



Medicare 2026 Part C & D Display Measure Technical Notes

Updated – 12/16/2025

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General

This document describes the metric, data source, and reporting time period for each Medicare Part C or Part D display measure. All data are reported at the contract level. The data do not reflect information for National PACE, 1833 Cost contracts, 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 2026, CMS:

- Introduced eleven measures to the display page:
 - a. Adult Immunization Status - Influenza
 - b. Adult Immunization Status - Pneumococcal
 - c. Adult Immunization Status - Td/Tdap
 - d. Adult Immunization Status - Zoster
 - e. Adult Immunization Status - Average
 - f. Depression Screening and Follow-Up - Depression Screening
 - g. Depression Screening and Follow-Up - Follow-Up on Positive Screen
 - h. Depression Screening and Follow-Up – Average
 - i. Medication Adherence for Diabetes Medications
 - j. Medication Adherence for Hypertension (RAS antagonists)
 - k. Medication Adherence for Cholesterol (Statins)
- Moved three measures to the 2026 Star Ratings:
 - a. Kidney Health Evaluation for Patients with Diabetes
 - b. Improving or Maintaining Physical Health
 - c. Improving or Maintaining Mental Health
- Retired two measures from the display page:
 - a. Antidepressant Medication Management
 - b. Testing to Confirm Chronic Obstructive Pulmonary Disease

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
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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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC02 - Continuous Beta Blocker Treatment

Title	Description
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HEDIS Label: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Measure Reference: NCQA HEDIS MY 2024 Technical Specifications Volume 2, page 141

Metric: The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI (denominator) and who received persistent beta-blocker treatment for six months after discharge (numerator).

Exclusions: Required exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.

Title	Description
	<ul style="list-style-type: none"> •Members who die any time during the measurement year. •Members with a medication dispensing event that indicates a contraindication to beta-blocker therapy. •Members with a diagnosis that indicates a contraindication to beta-blocker therapy any time during the member's history through the end of the continuous enrollment period. <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 on or between July 1 of the year prior to the measurement year and the end of the measurement year. – Living long-term in an institution any time on or between July 1 of the year prior to the measurement year and the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. <ul style="list-style-type: none"> • Members 66 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"> – Frailty. At least two indications of frailty with different dates of service any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. – Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: <ul style="list-style-type: none"> • Advanced illness on at least two different dates of service. Do not include laboratory claims. • Dispensed dementia medication. <ul style="list-style-type: none"> • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Value Set) with different dates of service any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. <p>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p>

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC03 - 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: 03/2025 – 06/2025</p> <p>General Trend: Higher is better</p> <p>Data Display: Numeric with no decimal place</p>

Measure: DMC04 - 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: 01/2025 – 06/2025</p> <p>General Trend: Lower is better</p> <p>Data Display: Time</p> <p>Compliance Standard: 2:00</p>

Measure: DMC05 - 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: 03/2025 – 06/2025</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC06 - Access to Primary Care Doctor Visits

Title	Description
	<p>HEDIS Label: Adults' Access to Preventive/Ambulatory Health Services (AAP)</p> <p>Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 433</p> <p>Metric: The percentage of members 20 years and older (denominator) who had an ambulatory or preventive care visit during the measurement year (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: 01/01/2024 – 12/31/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC07 – Call Center – Calls Disconnected When Customer Calls Health Plan

Title	Description
	<p>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.</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: 01/2025 – 06/2025</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with 2 decimal places</p> <p>Compliance Standard: 5%</p>

Measure: DMC08 - 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: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC09 - 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: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC10 - 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 2024 Technical Specifications Volume 2, page 396	
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.

Title	Description
	The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2024 – 12/31/2024
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC11 - 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 2024 Technical Specifications Volume 2, page 396
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>
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.
	The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2024 – 12/31/2024
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC12 - 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 2024 Technical Specifications Volume 2, page 396
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.
	The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2024 – 12/31/2024

Title	Description
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC13 - Hospitalization for Potentially Preventable Complications

Title	Description
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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.

- 1) Data for contracts whose Observed / Expected ratio is either < 0.2 or > 5.0 have been excluded.
- 2) Data for contracts with < 200 in the denominator have been excluded.

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.

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".

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

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: 01/01/2024 – 12/31/2024

General Trend: Lower is better

Data Display: Rate per 1,000 members with no decimal place

Measure: DMC14 - 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: 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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC15 - 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).	

Title	Description
	<p>2. Identify the discharge date for the stay.</p> <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>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC16 - Transitions of Care - Patient Engagement After Inpatient Discharge

Title	Description
	<p>HEDIS Label: Transitions of Care (TRC)</p> <p>Measure Reference: NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 330</p> <p>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.</p> <p>Exclusions: Members in hospice are excluded from the eligible population.</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>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p>

Title	Description
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC17 - 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: 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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC18 - 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: 2022-2024 Cohort 25 Performance Measurement Results (2022 Baseline data collection, 2024 Follow-up data collection)	

Title	Description
Data Source Category: Survey of Enrollees	
Data Time Frame: 07/19/2024 – 11/01/2024	
General Trend: Higher is better	
Data Display: Numeric with no decimal place	

Measure: DMC19 - 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: The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
	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 2026 Star Ratings Technical Notes.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC20 - 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: <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.

Title	Description
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The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC21 - Cardiac Rehabilitation – Engagement 1

Title	Description
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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:
- 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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC22 - Cardiac Rehabilitation – Engagement 2

Title	Description
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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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC23 - Cardiac Rehabilitation – Initiation

Title	Description
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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.

