Medicare 2023 Part C & D Display Measure Technical Notes

Updated – 01/24/2023

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General

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

These display measures are not part of the Star Ratings. Display measures may have been transitioned from the Star Ratings. They may be new measures being tested before inclusion into the Star Ratings. Lastly, some measures are displayed for informational purposes only. As indicated in the 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 2023, CMS:

- Introduced five measures to the display page:
    a. Cardiac Rehabilitation – Achievement
    b. Cardiac Rehabilitation – Engagement 1
    c. Cardiac Rehabilitation – Engagement 2
    d. Cardiac Rehabilitation – Initiation
    e. Initial Opioid Prescribing (IOP-LD)
- Retired one measures from the display page:
    a. Osteoporosis Testing
- Moved Controlling Blood Pressure to the 2023 Star Ratings

Contact Information

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

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

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

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

Part C Display Measure Details

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

Title	Description
HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 251
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator).
Exclusions:	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. Organizations must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC02 - Antidepressant Medication Management (6 months)

Title	Description
HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 238
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (numerator).
Exclusions:	Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population: • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: – AMM Stand Alone Visits Value Set with Major Depression Value Set. – AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set. • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

Title	Description
Exclusions:	• An acute or nonacute inpatient discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. For a direct transfer, use the discharge date from the last discharge.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC03 - Continuous Beta Blocker Treatment

Title	Description
HEDIS Label:	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 161
Metric:	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI (denominator) and who received persistent beta-blocker treatment for six months after discharge (numerator).
Exclusions:	Exclude members who meet any of the following criteria: • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). • A dispensed dementia medication. (Optional) Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member's history through the end of the continuous enrollment period meet criteria: • Asthma (Asthma Value Set). • COPD (COPD Value Set). • Obstructive chronic bronchitis (Obstructive Chronic Bronchitis Value Set). • Chronic respiratory conditions due to fumes and vapors (Chronic Respiratory Conditions Due to Fumes/Vapors Value Set). • Hypotension, heart block >1 degree or sinus bradycardia (Beta-Blocker

Title	Description
Exclusions:	Contraindications Value Set). • A medication dispensing event indicative of a history of asthma (Table PBH-D). • Intolerance or allergy to beta-blocker therapy.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC04 - Testing to Confirm Chronic Obstructive Pulmonary Disease

Title	Description
HEDIS Label:	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 135
Metric:	The percentage of members 40 or older with a new diagnosis or newly active Chronic Obstructive Pulmonary Disease (COPD) during the measurement year (denominator), who received appropriate spirometry testing to confirm the diagnosis (numerator).
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC05 - Doctors who Communicate Well

Title	Description
Metric:	This case-mix adjusted composite measure is used to assess how well doctors communicate. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned. CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? • In the last 6 months, how often did your personal doctor listen carefully to you? • In the last 6 months, how often did your personal doctor show respect for what you had to say? • In the last 6 months, how often did your personal doctor spend enough time with you?
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2022 – 06/2022
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMC06 - Call Center – Beneficiary Hold Time

Title	Description
Metric:	This measure is defined as the average time spent on hold by the call surveyor following the navigation of the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and prior to reaching a live person for the "Customer Service for Current Members – Part C" phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part C contract beneficiary customer service phone number, divided by the number of eligible calls made to the Part C contract beneficiary customer service phone number. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the "hold" queue.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call center
Data Source Description:	Call center surveillance monitoring data collected by CMS. The "Customer Service for Current Members – Part C" phone number associated with each contract was monitored. This measure is based on calls to the current enrollee phone number.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2022 – 06/2022
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMC07 - Pneumonia Vaccine

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator). CAHPS Survey Question (question number varies depending on survey type): • Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime and these are different from a flu shot. It is also called the pneumococcal vaccine.
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2022 – 06/2022
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC08 - Access to Primary Care Doctor Visits

Title	Description
HEDIS Label:	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 405
Metric:	The percentage of members 20 years and older (denominator) who had an ambulatory or preventive care visit during the measurement year (numerator).
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place
Compliance Standard:	85%

Measure: DMC09 - Call Center - Calls Disconnected When Customer Calls Health Plan

Title	Description
Metric:	This measure is defined as the number of calls unexpectedly dropped by the Medicare Advantage (MA) Plan or Medicare-Medicaid Plan (MMP) divided by the total number of calls made to the phone number associated with the contract.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call center
Data Source Description:	Call center surveillance monitoring data collected by CMS. The “Customer Service for Current Members – Part C” phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2022 – 06/2022
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places
Compliance Standard:	5%

