Medicare 2014 Part C & D Display Measure Technical Notes

Updated – 12/12/2013

Document Change Log:

Previous Version	Description of Change	Revision Date
-	Initial Release of the Display Measure Technical Notes	12/12/2013

Table of Contents

General

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

These display measures are not part of the Star Ratings. Display measures may have been transitioned from the Star Ratings. These can also be new measures being tested before inclusion into the Star Ratings. Lastly, some measures are displayed for informational purposes only. As indicated in the 2014 Call Letter, CMS will give advance notice if display measures are being considered for inclusion to the Star Ratings. Data for display page measures will continue to be collected and monitored, and poor scores on display measures are subject to compliance actions by CMS.

For 2014, CMS is

- Transitioning three Star Rating measures due to the lack of variation in the scores across contracts with the scores being skewed very high:
  - Enrollment Timeliness
  - Getting Information from Drug Plan
  - Call Center – Pharmacy Hold Time

- Introducing four areas with potential for being included in future Star Ratings:
  - Pharmacotherapy Management of COPD Exacerbation (PCE) (Part C).
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (Part C).
  - HEDIS Scores for Low Enrollment Contracts (Part C).
  - Variation of MPF Price Accuracy (Part D) called “Plan Submitted Higher Prices for Display on MPF”

Contact Information

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

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

Part C Display Measure Details

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

HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 191
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC02 - Call Answer Timeliness

HEDIS Label:	Call Answer Timeliness (CAT)
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 264
Metric:	The percentage of calls received by the organization's member services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC03 - Antidepressant Medication Management (6 months)

HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 182
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC04 - Continuous Beta Blocker Treatment

HEDIS Label:	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 147
Metric:	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI (denominator) and who received persistent beta-

blocker treatment for six months after discharge (numerator).

Data Source: HEDIS

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Higher is better

Data Display: Percentage with no decimal point

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

HEDIS Label: Annual Monitoring for Patients on Persistent Medication (MPM)

Measure Reference: NCQA HEDIS 2013 Technical Specifications Volume 2, page 208

Metric: The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (denominator) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year (numerator).

Data Source: HEDIS

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC06 - Osteoporosis Testing

HEDIS Label: Osteoporosis Testing in Older Women (OTO)

Measure Reference: NCQA HEDIS 2013 Technical Specifications Volume 2, page 231

Metric: The percentage of Medicare women 65 years of age and older (denominator) who report ever having received a bone density test to check for osteoporosis (numerator).

Data Source: HEDIS / HOS

Data Time Frame: 04/18/2012 - 07/31/2012

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC07 - Testing to Confirm Chronic Obstructive Pulmonary Disease

HEDIS Label: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Measure Reference: NCQA HEDIS 2013 Technical Specifications Volume 2, page 117

Metric: The percentage of members 40 or older with a new diagnosis or newly active Chronic Obstructive Pulmonary Disease (COPD) during the measurement year (denominator), who received appropriate spirometry testing to confirm the diagnosis (numerator).

Data Source: HEDIS

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC08 - Doctors who Communicate Well

Metric: This case mix adjusted composite measure is used to assess how well doctors communicate. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

CAHPS Survey Questions (question numbers vary depending on survey type):
• In the last 6 months, how often did your personal doctor listen carefully to you?
• In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
• In the last 6 months, how often did your personal doctor show respect for what you had to say?
• In the last 6 months, how often did your personal doctor spend enough time with you?

Data Source: CAHPS

Data Time Frame: 02/15/2013 - 05/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC09 - Call Center – Beneficiary Hold Time

Metric: This measure is defined as the average time spent on hold by the call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the "Customer Service for Current Members – Part C" phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part C contract beneficiary customer service call center, divided by the number of eligible calls made to the Part C contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the "hold" queue.

Exclusions: Data were not collected from contracts that cover U.S. territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.