Title	Description
	<ul style="list-style-type: none"> 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. <p>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC24 - Colorectal Cancer Screening (Age 45-75)

Title	Description
HEDIS Label: Colorectal Cancer Screening (COL-E)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 578	
Metric: The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.	
Exclusions:	<ul style="list-style-type: none"> Members who use hospice services or elect to use a hospice benefit any time during the measurement period. Members who died any time during the measurement period. Members who had colorectal cancer any time during the member's history through December 31 of the measurement year. Do not include laboratory claims. Members who had a total colectomy any time during the member's history through December 31 of the measurement period. Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: <ul style="list-style-type: none"> Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. Living long-term in an institution any time during the measurement period. Members 66 years of age and older by the end of the measurement period 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"> Frailty. At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims. Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> Advanced illness on at least two different dates of service. Do not include laboratory claims. Dispensed dementia medication. Members receiving palliative care any time during the measurement period.

Title	Description
	<ul style="list-style-type: none"> Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims. <p>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p> <p>Primary Data Source: HEDIS</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMC25 - Adult Immunization Status - Influenza

Title	Description
HEDIS Label: Adult Immunization Status (AIS)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 643	
Metric: The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza.	
Exclusions: Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.	
Members who die any time during the measurement period.	
The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC26 - Adult Immunization Status - Pneumococcal

Title	Description
HEDIS Label: Adult Immunization Status (AIS)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 643	
Metric: The percentage of members 66 years of age and older who are up to date on recommended routine vaccines for pneumococcal.	
Exclusions: Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.	
Members who die any time during the measurement period.	

Title	Description
	The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC27 - Adult Immunization Status - Td/Tdap

Title	Description
HEDIS Label: Adult Immunization Status (AIS)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 643	
Metric: The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap).	
Exclusions: Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.	
Members who die any time during the measurement period.	
The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC28 - Adult Immunization Status - Zoster

Title	Description
HEDIS Label: Adult Immunization Status (AIS)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 643	
Metric: The percentage of members 50 years of age and older who are up to date on recommended routine vaccines for zoster.	
Exclusions: Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.	
Members who die any time during the measurement period.	
The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	

Title	Description
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC29 - Adult Immunization Status - Average

Title	Description
HEDIS Label: Adult Immunization Status (AIS)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 643	
Metric: The average of the Adult Immunization Status – Influenza, Adult Immunization Status – Pneumococcal, Adult Immunization Status – Td/Tdap, and Adult Immunization Status – Zoster measures.	
Exclusions: Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.	
Members who die any time during the measurement period.	
The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
Primary Data Source: HEDIS	
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC30 - Depression Screening and Follow-Up - Depression Screening

Title	Description
HEDIS Label: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 606	
Metric: The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument.	
Exclusions: <ul style="list-style-type: none"> Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period. Members with depression that starts during the year prior to the measurement period. Members who use hospice services or elect to use a hospice benefit any time during the measurement period. Members who die any time during the measurement period. 	
The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.	
Primary Data Source: HEDIS	

Title	Description
Data Source Category: Health and Drug Plans	
Data Time Frame: 01/01/2024 – 12/31/2024	
General Trend: Higher is better	
Data Display: Percentage with no decimal place	

Measure: DMC31 - Depression Screening and Follow-Up - Follow-Up on Positive Screen

Title	Description
HEDIS Label: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 606	
Metric: The percentage of members 12 years of age and older who received follow-up care within 30 days of a positive depression screen finding.	
Exclusions:	<ul style="list-style-type: none"> • Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period. • Members with depression that starts during the year prior to the measurement period. • Members who use hospice services or elect to use a hospice benefit any time during the measurement period. • Members who die any time during the measurement period. <p>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p>

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMC32 - Depression Screening and Follow-Up - Average

Title	Description
HEDIS Label: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	
Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 606	
Metric: The average of the Depression Screening and Follow-Up - Depression Screening and the Depression Screening and Follow-Up - Follow-Up on Positive Screen measures.	
Exclusions:	<ul style="list-style-type: none"> • Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period. • Members with depression that starts during the year prior to the measurement period. • Members who use hospice services or elect to use a hospice benefit any time during the measurement period. • Members who die any time during the measurement period. <p>The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.</p>

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Title	Description
Data Time Frame: 01/01/2024 – 12/31/2024	
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: 01/2025 – 06/2025</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: 01/2025 – 06/2025</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
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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).³

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 MediSpan and then First Data Bank (FDB) if Medi-Span data is unavailable 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.

³ CMS uses the FDA NSDE and RxNorm reference data sources to assign brand/generic status. If the drug's status is consistent across sources, it will be assigned based on the FDA NSDE; otherwise, CMS will assign the status based on the higher of the brand or generic dispensing fee.

Title	Description
General Notes:	Please see Attachment C: Calculating Measure DMD03 MPF – Stability for more information about this measure.
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	<p>Data used in this measure are obtained from PDE data and MPF Pricing Files. Reference data sources include HPMS approved formulary extracts, Formulary Reference File, RxNorm, FDA NSDE data, and data from First DataBank and Medispan.</p> <p>The PDE data for this measure come from the data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024 - December 31, 2024. 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 2024 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:	01/01/2024 – 12/31/2024
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMD04 - Call Center – Pharmacy Hold Time

Title	Description
Metric:	This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and prior to reaching a live person for the “pharmacy technical help desk” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract pharmacy technical help desk divided by the number of eligible calls made to the Part D contract pharmacy technical help desk. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call center
Data Source Description:	Call center data collected by CMS. The pharmacy technical help desk phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2025 – 06/2025

Title	Description
General Trend: Lower is better	
Data Display: Time	
Compliance Standard: 2:00	

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

Title	Description
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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: $(\text{Total amount that MPF is higher than PDE} + \text{Total PDE cost}) / (\text{Total PDE cost})$.