Measure: DMC10 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

Title	Description
HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation (PCE)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 139
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:	01/01/2021 – 12/31/2021

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

Measure: DMC11 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

Title	Description
HEDIS Label:	Pharmacotherapy Management of COPD Exacerbation (PCE)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 139
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:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC12 - Initiation of Alcohol or other Drug Treatment

Title	Description
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 411
Metric:	The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC13 - Engagement of Alcohol or other Drug Treatment

Title	Description
HEDIS Label:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 411
Metric:	The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Exclusions:	None listed.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC14 - Hospitalization for Potentially Preventable Complications

Title	Description
HEDIS Label:	Hospitalization for Potentially Preventable Complications (HPC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 537
Metric:	For members 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.
Exclusions:	CMS and NCQA have developed the following rules for removing outlier data which cause distorted results. 1) Data for contracts whose Observed / Expected ratio is either < 0.2 or > 5.0 have been excluded. 2) Data for contracts with < 200 in the denominator have been excluded. Formulas to implement the above rules as well calculate the measure are contained in Attachment B. Contracts whose data were dropped because of these rules will be marked with the message "Insufficient data".
General Notes:	1876 Cost contracts, Demonstration MMP contracts and contracts whose data were dropped due to the exclusion rules were not included in the calculation of the National Observed Average.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Rate per 1,000 members with no decimal place

Measure: DMC15 - Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions

Title	Description
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 318
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Exclusions:	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021

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

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

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 308
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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

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

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 308
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:

Title	Description
Exclusions:	1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

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

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 308
Metric:	The percentage of discharges for members 18 years of age and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
Exclusions:	Members in hospice are excluded from the eligible population. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

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

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 308
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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC20 - Transitions of Care - Average

Title	Description
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 308
Metric:	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information
Exclusions:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. If the discharge is followed by a readmission or direct transfer to an acute or nonacute

Title	Description
Exclusions:	inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC21 - Plan All-Cause Readmissions (18+)

Title	Description
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 504
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment C: Calculating Measure DMC21: Plan All-Cause Readmissions (18+) for the complete formula, example calculation and National Average Observation value used to complete this measure.
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was 150 or less.
General Notes:	In past Star Ratings, 1876 Cost contracts voluntarily reported data in this measure even though they were not required to do so.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Title	Description
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMC22 - Plan All-Cause Readmissions (18-64)

Title	Description
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 504
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 to 64 years of age using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment D: Calculating Measure DMC22: Plan All-Cause Readmissions (18-64) for the complete formula, example calculation and National Average Observation value used to complete this measure.
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was 150 or less.
General Notes:	In past Star Ratings, 1876 Cost contracts voluntarily reported data in this measure even though they were not required to do so.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMC23 - Plan All-Cause Readmissions (65+)

Title	Description
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 504
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 65 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment E: Calculating Measure DMC23: Plan All-Cause Readmissions (65+) for the complete formula, example calculation and National Average Observation value used to complete this measure.
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was 150 or less.
General Notes:	In past Star Ratings, 1876 Cost contracts voluntarily reported data in this measure even though they were not required to do so.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DMC24 - 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:	2019-2021 Cohort 22 Performance Measurement Results (2019 Baseline data collection, 2021 Follow-up data collection)
Data Source Category:	Survey of Enrollees

Title	Description
Data Time Frame:	07/19/2021 – 11/01/2021
General Trend:	Higher is better
Data Display:	Numeric with no decimal place

Measure: DMC25 - Care of Older Adults - Functional Status

Title	Description
HEDIS Label:	Care for Older Adults (COA) – Functional Status Assessment
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 121
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one functional status assessment (Functional Status Assessment Value Set) during the measurement year (numerator).
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2020 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC26 - Kidney Health Evaluation for Patients With Diabetes

Title	Description
HEDIS Label:	Kidney Health Evaluation for Patients With Diabetes (KED)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 202
Metric:	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Exclusions:	• Members with evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. Exclude members who meet any of the following criteria: • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during 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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better

Title	Description
Data Display:	Percentage with no decimal place

Measure: DMC27 - Improving or Maintaining Physical Health

Title	Description
Measure Reference:	NCQA HEDIS 2020 Specifications for The Medicare Health Outcomes Survey Volume 6 and Medicare HOS 2019-2021 Cohort 22 MAO Performance Measurement Report
Metric:	The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose physical health status was the same or better than expected (numerator).
Exclusions:	Contracts with less than 30 responses are suppressed.
Primary Data Source:	HOS
Data Source Description:	2019-2021 Cohort 22 Performance Measurement Results (2019 Baseline data collection, 2021 Follow-up data collection) 2-year PCS change – Questions: 1, 2a-b, 3a-b & 5 These comparisons are pre- and post-pandemic.
Data Source Category:	Survey of Enrollees
Data Time Frame:	07/19/2021-11/01/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC28 - Improving or Maintaining Mental Health