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

Data Time Frame: 01/07/2013 – 02/01/2013, 04/01/2013 – 04/26/2013 (Monday - Friday)

General Trend: Lower is better

Data Display: Time

Compliance Standard: 2:00

Measure: DMC10 - Call Center – Information Accuracy

Metric:	This measure is defined as the percent of the time Customer Service Representatives (CSR) answered questions correctly. The calculation of this measure is the number of times the CSR answered the questions correctly divided by the number of questions asked.
Exclusions:	Data were not collected from contracts that cover U.S. territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, MA-PDs and PDPs under sanction, organizations that did not have a phone number accessible to survey callers, or phone lines that only cover SNP plans.
Data Source:	Call Center surveillance monitoring data collected by CMS. The "Customer Service for Prospective Members – Part C" phone number associated with each contract was monitored. This measure is based on calls to the prospective enrollee call center.
Data Time Frame:	02/11/2013 – 05/31/2013 (Monday - Friday)
General Trend:	Higher is better
Data Display:	Percentage with no decimal point
Compliance Standard:	75%

Measure: DMC11 - Pneumonia Vaccine

Metric:	The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator). CAHPS Survey Question (question number varies depending on survey type): • Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from a flu shot. It is also called the pneumococcal vaccine.
Data Source:	CAHPS
Data Time Frame:	02/15/2013 - 05/31/2013
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC12 - Access to Primary Care Doctor Visits

HEDIS Label:	Adults' Access to Preventive/Ambulatory Health Services
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 242
Metric:	The percentage of members 20 years and older (denominator) who had an ambulatory or preventive care visit during the measurement year (numerator).
Exclusions:	None listed.
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point
Compliance Standard:	85%

Measure: DMC13 - Grievance Rate

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

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

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

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

This is calculated as:{[(Quarter 1 Total Grievances + Quarter 2 Total Grievances + Quarter 3 Total Grievances + Quarter 4 Total Grievances)/ Average contract enrollment] * 1,000 * 30} / Number of days in period.

For MA-PDs, the grievances reported under the Part C Reporting Requirements and the Part D Reporting Requirements are combined in order to report a contract-level grievance rate.

Exclusions: A contract must have a minimum of 800 enrollees to have a grievance rate calculated. Contracts with fewer than 800 enrollees will be listed as "No Data Available."

Grievance rates are also not calculated for those contracts that did not score at least 95% on data validation for the Grievances reporting sections, those contracts that did not have data for all four quarters, and for those contracts that were not compliant with data validation standards/sub-standards for at least one of the following Grievance data elements:

- Fraud grievances (Element 5.1)
- Enrollment/disenrollment grievances (Element 5.2)
- Benefit package grievances (Element 5.3)
- Access grievances (Element 5.4)
- Marketing grievances (Element 5.5)
- Customer Service grievances (Element 5.6)
- Privacy issue grievances (Element 5.7)
- Quality of care grievances (Element 5.8)
- Appeals grievances (Element 5.9)
- Other grievances (Element 5.10)

These contracts will be shown as “CMS identified issues with this plan’s data”.

Data Source: Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2013 Data Validation cycle.

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Lower is better

Data Display: Rate with 2 decimal points

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

Metric:	This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new SNP enrollees for the contract and the number of SNP enrollees eligible for an annual reassessment for the contract. The numerator for this measure is the sum of the number of initial assessments performed on new SNP enrollees during the reporting period and the number of annual reassessments performed on SNP enrollees eligible for a reassessment. The equation for calculating the SNP health risk assessment rate is: [(Number of initial assessments performed on new SNP enrollees during reporting period + Number of annual reassessments performed on SNP enrollees eligible for a reassessment) / (Number of new SNP enrollees + Number of SNP enrollees eligible for an annual reassessment)]
Exclusions:	A contract must have a minimum of 30 SNP enrollees eligible to have a SNP assessment rate calculated. Contracts with fewer than 30 eligible enrollees will be listed as "No Data Available." SNP assessment rates are also not calculated for contracts that did not score at least 70% on data validation for the SNP Care Management reporting measure, or whose SNP Care Management data elements were not compliant with data validation standards/sub-standards. These contracts will be shown as "CMS Found Issues with Plan's Data".
Data Source:	Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2012 Data Validation cycle.
Data Time Frame:	01/01/2011 - 12/31/2011
General Trend:	Higher is better
Data Display:	Percentage with 1 decimal point

Measure: DMC15 - Calls Disconnected When Customer Calls Health Plan

Metric:	This measure is defined as the number of calls unexpectedly dropped by the sponsor while the call surveyor was navigating the IVR or connected with a customer service representative (CSR) divided by the total number of calls made to the phone number associated with the contract.
Exclusions:	Data were not collected from contracts that cover U.S territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number.
Data Source:	Call Center surveillance monitoring data collected by CMS. The "Customer Service for Current Members – Part C" phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.
Data Time Frame:	01/07/2013 – 02/01/2013, 04/01/2013 – 04/26/2013 (Monday - Friday)
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal points
Compliance Standard:	5%

