



Medicare 2025 Part C & D Display Measure Technical Notes

Updated – 12/04/2024

Table of Contents

GENERAL	1
CONTACT INFORMATION	2
PART C DISPLAY MEASURE DETAILS	3
Measure: DMC01 - Follow-up Visit after Hospital Stay for Mental Illness (within 30 days of discharge)	3
Measure: DMC02 - Antidepressant Medication Management (6 months)	3
Measure: DMC03 - Continuous Beta Blocker Treatment	4
Measure: DMC04 - Testing to Confirm Chronic Obstructive Pulmonary Disease	5
Measure: DMC05 - Doctors who Communicate Well	5
Measure: DMC06 - Call Center – Beneficiary Hold Time	6
Measure: DMC07 - Pneumonia Vaccine	6
Measure: DMC08 - Access to Primary Care Doctor Visits	7
Measure: DMC09 – Call Center – Calls Disconnected When Customer Calls Health Plan	7
Measure: DMC09 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	7
Measure: DMC11 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	8
Measure: DMC12 - Initiation of Substance Use Disorder Treatment	8
Measure: DMC13 - Engagement of Substance Use Disorder Treatment	8
Measure: DMC14 - Initiation and Engagement of Substance Use Disorder Treatment Average	9
Measure: DMC15 - Hospitalization for Potentially Preventable Complications	9
Measure: DMC16 - Transitions of Care - Medication Reconciliation Post-Discharge	10
Measure: DMC17 - Transitions of Care - Notification of Inpatient Admission	11
Measure: DMC18 - Transitions of Care - Patient Engagement After Inpatient Discharge	11
Measure: DMC19 - Transitions of Care - Receipt of Discharge Information	12
Measure: DMC20 - Physical Functioning Activities of Daily Living	13
Measure: DMC21 - Care for Older Adults - Functional Status	14
Measure: DMC22 - Kidney Health Evaluation for Patients With Diabetes	14
Measure: DMC23 - Improving or Maintaining Physical Health	16
Measure: DMC24 - Improving or Maintaining Mental Health	16
Measure: DMC25 - Cardiac Rehabilitation – Achievement	16
Measure: DMC26 - Cardiac Rehabilitation – Engagement 1	17
Measure: DMC27 - Cardiac Rehabilitation – Engagement 2	18
Measure: DMC28 - Cardiac Rehabilitation – Initiation	18
Measure: DMC29 - Colorectal Cancer Screening (Age 45-75)	19
PART D DISPLAY MEASURE DETAILS	20
Measure: DMD01 - Call Center – Calls Disconnected When Customer Calls Drug Plan	20
Measure: DMD02 - Call Center – Beneficiary Hold Time	20
Measure: DMD03 - MPF – Stability	21
Measure: DMD04 - Call Center – Pharmacy Hold Time	22
Measure: DMD05 - Plan Submitted Higher Prices for Display on MPF	23
Measure: DMD06 - Reminders to Fill Prescriptions	25
Measure: DMD07 - Reminders to Take Medications	25
Measure: DMD08 - Antipsychotic Use in Persons with Dementia (APD)	25
Measure: DMD09 - Antipsychotic Use in Persons with Dementia – for Long-Term Nursing Home Residents (APD-LTNH)	27
Measure: DMD10 - Concurrent Use of Opioids and Benzodiazepines (COB)	28

Measure: DMD11 - Use of Opioids at High Dosage in Persons Without Cancer (OHD)	30
Measure: DMD12 - Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	31
Measure: DMD13 - Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	33
Measure: DMD14 - Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	35
Measure: DMD15 - Initial Opioid Prescribing (IOP-LD)	36
Measure: DMD16 - Persistence to Basal Insulin (PST-INS)	38
COMMON PART C & D DISPLAY MEASURE DETAILS	40
Measure: DME01 - Grievance Rate	40
Measure: DME02 - Disenrollment Reasons – Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-only)	41
Measure: DME03 - Disenrollment Reasons – Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only) ...	42
Measure: DME04 - Disenrollment Reasons – Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)	43
Measure: DME05 - Disenrollment Reasons – Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP) ..	44
Measure: DME06 - Disenrollment Reasons – Problems Getting Information and Help from the Plan (MA-PD, PDP)	45
Measure: DME07 - Beneficiary Access and Performance Problems	46
ATTACHMENT A: NATIONAL AVERAGES FOR PART C AND D DISPLAY MEASURES	48
Table A-1: National Averages for Part C Display Measures	48
Table A-2: National Averages for Part D Display Measures	49
Table A-3: National Averages for Common Part C and D Display Measures	50
ATTACHMENT B: CALCULATING MEASURE DMC15: HOSPITALIZATION FOR POTENTIALLY PREVENTABLE COMPLICATIONS – TOTAL ACSC (M/F TOTAL)	51
ATTACHMENT C: CALCULATING MEASURE DMD03: MPF – STABILITY	52
Table C-1: Example of Quarterly Stability Index Calculation for Quarter 2 (Q2)	53
ATTACHMENT D: CALCULATING MEASURE DMD05: PLAN SUBMITTED HIGHER PRICES FOR DISPLAY ON MPF	54
Table D-1: Example of MPF Composite Display Measure Accuracy Score Calculation	57

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, 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 Calendar Year (CY) 2019 Medicare Part C and D Final Rule, published in April 2018, 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 2025, there are no changes to the measure set.

Contact Information

The contact below can assist you with various aspects of the display measures:

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

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

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

Part C Display Measure Details

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

Title	Description
HEDIS Label: Follow-Up After Hospitalization for Mental Illness (FUH)	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 260	
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: 01/01/2023 – 12/31/2023	
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 MY 2023 Technical Specifications Volume 2, page 247	
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 IPSP, through the IPSP and the 60 days after the IPSP. 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	

Title	Description
	<p>Value Set).</p> <ul style="list-style-type: none"> • An acute or nonacute inpatient discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. <p>For a direct transfer, use the discharge date from the last discharge.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC03 - Continuous Beta Blocker Treatment

Title	Description
	<p>HEDIS Label: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)</p> <p>Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 161</p> <p>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).</p> <p>Exclusions: Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: <ul style="list-style-type: none"> – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: <ul style="list-style-type: none"> – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). • A dispensed dementia medication. <p>(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:</p> <ul style="list-style-type: none"> • 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

Title	Description
	<p>Conditions Due to Fumes/Vapors Value Set).</p> <ul style="list-style-type: none"> • Hypotension, heart block greater than 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. <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC04 - Testing to Confirm Chronic Obstructive Pulmonary Disease

Title	Description
	<p>HEDIS Label: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)</p> <p>Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 133</p> <p>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).</p> <p>Exclusions: None listed.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC05 - Doctors who Communicate Well

Title	Description
	<p>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.</p> <p>CAHPS Survey Questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none"> • 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? <p>Primary Data Source: CAHPS</p> <p>Data Source Category: Survey of Enrollees</p> <p>Data Time Frame: 03/2024 – 06/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Numeric with no decimal place</p>

Measure: DMC06 - Call Center – Beneficiary Hold Time

Title	Description
	<p>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.</p> <p>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.</p> <p>Primary Data Source: Call center</p> <p>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.</p> <p>Data Source Category: Data Collected by CMS Contractors</p> <p>Data Time Frame: 01/2024 – 06/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Time</p> <p>Compliance Standard: 2:00</p>

Measure: DMC07 - Pneumonia Vaccine

Title	Description
	<p>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):</p> <ul style="list-style-type: none">• 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. <p>Primary Data Source: CAHPS</p> <p>Data Source Category: Survey of Enrollees</p> <p>Data Time Frame: 03/2024 – 06/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC08 - Access to Primary Care Doctor Visits

Title	Description
HEDIS Label: Adults' Access to Preventive/Ambulatory Health Services (AAP)	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 433	
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: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC09 - 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: 01/2024 – 06/2024	
General Trend: Lower is better	
Data Display: Percentage with 2 decimal places	
Compliance Standard: 5%	

Measure: DMC09 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

Title	Description
HEDIS Label: Pharmacotherapy Management of COPD Exacerbation (PCE)	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 138	
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: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	

Title	Description
Data Display: Percentage with no decimal place	

Measure: DMC11 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

Title	Description
HEDIS Label: Pharmacotherapy Management of COPD Exacerbation (PCE)	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 138	
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: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC12 - Initiation of Substance Use Disorder Treatment