Title	Description
Measure Reference:	NCQA HEDIS 2020 Specifications for The Medicare Health Outcomes Survey Volume 6 and Medicare HOS 2019-2021 Cohort 22 MAO Performance Measurement Report
Metric:	The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose mental health status was the same or better than expected (numerator).
Exclusions:	Contracts with less than 30 responses are suppressed.
Primary Data Source:	HOS
Data Source Description:	2019-2021 Cohort 22 Performance Measurement Results (2019 Baseline data collection, 2021 Follow-up data collection) 2-year MCS change – Questions: 4a-b, 6a-c, & 7 These comparisons are pre- and post-pandemic.
Data Source Category:	Survey of Enrollees
Data Time Frame:	07/19/2021-11/01/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC29 – Cardiac Rehabilitation - Achievement

Title	Description
HEDIS Label:	Cardiac Rehabilitation – Achievement
Measure Reference:	NCQA HEDIS MY 2020 and 2021 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.

Title	Description
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. – Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC30 – Cardiac Rehabilitation – Engagement 1

Title	Description
HEDIS Label:	Cardiac Rehabilitation – Engagement 1
Measure Reference:	NCQA HEDIS MY 2020 and 2021 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.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC31 – Cardiac Rehabilitation – Engagement 2

Title	Description
HEDIS Label:	Cardiac Rehabilitation – Engagement 2
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 176
Metric:	The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. – Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMC32 – Cardiac Rehabilitation - Initiation

Title	Description
HEDIS Label:	Cardiac Rehabilitation - Initiation
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 176
Metric:	The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. – Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) any time during the intake period through the end of the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans

Title	Description
Data Time Frame:	01/01/2021 – 12/31/2021
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
Metric:	This measure is defined as the number of calls unexpectedly dropped by the sponsor divided by the total number of calls made to the phone number associated with the contract.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call center
Data Source Description:	Call center surveillance monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored. This measure is based on calls to the current enrollee phone number.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2022 – 06/2022
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places
Compliance Standard:	5%

Measure: DMD02 - Call Center – Beneficiary Hold Time

Title	Description
Metric:	This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and prior to reaching a live person for the “Customer Service for Current Members – Part D” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract beneficiary customer service phone number divided by the number of eligible calls made to the Part D contract beneficiary customer service phone number. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.
Primary Data Source:	Call center
Data Source Description:	Call center monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/2022 – 06/2022
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

Measure: DMD03 - MPF – Stability

Title	Description
Metric:	This measure evaluates stability in a plan's point of sale prices. The stability price index uses final prescription drug event (PDE) data to assess changes in prices over the contract year. It is defined as the average change in price of a specified basket of drugs each quarter. A basket of drugs defined by quarter 1 PDEs is priced using quarter 1 average prices for each drug first. The same basket is then priced using quarter 2 average prices. The 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 • 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. • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data were obtained from a number of sources: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span. The PDE data for this measure come from data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. Only final action PDE claims are used to

Title	Description
Data Source Description:	calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Data Time Frame:	01/01/2021 – 12/31/2021
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:	01/2022 – 06/2022
General Trend:	Lower is better
Data Display:	Time
Compliance Standard:	2:00

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

Title	Description
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract’s score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the MPF price is higher than the PDE price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the MPF price is higher than the PDE price. Therefore, prices that are understated on MPF—that is, the reported price is lower than the actual price—will not count against a plan’s score. The accuracy index is computed as: (Total amount that PF is higher than PDE + Total PDE cost) / (Total PDE cost).

Title	Description

Metric: The claim percentage index is computed as (Total number of PDEs where PF cost is higher than PDE)/ (Total Number of PDEs)

The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have MPF prices greater than PDE prices.

A contract's score is computed using its accuracy index and claim percentage index as: 0.5 x (100 – ((accuracy index - 1) x 100)) + 0.5 x ((1 – claim percentage index) x 100).