The claim percentage index is computed as $(\text{Total number of PDEs where MPF cost is higher than PDE}) / (\text{Total Number of PDEs})$

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 file.⁴
- 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 MPF⁵

⁴ MPF 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 Medi-Span and then First Data Bank (FDB) if Medi-Span data is unavailable 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.

⁵ 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
	<ul style="list-style-type: none"> • 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. <p>General Notes: Please see Attachment D: Calculating Measure DMD05: Plan Submitted Higher Prices for Display on MPF for more information about this measure.</p> <p>Primary Data Source: PDE data, MPF Pricing Files</p> <p>Data Source Description: Data used in this measure are obtained from PDE data and MPF Pricing Files. Reference data sources include HPMS approved formulary extracts, Formulary Reference File, RxNorm, FDA NSDE data, and data from First DataBank and Medi-span.</p> <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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024 - September 30, 2024. 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 2024 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 Source Category: Data Collected by CMS Contractors</p> <p>Data Time Frame: 01/01/2024 – 09/30/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Numeric with no decimal place</p>

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: 03/2025 – 06/2025</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: 03/2025 – 06/2025</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 percentage of Part D beneficiaries 65 years or older with a diagnosis of or prescriptions for dementia, who received at least one prescription and greater than 30 total days' supply for any antipsychotic medication, without evidence of an appropriate indication for antipsychotic use.</p> <p>The percentage is calculated as: $[(\text{The number of member-years of enrolled beneficiaries 65 years and older in the denominator who received at least one prescription and greater than 30 total days' supply for any antipsychotic medication during the measurement period, AND who did not have a diagnosis for appropriate indication for antipsychotic use or take an antipsychotic medication indicated for treatment of major depression during the measurement period (numerator)}) \div (\text{the number of member-years of enrolled beneficiaries 65 years and older who had either (i) a dementia diagnosis and/or (ii) two or more prescription claims with unique dates of service for a cholinesterase inhibitor or NMDA receptor antagonist during the measurement period (denominator)})] * 100.$</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> <p>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).</p> <p>Exclusions:</p> <ul 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 Diseases, or Tourette's Syndrome) are excluded from the numerator.• Indication for treatment of major depression that overlaps with the measurement period are excluded from the numerator. <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>

Title	Description
<p>Data Source Description:</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal place</p>	<p>The data for this measure come from PDE data files submitted to CMS Drug Data Processing System (DDPS) and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>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.</p> <p>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</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.

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

Title	Description
	<p data-bbox="305 218 1510 384">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="384 420 1515 785">The percentage is calculated as: $\left[\frac{\text{(The number of member-years of enrolled beneficiaries 65 years and older in the denominator who received at least one prescription and greater than 30 total days' supply for any antipsychotic medication with a date of service during a LTNH episode and during the measurement period AND who did not have a diagnosis for appropriate indication for antipsychotic use or taken an antipsychotic medication indicated for treatment of major depression during the measurement period)}}{\text{(the number of member-years of enrolled beneficiaries 65 years and older who had either (i) a dementia diagnosis and/or (ii) two or more prescription claims with unique dates of service for a cholinesterase inhibitor or NMDA receptor antagonist AND who had at least one nursing home episode that is greater than 100 days that overlaps with the measurement period)}}} \right] * 100.$</p> <p data-bbox="384 821 1471 951">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="384 987 1510 1087">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 1102 1515 1304">Exclusions:</p> <ul data-bbox="435 1102 1515 1304" 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) are excluded from the numerator.• Indication for treatment of major depression that overlaps with the measurement period are excluded from the numerator. <p data-bbox="217 1318 1515 1449">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 1463 509 1495">Primary Data Source: PDE data</p> <p data-bbox="110 1509 1523 1904">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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024- December 31, 2024. 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 2024 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>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</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: 01/01/2024 – 12/31/2024</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 as 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 increases the risk of adverse events such as respiratory depression, overdose, and death. 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. Continuous enrollment (CE) is defined as continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month.</p> <p>The percentage is calculated as: $\left[\frac{\text{(The number of CE beneficiaries in the denominator with at least 2 prescription claims of a benzodiazepine with unique dates of service (DOS) and concurrent use of opioids and benzodiazepines during the measurement period (numerator))}}{\text{(the number of CE beneficiaries, 18 years or older, with at least 2 prescription claims of a prescription opioid with unique DOS and at least 15 cumulative days' supply of opioids during the measurement period (denominator))}} \right] * 100$.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Contracts with 30 or fewer CE beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified: • Beneficiaries who have elected to receive hospice care during the measurement year. • Beneficiaries with a cancer diagnosis during the measurement year. • Beneficiaries with a sickle cell disease diagnosis during the measurement year. • Beneficiaries receiving palliative care during the measurement period.