Title	Description
HEDIS Label: Initiation and Engagement of Substance Use Disorder Treatment (IET): Initiation of Substance Use Disorder Treatment rate	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 436	
Metric: The percentage of new substance use disorder (SUD) episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. <i>(Please note the intake period is November 15 of the year prior to the measurement year – November 14 of the measurement year.)</i>	
Exclusions: Required exclusions: <ul style="list-style-type: none"> Members in hospice or using hospice services any time during the measurement year. Members who died any time during the measurement year. 	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC13 - Engagement of Substance Use Disorder Treatment

Title	Description
HEDIS Label: Initiation and Engagement of Substance Use Disorder Treatment (IET): Engagement of Substance Use Disorder Treatment rate	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 436	
Metric: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. <i>(Please note the intake period is November 15 of the year prior to the measurement year – November 14 of the measurement year.)</i>	

Title	Description
Exclusions:	Required exclusions: <ul style="list-style-type: none"> Members in hospice or using hospice services any time during the measurement year. Members who died any time during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC14 - Initiation and Engagement of Substance Use Disorder Treatment Average

Title	Description
HEDIS Label:	Initiation and Engagement of Substance Use Disorder Treatment
Measure Reference:	NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 436
Metric:	The average of the Initiation of Substance Use Disorder Treatment and the Engagement of Substance Use Disorder Treatment rates.
Exclusions:	Required exclusions: <ul style="list-style-type: none"> Members in hospice or using hospice services any time during the measurement year. Members who died any time during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2023 – 12/31/2023
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 MY 2023 Technical Specifications Volume 2, page 540
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. <ol style="list-style-type: none"> 1) Data for contracts whose Observed / Expected ratio is either less than 0.2 or greater than 5.0 have been excluded. 2) Data for contracts with less than 200 in the denominator have been excluded.
	Members in hospice or using hospice services anytime during the measurement year.
	Members enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

Title	Description
	Members living long-term in an institution any time during the measurement year, as identified by the LTI flag in the Monthly Membership Detail Data File.
	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:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Data Display:	Rate per 1,000 members with no decimal place

Measure: DMC16 - Transitions of Care - Medication Reconciliation Post-Discharge

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 330
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: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC17 - Transitions of Care - Notification of Inpatient Admission

Title	Description
-------	-------------

HEDIS Label: Transitions of Care (TRC)

Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 330

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: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC18 - Transitions of Care - Patient Engagement After Inpatient Discharge

Title	Description
-------	-------------

HEDIS Label: Transitions of Care (TRC)

Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 330

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:

Title	Description
	<ol style="list-style-type: none"> 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). <p>Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC19 - Transitions of Care - Receipt of Discharge Information

Title	Description
HEDIS Label: Transitions of Care (TRC)	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 330	
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:	<p>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.</p> <p>Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded.</p> <p>To identify acute and nonacute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. <p>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:</p> <ol style="list-style-type: none"> 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). <p>Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC20 - Physical Functioning Activities of Daily Living

Title	Description
-------	-------------

Metric: The adjusted mean change score from baseline to two-year follow-up on the PFADL measure among sampled Medicare enrollees 65 years of age and older.
Please see https://www.hosonline.org/globalassets/hos-online/survey-results/mhos_pfadl_change_measure.pdf for a more detailed methodology used to score the PFADL change measure.

Primary Data Source: HOS

Data Source Description: 2021-2023 Cohort 24 Performance Measurement Results (2021 Baseline data collection, 2023 Follow-up data collection)

Data Source Category: Survey of Enrollees

Data Time Frame: 07/19/2023 – 11/01/2023

General Trend: Higher is better

Data Display: Numeric with no decimal place

Measure: DMC21 - Care for Older Adults - Functional Status

Title	Description
HEDIS Label: Care for Older Adults (COA) – Functional Status Assessment	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 115	
Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one functional status assessment (Functional Status Assessment Value Set) during the measurement year (numerator).	
Exclusions: SNP benefit packages whose enrollment was less than 30 as of February 2022 SNP Comprehensive Report were excluded from this measure.	
General Notes: The formula used to calculate this measure can be found in Attachment E of the 2025 Star Ratings Technical Notes.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC22 - Kidney Health Evaluation for Patients With Diabetes

Title	Description
HEDIS Label: Kidney Health Evaluation for Patients With Diabetes (KED)	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 213	
Metric: The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	
Exclusions: Required exclusions for members who meet any of the following criteria:	
	<ul style="list-style-type: none">• Members who did not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.• Members with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of the measurement year.• Members in hospice or using hospice services any time during the measurement year.• Members who died any time during the measurement year.• Members receiving palliative care any time during the measurement year.
Exclude members who meet any of the following criteria:	
	<ul style="list-style-type: none">• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:<ul style="list-style-type: none">– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.• Members 66-80 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:<ul style="list-style-type: none">– At least two indications of frailty with different dates of service during the measurement year.– Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

Title	Description
	<ul style="list-style-type: none"> ○ At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. ○ At least one acute inpatient encounter with an advanced illness diagnosis. ○ At least on acute inpatient discharge with an advanced illness diagnosis on the discharge claim. ○ A dispensed dementia medication. <ul style="list-style-type: none"> • Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC23 - Improving or Maintaining Physical Health

Title	Description
Measure Reference:	NCQA HEDIS 2021 Specifications for The Medicare Health Outcomes Survey Volume 6 and Medicare HOS -2023 Cohort 24 MAO Performance Measurement Report
Metric:	The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose physical health status was the same or better than expected (numerator).
Exclusions:	Contracts with less than 100 responses are suppressed.
Primary Data Source:	HOS
Data Source Description:	2021-2023 Cohort 24 Performance Measurement Results (2021 Baseline data collection, 2023 Follow-up data collection)
	2-year PCS change – Questions: 1, 2a-b, 3a-b & 5
	These comparisons are pre- and post-pandemic.
Data Source Category:	Survey of Enrollees
Data Time Frame:	07/19/2023 – 11/01/2023
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC24 - Improving or Maintaining Mental Health

Title	Description
Measure Reference:	NCQA HEDIS 2021 Specifications for The Medicare Health Outcomes Survey Volume 6 and Medicare HOS 2021-2023 Cohort 24 MAO Performance Measurement Report
Metric:	The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose mental health status was the same or better than expected (numerator).
Exclusions:	Contracts with less than 100 responses are suppressed.
Primary Data Source:	HOS
Data Source Description:	2021-2023 Cohort 24 Performance Measurement Results (2021 Baseline data collection, 2023 Follow-up data collection)
	2-year MCS change – Questions: 4a-b, 6a-c, & 7
	These comparisons are pre- and post-pandemic.
Data Source Category:	Survey of Enrollees
Data Time Frame:	07/19/2023 – 11/01/2023
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC25 - Cardiac Rehabilitation – Achievement

Title	Description
HEDIS Label:	Cardiac Rehabilitation – Achievement
Measure Reference:	NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 176
Metric:	The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
Exclusions:	<ul style="list-style-type: none">Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:

Title	Description
	<ul style="list-style-type: none"> – Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. – Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC26 - Cardiac Rehabilitation – Engagement 1

Title	Description
HEDIS Label: Cardiac Rehabilitation – Engagement 1	
Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 176	
Metric: The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.	
Exclusions:	<ul style="list-style-type: none"> • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: <ul style="list-style-type: none"> – Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. – Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC27 - Cardiac Rehabilitation – Engagement 2

Title	Description
-------	-------------

HEDIS Label: Cardiac Rehabilitation – Engagement 2

Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 176

Metric: The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

- Exclusions:
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
 - Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year.
 - Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year.
 - Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness.
 - Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC28 - Cardiac Rehabilitation – Initiation

Title	Description
-------	-------------

HEDIS Label: Cardiac Rehabilitation – Initiation

Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 176

Metric: The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.

- Exclusions:
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
 - Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year.
 - Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year.
 - Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness.
 - Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set;

Title	Description
	Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2023 – 12/31/2023	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC29 - Colorectal Cancer Screening (Age 45-75)

Title	Description
	HEDIS Label: Colorectal Cancer Screening (COL)
	Measure Reference: NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 102
	Metric: The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Exclusions: Required Exclusions:

- Members who had colorectal cancer or a total colectomy any time during the member's history through December 31 of the measurement year.
- Members in hospice or using hospice services any time during the measurement year.
- Members who died any time during the measurement year.
- Members receiving palliative care any time during the measurement year.