Exclusions: A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria:

• If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible.
• Drug must appear in formulary file and in MPF pricing file
• PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan.
• Date of service must occur at a time that data are not suppressed for the plan on MPF
• PDE must not be a compound claim
• PDE must not be a non-covered drug

Primary Data Source: PDE data, MPF Pricing Files

Data Source Description: Data were obtained from a number of data sources: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span.

The PDE data for this measure come from data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-September 30, 2021. 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 2021 PDE submission deadline are used to calculate this measure. Only final action PDE claims are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.

Data Source Category: Data Collected by CMS Contractors

Data Time Frame: 01/01/2021 – 09/30/2021

General Trend: Higher is better

Data Display: Numeric with no decimal place

Measure: DMD06 - Reminders to Fill Prescriptions

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about filling or refilling a prescription (numerator). CAHPS Survey Question (question numbers vary depending on survey type): • In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2022 – 05/2022
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

Measure: DMD07 - Reminders to Take Medications

Title	Description
Metric:	The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about taking medications as directed (numerator). CAHPS Survey Question (question numbers vary depending on survey type): • In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you were taking medications as directed?
Primary Data Source:	CAHPS
Data Source Category:	Survey of Enrollees
Data Time Frame:	03/2022 – 05/2022
General Trend:	Higher is better
Data Display:	Percentage with no decimal place

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

Title	Description
Metric:	This measure is defined as the percent of Part D beneficiaries 65 years or older with a diagnosis of or prescriptions for dementia, who received at least one prescription and greater than 30 cumulative days supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome. The percentage is calculated as: [(The number of member-years of enrolled beneficiaries 65 years and older who received at least one prescription and greater than 30 cumulative days supply for any antipsychotic medication (numerator)) divided by (the number of member-years of enrolled beneficiaries 65 years and older who had either (i) a dementia diagnosis and/or (ii) two or more prescription claims with unique dates of service and total days supply greater than 60 cumulative days for a cholinesterase inhibitor or NMDA receptor antagonist during the period measured (denominator))]*100. The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Antipsychotic Use in Persons with Dementia (APD) is adapted from the

Title	Description
Metric:	Antipsychotic Use in Persons with Dementia measure developed and endorsed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with a diagnosis for schizophrenia, bipolar disorder, Huntington's Disease, or Tourette's Syndrome are excluded from the numerator.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.
Primary Data Source:	PDE data
Data Source Description:	The data for this measure come from PDE data files submitted to CMS Drug Data Processing System (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The APD measure rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources include Common Medicare Environment (CME) for enrollment information, the Minimum Data Set (MDS) for nursing home information, the Risk Adjustment Processing System (RAPS) RxHCC data for diagnosis information, the Common Working File (CWF) ICD-10-CM codes to identify diagnoses, the Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

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

Title	Description
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 cumulative days supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome AND were long-term nursing home (LTNH) residents during the measurement period. The percentage is calculated as: [(The number of member-years of enrolled beneficiaries 65 years and older who received at least one prescription and greater than 30 cumulative days supply for any antipsychotic medication with a date of service during

Title	Description
Metric:	a LTNH episode (numerator)) divided by (the number of member-years of enrolled beneficiaries 65 years and older who had either (i) a dementia diagnosis and/or (ii) two or more prescription claims with unique dates of service and total days supply greater than 60 cumulative days 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 during the period measured (denominator))]*100. The member-year enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation. The Antipsychotic Use in Persons with Dementia Long-Term Nursing Home Residents (APD-LTNH) is adapted from the Antipsychotic Use in Persons with Dementia measure developed and endorsed by the Pharmacy Quality Alliance (PQA).
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with a diagnosis for schizophrenia, bipolar disorder, Huntington's Disease, or Tourette's Syndrome are excluded from the numerator.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.
Primary Data Source:	PDE data
Data Source Description:	The data for this measure come from PDE data files submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021- December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The APD-LTNH measure rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete NDC list will be posted along with these technical notes. Additional data sources include the Common Medicare Environment (CME) for enrollment information, the Minimum Data Set (MDS) for nursing home information, the Risk Adjustment Processing System (RAPS) RxHCC data for diagnosis information, the Common Working File (CWF) ICD-10-CM codes used to identify diagnoses, the Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