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 PQA medication or NDC lists, are excluded from CMS analyses.
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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>The COB measure rate 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>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment 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:	01/01/2024 – 12/31/2024
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="305 184 1536 415">Metric: This measure is defined as 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="386 453 1536 651">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="386 688 1536 814">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="256 835 1536 1108">Exclusions:</p> <ul data-bbox="435 835 1536 1108" style="list-style-type: none">• Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified:• Beneficiaries who have elected to receive hospice care during the measurement year.• Beneficiaries with a cancer diagnosis during the measurement year.• Beneficiaries with a sickle cell disease diagnosis during the measurement year.• Beneficiaries receiving palliative care during the measurement period. <p data-bbox="217 1125 1536 1251">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 1268 509 1297">Primary Data Source: PDE data</p> <p data-bbox="110 1314 1536 1743">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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 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="386 1780 1536 1881">The OHD measure rate 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 data-bbox="386 1919 1536 1948">The data cutoff date for all the additional data sources listed below is determined by the</p>

Title	Description
	<p>same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment 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: 01/01/2024 – 12/31/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal places</p>

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

Title	Description
	<p>Metric: This measure is defined as 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.</p> <p>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.</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 are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified: • Beneficiaries who have elected to receive hospice care during the measurement year. • Beneficiaries with a cancer diagnosis during the measurement year. • Beneficiaries with a sickle cell disease diagnosis during the measurement year. • Beneficiaries receiving palliative care during the measurement period. <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 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.</p> <p>Primary Data Source: PDE data</p>

Title	Description
<p>Data Source Description:</p> <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with 2 decimal places</p>	<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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>The OMP measure rate 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>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment 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.

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

Title	Description
	<p data-bbox="305 218 1523 552">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. Continuous enrollment (CE) is defined as continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month.</p> <p data-bbox="386 588 1502 819">The percentage is calculated as: $\left[\frac{\text{The number of CE beneficiaries in the denominator with concurrent use of 2 or more ACH medications during the measurement period. Each medication must have at least 2 prescription claims with unique dates of service during the measurement period (numerator)}}{\text{the number of CE beneficiaries, 65 years or older, with at least 2 prescription claims with unique dates of service of the same ACH medication during the measurement period (denominator)}} \right] * 100.$</p> <p data-bbox="256 867 1518 1035">Exclusions:</p> <ul style="list-style-type: none">• Contracts with 30 or fewer CE beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified:• Beneficiaries who have elected to receive hospice care during the measurement period. <p data-bbox="215 1050 1515 1182">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 1194 509 1224">Primary Data Source: PDE data</p> <p data-bbox="110 1241 1523 1640">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, 2024-December 31, 2024. 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 2024 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p data-bbox="386 1675 1502 1774">The Poly-ACH measure rate 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 data-bbox="386 1810 1518 1908">The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none">• Common Medicare Environment (CME) used for enrollment information

Title	Description
	<ul style="list-style-type: none"> 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: 01/01/2024 – 12/31/2024

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
	<p>Metric: This measure is defined as the percentage of Part D beneficiaries 65 years 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. Continuous enrollment (CE) is defined as continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month.</p> <p>The percentage is calculated as: $\left[\frac{\text{(The number of CE beneficiaries in the denominator with concurrent use of 3 or more CNS active medications during the measurement period. Each medication must have at least 2 prescription claims with unique dates of service during the measurement period (numerator))}}{\text{(the number of CE beneficiaries, 65 years or older, with at least 2 prescription claims with unique dates of service of the same CNS active medication during the measurement period (denominator))}} \right] * 100$.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> Contracts with 30 or fewer CE beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified: Beneficiaries who have elected to receive hospice care during the measurement period. Beneficiaries with a seizure disorder diagnosis during the measurement. <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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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</p>

Title	Description
	<p>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 2024 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>The Poly-CNS measure rate 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>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment information • 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. <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal places</p>

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

Title	Description
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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 are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified:
- Beneficiaries who have elected to receive hospice care at any time during the measurement period or the 90 days prior to the IPSD.
- Beneficiaries with a cancer diagnosis at any time during the measurement period or the 90 days prior to the IPSD.
- Beneficiaries with a sickle cell disease diagnosis at any time during the measurement period or the 90 days prior to the IPSD.
- Beneficiaries receiving palliative care during the measurement period or the 90 days prior to the IPSD.

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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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

Title	Description
	<p>final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2024 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 rate 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>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none"> • Common Medicare Environment (CME) used for enrollment information • 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: 01/01/2024 – 12/31/2024</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>Metric: The persistence of basal insulin (PST-INS) measure is adapted from the PST-INS measure developed and endorsed by the Pharmacy Quality Alliance (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. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period. No enrollment gaps during the treatment period are allowed.</p> <p>The percentage is calculated as [(the number of CE 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 CE beneficiaries, 18 years or older with one or more prescription claims for basal insulin during the measurement period who have at least one prescription claim for basal insulin with an expected refill date during the treatment period(denominator))].</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Contracts with 30 or fewer continuously enrolled beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified:

Title	Description
	<ul style="list-style-type: none"> Beneficiaries with more than 1-day gap in enrollment during the treatment period. Beneficiaries with a gestational diabetes diagnosis during the measurement period. Beneficiaries who have elected to receive hospice care at any time during the measurement period. Beneficiaries with end-stage renal disease (ESRD) during the measurement period are excluded. Beneficiaries who received one or more prescription claims for mixed insulins with a date of service during the measurement period. Beneficiaries who received one or more prescription claims for regular insulin (U-500) with a date of service during the measurement period. <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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 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 rate 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>The data cutoff date for all the additional data sources listed below is determined by the same PDE submission deadline for the annual Part D payment reconciliation. Additional data sources include the following:</p> <ul style="list-style-type: none"> Common Medicare Environment (CME) is used for enrollment information 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: 01/01/2024 – 12/31/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMD17 - Medication Adherence for Diabetes Medications with Risk Adjustment (RA)