Exclude members who meet any of the following criteria:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
 - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
 - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
- Members 66 years of age and older as of December 31 of the measurement year with frailty *and* advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded:
 - At least two indications of frailty with different dates of service during the measurement year.
 - Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 1. At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters or nonacute inpatient discharges.
 2. At least one acute inpatient encounter with an advanced illness diagnosis.
 3. At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim.
 4. A dispensed dementia medication.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Data Display: Percentage with no decimal place

Part D Display Measure Details

Measure: DMD01 - Call Center – Calls Disconnected When Customer Calls Drug Plan

Title	Description
	<p>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.</p> <p>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.</p> <p>Primary Data Source: Call center</p> <p>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.</p> <p>Data Source Category: Data Collected by CMS Contractors</p> <p>Data Time Frame: 01/2024 – 06/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with 2 decimal places</p> <p>Compliance Standard: 5%</p>

Measure: DMD02 - Call Center – Beneficiary Hold Time

Title	Description
	<p>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.</p> <p>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.</p> <p>Primary Data Source: Call center</p> <p>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.</p> <p>Data Source Category: Data Collected by CMS Contractors</p> <p>Data Time Frame: 01/2024 – 06/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Time</p> <p>Compliance Standard: 2:00</p>

Measure: DMD03 - 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 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 stability price index of 1 indicates a plan had no increase in prices from the beginning to the end of the year. A stability price index smaller than 1 indicates that prices decreased, while a stability price index greater than 1 indicates that prices increased.

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

$$100 - ((\text{stability price index} - 1) \times 100).$$

Exclusions: A contract must have at least one drug with at least 10 claims in each quarter for the stability price index to be calculated. PDEs must also meet the following criteria:

- Pharmacy number on PDE must appear in Medicare Plan Finder (MPF) pharmacy cost file
- 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 file¹
- Date of service must occur at a time that data are not suppressed for the plan on MPF²
- PDE must not be a compound claim
- PDE must not be a non-covered drug
- PDEs must be able to be assigned a Generic Sequence Number brand/generic (GSN-BG).

General Notes: Please see Attachment C: Calculating Measure DMD03 MPF – Stability for more information about this measure.

¹ Formularies list drugs at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use First Data Bank (FDB) and MediSpan to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to formulary reference NDCs.

² Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

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, and data from First DataBank and Medi-span.
	The PDE data for this measure come from data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the MPF measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the MPF measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMD04 - Call Center – Pharmacy Hold Time

Title	Description
	<p>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.</p> <p>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.</p>
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:	01/2024 – 06/2024
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMD05 - Plan Submitted Higher Prices for Display on MPF

Title	Description
-------	-------------

Metric: This measure evaluates the accuracy of drug prices posted on the Medicare Plan Finder (MPF) tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference.

The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the MPF price is higher than the PDE price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the MPF price is higher than the PDE price. Therefore, prices that are understated on MPF—that is, the reported price is lower than the actual price—will not count against a plan's score.

The accuracy index is computed as: (Total amount that MPF is higher than PDE + Total PDE cost) / (Total PDE cost).

The claim percentage index is computed as (Total number of PDEs where MPF cost is higher than PDE)/ (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 MPF prices greater than PDE prices.

A contract's score is computed using its accuracy index and claim percentage index as: $0.5 \times (100 - ((\text{accuracy index} - 1) \times 100)) + 0.5 \times ((1 - \text{claim percentage index}) \times 100)$.

Exclusions: A contract with fewer than 30 PDE claims over the measurement period will not have the measure calculated. PDEs must also meet the following criteria:

- 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 file³.
- 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 score for the plan.
- Date of service must occur at a time that data are not suppressed for the plan on MPF⁴
- PDE must not be a compound claim
- PDE must not be a non-covered drug
- The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

³ Medicare Plan Finder prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use First Data Bank (FDB) and Medi-Span to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to MPF reference NDCs.

⁴ Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

Title	Description
General Notes:	Please see Attachment D: Calculating Measure DMD05: Plan Submitted Higher Prices for Display on MPF for more information about this measure.
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data were obtained from a number of data sources: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span.
	<p>The PDE data for this measure are from data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-September 30, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the MPF measure calculations. If the PDE edit is informational, and therefore does not result in the PDE being rejected, then the PDE is used in the MPF measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p>
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2023 – 09/30/2023
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMD06 - Reminders to Fill Prescriptions

Title	Description
	<p>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 number varies depending on survey type):</p> <ul style="list-style-type: none">• 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? <p>Primary Data Source: CAHPS</p> <p>Data Source Category: Survey of Enrollees</p> <p>Data Time Frame: 03/2024 – 06/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMD07 - Reminders to Take Medications

Title	Description
	<p>Metric: The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about taking medications as directed (numerator). CAHPS Survey Question (question number varies depending on survey type):</p> <ul style="list-style-type: none">• 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? <p>Primary Data Source: CAHPS</p> <p>Data Source Category: Survey of Enrollees</p> <p>Data Time Frame: 03/2024 – 06/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMD08 - Antipsychotic Use in Persons with Dementia (APD)

Title	Description
	<p>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 total days' supply for any antipsychotic medication, without evidence of an appropriate indication for antipsychotic use.</p> <p>The percentage is calculated as: [(The number of member-years of enrolled beneficiaries 65 years and older in the denominator who received at least one prescription and greater than 30 total days' supply for any antipsychotic medication during the measurement period, AND who did not have a diagnosis for appropriate indication for antipsychotic use or take an antipsychotic medication indicated for treatment of major depression during the measurement period (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 with unique dates of service for a cholinesterase inhibitor or NMDA receptor antagonist during the period measured (denominator))]*100.</p> <p>The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is 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.</p>

Title	Description
-------	-------------

The Antipsychotic Use in Persons with Dementia (APD) is adapted from the Antipsychotic Use in Persons with Dementia measure developed and endorsed by the Pharmacy Quality Alliance (PQA).

- Exclusions:
- Contracts with 30 or fewer enrolled member-years (in the denominator)
 - Beneficiaries with an appropriate indication for antipsychotic use (schizophrenia, bipolar disorder, Huntington's Diseases, or Tourette's Syndrome) or major depression diagnosis that overlaps with the measurement period 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 PQA medication or NDC lists, are excluded from CMS analyses.

Primary Data Source: PDE data

Data Source Description: The data for this measure come from PDE data files submitted to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline 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 National Drug Code (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
- Minimum Data Set (MDS) for nursing home information
- Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes
- Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes
- PQA Medication Lists, which include the NDCs for this measure.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Lower is better

Data Display: Percentage with no decimal place

Measure: DMD09 - Antipsychotic Use in Persons with Dementia – for Long-Term Nursing Home Residents (APD-LTNH)

Title	Description
	<p data-bbox="305 233 1510 401">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 total days' supply for any antipsychotic medication, without evidence of an appropriate indication for antipsychotic use AND were long-term nursing home (LTNH) residents during the measurement period.</p> <p data-bbox="384 434 1510 804">The percentage is calculated as: [(The number of member-years of enrolled beneficiaries 65 years and older in the denominator who received at least one prescription and greater than 30 total days' supply for any antipsychotic medication with a date of service during a LTNH episode and during the measurement period AND who did not have a diagnosis for appropriate indication for antipsychotic use or taken an antipsychotic medication indicated for treatment of major depression during the measurement period(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 with unique dates of service for a cholinesterase inhibitor or NMDA receptor antagonist AND who had at least one nursing home episode that is greater than 100 days that overlaps with the period measured (denominator))]*100.</p> <p data-bbox="384 837 1471 968">The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is 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.</p> <p data-bbox="384 1001 1510 1102">The Antipsychotic Use in Persons with Dementia Long-Term Nursing Home Residents (APD-LTNH) is adapted from the Antipsychotic Use in Persons with Dementia measure developed and endorsed by the Pharmacy Quality Alliance (PQA).</p> <p data-bbox="256 1115 1510 1283">Exclusions:</p> <ul data-bbox="435 1115 1510 1283" style="list-style-type: none"> • Contracts with 30 or fewer enrolled member-years (in the denominator). • Beneficiaries with an appropriate indication for antipsychotic use (schizophrenia, bipolar disorder, Huntington's Disease, or Tourette's Syndrome) or major depression diagnosis that overlaps with the measurement period are excluded from the numerator. . <p data-bbox="217 1297 1510 1428">General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.</p> <p data-bbox="147 1442 509 1476">Primary Data Source: PDE data</p> <p data-bbox="110 1491 1510 1890">Data Source Description: The data for this measure come from PDE data files submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023- December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p>