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

Title	Description
Metric:	The measure is defined by the percentage of Part D beneficiaries, 18 years or older, with concurrent use of prescription opioids and benzodiazepines during the measurement period. While there may be instances where it is appropriate for concurrent use of opioids and benzodiazepines, the concurrent use of prescription opioids with benzodiazepines is deemed a serious safety concern for Part D beneficiaries. The COB measure is adapted from the Concurrent Use of Opioids and Benzodiazepines developed and endorsed by the Pharmacy Quality Alliance (PQA). The PQA defines concurrent use as overlapping days supply for at least 30 cumulative days during the measurement period. The COB measurement period starts at the date of the first opioid prescription claim and the end of the enrollment episode must extend at least 30 days from the first opioid prescription claim. The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator with at least 2 prescription claims of a benzodiazepine with unique dates of service and concurrent use of opioids and benzodiazepines during the measurement period (numerator)) divided by (the number of member-years of enrolled beneficiaries, 18 years or older, with at least 2 prescription claims of a prescription opioid with unique dates of service and at least 15 cumulative days supply of opioids during the measurement period (denominator))] * 100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries enrolled in hospice during the measurement year are excluded. Beneficiaries with a cancer diagnosis during the measurement year are excluded. Beneficiaries with a sickle cell disease diagnosis during the measurement year are excluded.
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 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The Concurrent Use of Opioids and Benzodiazepines is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes.

Title	Description
Data Source Description:	Additional data sources used are the Common Medicare Environment (CME) used for enrollment information, the Medicare Enrollment Database (EDB) used for hospice enrollment, the Risk Adjustment Processing System (RAPS) used for RxHCC cancer diagnoses, the Common Working File (CWF) used to identify diagnoses based on ICD-10-CMs, the Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

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

Title	Description
Metric:	This measure is defined by the percentage of Part D beneficiaries, 18 years of age or older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. This measure is adapted from the Use of Opioids at High Dosage in Persons without Cancer measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The opioid measurement period starts at the date of the first opioid prescription claim and the end of the enrollment episode must extend at least 90 days from the first opioid prescription claim. The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator with an average daily MME greater than or equal to 90 MME (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. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries enrolled in hospice during the measurement year are excluded. Beneficiaries with a cancer diagnosis during the measurement year are excluded. Beneficiaries with a sickle cell diagnosis during the measurement year are excluded.
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 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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

Title	Description
Data Source Description:	PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2021 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. The Use of Opioids from Multiple Providers in Persons Without Cancer is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. Additional data sources used are the Common Medicare Environment (CME) used for enrollment information, the Medicare Enrollment Database (EDB) used for hospice enrollment, the Risk Adjustment Processing System (RAPS) used for RxHCC cancer diagnoses, the Common Working File (CWF) used to identify diagnoses based on ICD-10-CMs, the Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

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

Title	Description
Metric:	This measure is defined by the percentage of Part D beneficiaries, 18 years of age or older who received prescriptions from 4 or more prescribers AND 4 or more pharmacies within 180 days or less. This measure is adapted from the Use of Opioids from Multiple Providers in Persons without Cancer measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The opioid measurement period starts at the date of the first opioid prescription claim and the end of the enrollment episode must extend at least 90 days from the first opioid prescription claim. The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator who received opioids from 4 or more prescribers and 4 or more pharmacies within 180 days or less (numerator)) divided by (the number of member-years of enrolled beneficiaries, 18 years or age or older, with at least 2 prescription claims of a prescription opioid on unique dates of service and at least 15 cumulative days supply over a period of 90 days or longer during the measurement period (denominator))] *100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries enrolled in hospice during the measurement year are excluded. Beneficiaries with a cancer diagnosis during the measurement year are excluded. Beneficiaries with a sickle cell diagnosis during the measurement year are excluded.
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

Title	Description
General Notes:	the medication or the National Drug Code (NDC) lists, are excluded from CMS analyses. Beneficiaries must be enrolled in a Part D plan for at least one month.
Primary Data Source:	PDE data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The Use of Opioids from Multiple Providers in Persons Without Cancer is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. Additional data sources used are the Common Medicare Environment (CME) used for enrollment information, the Medicare Enrollment Database (EDB) used for hospice enrollment, the Risk Adjustment Processing System (RAPS) used for RxHCC cancer diagnoses, the Common Working File (CWF) used to identify cancer diagnoses based on ICD-10-CMs, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

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

Title	Description
Metric:	This measure is defined as the percentage of Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period. The use of multiple anticholinergics in older adults is associated with an increased risk of cognitive decline. The Poly-ACH measure is adapted from the Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The PQA defines concurrent use as overlapping days supply for at least 30 cumulative days during the measurement period. The polypharmacy measurement period starts at the date of the first prescription claim and the end of the enrollment episode must extend at least 30 days from the first prescription claim. The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator with concurrent use of 2 or more ACH medications during the measurement period. Each medication must have at least 2 prescription claims with unique dates of service during the measurement period (numerator)) divided by (the number of member-years of enrolled beneficiaries, 65 years or older, with at least 2