Title	Description
	<p data-bbox="305 180 1521 684">Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase-4 (DPP-4) inhibitors, glucose-dependent insulintropic polypeptide and glucagon-like peptide-1 (GIP/GLP-1) receptor agonists, meglitinides, and sodium-glucose cotransporter 2 (SGLT2) inhibitors. The proportion of days covered (PDC) is the percentage of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for a target medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period.</p> <p data-bbox="384 720 1521 984">The percentage is calculated as the number of continuously enrolled Medicare Part D beneficiaries, 18 years and older, with a PDC of 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two fills of diabetes medication(s) on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator). Once the unadjusted rate is calculated, the measure is risk adjusted at the beneficiary level.</p> <p data-bbox="384 1020 1521 1218">The Medication Adherence measure is adapted from the Medication Adherence Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The Medication Adherence for Diabetes Medications measure rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.</p> <p data-bbox="256 1232 1521 1430">Exclusions: Contracts with 30 or fewer continuously enrolled beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified:</p> <ul data-bbox="384 1335 1174 1430" style="list-style-type: none">• Beneficiaries who have elected to receive hospice care• ESRD diagnosis or dialysis coverage dates• One or more prescriptions for insulin in the treatment period <p data-bbox="217 1444 1521 1812">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. The PDC calculation is adjusted for overlapping prescriptions for the same drug, which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. Additionally, the measure is risk adjusted for the following characteristics: age, sex, LIS/Dual eligible status, and disability status. See Attachment E: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary’s treatment period.</p> <p data-bbox="147 1827 846 1858">Primary Data Source: Prescription Drug Event (PDE) data</p> <p data-bbox="110 1873 1521 1934">Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2024 PDE submission deadline</p>

Title	Description
	<p>for annual Part D payment reconciliation with dates of service from January 1, 2024December 31, 2024. 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, 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 2024 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>Additional data sources include the Common Medicare Environment (CME), the Common Working File (CWF), and the Encounter Data Systems (EDS). The data cutoff date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation.</p> <ul style="list-style-type: none"> • CME is used for enrollment information and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Data Display: Percentage with no decimal place

Measure: DMD18 - Medication Adherence for Hypertension (RAS antagonists) with Risk Adjustment(RA) (ADH-RAS RA)

Title	Description
	<p>Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: ACEI, ARB, or direct renin inhibitor medications. The proportion of days covered (PDC) is the percentage of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for the target medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period.</p> <p>The percentage is calculated as the number of continuously enrolled beneficiaries, 18 years and older, with a PDC of 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two RAS antagonist medication fills on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator). The Part D Medication Adherence measure is adapted from the Medication Adherence Proportion of Days Covered measure that was developed and endorsed by the PQA. Once the unadjusted rate is calculated, the measure is risk adjusted at the beneficiary level.</p> <p>The Part D Medication Adherence for Hypertension (RAS antagonists) measure rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.</p> <p>Exclusions: Contracts with 30 or fewer continuously enrolled beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period unless otherwise specified:</p> <ul style="list-style-type: none"> • Beneficiaries who have elected to receive hospice care • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan during the treatment period <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. The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. Additionally, the measure is risk adjusted for the following characteristics: age, sex, LIS/Dual eligible status, and disability status. See Attachment E: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary’s treatment period.</p> <p>Primary Data Source: Prescription Drug Event (PDE) data</p> <p>Data Source Description: The data for this measure come from PDE data submitted to the CMS DDPS and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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, then the PDE is used in the Patient Safety</p>

Title	Description
	<p>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 2024 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>Additional data sources include the CME, the CWF, and the EDS. The data cutoff date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation.</p> <ul style="list-style-type: none"> • CME is used for enrollment information and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes. <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal place</p>

Measure: DMD19 - Medication Adherence for Cholesterol (Statins) with Risk Adjustment (RA) (ADH-Statins RA)

Title	Description
	<p data-bbox="305 218 1487 617">Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for statin cholesterol medications. The proportion of days covered (PDC) is the percentage of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for a statin medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period.</p> <p data-bbox="386 653 1520 884">The percentage is calculated as the number of continuously enrolled beneficiaries, 18 years and older, with a PDC of 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two statin cholesterol medication fills on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator). Once the unadjusted rate is calculated, the measure is risk adjusted at the beneficiary level.</p> <p data-bbox="386 919 1479 1115">The Medication Adherence measure is adapted from the Medication Adherence Proportion of Days Covered measure that was developed and endorsed by the PQA. See the medication list for this measure. The Medication Adherence for Cholesterol (Statins) measure rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.</p> <p data-bbox="256 1136 1500 1297">Exclusions: Contracts with 30 or fewer continuously enrolled beneficiaries (in the denominator). Beneficiaries are also excluded from the denominator if the following occur at any time during the measurement period:</p> <ul data-bbox="386 1234 1114 1297" style="list-style-type: none">• Beneficiaries who have elected to receive hospice care• ESRD diagnosis or dialysis coverage dates <p data-bbox="217 1314 1511 1675">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. The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. Additionally, the measure is risk adjusted for the following characteristics: age, sex, LIS/Dual eligible status, and disability status. See Attachment E: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary’s treatment period.</p> <p data-bbox="147 1692 846 1724">Primary Data Source: Prescription Drug Event (PDE) data</p> <p data-bbox="110 1740 1511 1934">Data Source Description: The data for this measure come from PDE data submitted by drug plans to the CMS DDPS and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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, then the PDE is used in the Patient Safety</p>

Title	Description
	<p>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 2024 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.</p> <p>Additional data sources include the CME, the CWF, and the EDS. The data cutoff date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation.</p> <ul style="list-style-type: none"> • CME is used for enrollment information and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes. <p>Data Source Category: Health and Drug Plans</p> <p>Data Time Frame: 01/01/2024 – 12/31/2024</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
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Metric: This measure is defined as the number of grievances filed with the health plan per 1,000 enrollees per month.