Title	Description
	<p>The APD-LTNH measure rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes.</p> <p>Additional data sources include the:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) for enrollment information • Minimum Data Set (MDS) for nursing home information • Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes • Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes • PQA Medication Lists, which include the NDCs for this measure. <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMD10 - Concurrent Use of Opioids and Benzodiazepines (COB)

Title	Description
	<p>Metric: The measure is defined by the percentage of Part D beneficiaries, 18 years or older, with concurrent use of prescription opioids and benzodiazepines during the measurement period. While there may be instances where it is appropriate for concurrent use of opioids and benzodiazepines, the concurrent use of prescription opioids with benzodiazepines is deemed a serious safety concern for Part D beneficiaries. The COB measure is adapted from the Concurrent Use of Opioids and Benzodiazepines developed and endorsed by the Pharmacy Quality Alliance (PQA). The PQA defines concurrent use as overlapping days' supply for an opioid and benzodiazepine at least 30 cumulative days during the measurement period. The COB measurement period starts at the date of the first opioid prescription claim and the end of the enrollment episode must extend at least 30 days from the first opioid prescription claim.</p> <p>The percentage is calculated as: $\left[\frac{\text{(The number of member-years of beneficiaries in the denominator with at least 2 prescription claims of a benzodiazepine with unique dates of service and concurrent use of opioids and benzodiazepines during the measurement period (numerator))}}{\text{(the number of member-years of enrolled beneficiaries, 18 years or older, with at least 2 prescription claims of a prescription opioid with unique dates of service and at least 15 cumulative days' supply of opioids during the measurement period (denominator))}} \right] * 100$.</p> <p>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.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Contracts with 30 or fewer enrolled member-years (in the denominator). • Beneficiaries in hospice during the measurement year are excluded. • Beneficiaries with a cancer diagnosis during the measurement year are excluded. • Beneficiaries with a sickle cell disease diagnosis during the measurement year are excluded.

Title	Description
	<ul style="list-style-type: none"> Beneficiaries receiving palliative care during the measurement period are excluded.
General Notes:	<p>Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.</p>
Primary Data Source:	PDE data
Data Source Description:	<p>The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p>
	<p>The Concurrent Use of Opioids and Benzodiazepines is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.</p>
	<p>Additional data sources used are the:</p>
	<ul style="list-style-type: none"> Common Medicare Environment (CME) used for enrollment information Medicare Enrollment Database (EDB) used to identify beneficiaries who elected to receive hospice care. Due to CMS’s migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Data Display:	Percentage with no decimal places

Measure: DMD11 - Use of Opioids at High Dosage in Persons Without Cancer (OHD)

Title	Description
	<p data-bbox="305 199 1536 430">Metric: This measure is defined by the percentage of Part D beneficiaries, 18 years of age or older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. This measure is adapted from the Use of Opioids at High Dosage in Persons without Cancer measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The opioid episode starts at the date of the first opioid prescription claim and the end of the enrollment episode must extend at least 90 days from the first opioid prescription claim.</p> <p data-bbox="380 468 1536 667">The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator with an average daily MME greater than or equal to 90 MME during the opioid episode (numerator)) divided by (the number of member-years of enrolled beneficiaries, 18 years or older, with at least 2 prescription claims of a prescription opioid on unique dates of service and at least 15 cumulative opioid days' supply over a period of 90 days or longer during the measurement period (denominator))] * 100.</p> <p data-bbox="380 705 1536 831">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.</p> <p data-bbox="256 848 1536 1121">Exclusions:</p> <ul data-bbox="435 848 1536 1121" style="list-style-type: none">• Contracts with 30 or fewer enrolled member-years (in the denominator).• Beneficiaries in hospice during the measurement year are excluded.• Beneficiaries with a cancer diagnosis during the measurement year are excluded.• Beneficiaries with a sickle cell diagnosis during the measurement year are excluded.• Beneficiaries receiving palliative care during the measurement period are excluded. <p data-bbox="217 1138 1536 1264">General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.</p> <p data-bbox="149 1281 509 1312">Primary Data Source: PDE data</p> <p data-bbox="110 1329 1536 1759">Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p data-bbox="380 1797 1536 1894">The OHD measure is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.</p>

Title	Description
-------	-------------

Additional data sources used are the:

- Common Medicare Environment (CME) used for enrollment information
- Medicare Enrollment Database (EDB) used to identify beneficiaries who elected to receive hospice care. Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database.
- Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes
- Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes
- PQA Medication Lists, which include the NDCs for this measure.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Lower is better

Data Display: Percentage with no decimal places

Measure: DMD12 - Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)

Title	Description
-------	-------------

Metric: This measure is defined by the percentage of Part D beneficiaries, 18 years of age or older who received prescriptions from 4 or more prescribers AND 4 or more pharmacies within 180 days or less. This measure is adapted from the Use of Opioids from Multiple Providers in Persons without Cancer measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The opioid episode starts at the date of the first opioid prescription claim and the end of the enrollment episode must extend at least 90 days from the first opioid prescription claim.

The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator who received opioids from 4 or more prescribers and 4 or more pharmacies within 180 days or less (numerator)) divided by (the number of member-years of enrolled beneficiaries, 18 years or age or older, with at least 2 prescription claims of a prescription opioid on unique dates of service and at least 15 cumulative days' supply over a period of 90 days or longer during the measurement period (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.

- Exclusions:**
- Contracts with 30 or fewer enrolled member-years (in the denominator).
 - Beneficiaries in hospice during the measurement year are excluded.
 - Beneficiaries with a cancer diagnosis during the measurement year are excluded.
 - Beneficiaries with a sickle cell diagnosis during the measurement year are excluded.
 - Beneficiaries receiving palliative care during the measurement period are excluded.

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 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.
Primary Data Source:	PDE data
Data Source Description:	<p>The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>The Use of Opioids from Multiple Providers in Persons Without Cancer is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.</p> <p>Additional data sources used are the:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment information • Medicare Enrollment Database (EDB) used to identify beneficiaries who elected to receive hospice care. Due to CMS’s migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes • Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes • PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

Measure: DMD13 - Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

Title	Description
	<p data-bbox="305 233 1523 569">Metric: This measure is defined as the percentage of Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period. The use of multiple anticholinergics in older adults is associated with an increased risk of cognitive decline. The Poly-ACH measure is adapted from the Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The PQA defines concurrent use as overlapping days' supply for at least 30 cumulative days during the measurement period. The Poly-ACH measurement period starts at the date of the first anticholinergic prescription claim and the end of the enrollment episode must extend at least 30 days from the first prescription claim.</p> <p data-bbox="384 600 1503 835">The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator with concurrent use of 2 or more ACH medications during the measurement period. Each medication must have at least 2 prescription claims with unique dates of service during the measurement period (numerator)) divided by (the number of member-years of enrolled beneficiaries, 65 years or older, with at least 2 prescription claims with unique dates of service of the same medication in the targeted drug classes of ACH during the measurement period (denominator))] * 100.</p> <p data-bbox="384 867 1503 999">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.</p> <p data-bbox="256 1014 1406 1087">Exclusions:</p> <ul data-bbox="435 1014 1406 1087" style="list-style-type: none">• Contracts with 30 or fewer enrolled member-years (in the denominator).• Beneficiaries in hospice during the measurement period are excluded. <p data-bbox="217 1098 1515 1230">General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.</p> <p data-bbox="147 1241 509 1272">Primary Data Source: PDE data</p> <p data-bbox="110 1287 1498 1692">Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p data-bbox="384 1724 1503 1854">The Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.</p>

Additional data sources used are the:

Title	Description
	<ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment information • Medicare Enrollment Database (EDB) used to identify beneficiaries who elected to receive hospice care. Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes • Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes • PQA Medication Lists, which include the NDCs for this measure.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Lower is better

Data Display: Percentage with no decimal places

Measure: DMD14 - Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)

Title**Description**

Metric: This measure is defined by the percentage of individuals 65 year of age or older with concurrent use of three or more unique central-nervous system (CNS) active medications. Use of multiple CNS active medications in older adults is associated with an increased risk of falls. The Poly-CNS measure is adapted from the Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The PQA defines concurrent use as overlapping days' supply for at least 30 cumulative days during the measurement period. The Poly-CNS measurement period starts at the date of the first CNS prescription claim and the end of the enrollment episode must extend at least 30 days from the first prescription claim.