Title	Description
Metric:	prescription claims with unique dates of service of the same medication in the targeted drug classes of ACH during the measurement period (denominator))] * 100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries enrolled in hospice during the measurement period are excluded.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the 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 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. Additional data sources used are the Common Medicare Environment (CME) used for enrollment information, the Medicare Enrollment Database (EDB) used for hospice enrollment, the Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes, the Encounter Data Systems (EDS) used to identify diagnoses based on ICD-10-CM codes, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

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

Title	Description
Metric:	This measure is defined by the percentage of individuals 65 year of age or older with concurrent use of three or more unique central-nervous system (CNS) active medications. Use of multiple CNS active medications in older adults is associated with an increased risk of falls. The Poly-CNS measure is adapted from the Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults measure developed and endorsed by the Pharmacy Quality Alliance (PQA). The PQA defines concurrent use as overlapping days supply for at least 30 cumulative days during the measurement period. The polypharmacy measurement period starts at the date of the first prescription fill and the end of the enrollment episode must extend at least 30 days from the first prescription fill. The percentage is calculated as: [(The number of member-years of beneficiaries in the denominator with concurrent use of 3 or more CNS active medications during the measurement period. Each medication must have at least 2 prescription claims with unique dates of service during the measurement period (numerator)) divided by (the number of member-years of enrolled beneficiaries, 65 years or older, with at least 2 prescription claims with unique dates of service of the same medication in the targeted drug classes of CNS active during the measurement period (denominator))] * 100. The member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. For instance, if a beneficiary is enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries enrolled in hospice during the measurement period are excluded. Beneficiaries with a seizure disorder diagnosis during the measurement year.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.
Primary Data Source:	PDE data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing System (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. Additional data sources used are the Common Medicare Environment (CME) used for enrollment information, the Medicare Enrollment Database (EDB) used for hospice

Title	Description
Data Source Description:	enrollment, the Common Working File (CWF) used to identify diagnoses based on ICD-10-CM codes, the Encounter Data Systems (EDS) use to identify diagnoses based on ICD-10-CM codes, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

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

Title	Description
Metric:	The Initial Opioid Prescribing for Long Duration (IOP-LD) measure is adapted from the IOP-LD measure developed by the Pharmacy Quality Alliance (PQA). The IOP-LD measure analyzes the percentage of beneficiaries, 18 years or older, who were prescribed at least one initial opioid prescription for more than 7 cumulative days' supply. The initial opioid prescription is defined as the earliest date of service (DOS) of an opioid prescription claim during the measurement year following a negative medication history. 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) 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 turns 65 years old and enrolled for six out of twelve months of the year, they will count as only 0.5 member-years in the rate calculation.
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). Beneficiaries with a cancer diagnosis at any time during the measurement period or the 90 days prior to the start of the measurement period. Beneficiaries with a sickle cell disease diagnosis at any time during the measurement period or the 90 days prior to the start of the measurement period are excluded from the denominator. Beneficiaries who are enrolled in hospice at any time during the measurement period or the 90 days prior to the start of the measurement period are excluded from the denominator.
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act,

Title	Description
General Notes:	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 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. The IOP-LD measure is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology maintained by the PQA. The complete National Drug Code (NDC) list will be posted along with these technical notes. Additional data sources used are the Common Medicare Environment (CME) used for enrollment information, the Medicare Enrollment Database (EDB) used for hospice enrollment, the Risk Adjustment Processing System (RAPS), the 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, and the PQA Medication Lists, which include the NDCs for this measure.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with 2 decimal places

Common Part C & D Display Measure Details

Measure: DME01 - Grievance Rate

Title	Description
Metric:	This measure is defined as the number of grievances filed with the health plan per 1,000 enrollees per month. 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 and plans with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2022) 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 2022 Data Validation cycle.
Data Source Category:	Health and Drug Plans
Data Time Frame:	01/01/2021 – 12/31/2021
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
Metric:	“Problems Getting Needed Care, Coverage, and Cost Information” is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because you were frustrated by the plan’s approval process for care, tests, or treatment? (b) Did you leave the plan because you had problems getting the care, tests, or treatment you needed? (c) Did you leave the plan because you had problems getting the plan to pay a claim? (d) Did you leave the plan because it was hard to get information from the plan -- like which health care services were covered or how much a specific test or treatment would cost?