Measure: DMC16 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 120
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.
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC17 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 120
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.
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC18 - Initiation of Alcohol or other Drug Treatment

HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 248
Metric:	The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC19 - Engagement of Alcohol or other Drug Treatment

HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Reference:	NCQA HEDIS 2013 Technical Specifications Volume 2, page 248
Metric:	The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Data Source:	HEDIS
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Part D Display Measure Details

Measure: DMD01 - Timely Receipt of Case Files for Appeals

Metric: This measure is defined as the percent of case files that were requested by the IRE that were received timely from the plan. (Timely is defined as files being received from the plan within 48 hours for Standard appeals, and within 24 hours for Expedited appeals.)

Numerator = The number of case files requested that were received in the required time frame.

Denominator = The number of case files requested by the IRE.

This is calculated as: [(The number of case files received in the required timeframe) / (The number of case files requested by the IRE)] * 100.

Exclusions: None

Data Source: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.

These data are limited to appeal cases requested by beneficiaries and the IRE requests files from the plans. Cases auto-forwarded to the IRE are excluded.

Data Time Frame: 01/01/2013 - 06/30/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD02 - Timely Effectuation of Appeals

Metric: This measure is defined as the percent of appeals that required effectuation that the plan effectuated in a timely manner (Timely is defined as within one day of decision notification for Expedited appeals, or three days of decision notification for Standard appeals.).

Numerator = The number of appeals that were effectuated timely.

Denominator = The number of the dispositions which required effectuation. Appeals with a disposition of “Fully Reverse Plan” or “Partially Reverse Plan” require effectuation. This measure looks at the most recent proceeding where effectuation is required in the event of ALJ’s or Reopenings.

This is calculated as: [(The number of appeals that were effectuated timely) / (The number of dispositions that required effectuation)] * 100.

Exclusions: None. These data are based on the report generation date. If the IRE does not receive a notice of effectuation before the timeframe has elapsed, the IRE will count the appeal as non-timely. Discrepancies may occur if the IRE receives the effectuation notice late, despite the actual effectuation occurring timely. Re-openings and ALJ decisions may also negate the need for effectuation.

Data Source: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.

Timely is defined as within one day of decision notification for Expedited appeals, or three days of decision notification for Standard appeals. For appeals involving plans making payments, timely is defined as payment being made within 30 calendar days of decision notification.

Data Time Frame: 01/01/2013 - 06/30/2013

General Trend: Higher is better

Data Display: Percentage with 2 decimal points

Measure: DMD03 - Calls Disconnected When Customer Calls Drug Plan

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

Exclusions: Data were not collected from contracts that cover U.S. territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number.

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

Data Time Frame: 02/04/2013 – 03/01/2013, 04/29/2013 – 05/24/2013 (Monday - Friday)

General Trend: Lower is better

Data Display: Percentage with 2 decimal points

Compliance Standard: 5%

Measure: DMD04 - Call Center – Beneficiary Hold Time

Metric: This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the “Customer Service for Current Members – Part D” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract beneficiary customer service call center divided by the number of eligible calls made to the Part D contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.

Exclusions: Data were not collected from contracts that cover U.S. territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number.

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

Data Time Frame: 01/07/2013 – 02/01/2013, 04/01/2013 – 04/26/2013 (Monday - Friday)

General Trend: Lower is better

Data Display: Time

Compliance Standard: 2:00

Measure: DMD05 - Call Center – Information Accuracy

Metric:	This measure is defined as the percent of the time CSRs answered questions correctly. The calculation of this measure is the number of times the CSR answered the questions correctly divided by the number of questions asked.
Exclusions:	Contracts that cover U.S. territories, 1876 Cost, Demo, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, MA-PDs and PDPs under sanction, organizations that did not have a phone number.
Data Source:	Call Center surveillance monitoring data collected by CMS. The "Customer Service for Prospective Members – Part D" phone number associated with each contract was monitored. This measure is based on calls to the prospective enrollee call center.
Data Time Frame:	02/11/2013 – 05/31/2013
General Trend:	Higher is better
Data Display:	Percentage with no decimal point
Compliance Standard:	75%