The percentage is calculated as: $[(\text{The number of member-years of beneficiaries in the denominator with concurrent use of 3 or more CNS active medications during the measurement period. Each medication must have at least 2 prescription claims with unique dates of service during the measurement period (numerator)}) \div (\text{the number of member-years of enrolled beneficiaries, 65 years or older, with at least 2 prescription claims with unique dates of service of the same medication in the targeted drug classes of CNS active during the measurement period (denominator)})] * 100.$

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.

- Exclusions:**
- Contracts with 30 or fewer enrolled member-years (in the denominator).
 - Beneficiaries in hospice during the measurement period are excluded.
 - Beneficiaries with a seizure disorder diagnosis during the measurement year.

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.

Primary Data Source: PDE data

Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.

The Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.

Additional data sources used are the:

Title	Description
	<ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment information • Medicare Enrollment Database (EDB) used to identify beneficiaries who elected to receive hospice care. Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes • Encounter Data Systems (EDS) use to identify diagnoses based on ICD-10-CM codes • PQA Medication Lists, which include the NDCs for this measure.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Lower is better

Data Display: Percentage with no decimal places

Measure: DMD15 - Initial Opioid Prescribing (IOP-LD)

Title	Description
-------	-------------

Metric:

The Initial Opioid Prescribing for Long Duration (IOP-LD) measure is adapted from the IOP-LD measure developed by the Pharmacy Quality Alliance (PQA). The IOP-LD measure analyzes the percentage of beneficiaries, 18 years or older, who were prescribed at least one initial opioid prescription for more than 7 cumulative days' supply. The initial prescription start date (IPSD) is defined as the earliest date of service (DOS) of an opioid prescription claim during the measurement year. A beneficiary may have more than one initial opioid prescription during the measurement period. The lookback period is a period of 90 days prior to each opioid prescription. The negative medication history is defined as beneficiaries with no prescription claims for opioids in the lookback period. The opioid initiation period is the 3-day time period when the numerator is assessed. The opioid initiation period includes the date of the initial opioid prescription plus 2 days. There may be multiple initial opioid prescriptions, so there may be multiple opioid initiation periods.

The percentage is calculated as [(the number of member-years of beneficiaries in the denominator with more than 7 cumulative days' supply for opioid prescription claims within any 3-day opioid initiation period (numerator)) divided by (the number of member-years of enrolled beneficiaries, 18 years or older, with 1 or more opioid prescription claim(s) in the measurement period with a negative medication history during the 90-day lookback period (denominator))].

The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is 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.

- Exclusions:
- Contracts with 30 or fewer enrolled member-years (in the denominator).
 - Beneficiaries who are in hospice at any time during the measurement period or the 90 days prior to the IPSD are excluded from the denominator.
 - Beneficiaries with a cancer diagnosis at any time during the measurement period or the 90 days prior to the IPSD are excluded from the denominator.

Title	Description
	<ul style="list-style-type: none"> Beneficiaries with a sickle cell disease diagnosis at any time during the measurement period or the 90 days prior to the IPSD are excluded from the denominator. Beneficiaries receiving palliative care during the measurement period or the 90 days prior to the IPSD are excluded from the denominator. <p>General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.</p> <p>Primary Data Source: PDE data</p> <p>Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>The IOP-LD measure is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.</p> <p>Additional data sources used are the:</p> <ul style="list-style-type: none"> Common Medicare Environment (CME) used for enrollment information Medicare Enrollment Database (EDB) used to identify beneficiaries who elected to receive hospice care. Due to CMS’s migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes Encounter Data System (EDS) used to identify diagnoses based on ICD-10-CM codes PQA Medication Lists, which include the NDCs for this measure. <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal places</p>

Measure: DMD16 - Persistence to Basal Insulin (PST-INS)

Title	Description
	<p data-bbox="305 197 1526 596">Metric: The persistence of basal insulin (PST-INS) measure is adapted from the PST-INS measure developed by the measure steward by the PQA. The PST-INS measure analyzes the percentage of Medicare Part D beneficiaries, 18 years or older, who were treatment persistent to basal insulin during the measurement period. Treatment persistence is defined as the continued use of basal insulin throughout the treatment period (individuals with all refills for basal insulin occurring on or prior to the expected refill date). The treatment period is the individual's treatment period beginning on the earliest date of service for a basal insulin medication during the measurement period and extends through whichever comes first: the last day of the measurement period, death, or disenrollment. The treatment period must be at least 91 days during the measurement period. The expected refill date is calculated using the date of service and the appropriate value from the reference table to estimate the days' supply.</p> <p data-bbox="386 632 1526 800">The percentage is calculated as [(the number of beneficiaries in the denominator with continued use of basal insulin throughout the treatment period (individuals with all refills for basal insulin occurring on or prior to the expected refill date (numerator)) divided by (the number of continuously enrolled beneficiaries, 18 years or older with one or more prescription claims for basal insulin during the measurement period (denominator))].</p> <p data-bbox="256 814 1526 1360">Exclusions:</p> <ul data-bbox="435 814 1526 1360" style="list-style-type: none">• Contracts with 30 or fewer continuously enrolled beneficiaries (in the denominator).• Beneficiaries with more than 1-day gap in enrollment during the treatment period are excluded from the denominator.• Beneficiaries with a gestational diabetes diagnosis during the measurement period are excluded from the denominator.• Beneficiaries in hospice at any time during the measurement period are excluded from the denominator.• Beneficiaries with end-stage renal disease (ESRD) during the measurement period are excluded from the denominator.• Beneficiaries who received one or more prescription claims for mixed insulins with a date of service during the measurement period are excluded from the denominator.• Beneficiaries who received one or more prescription claims for regular insulin (U-500) with a date of service during the measurement period are excluded from the denominator. <p data-bbox="217 1375 1526 1507">General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.</p> <p data-bbox="147 1522 509 1549">Primary Data Source: PDE data</p> <p data-bbox="110 1564 1526 1896">Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected by DDPS, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023</p>

Title	Description
	<p>PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>The PST-INS measure is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. The Reference Table is also posted along with the technical notes.</p> <p>Additional data sources used are the:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) is used for enrollment information • Medicare Enrollment Database (EDB) is used to identify beneficiaries who elected to receive hospice care or ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • Common Working File (CWF) is used to identify diagnoses based on ICD-10-CM codes • Encounter Data System (EDS) is used to identify diagnoses based on ICD-10-CM codes • PQA Medication Lists, which include the NDCs for this measure. <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Common Part C & D Display Measure Details

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. $\text{Numerator} = (\text{Quarter 1 Total Grievances} + \text{Quarter 2 Grievances} + \text{Quarter 3 Grievances} + \text{Quarter 4 Grievances}) * 1,000 * 30$ $\text{Denominator} = \text{Average Enrollment} * \text{Number of days in period}$ 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. Contracts that indicate there is no data to report for a quarter are assumed to have 0 grievances in that quarter. Exclusions: 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 termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are listed as "No Data Available." 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 were not compliant with data validation standards/sub-standard for Element A. These contracts excluded from the measure due to data validation issues are shown as "CMS identified issues with this plan's data." 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 2023 Data Validation cycle. Data Source Category: Health and Drug Plans Data Time Frame: 01/01/2023 – 12/31/2023 General Trend: Lower is better Data Display: Numeric with 2 decimal places

Measure: DME02 - Disenrollment Reasons – Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-only)

Title	Description
	<p>Metric: “Problems Getting the Plan to Provide and Pay for Needed Care” is a composite of the following survey questions (question numbers vary depending on survey type):</p> <p>(a) Did you leave the plan because you were frustrated by the plan’s approval process for care, tests, or treatment?</p> <p>(b) Did you leave the plan because you had problems getting the care, tests, or treatment you needed?</p> <p>(c) Did you leave the plan because you had problems getting the plan to pay a claim?</p> <p>(d) Did you leave the plan because it was hard to get information from the plan about which health care services were covered or how much a specific test or treatment would cost?</p> <p>Each of these questions asked about a disenrollment reason related to the beneficiary’s experiences with getting the plan to provide and pay for needed care. Scores range from 0 to 100. A lower mean indicates that reasons related to problems getting the plan to provide and pay for needed care were endorsed less frequently by disenrollees.</p> <p>Scores are suppressed if they are measured with very low reliability (< 0.60), are not statistically different from the national mean, and the relative standard error (a measure of precision) is greater than 10%.</p> <p>Exclusions: Contracts with fewer than 30 responses are excluded.</p> <p>General Notes: Disenrollment Reasons Survey results were sent to each contract's Medicare Compliance Officer in September 2024. These reports provide further explanation of the Disenrollment Reasons composite measures</p> <p>Primary Data Source: Disenrollment Reasons Survey</p> <p>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).</p> <p>Data Source Category: Survey of Enrollees</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal place</p>

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 disenrollment reason related to the coverage of doctors and hospitals by the plan. Scores range from 0 to 100. A lower mean indicates that reasons related to problems with coverage of doctors and hospitals were endorsed less frequently by disenrollees.

