementia - for Long-Term Nursing Home Residents

Title	Description
Metric:	This measure is defined as the percent 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 AND were long-term nursing home (LTNH) residents during the measurement period. The 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 with a date of service during a LTNH episode (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 greater than 60 for a dementia drug AND who had at least one nursing home episode that is greater than 100 days during the period measured (denominator))]*100. The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Antipsychotic Use in Persons with Dementia Long-Term Nursing Home Residents (APD-LTNH) is adapted from the APD measure concept first developed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with a dementia diagnosis and an exclusion diagnosis (schizophrenia, bipolar disorders, Huntington's Disease, and Tourette Syndrome) are excluded from the numerator.

Title	Description
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or NDC lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.
Primary Data Source:	PDE data
Data Source Description:	Data Source Description: The data for this measure come from PDE data files submitted by drug plans to Medicare for January 1, 2018-December 31, 2018 by June 30, 2019. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The APD-LTNH measure rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources include the Common Medicare Environment (CME) for enrollment information, the Minimum Data Set (MDS) for nursing home information, the Risk Adjustment Processing System (RAPS) RxHCC data for diagnosis information, and the Common Working File (CWF) ICD-10-CM codes used to identify diagnoses.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMD17 - Use of Opioids at High Dosage and from Multiple Providers

Title	Description
Metric:	This measure analyzes the proportion (XX out of 1,000) of Medicare Part D beneficiaries 18 years or older without cancer or enrolled in hospice receiving prescriptions for opioids with a daily morphine milligram equivalent (MME) greater than 120 mg for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies. The rate is calculated as: (The number of member-years of beneficiaries with greater than 120 mg MME for more than 90 consecutive days AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies (numerator)) / divided by (the number of member-years of enrolled beneficiaries with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15, within the period measured (denominator))]*1000. The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 18 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with cancer or enrolled in hospice are excluded from the denominator.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the medication or the National Drug Code (NDC) lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month of the measurement period.

Title	Description
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, 2018-December 31, 2018 by June 30, 2019. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The Use of Opioids at High Dose and from Multiple Providers (OHDMP) rate is calculated using the NDC list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources include the Common Medicare Environment (CME) for enrollment information, the Medicare Enrollment Database (EDB) for hospice information, the Risk Adjustment Processing System (RAPS) RxHCC for cancer diagnoses, and the Common Working File (CWF) ICD-10-CM codes to identify cancer diagnoses.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Numeric with 2 decimal places

Measure: DMD18 - MPF Price Accuracy

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 and claim percentage index. The accuracy index and claim percentage index compare point-of-sale PDE prices to plan-reported MPF prices and determines the magnitude of differences found. Using each PDE's date of service, the price displayed on MPF is compared to the PDE price. The accuracy index considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index also considers both ingredient cost and dispensing while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF—that is, the reported price is higher than the actual price—will not count against a plan's accuracy score. The accuracy index is computed as: (Total amount that PDE is higher than PF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than PF)/ (Total number of PDEs) The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index and claim percentage index as: .5 x (100 – ((accuracy index - 1) x 100)) + .5 x ((1 – claim percentage index) x 100).
Exclusions:	A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria:

Title	Description
	• If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. • Drug must appear in formulary file and in MPF pricing file • PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. • 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 used in this measure are obtained from a number of sources: PDE data and MPF Pricing Files are the primary data sources. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used. Post-reconciliation PDE adjustments are not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DME01 - 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. 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)

Title	Description
	• 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:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Numeric with 2 decimal places

Measure: DME02 - 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. Scores with very-low reliability (below 0.60) that are not statistically significantly different from the national average are suppressed because there is not enough evidence to say whether the contract is different from the national average.
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: 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:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME03 - 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. Scores with very-low reliability (below 0.60) that are not statistically significantly different from the national average are suppressed because there is not enough evidence to say whether the contract is different from the national average.
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:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME04 - 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. Scores with very-low reliability (below 0.60) that are not statistically significantly different from the national average are suppressed because there is not enough evidence to say whether the contract is different from the national average.
Exclusions:	Contracts with less than 30 responses are excluded.
Primary Data Source:	Disenrollment Reasons Survey

Title	Description
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:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME05 - 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 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. Scores for this composite measure are based on 2 years of data from 2017 (prior year) and 2018 (current year) survey data. To calculate the composite measure, we first calculate single year scores for 2017 and for 2018. The prior year's score is then adjusted to account for the change in the national averages for this composite measure between 2017 and 2018. The adjustment is calculated by subtracting the prior year's (2017) national average score from the current year's (2018) national average score. This adjustment is then added to the prior year's score. This adjusted 2017 score is then averaged with the 2018 current year score to produce the final 2-year composite score that is reported. National average one-year scores are calculated separately for MA-PD and PDP plans . For plans without scores from the prior year (2017), the final composite score reflects the current one-year (2018) score only. Scores with very-low reliability (below 0.60) that are not statistically significantly different from the national average are suppressed because there is not enough evidence to say whether the contract is different from the national average.
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:

Title	Description
	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:	01/01/2018 – 12/31/2018 for current reporting year, and 01/01/2017 – 12/31/2017 for previous reporting year, if available
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME06 - Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)

Title	Description
Metric:	"Problems Getting Information and Help from the Plan" is 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 and help from the plan. Scores range from 0 to 100 and a lower mean indicates that problems with getting information and help from the plan reasons were endorsed less frequently by disenrollees from your contract. Scores for this composite measure are based on 2 years of data from 2017 (prior year) and 2018 (current year) survey data. To calculate the composite measure, we first calculate single year scores for 2017 and for 2018. The prior year's score is then adjusted to account for the change in the national averages for this composite measure between 2017 and 2018. The adjustment is calculated by subtracting the prior year's (2017) national average score from the current year's (2018) national average score. This adjustment is then added to the prior year's score. This adjusted 2017 score is then averaged with the 2018 current year score to produce the final 2-year composite score that is reported. National average one-year scores are calculated separately for MA-PD and PDP plans . For plans without scores from the prior year (2017), the final composite score reflects the current one-year (2018) score only. Scores with very-low reliability (below 0.60) that are not statistically significantly different from the national average are suppressed because there is not enough evidence to say whether the contract is different from the national average.
Exclusions:	Contracts with less than 30 responses are excluded.

Title	Description
General Notes:	In prior years, this measure was labeled “Problems Getting Information about Prescription Drugs.” Although the measure label has been revised, the items that make up the composite have not changed.
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:	01/01/2018 – 12/31/2018
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME07 - Beneficiary Access and Performance Problems

Title	Description
Metric:	This measure is based on CMS’ Compliance Activity Module (CAM) data (this includes: notices of non-compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity). ● Contracts’ scores are based on a scale of 0-100 points. ● The starting score for each contract works as follows: ○ Contracts with an effective date of 1/1/2018 or later are marked as “Plan too new to be measured.” ○ All contracts with an effective date prior to 1/1/2018 begin with a score 100. ● The following deductions are taken from the contracts starting score: ○ Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows: ■ 0 – 2 CAM Score – 0 points ■ 3 – 9 CAM Score – 20 points ■ 10 – 19 CAM Score – 40 points ■ 20 – 29 CAM Score – 60 points ■ ≥ 30 CAM Score – 80 points Calculation of the CAM score combines the notices of non-compliance, warning letters (with or without business plan) and ad-hoc CAPs and their severity. The formula used is as follows: CAM Score = (NC * 1) + (woBP * 3) + (wBP * 4) + (6 * CAP Severity) Where: NC = Number of Notices of Non-Compliance woBP = Number of Warning Letters without Business Plan wBP = Number of Warning Letters with Business Plan CAP Severity = Sum of the severity of each individual ad-hoc CAP given to a contract during the measurement period. Each CAP is rated as one of the following: 3 – ad-hoc CAP with beneficiary access impact 2 – ad-hoc CAP with beneficiary non-access impact 1 – ad-hoc CAP no beneficiary impact
Exclusions:	CAM entries with the following characteristics were removed prior to processing the BAPP score: • Ad-hoc CAPs with a topic of "Star Ratings" • Notices of Non-Compliance with a topic of "Financial Concerns--Solvency, Reporting, Licensure, Other"
Primary Data Source:	Compliance Activity Module (CAM)

Title	Description
Data Source Description:	Ad hoc CAPs and compliance actions that occurred during the 12 month past performance review period between January 1, 2017 and December 31, 2017. For compliance actions, the date the action was issued is used for pulling the data from HPMS. The "date the action was issued" is the date that the compliance letter was sent to the contract, not the date when the issue occurred.
Data Source Category:	CMS Administrative Data
Data Time Frame:	01/01/2018 – 12/31/2018
General Trend:	Higher is better
Data Display:	Numeric 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 2020 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)	46%
DMC02	Antidepressant Medication Management (6 months)	59%
DMC03	Continuous Beta Blocker Treatment	87%
DMC04	Osteoporosis Testing	74%
DMC05	Testing to Confirm Chronic Obstructive Pulmonary Disease	33%
DMC06	Doctors who Communicate Well	92
DMC07	Call Center – Beneficiary Hold Time	0:34
DMC08	Pneumonia Vaccine	69%
DMC09	Access to Primary Care Doctor Visits	95%
DMC10	Call Center - Calls Disconnected When Customer Calls Health Plan	1.69%
DMC11	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	69%
DMC12	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	78%
DMC13	Initiation of Alcohol or other Drug Treatment	34%
DMC14	Engagement of Alcohol or other Drug Treatment	4%
DMC15	Hospitalization for Potentially Preventable Complications	45
DMC16	Plan Makes Timely Decisions about Appeals	95%
DMC17	Controlling High Blood Pressure	68%
DMC18	Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	55%
DMC19	Transitions of Care - Medication Reconciliation Post-Discharge	52%
DMC20	Transitions of Care - Notification of Inpatient Admission	16%
DMC21	Transitions of Care - Patient Engagement After Inpatient Discharge	81%
DMC22	Transitions of Care - Receipt of Discharge Information	10%
DMC23	Transitions of Care - Average	41%