Numerator = (Quarter 1 Total Grievances + Quarter 2 Grievances + Quarter 3 Grievances + Quarter 4 Grievances) * 1,000 * 30

Denominator = Average Enrollment * Number of days in period

For MAOs, Total Grievances includes grievances reported per the Part C Reporting Requirements. For PDPs, Total Grievances includes grievances reported per the Part D Reporting Requirements. For MA-PDs, Part C and Part D grievances are combined in order to report a single contract-level rate. 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 with an effective termination date on or before the deadline to submit data validation results to CMS (deadline June 15, 2025 and data validation results pulled in July 2025) 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 2025 Data Validation cycle.

Data Source Category: Health and Drug Plans

Data Time Frame: 01/01/2024 – 12/31/2024

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> <ul style="list-style-type: none">(a) Did you leave the plan because you were frustrated by the plan’s approval process for care, tests, or treatment?(b) Did you leave the plan because you had problems getting the care, tests, or treatment you needed?(c) Did you leave the plan because you had problems getting the plan to pay a claim?(d) Did you leave the plan because it was hard to get information from the plan about which health care services were covered or how much a specific test or treatment would cost? <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: 01/01/2024 – 12/31/2024</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
	<p data-bbox="305 216 1523 415">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?</p> <p data-bbox="386 451 1523 583">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.</p> <p data-bbox="386 619 1523 716">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 data-bbox="256 730 1081 762">Exclusions: Contracts with fewer than 30 responses are excluded.</p> <p data-bbox="215 777 1523 873">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="147 888 786 919">Primary Data Source: Disenrollment Reasons Survey</p> <p data-bbox="110 934 1523 1066">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 1081 639 1113">Data Source Category: Survey of Enrollees</p> <p data-bbox="183 1127 711 1159">Data Time Frame: 01/01/2024 – 12/31/2024</p> <p data-bbox="215 1173 578 1205">General Trend: Lower is better</p> <p data-bbox="235 1220 821 1251">Data Display: Percentage with no decimal place</p>

Measure: DME04 - Disenrollment Reasons – Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)

Title	Description
	<p>Metric: “Financial Reasons for Disenrollment” 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 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? <p>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.</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 less 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: 01/01/2024 – 12/31/2024</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal place</p>

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 (< 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: 01/01/2024 – 12/31/2024 for current reporting year, and 01/01/2023 – 12/31/2023 for previous reporting year, if available</p> <p>General Trend: Lower is better</p>

Title	Description
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Data Display: Percentage with no decimal place

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

Title	Description
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Metric: “Problems Getting Information and Help from the Plan” is a composite of the following survey questions (question numbers vary depending on survey type):

- (a) Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription?
- (b) Did you leave the plan because it was hard to get information from the plan -- like which prescription medicines were covered or how much a specific medicine would cost?
- (c) Did you leave the plan because you were unhappy with how the plan handled a question or complaint?
- (d) Did you leave the plan because you could not get the information or help you needed from the plan?
- (e) Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

Each of these questions asked about a 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.

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.

For plans without scores from the prior year (2022), the final composite score reflects the current one-year (2023) score only.

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%.

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

Title	Description
Data Time Frame:	01/01/2024 – 12/31/2024 for current reporting year, and 01/01/2023 – 12/31/2023 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 ■ ≥ 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: 01/01/2024 – 12/31/2024</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 2026 display measures.⁶

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)	51%
DMC02	Continuous Beta Blocker Treatment	72%
DMC03	Doctors who Communicate Well	93%
DMC04	Call Center – Beneficiary Hold Time	0:32
DMC05	Pneumonia Vaccine	68%
DMC06	Access to Primary Care Doctor Visits	95%
DMC07	Call Center - Calls Disconnected When Customer Calls Health Plan	1.01
DMC08	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	75%
DMC09	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	84%
DMC10	Initiation of Substance Use Disorder (SUD) Treatment	35%
DMC11	Engagement of Substance Use Disorder (SUD) Treatment	5%
DMC12	Initiation and Engagement of Substance Use Disorder Treatment Average	20%
DMC13	Hospitalization for Potentially Preventable Complications	37%
DMC14	Transitions of Care - Medication Reconciliation Post-Discharge	77%
DMC15	Transitions of Care - Notification of Inpatient Admission	52%
DMC16	Transitions of Care - Patient Engagement After Inpatient Discharge	88%
DMC17	Transitions of Care - Receipt of Discharge Information	34%
DMC18	Physical Functioning Activities of Daily Living	94%
DMC19	Care of Older Adults - Functional Status	84%
DMC20	Cardiac Rehabilitation - Achievement	5%
DMC21	Cardiac Rehabilitation - Engagement 1	11%
DMC22	Cardiac Rehabilitation - Engagement 2	10%
DMC23	Cardiac Rehabilitation - Initiation	8%
DMC24	Colorectal Cancer Screening (45-75)	70%
DMC25	Adult Immunization Status - Influenza	39%
DMC26	Adult Immunization Status - Pneumococcal	52%
DMC27	Adult Immunization Status - Td/Tdap	32%
DMC28	Adult Immunization Status - Zoster	22%
DMC29	Adult Immunization Status - Average	36%
DMC30	Depression Screening and Follow-Up - Depression Screening	16%
DMC31	Depression Screening and Follow-Up - Follow-Up on Positive Screen	69%
DMC32	Depression Screening and Follow-Up - Average	47%

⁶ All contracts are weighted equally in these averages.