Scores are suppressed if they are measured with very low reliability (less than 0.60), are not statistically different from the national mean, and the relative standard error (a measure of precision) is greater than 10%.

Exclusions: Contracts with fewer than 30 responses are excluded.

General Notes: Disenrollment Reasons Survey results were sent to each contract's Medicare Compliance Officer in September 2024. These reports provide further explanation of the Disenrollment Reasons composite measures

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: 01/01/2023 – 12/31/2023

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 premium 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 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?
- (e) Did you leave the plan because it turned out to be more expensive than you expected?

Each of these questions asked about a disenrollment reason related to the cost or affordability of services. Scores range from 0 to 100. A lower mean indicates that financial reasons were endorsed less frequently by disenrollees.

Scores are suppressed if they are measured with very low reliability (less than 0.60), are not statistically different from the national mean, and the relative standard error (a measure of precision) is greater than 10%.

Exclusions: Contracts with less than 30 responses are excluded.

General Notes: Disenrollment Reasons Survey results were sent to each contract's Medicare Compliance Officer in September 2024. These reports provide further explanation of the Disenrollment Reasons composite measures

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: 01/01/2023 – 12/31/2023

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
	<p>Metric: “Problems with Prescription Drug Benefits and Coverage” is a composite of the following survey questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none"> (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? <p>Each of these questions asked about a disenrollment reason related to prescription drug benefits and coverage. Scores range from 0 to 100. A lower mean indicates that reasons related to problems with prescription drug benefits and coverage were endorsed less frequently by disenrollees.</p> <p>Scores for this composite measure are based on 2 years of data from 2022 (prior year) and 2023 (current year) survey data. To calculate the composite measure, we first calculate single year scores for 2022 and for 2023. The prior year’s score is then adjusted to account for the change in the national averages for this composite measure between 2022 and 2023. The adjustment is calculated by subtracting the prior year’s (2022) national average score from the current year’s (2023) national average score. This adjustment is then added to the prior year’s score. This adjusted 2022 score is then averaged with the 2023 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.</p> <p>For plans without scores from the prior year (2022), the final composite score reflects the current one-year (2023) score only.</p> <p>Scores are suppressed if they are measured with very low reliability (less than 0.60), are not statistically different from the national mean, and the relative standard error (a measure of precision) is greater than 10%.</p> <p>Exclusions: Contracts with fewer than 30 responses are excluded.</p> <p>General Notes: Disenrollment Reasons Survey results were sent to each contract's Medicare Compliance Officer in September 2024. These reports provide further explanation of the Disenrollment Reasons composite measures</p> <p>Primary Data Source: Disenrollment Reasons Survey</p> <p>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).</p> <p>Data Source Category: Survey of Enrollees</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023 for current reporting year, and 01/01/2022 – 12/31/2022 for previous reporting year, if available</p> <p>General Trend: Lower is better</p>

Title	Description
	Data Display: Percentage with no decimal place

Measure: DME06 - Disenrollment Reasons – Problems Getting Information and Help from the Plan (MA-PD, PDP)	
Title	Description
	<p data-bbox="305 344 1490 413">Metric: “Problems Getting Information and Help from the Plan” is a composite of the following survey questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none"> <li data-bbox="386 413 1498 480">(a) Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription? <li data-bbox="386 480 1479 577">(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? <li data-bbox="386 577 1453 644">(c) Did you leave the plan because you were unhappy with how the plan handled a question or complaint? <li data-bbox="386 644 1421 711">(d) Did you leave the plan because you could not get the information or help you needed from the plan? <li data-bbox="386 711 1471 779">(e) Did you leave the plan because their customer service staff did not treat you with courtesy and respect? <p data-bbox="386 814 1516 947">Each of these questions asked about a disenrollment reason related to the beneficiary's experiences with getting information and help from the plan. Scores range from 0 to 100. A lower mean indicates that reasons related to problems with getting information and help from the plan were endorsed less frequently by disenrollees.</p> <p data-bbox="386 982 1510 1314">Scores for this composite measure are based on 2 years of data from 2022 (prior year) and 2023 (current year) survey data. To calculate the composite measure, we first calculate single year scores for 2022 and for 2023. The prior year's score is then adjusted to account for the change in the national averages for this composite measure between 2022 and 2023. The adjustment is calculated by subtracting the prior year's (2022) national average score from the current year's (2023) national average score. This adjustment is then added to the prior year's score. This adjusted 2022 score is then averaged with the 2023 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.</p> <p data-bbox="386 1350 1482 1417">For plans without scores from the prior year (2022), the final composite score reflects the current one-year (2023) score only.</p> <p data-bbox="386 1453 1487 1549">Scores are suppressed if they are measured with very low reliability (less than 0.60), are not statistically different from the national mean, and the relative standard error (a measure of precision) is greater than 10%.</p> <p data-bbox="256 1564 1060 1598">Exclusions: Contracts with less than 30 responses are excluded.</p> <p data-bbox="215 1608 1521 1705">General Notes: Disenrollment Reasons Survey results were sent to each contract's Medicare Compliance Officer in September 2024. These reports provide further explanation of the Disenrollment Reasons composite measures</p> <p data-bbox="147 1719 786 1753">Primary Data Source: Disenrollment Reasons Survey</p> <p data-bbox="110 1766 1503 1898">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).</p> <p data-bbox="134 1911 638 1944">Data Source Category: Survey of Enrollees</p>

Title	Description
Data Time Frame:	01/01/2023 – 12/31/2023 for current reporting year, and 01/01/2022 – 12/31/2022 for previous reporting year, if available
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME07 - Beneficiary Access and Performance Problems

Title	Description
	<p>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).</p> <ul style="list-style-type: none"> • Contracts' scores are based on a scale of 0-100 points. • The starting score for each contract works as follows: <ul style="list-style-type: none"> ◦ Contracts with an effective date of 1/1/2021 or later are marked as "Plan too new to be measured." ◦ All contracts with an effective date prior to 1/1/2021 begin with a score 100. • The following deductions are taken from the contracts starting score: <ul style="list-style-type: none"> ◦ Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows: <ul style="list-style-type: none"> ■ 0 – 2 CAM Score – 0 points ■ 3 – 9 CAM Score – 20 points ■ 10 – 19 CAM Score – 40 points ■ 20 – 29 CAM Score – 60 points ■ Greater than or equal to 30 CAM Score – 80 points <p>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:</p> $\text{CAM Score} = (\text{NC} * 1) + (\text{woBP} * 3) + (\text{wBP} * 4) + (6 * \text{CAP Severity})$ <p>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:</p> <ul style="list-style-type: none"> 3 – ad-hoc CAP with beneficiary access impact 2 – ad-hoc CAP with beneficiary non-access impact 1 – ad-hoc CAP no beneficiary impact <p>Exclusions: CAM entries with the following characteristics were removed prior to processing the BAPP score:</p> <ul style="list-style-type: none"> • Ad-hoc CAPs with a topic of "Star Ratings" • Notices of Non-Compliance with a topic of "Financial Concerns--Solvency, Reporting, Licensure, Other" <p>Primary Data Source: Compliance Activity Module (CAM)</p> <p>Data Source Description: Ad hoc CAPs and compliance actions that occurred during the 12 month past performance review period between January 1, 2021 and December 31, 2021. 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.</p> <p>Data Source Category: CMS Administrative Data</p> <p>Data Time Frame: 01/01/2023 – 12/31/2023</p>

Title	Description
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 2025 display measures.⁵