Title	Description
Metric:	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. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean.
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 2022. 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: disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 -– Retroactive, or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME03 - Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)

Title	Description
Metric:	"Problems with Coverage of Doctors and Hospitals" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan? (b) Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan? Each of these questions asked about a disenrollment reason related to the coverage of doctors and hospitals by the plan. Scores range from 0 to 100. A lower mean indicates that reasons related to problems with coverage of doctors and hospitals were endorsed less frequently by disenrollees. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean.
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 2022. 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:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

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

Title	Description
Metric:	"Financial Reasons for Disenrollment" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because the monthly fee that the health plan charges to provide coverage for health care and prescription medicines went up? (b) Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up? (c) Did you leave the plan because you found a health plan that costs less? (d) Did you leave the plan because a change in your personal finances meant you could no longer afford the plan? (e) Did you leave the plan because it turned out to be more expensive than you expected? Each of these questions asked about a disenrollment reason related to the cost or affordability of services. Scores range from 0 to 100. A lower mean indicates that financial reasons were endorsed less frequently by disenrollees. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean.
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 2022. These reports provide further explanation of the Disenrollment Reasons composite measures
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive, or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

Measure: DME05 - Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)

Title	Description
Metric:	"Problems with Prescription Drug Benefits and Coverage" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because they changed the list of prescription medicines they cover? (b) Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed? (c) Did you leave the plan because you had problems getting the medicines your doctor

Title	Description
	prescribed? (d) Did you leave the plan because it was difficult to get brand name medicines? (e) Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers? Each of these questions asked about a 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. Scores for this composite measure are based on 2 years of data from 2020 (prior year) and 2021 (current year) survey data. To calculate the composite measure, we first calculate single year scores for 2020 and for 2021. The prior year's score is then adjusted to account for the change in the national averages for this composite measure between 2020 and 2021. The adjustment is calculated by subtracting the prior year's (2020) national average score from the current year's (2021) national average score. This adjustment is then added to the prior year's score. This adjusted 2020 score is then averaged with the 2021 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 (2020), the final composite score reflects the current one-year (2021) score only. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean.
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 2022. These reports provide further explanation of the Disenrollment Reasons composite measures
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive, or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2021 – 12/31/2021 for current reporting year, and 01/01/2020 – 12/31/2020 for previous reporting year, if available
General Trend:	Lower is better
Data Display:	Percentage with no decimal place

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

Title	Description
Metric:	"Problems Getting Information and Help from the Plan" is a composite of the following survey questions (question numbers vary depending on survey type): (a) Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription? (b) Did you leave the plan because it was hard to get information from the plan -- like which prescription medicines were covered or how much a specific medicine would

Title	Description
	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 2020 (prior year) and 2021 (current year) survey data. To calculate the composite measure, we first calculate single year scores for 2020 and for 2021. The prior year's score is then adjusted to account for the change in the national averages for this composite measure between 2020 and 2021. The adjustment is calculated by subtracting the prior year's (2020) national average score from the current year's (2021) national average score. This adjustment is then added to the prior year's score. This adjusted 2020 score is then averaged with the 2021 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 (2020), the final composite score reflects the current one-year (2021) score only. Scores are suppressed if they are measured with very low reliability (< 0.60) and not statistically different from the national mean.
Exclusions:	Contracts with less than 30 responses are excluded.
General Notes:	In prior years, this measure was labeled "Problems Getting Information about Prescription Drugs." Although the measure label has been revised, the items that make up the composite have not changed. Disenrollment Reasons Survey results were sent to each contract's Medicare Compliance Officer in September 2022. These reports provide further explanation of the Disenrollment Reasons composite measures
Primary Data Source:	Disenrollment Reasons Survey
Data Source Description:	Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive, or 99 - Other (not supplied by beneficiary).
Data Source Category:	Survey of Enrollees
Data Time Frame:	01/01/2021 – 12/31/2021 for current reporting year, and 01/01/2020 – 12/31/2020 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
Metric:	This measure is based on CMS' Compliance Activity Module (CAM) data (this includes: notices of non-compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity). ● Contracts' scores are based on a scale of 0-100 points. ● The starting score for each contract works as follows: ○ Contracts with an effective date of 1/1/2021 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: ○ Contracts that have a CAM score (CAM score calculation is discussed below) are reduced as follows: ■ 0 – 2 CAM Score – 0 points ■ 3 – 9 CAM Score – 20 points ■ 10 – 19 CAM Score – 40 points ■ 20 – 29 CAM Score – 60 points ■ ≥ 30 CAM Score – 80 points Calculation of the CAM score combines the notices of non-compliance, warning letters (with or without business plan) and ad-hoc CAPs and their severity. The formula used is as follows: CAM Score = (NC * 1) + (woBP * 3) + (wBP * 4) + (6 * CAP Severity) Where: NC = Number of Notices of Non-Compliance woBP = Number of Warning Letters without Business Plan wBP = Number of Warning Letters with Business Plan CAP Severity = Sum of the severity of each individual ad-hoc CAP given to a contract during the measurement period. Each CAP is rated as one of the following: 3 – ad-hoc CAP with beneficiary access impact 2 – ad-hoc CAP with beneficiary non-access impact 1 – ad-hoc CAP no beneficiary impact
Exclusions:	CAM entries with the following characteristics were removed prior to processing the BAPP score: • Ad-hoc CAPs with a topic of "Star Ratings" • Notices of Non-Compliance with a topic of "Financial Concerns--Solvency, Reporting, Licensure, Other"
Primary Data Source:	Compliance Activity Module (CAM)
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.
Data Source Category:	CMS Administrative Data
Data Time Frame:	01/01/2021 – 12/31/2021
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 2023 display measures.[1]