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	0.88	0.75
DMD02	Call Center – Beneficiary Hold Time	0:30	0:36
DMD03	MPF – Stability	100%	100%
DMD04	Call Center – Pharmacy Hold Time	0:20	0:17
DMD05	Plan Submitted Higher Prices for Display on MPF	57	56
DMD06	Reminders to Fill Prescriptions	55%	53%
DMD07	Reminders to Take Medications	35%	27%
DMD08	Antipsychotic Use in Persons with Dementia (APD)	8%	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)	13%	14%
DMD11	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	5%	5%
DMD12	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	0.29%	0.21%
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%	10%
DMD15	Initial Opioid Prescribing (IOP-LD)	17%	12%
DMD16	Persistence to Basal Insulin (PST-INS)	70%	69%
DMD17	Medication Adherence for Diabetes Medications	87%	86%
DMD18	Medication Adherence for Hypertension (RAS antagonists)	90%	88%
DMD19	Medication Adherence for Cholesterol (Statins)	88%	87%

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

Measure ID	Measure Name	MA Average	PDP Average
DME01	Grievance Rate	7.21	1.54
DME02	Disenrollment Reasons – Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-only)	15%	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%	9%
DME06	Disenrollment Reasons – Problems Getting Information and Help from the Plan (MA-PD, PDP)	11%	6%
DME07	Beneficiary Access and Performance Problems	94	95

Attachment B: Calculating Measure DMC13: 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

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

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

$$\text{NatAvgObs} = 0.139245$$

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

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

The actual calculated National Observed Rate used in the 2026 display measures was 0.033213782425038.

Attachment C: Calculating Measure DMD03: MPF – Stability

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

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-BG⁸) 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

⁸ CMS uses the FDA NSDE and RxNorm reference data sources to assign brand/generic status. If the drug's status is consistent across sources, it will be assigned based on the FDA NSDE; otherwise, CMS will assign the status based on the higher of the brand or generic dispensing fee.

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.

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

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

GSN_BG	Q1 Total Quantity (q_{ij1})	Q1 \$/Unit (p_{ij1})	Q1 ($q_{ij1} * p_{ij1}$)	Q2 Total Quantity (q_{ij2})	Q2 \$/Unit (p_{ij2})	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

Only contracts with at least 30 eligible claims throughout the year are included in the accuracy measure. This ensures that the sample size of PDEs is large enough to produce a reliable accuracy score.

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 price⁹ reported on Medicare Plan Finder multiplied by the quantity listed on the PDE, plus the MPF dispensing fee.

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 file¹⁰.
3. The reference NDC must be on the plan's formulary. Drugs omitted from the plan's formulary are not included in the measure calculation, regardless of whether the drug is on the excluded drug supplemental file.
4. Because the retail unit cost reported on MPF is intended to apply to a 1, 2, or 3-month supply of a drugs, 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.

⁹ MPF 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 MPF unit cost posted on medicare.gov on the date of the PDE.

¹⁰ MPF 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 Medi-Span and then First Data Bank (FDB) if Medi-Span data is unavailable 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.

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 assigned¹¹.
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.

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,¹² 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 PDE¹³. 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.^{14, 15} 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.

¹¹ 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.

¹² 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.

¹³ When assigning the MPF dispensing fee, CMS identifies brand or generic status of a drug using reference data sources (FDA NSDE and RxNorm). If a drug's status is inconsistent, CMS will assign the higher of the brand or generic dispensing fee.

¹⁴ 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.

¹⁵ 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.

$$\text{Claim Percentage Index} = \left(\frac{\sum_i \text{Claims}_{iMPF > PDE}}{\sum_i \text{Claims}_{iTotal}} \right)$$

where

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

Claims_{iTotal} is the total number of claims

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 MPF 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 (from by the pharmacy cost file) and unit cost (from 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	Assigned 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	01/08/2024	3.82	2	60	60	01/06/24 - 01/19/24	0.014	2.25	2.75	B	5.82	3.09	0
B	222	01/24/2024	0.98	2	30	60	01/20/24 - 02/02/24	0.83	1.75	2.5	G	2.98	27.40	24.42
C	333	02/11/2024	10.48	1.5	24	28	02/03/24 - 02/16/24	0.483	2.5	2.5	B	11.98	14.09	2.112
D	444	02/21/2024	47	1.5	90	30	02/17/24 - 03/01/24	0.48	1.5	2.25	G	48.50	45.45	0
								PDE = Prescription Drug Event MPF = Medicare Plan Finder			Totals	69.28		26.532
											Price Accuracy Index			26.532
											Claim Percentage Index			0.5
											MPF Composite Display Measure Accuracy Score			56

Attachment E: Medication Adherence Measure Calculations Examples

PDC Adjustments for Overlapping fills

A.1 Non-Overlapping Fills of 2 Different Drugs

In this example, a beneficiary fills benazepril and captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the captopril prescription after the days' supply for the benazepril medication ended.