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)	50%
DMC02	Antidepressant Medication Management (6 months)	67%
DMC03	Continuous Beta Blocker Treatment	72%
DMC04	Testing to Confirm Chronic Obstructive Pulmonary Disease	28%
DMC05	Doctors who Communicate Well	93
DMC06	Call Center – Beneficiary Hold Time	0:37
DMC07	Pneumonia Vaccine	68%
DMC08	Access to Primary Care Doctor Visits	95%
DMC09	Call Center – Calls Disconnected When Customer Calls Health Plan	1.45
DMC10	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	74%
DMC11	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	84%
DMC12	Initiation of Substance Use Disorder Treatment	35%
DMC13	Engagement of Substance Use Disorder Treatment	5%
DMC14	Initiation and Engagement of Substance Use Disorder Treatment Average	20%
DMC15	Hospitalization for Potentially Preventable Complications	18%
DMC16	Transitions of Care – Medication Reconciliation Post-Discharge	72%
DMC17	Transitions of Care – Notification of Inpatient Admission	45%
DMC18	Transitions of Care – Patient Engagement After Inpatient Discharge	86%
DMC19	Transitions of Care – Receipt of Discharge Information	29%
DMC20	Physical Functioning Activities of Daily Living	94%
DMC21	Care for Older Adults – Functional Status	80%
DMC22	Kidney Health Evaluation for Patients With Diabetes	52%
DMC23	Improving or Maintaining Physical Health ⁶	70%
DMC24	Improving or Maintaining Mental Health ⁶	83%
DMC25	Cardiac Rehabilitation – Achievement	4%
DMC26	Cardiac Rehabilitation – Engagement 1	11%
DMC27	Cardiac Rehabilitation – Engagement 2	10%
DMC28	Cardiac Rehabilitation – Initiation	8%
DMC29	Colorectal Cancer Screening (Age 45-75)	71%

⁵ All contracts are weighted equally in these averages.

⁶ These comparisons on are pre- and post-pandemic.

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

Measure ID	Measure Name	MAPD Average	PDP Average
DMD01	Call Center – Calls Disconnected When Customer Calls Drug Plan	1.35%	1.59%
DMD02	Call Center – Beneficiary Hold Time	0:35	0:32
DMD03	MPF – Stability	100	100
DMD04	Call Center – Pharmacy Hold Time	0:27	0:23
DMD05	Plan Submitted Higher Prices for Display on MPF	74	66
DMD06	Reminders to Fill Prescriptions	55%	51%
DMD07	Reminders to Take Medications	34%	24%
DMD08	Antipsychotic Use in Persons with Dementia (APD)	7%	9%
DMD09	Antipsychotic Use in Persons with Dementia – for Long-Term Nursing Home Residents (APD-LTNH)	7%	7%
DMD10	Concurrent Use of Opioids and Benzodiazepines (COB)	14%	15%
DMD11	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	6%	5%
DMD12	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	0.40%	0.36%
DMD13	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	9%	7%
DMD14	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	13%	11%
DMD15	Initial Opioid Prescribing (IOP-LD)	17%	13%
DMD16	Persistence to Basal Insulin (PST-INS)	70%	70%

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

Measure ID	Measure Name	MA Average	PDP Average
DME01	Grievance Rate	6.73	1.49
DME02	Disenrollment Reasons – Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-only)	17%	N/A
DME03	Disenrollment Reasons – Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)	23%	N/A
DME04	Disenrollment Reasons – Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)	19%	53%
DME05	Disenrollment Reasons – Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	8%	12%
DME06	Disenrollment Reasons – Problems Getting Information and Help from the Plan (MA-PD, PDP)	12%	5%
DME07	Beneficiary Access and Performance Problems	90	96

**Attachment B: Calculating Measure DMC15:
Hospitalization for Potentially Preventable Complications – Total ACSC (M/F Total)**

All data is available in the CMS 2023 HEDIS® Public Use File (PUF)⁷ and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the NonOutlierMemberCount, ObservedCount and ExpectedCount values from the HPC Total ACSC (M/F Total) indicator (IndicatorKey = 201315_20).

For each contract, calculate the Total ACSC (M/F Total) Observed-over-Expected Ratio (OE):

$$OE = \left(\frac{\text{ObservedCount}}{\text{ExpectedCount}} \right)$$

Calculate the national average of the Total ACSC (M/F Total) Observed Rate:

$$\text{NatAvgObs} = \text{Average} \left(\left(\frac{\text{ObservedCount}_1}{\text{NonOutlierMemberCount}_1} \right), \dots, \left(\frac{\text{ObservedCount}_n}{\text{NonOutlierMemberCount}_n} \right) \right)$$

Where 1 through n are all contracts with a Total ACSC (M/F Total) NonOutlierMemberCount larger than or equal to 150, and a Total ACSC (M/F Total) OE larger than or equal to 0.2 and less than or equal to 5.0.

For each contract, calculate the Final Rate and convert to percentages:

$$\text{Final Rate} = OE \times \text{NatAvgObs} \times 1000$$

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	IndicatorKey	NonOutlierMemberCount	ObservedCount	ExpectedCount
Contract 1	201315_20	4,792	641	642
Contract 2	201315_20	4,761	688	668
Contract 3	201315_20	8,629	1,126	1,070
Contract 4	201315_20	533	79	73

$$\text{NatAvgObs} = \text{Average} \left(\left(\frac{641}{4,792} \right), \left(\frac{688}{4,761} \right), \left(\frac{1,126}{8,629} \right), \left(\frac{79}{533} \right) \right)$$

$$\text{NatAvgObs} = \text{Average} \left((0.13376), (0.14451), (0.13049), (0.14822) \right)$$

$$\text{NatAvgObs} = 0.139245$$

$$\text{Final Rate Contract 1} = \left(\left(\frac{641}{642} \right) \times 0.139245 \right) \times 1000 = 139.028$$

$$\text{Final Rate reported for Contract 1} = 139$$

The actual calculated National Observed Rate used in the 2025 display measures was 0. 0.032521843923963.

⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files>

Attachment C: Calculating Measure DMD03: MPF – Stability

The MPF Stability measure evaluates the stability in contracts' drug prices over the course of the contract year.

Contract Selection

The MPF Stability measure is calculated for contracts with at least one plan meeting all of the following criteria:

- Not a PACE plan
- Not a demonstration plan
- Not an employer plan
- Part D plan
- Plan not terminated during the contract year

PDE Price Stability Index

The PDE Price Stability index measures the average quarterly change in prices of a specified basket of drugs. The drug basket is composed of drugs (grouped by GSN-BG) with at least 10 PDE claims in all four quarters. The index weights the price of each drug by the relative consumption of that product in the previous quarter, so that price changes in heavily utilized drugs contribute more to the index.

To detail each component of the index, the stability index (S_{jt}) for contract j and quarter t can be summarized using the following formula:

$$S_{jt} = \frac{\sum_i p_{jit} q_{ji(t-1)}}{\sum_i p_{ji(t-1)} q_{ji(t-1)}}$$

Where

p_{jit} = average unit price of drug i in quarter t

$p_{ji(t-1)}$ = average unit price of drug i in quarter $(t-1)$

$q_{ji(t-1)}$ = quantities of drug i consumed in the previous quarter

The annual index, which we define as the average of S_{j2} , S_{j3} , and S_{j4} , can be summarized as:

$$S_j = \frac{S_{j2} + S_{j3} + S_{j4}}{3}$$

or

$$S_j = \frac{\frac{\sum_i p_{ji2} q_{ji1}}{\sum_i p_{ji1} q_{ji1}} + \frac{\sum_i p_{ji3} q_{ji2}}{\sum_i p_{ji2} q_{ji2}} + \frac{\sum_i p_{ji4} q_{ji3}}{\sum_i p_{ji3} q_{ji3}}}{3}$$

Example of PDE Price Stability Index Calculation

Table C-1 provides an example calculation of the PDE Price Stability index for a contract (contract j) with only two GSN-BGs for quarters 1 and 2. This is an abbreviated example for illustrative purposes only. The actual price stability index for each contract is based on a full year of PDE data and is the average of the 3 quarterly indexes computed: quarter 1 to 2; quarter 2 to 3; and quarter 3 to 4.

The quantities from the previous quarter (in this case, quarter 1) define the basket of drugs studied; there are 100 units of drug 999999.B and 50 units of 999999.G sold in that quarter. In total, this basket costs \$1,005 in quarter 1. These quantities from quarter 1 (q_{ij}^1) are multiplied by the unit costs of the two drugs in quarter 2 (p_{ij}^2) to calculate the quarter 2 contract-level cost, yielding \$1,029 (\$1,025 for 999999.B + \$4 for 999999.G). The stability index is computed as \$1,029/\$1,005 or 1.02388. If quarters 3 and 4 were included, the PDE Price Stability index would be the average of 1.02388 and the other two values computed for quarters 2 to 3 and quarters 3 to 4.