Measure: DMD06 - Drug-Drug Interactions

Metric:	This measure is defined as the percent of Medicare Part D beneficiaries who received a prescription for a target medication during the measurement period and who were dispensed a prescription for a contraindicated medication with or subsequent to the initial prescription. Numerator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication with at least one day overlap with a contraindicated medication. Denominator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication. This is calculated as: [(Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication with at least one day overlap with a contraindicated medication)/(Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication)]*100.
Exclusions:	A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).
Data Source:	The Drug-Drug Interaction (DDI) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2012-December 31, 2012, and processed by June 30, 2013. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes
Data Time Frame:	01/01/2012 - 12/31/2012
General Trend:	Lower is better
Data Display:	Percentage with 1 decimal point

Measure: DMD07 - Diabetes Medication Dosing

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

Numerator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose.

Denominator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed at least one prescription of an oral hypoglycemic.

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

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

Data Source: The Diabetes Medication Dosing (DMD) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2012-December 31, 2012, and processed by June 30, 2013. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes.

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Lower is better

Data Display: Percentage with 2 decimal points

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

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

Exclusions: Any contract that exclusively services U.S. territories is excluded from the

match rate analysis. Also, sponsors that did not have any LIS beneficiaries enrolled in their plan during the analysis period did not have match rates available.

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

Data Time Frame: 02/01/2013 - 06/30/2013

General Trend: Higher is better

Data Display: Percentage with 2 decimal points

Compliance Standard: 95%

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

Metric: This measure is defined as percent of pricing/formulary data file submissions that do not result in suppression of pricing data on www.medicare.gov.

Numerator = Number of pricing data file submissions that do not result in suppression of pricing data on www.medicare.gov

Denominator = Total number of pricing data submissions

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

Exclusions: None.

Data Source: CMS Administrative Data

Data Time Frame: 10/01/2012 - 09/30/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD10 - MPF – Stability

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

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

To convert the index into the stability score, we use the formula below. The

score is rounded to the nearest whole number.

100 – ((stability index – 1) x 100).

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

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

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Higher is better

Data Display: Rate with no decimal point

Measure: DMD11 - Grievance Rate

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

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

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

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

This is calculated as:{[(Quarter 1 Total Grievances + Quarter 2 Total Grievances + Quarter 3 Total Grievances + Quarter 4 Total Grievances)/ Average contract enrollment] * 1,000 * 30} / Number of days in period.

For MA-PDs, the grievances reported under the Part C Reporting Requirements and the Part D Reporting Requirements are combined in order to report a contract-level grievance rate.

Exclusions: A contract must have a minimum of 800 enrollees to have a grievance rate calculated. Contracts with fewer than 800 enrollees will be listed as "No Data Available."

Grievance rates are also not calculated for those contracts that did not score at least 95% on data validation for the Grievances reporting sections, those contracts that did not have data for all four quarters, and for those contracts that were not compliant with data validation standards/sub-standards for at least one of the following Grievance data elements:
- Enrollment, plan benefits, or pharmacy access grievances – Total number of grievances (Element A)
- Customer Service – Total number of grievances (Element C)
- Coverage determinations and Redeterminations process – Total number of

grievances (Element E)
• Other – Total number of grievances (Element G)

These contracts will be shown as “CMS identified issues with this plan’s data”.

Data Source: Data were reported by contracts to CMS through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2013 Data Validation cycle.

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Lower is better

Data Display: Rate with 2 decimal points

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

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

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

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

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

Exclusions: A contract must have 31 or more non-LTC beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period to have an MTM CMR rate calculated. Contracts with 30 or fewer beneficiaries meeting the denominator criteria will be listed as “No Data Available.” MTM CMR rates are also not calculated for those contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section, and for those contracts that were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements:
• LTC Enrollment Indicator (Element G)
• Enrollment Date (Element H)
• Opt Out Date (Element I)
• CMR Received Indicator (Element M)
• CMR Received Date (Element N)

These contracts will be shown as “CMS identified issues with this plan’s data”.

Data Source: Data were reported by contracts to CMS per the Part D Reporting Requirements through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2013 Data Validation cycle.