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

Measure ID	Measure Name	MAPD Average	PDP Average
DMD01	Timely Receipt of Case Files for Appeals	91%	96%
DMD02	Timely Effectuation of Appeals	98.36%	95.87%
DMD03	Call Center - Calls Disconnected When Customer Calls Drug Plan	1.76%	1.12%
DMD04	Call Center – Beneficiary Hold Time	0:33	0:35
DMD05	Drug-Drug Interactions	3%	4%
DMD06	Diabetes Medication Dosing	0.35%	0.42%
DMD07	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	99%	100%
DMD08	MPF – Stability	100	100
DMD09	Call Center – Pharmacy Hold Time	0:17	0:15
DMD10	Plan Submitted Higher Prices for Display on MPF	84	91
DMD11	Reminders to Fill Prescriptions	52%	50%
DMD12	Reminders to Take Medications	35%	27%

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

Measure ID	Measure Name	MAPD Average	PDP Average
DMD13	High Risk Medication	9%	10%
DMD14	Antipsychotic Use in Persons with Dementia	10%	9%
DMD15	Antipsychotic Use in Persons with Dementia - for Community-Only Residents	9%	9%
DMD16	Antipsychotic Use in Persons with Dementia - for Long-Term Nursing Home Residents	12%	8%
DMD17	Use of Opioids at High Dosage and from Multiple Providers	0.43	0.36
DMD18	MPF Price Accuracy	92	92

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

Measure ID	Measure Name	MA Average	PDP Average
DME01	Grievance Rate	5.34	2.21
DME02	Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only)	19%	N/A
DME03	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)	26%	N/A
DME04	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)	24%	38%
DME05	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	10%	13%
DME06	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)	12%	8%
DME07	Beneficiary Access and Performance Problems	90	89

Attachment B: Calculating Measure DMC15: Hospitalization for Potentially Preventable Complications, Total

All data come from the HEDIS 2019 M19_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
K	aomt6774	Acute ACSC Outlier Members - Total 67-74	UOS530-0290
L	comt6774	Chronic ACSC Outlier Members - Total 67-74	UOS530-0230
D	todt6774	Total ACSC 67-74 Total Observed Total ACSC Discharges	UOS530-0160
H	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
M	aomt7584	Acute ACSC Outlier Members - Total 75-84	UOS530-0310
N	comt7584	Chronic ACSC Outlier Members - Total 75-84	UOS530-0250
E	todt7584	Total ACSC 75-84 Total Observed Total ACSC Discharges	UOS530-0170
I	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
O	aomt85	Acute ACSC Outlier Members - Total 85+	UOS530-0330
P	comt85	Chronic ACSC Outlier Members - Total 85+	UOS530-0270
F	todt85	Total ACSC 85+ Total Observed Total ACSC Discharges	UOS530-0180
J	tedt85	Total ACSC 85+ Total Expected Total ACSC Discharges	UOS530-0210

Observed Count = D + E + F

Expected Count = H + I + J

Denominator = A + B + C – (K + L + M + N + O + P)

$$\text{National Observed Rate} = \text{Average}\left(\left(\frac{\text{Observed Count}_1}{\text{Denominator}_1}\right) + \ldots + \left(\frac{\text{Observed Count}_n}{\text{Denominator}_n}\right)\right)$$

where 1 through n are all contracts with numeric data.

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

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.

Example: Calculating the final rate for Contract 1

Formula Value	Contract 1	Contract 2	Contract 3	Contract 4
A	2,217	1,196	4,157	221
K	54	36	123	2
L	32	23	234	3
D	287	135	496	30
H	301	149	473	22
B	1,229	2,483	3,201	180
M	53	35	122	1
N	31	22	233	2
E	151	333	434	27
I	135	309	422	23

Formula Value	Contract 1	Contract 2	Contract 3	Contract 4
C	1,346	1,082	1,271	132
O	52	34	121	0
P	30	21	232	1
F	203	220	196	22
J	206	210	175	28

National Observed Rate = $\text{Average}\left(\left(\frac{287 + 151 + 203}{2217 + 1229 + 1346 - (54 + 32 + 53 + 31 + 52 + 30)}\right) + \left(\frac{135 + 333 + 220}{1196 + 2438 + 1082 - (36 + 23 + 35 + 22 + 34 + 21)}\right) + \left(\frac{496 + 434 + 196}{4157 + 3201 + 1271 - (123 + 234 + 122 + 233 + 121 + 232)}\right) + \left(\frac{30 + 27 + 22}{221 + 180 + 132 - (2 + 3 + 1 + 2 + 0 + 1)}\right)\right)$

National Observed Rate = $\text{Average}\left((0.14119) + (0.15138) + (0.14886) + (0.15076)\right)$

National Observed Rate = .148048

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

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

Final Rate Contract 1 = $\left(\left(\frac{641}{642}\right) \times .148048\right)$ x 1000 = 147.817

Final Rate reported in the Star Ratings for Contract 1 = 148

The actual calculated National Observed Rate used in the 2020 display measures was 0.037813522544438.