The PDE Price Stability index is constructed such that increases in price will increase the index and decreases in prices will decrease the index. If prices remain identical for all drugs across all quarters, the index will be equal to 1. Drugs accounting for a larger portion of expenditures will have a greater impact (whether positive or negative) on the index than drugs with comparatively low expenditures, such as 999999.G in the example in Table C-1. A PDE Price Stability index of 1 (no price increases) or lower (price decreases over the year) is desirable.

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

$$\text{Stability Score} = 100 - ((\text{PDE Price Stability Index} - 1) \times 100)$$

Table C-1: Example of Quarterly Stability Index Calculation for Quarter 2 (Q2)

GSN_BG	Q1 Total Quantity (q_{ij1})	Q1	Q1	Q2 Total Quantity	Q2	Q2 ($q_{ij1} * p_{ij2}$)
999999.B	100	\$10.00	\$1,000.00	100	\$10.25	\$1,025.00
999999.G	50	\$0.10	\$5.00	100	\$0.08	\$4.00
Sum across all drugs in contract			\$1,005.00			\$1,029.00
				Quarterly Stability Index (S_j):		1.02388

Attachment D: Calculating Measure DMD05: Plan Submitted Higher Prices for Display on MPF

The MPF Composite Display Measure Accuracy score is calculated by comparing the Medicare Plan Finder (MPF) price to the Prescription Drug Event (PDE) price and determining the magnitude and frequency of differences found when the former exceeds the latter.

Contract Selection

The MPF Accuracy measure is calculated for contracts with at least one plan meeting all of the following criteria:

- Not a PACE plan
- Not a demonstration plan
- Not an employer plan
- Part D plan
- Plan not terminated during the contract year

MPF Composite Display Measure Accuracy Score

To calculate the MPF Composite Display Measure Accuracy Score, the point-of-sale total cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the total cost resulting from using the unit price reported on Medicare Plan Finder.⁸

This comparison includes only PDEs for which a MPF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. 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. NCPDP numbers are mapped to their corresponding NPI numbers.
2. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.²
3. The reference NDC must be on the plan's formulary.
4. Because the retail unit cost reported on Plan Finder is intended to apply to a 1, 2, or 3-month supply of a drug, only claims with a Days Supply of 28-34, 60-62, or 90-93 are included. 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. For example, a plan that submits a 3 month retail supply of 100 days in their bid will have claims with a days supply of 90-100 included in their accuracy measure calculation.
5. PDEs for dates of service during which the plan was suppressed from Plan Finder or where the relevant pharmacy or drug was not reported in Plan Finder are not included since no Plan Finder cost can be assigned.³
6. PDEs for compound drugs or non-covered drugs are not included.
7. The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

⁸ Medicare Plan Finder unit costs are reported by plan, drug, days of supply, and pharmacy. The plan, drug, days of supply and pharmacy from the PDE are used to assign the corresponding Medicare Plan Finder unit cost posted on medicare.gov on the date of the PDE.

The MPF Composite Display Measure Accuracy Score factors in both how much and how often MPF prices exceeded the prices reflected on the PDE. The contract's MPF Composite Display Measure score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and MPF total cost,⁹ and the Claim Percentage Score, which measures the share of claims where PDE prices are greater than or equal to MPF prices.

Once MPF unit ingredient costs are assigned, the MPF ingredient cost is calculated by multiplying the unit costs reported on MPF by the quantity listed on the PDE. The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the MPF TC is the sum of the MPF ingredient cost and the MPF dispensing fee that corresponds to the same pharmacy, plan, and days of supply as that observed in the PDE. Each claim is then given a score based on the difference between the PDE TC and the MPF TC. If the PDE TC is higher than or equal to the MPF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when advertised costs are lower than or equal to point of sale costs. However, if the MPF TC is higher than the PDE TC, then the claim receives a score equal to the difference between the MPF TC and the PDE TC.^{10, 11} The contract level MPF Display Measure Accuracy Index is the sum of the claim level scores and PDE TC across all PDEs that meet the inclusion criteria, divided by the PDE TC for those same claims.

The MPF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a MPF TC higher than the PDE TC. Note that the best possible MPF Price Accuracy Index is 1, and the best possible MPF Claim Percentage Index is 0. This occurs when the PDE TC is never lower than the MPF TC. The formulas below illustrate the calculation of the contract level MPF Price Accuracy Index and MPF Claim Percentage Index:

$$\text{Price Accuracy Index} = \left(\frac{\sum_i \max(\text{TC}_{i\text{MPF}} - \text{TC}_{i\text{PDE}}, 0) + \sum_i \text{TC}_{i\text{PDE}}}{\sum_i \text{TC}_{i\text{PDE}}} \right)$$

where

$\text{TC}_{i\text{PDE}}$ is the ingredient cost plus dispensing fee reported in PDE_i , and

$\text{TC}_{i\text{MPF}}$ is the ingredient cost plus dispensing fee calculated from MPF data, based on the PDE_i reported NDC, days of supply, and pharmacy.

$$\text{Claim Percentage Index} = \left(\frac{\sum_i \text{Claims}_{i\text{MPF} > \text{PDE}}}{\sum_i \text{Claims}_{i\text{Total}}} \right)$$

Where

$\text{Claims}_{i\text{MPF} > \text{PDE}}$ is the total number of claims where the MPF price is greater than the PDE price

$\text{Claims}_{i\text{Total}}$ is the total number of claims

⁹ MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is \$10.237, then it is rounded to \$10.24. MPF unit costs are not rounded.

¹⁰ To account for potential rounding errors, this analysis requires that the MPF cost exceed the PDE cost by at least two cents (\$0.02) in order to be counted towards the accuracy score. For example, if the rounded MPF cost is \$10.25 and the PDE cost is \$10.23, the 2-cent difference would be counted towards plan's display measure accuracy score. However, if the PDE price is higher than \$10.23, the difference would not count towards the plan's display measure accuracy score.

¹¹ The MPF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the MPF price is lower than the floor price, the PDE price is compared against the floor price.

We use the following formulas to convert the Claim Percentage Index and Price Accuracy Index into the MPF Composite Display Measure score:

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{MPF Composite Display Measure Accuracy Score} = (0.5 \times \text{Claim Percentage Score}) + (0.5 \times \text{Price Accuracy Score})$$

The MPF Composite Display Measure Accuracy Score is rounded to the nearest whole number.

Example of MPF Composite Display Measure Accuracy Score Calculation

Table D-1 shows an example of the MPF Composite Display Measure Accuracy Score calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 eligible claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the MPF data that had been submitted by the contract and posted on Medicare.gov on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength, and dosage form. Using the reference NDC, the following MPF data are obtained: brand/generic dispensing fee (as assigned by the pharmacy cost file) and unit cost (as assigned by the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The MPF cost is computed as the quantity dispensed from PDE multiplied by the MPF unit cost plus the MPF brand/generic dispensing fee (brand or generic status is assigned based on the NDC), and then rounded to the nearest cent.

The last column shows the amount by which the rounded MPF cost is higher than the PDE cost. When the rounded MPF cost is less than or equal to the PDE cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table D-1: Example of MPF Composite Display Measure Accuracy Score Calculation

NDC	Pharmacy Number	PDE Data DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PDE Days of Supply	MPF Data Biweekly Posting Period	MPF Data Unit Cost	MPF Data Dispensing Fee Brand	MPF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost MPF	Calculated Value Amount that MPF is higher than PDE
A	111	01/08/2023	3.82	2	60	60	01/06/23 - 01/19/23	0.014	2.25	2.75	B	5.82	3.09	0
B	222	01/24/2023	0.98	2	30	60	01/20/23 - 02/02/23	0.83	1.75	2.5	G	2.98	27.40	24.42
C	333	02/11/2023	10.48	1.5	24	28	02/03/23 - 02/16/23	0.483	2.5	2.5	B	11.98	14.09	2.112
D	444	02/21/2023	47	1.5	90	30	02/17/23 - 03/01/23	0.48	1.5	2.25	G	48.50	45.45	0
							PDE = Prescription Drug Event				Totals	69.28		26.532
							MPF = Medicare Plan Finder				Price Accuracy Index			1.3830
											Claim Percentage Index			0.5
											MPF Composite Display Measure Accuracy Score			56