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Higher is better

Data Display: Percentage with 1 decimal point

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

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

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

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

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

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

* See Notes under Data Source for definition of LTI

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

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

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

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

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

Data Time Frame: 01/01/2012 - 12/31/2012

General Trend: Lower is better

Data Display: Percentage with 2 decimal points

Measure: DMD14 - Getting Information from Drug Plan

Metric: This case-mix adjusted composite measure is used to assess how easy it is for members to get information from the plan about prescription drug coverage and cost. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

CAHPS Survey Questions (question numbers vary depending on survey type):
• In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?
• In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?
• In the last 6 months, how often did your health plan give you all the information you needed about which prescription medicines were covered?
• In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?

Data Source: CAHPS

Data Time Frame: 02/15/2013 - 05/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD15 - Call Center – Pharmacy Hold Time

Metric: This measure is defined as the average time spent on hold by the call surveyor following navigation of the Interactive Voice Response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person for the Pharmacy Technical Help Desk phone number.

Exclusions: Data were not collected from MA-PDs and PDPs under sanction or from organizations that did not have a phone number accessible to survey callers.

Data Source: Call center data collected by CMS. The Pharmacy Technical Help Desk phone number associated with each contract was monitored.

Data Time Frame: 02/04/2013 – 03/01/2013, 04/29/2013 – 05/24/2013 (Monday - Friday)

General Trend: Lower is better

Data Display: Time

Compliance Standard: 2:00

Measure: DMD16 - Plan Submitted Higher Prices for Display on MPF

Metric: This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index.

The accuracy price index compares point-of-sale PDE prices to plan-reported MPF prices and determines the magnitude of differences found. Using each PDE's date of service, the price displayed on MPF is compared to the PDE price.

The accuracy index considers both ingredient cost and dispensing fee and measures the amount that the MPF price is higher than the PDE price. Therefore, prices that are understated on MPF—that is, the reported price is lower than the actual price—will not count against a plan's accuracy score.

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

The best possible accuracy index is 1. An index of 1 indicates that a plan did not have PDE prices less than MPF prices.

A contract's score is computed using its accuracy index as:
100 – ((accuracy index - 1) x 100).

Exclusions: A contract must have at least 30 claims over the measurement period for the price accuracy index. PDEs must also meet the following criteria:
• Pharmacy number on PDE must appear in MPF pharmacy cost file
• Drug must appear in formulary file and in MPF pricing file
• PDE must be for retail and/or specialty pharmacy
• PDE must be a 30 day supply
• Date of service must occur at a time that data are not suppressed for the plan on MPF
• PDE must not be a compound claim
• PDE must not be a non-covered drug
• PDE must be for retail pharmacy (pharmacies marked retail and mail order/HI/LTC are excluded)

Data Source: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span

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

General Trend: Higher is better

Data Display: Rate with no decimal point

Measure: DME01 - Enrollment Timeliness

Metric:	Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date Denominator = The total number of plan generated enrollment transactions submitted to CMS Calculation = [(The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date) / (The total number of plan generated enrollment transactions submitted to CMS)] * 100
Exclusions:	1. Contracts with 25 or fewer enrollment submissions during the measurement period, when summed. 2. Election Types: ICEP, IEP, IEP2 and AEP. 3. Employer/Union enrollments. 4. 1876 Cost Contract MA-only members. 5. Special Needs Plans. 6. Transaction Reply Codes 1-5 (TRC1, TRC2, TRC3, TRC4, TRC5) equal to any of the below: TRC's: ('001', '002', '003', '004', '006', '007', '008', '009', '019', '020', '032', '033', '034', '035', '036', '037', '038', '039', '042', '044', '045', '048', '056', '060', '062', '102', '103', '104', '105', '106', '107', '108', '109', '110', '114', '116', '122', '123', '124', '126', '127', '128', '129', '130', '133', '139', '156', '157', '162', '166', '169', '176', '184', '196', '200', '201', '202', '203', '211', '220', '257', '258', '263', '600', '601', '602', '603', '605', '611') TRCs are defined in the Plan Communication Users Guide Appendix Table I-2.
Data Source:	Medicare Advantage and Prescription Drug System (MARx) The data timeframe is the monthly enrollment files for January - July, 2013, which represents submission dates of 01/01/2013 - 07/31/2013.
Data Time Frame:	01/01/2013 - 07/31/2013
General Trend:	Higher is better
Data Display:	Percentage with no decimal point