Covered Days (No Adjustment):

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Benazepril	15	16	15	13			
Captopril					15	16	30

PDC Calculation:

Covered Days: 120

Treatment Period: 120

PDC: $120/120 = 100\%$

A.2 Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted single drug product. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing hydrochlorothiazide. However, hydrochlorothiazide is not a RAS antagonist, so this overlap is not shifted.

Before Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Lisinopril	15	16					
Lisinopril & HCTZ		16	15				
Benazepril & HCTZ			15				

PDC Calculation:

Covered Days: 59

Treatment Period: 120

PDC: $59/120 = 49\%$

After Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Lisinopril	15	16					
Lisinopril & HCTZ			15	13	3		
Benazepril & HCTZ			15	13			

PDC Calculation:

Covered Days: 62

Treatment Period: 120

PDC: $62/120 = 52\%$

A.3 Overlapping Fills of the Same and Different Drugs

In this example, a beneficiary is refilling both lisinopril and captopril. When a single and combination product both containing lisinopril overlap, there is an adjustment to the PDC. When lisinopril overlaps with captopril, we do not make any adjustment to the days covered.

Before Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation:

Covered Days: 92

Treatment Period: 120

PDC: $92/120 = 77\%$

After Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation:

Covered Days: 105

Treatment Period: 120

PDC: $105/120 = 88\%$

Risk Adjustment (RA)

RA consists of adjusting the Display page ADH measure rates for the following beneficiary-level characteristics:

- Age
- Sex
- Dual eligibility or LIS status
- Disability status

RA Methodology

1. For each individual in the denominator, using a multivariate, random effects logistic regression model, calculate the patient predicted probabilities of adherence.
2. Calculate the contract type unadjusted rate.
3. Calculate the unadjusted rate for each contract*.
4. For each contract, calculate the predicted measure rate. The predicted measure rate is the average of the patient predicted probabilities (from Step 1) of adherence for each contract.
5. For each contract, calculate the RA measure rate using the following formula:

$$\text{Risk Adjusted Adherence Rate} = \frac{\text{Unadjusted Rate (Step 3)}}{\text{Predicted Rate (Step 4)}} * \text{Contract Type Unadjusted Rate (Step 2)}$$

Additional Notes:

- The multivariate, random effects logistic regression model in Step 1 is stratified by MA-PD and PDP contract types.
- *Contracts with 30 or fewer enrolled beneficiaries in the measure denominator, are excluded from RA due to scores being unreliable. These contracts will receive “N/A” for their risk adjusted rate.

RA Indicators

Indicator	Possible Values	Definition	Evaluation Period
Age	18-54 55-64 65-69 70-74 75-79 80+	Age as of January 1 st of the measurement year.	1/1/20XX
Sex	Male/Female	Sex reported in the CME.	N/A
LIS or Dual Eligible status	Y/N	A beneficiary is considered LIS or Dual Eligible if the beneficiary is classified as LIS or Dual Eligible at any time during the measurement year.	1/1/20XX to 12/31/20XX
Disability status	Y/N	A beneficiary is considered as Disability if the initial entitlement reason is due to disability without ESRD or disability with ESRD.	N/A

Risk Adjusted Rates

The full range of possible scores for the risk adjusted rates will be between 0 and 100 percent.

Reference Table for 2026 Display page Medication Adherence Measures

Multivariate, Random Effects Logistic Regression Model Results, MAPD

Characteristics	ADH-Diabetes		ADH-RAS		ADH-Statins	
	Estimate	Odds	Estimate	Odds	Estimate	Odds
Intercept	1.73	5.65	2.19	8.95	2.16	8.69
Age Groups (base: 80+)						
18-54	-0.32	0.73	-0.22	0.80	-0.28	0.76
55-64	-0.03	0.97	0.06	1.06	-0.07	0.93
65-69	-0.01	0.99	0.07	1.07	-0.09	0.91
70-74	0.06	1.06	0.11	1.11	-0.02	0.98
75-79	0.06	1.06	0.09	1.10	0.02	1.02
Sex (Base: Female)						
Male	0.13	1.14	-0.06	0.94	0.04	1.04
LIS or Dual Status (Base: N)						
LIS or Dual	0.32	1.37	-0.16	0.85	-0.11	0.89
Disability Status (Base: N)						
Disability	-0.21	0.81	-0.19	0.83	-0.08	0.92

Multivariate, Random Effects Logistic Regression Model Results, PDP

Characteristics	ADH-Diabetes		ADH-RAS		ADH-Statins	
	Estimate	Odds	Estimate	Odds	Estimate	Odds
Intercept	1.70	5.47	2.00	7.39	1.90	6.67
Age Groups (base: 80+)						
18-54	-0.08	0.92	0.01	1.01	0.01	1.01
55-64	0.13	1.14	0.20	1.22	0.10	1.10
65-69	0.08	1.08	0.14	1.15	0.00	1.00
70-74	0.12	1.12	0.16	1.17	0.05	1.05
75-79	0.08	1.08	0.11	1.12	0.06	1.06
Sex (Base: Female)						

Male	0.19	1.21	-0.01	0.99	0.11	1.12
LIS or Dual Status (Base: N)						
LIS or Dual	-0.14	0.87	-0.44	0.65	-0.38	0.68
Disability Status (Base: N)						
Disability	-0.22	0.80	-0.23	0.79	-0.13	0.88

Unadjusted Contract Type Rates, after contract-level exclusions*

Measure	MA-PD	PDP
ADH-Diabetes	87%	86%
ADH-RAS	90%	88%
ADH-Statins	89%	87%

*Contracts with 30 or fewer enrolled beneficiaries in the measure denominator are excluded.