Table A-1: National Averages for Part C Display Measures

Measure ID	Measure Name	Average
DMC01	Follow-up Visit after Hospital Stay for Mental Illness (within 30 days of discharge)	46%
DMC02	Antidepressant Medication Management (6 months)	66%
DMC03	Continuous Beta Blocker Treatment	88%
DMC04	Testing to Confirm Chronic Obstructive Pulmonary Disease	27%
DMC05	Doctors who Communicate Well	92
DMC06	Call Center – Beneficiary Hold Time	0:36
DMC07	Pneumonia Vaccine	69%
DMC08	Access to Primary Care Doctor Visits	95%
DMC09	Call Center - Calls Disconnected When Customer Calls Health Plan	1.84
DMC10	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	73%
DMC11	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	83%
DMC12	Initiation of Alcohol or other Drug Treatment	34%
DMC13	Engagement of Alcohol or other Drug Treatment	5%
DMC14	Hospitalization for Potentially Preventable Complications	17
DMC15	Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	57%
DMC16	Transitions of Care - Medication Reconciliation Post-Discharge	65%
DMC17	Transitions of Care - Notification of Inpatient Admission	24%
DMC18	Transitions of Care - Patient Engagement After Inpatient Discharge	82%
DMC19	Transitions of Care - Receipt of Discharge Information	18%
DMC20	Transitions of Care - Average	46%
DMC21	Plan All-Cause Readmissions (18+)	12%
DMC22	Plan All-Cause Readmissions (18-64)	12%
DMC23	Plan All-Cause Readmissions (65+)	12%
DMC24	Physical Functioning Activities of Daily Living	94%
DMC25	Care of Older Adults - Functional Status	78%
DMC26	Kidney Health Evaluation for Patients With Diabetes	43%
DMC27	Improving or Maintaining Physical Health[2]	67%
DMC28	Improving or Maintaining Mental Health[2]	81%
DMC29	Cardiac Rehabilitation – Achievement	3%
DMC30	Cardiac Rehabilitation – Engagement 1	7%
DMC31	Cardiac Rehabilitation – Engagement 2	6%
DMC32	Cardiac Rehabilitation – Initiation	5%

[1] All contracts are weighted equally in these averages.
[2] These comparisons on are pre- and post-pandemic.

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

Measure ID	Measure Name	MAPD Average	PDP Average
DMD01	Call Center - Calls Disconnected When Customer Calls Drug Plan	1.84%	1.80%
DMD02	Call Center – Beneficiary Hold Time	0:35	0:34
DMD03	MPF – Stability	100	100
DMD04	Call Center – Pharmacy Hold Time	0:26	0:25
DMD05	Plan Submitted Higher Prices for Display on MPF	73	71
DMD06	Reminders to Fill Prescriptions	54%	50%
DMD07	Reminders to Take Medications	32%	23%
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)	8%	9%
DMD10	Concurrent Use of Opioids and Benzodiazepines (COB)	15.31%	16.15%
DMD11	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	6.60%	6.29%
DMD12	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	0.44%	0.30%
DMD13	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	8.93%	7.21%
DMD14	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	14.06%	13.58%
DMD15	Initial Opioid Prescribing (IOP-LD)	17.38%	13.58%

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

Measure ID	Measure Name	MA Average	PDP Average
DME01	Grievance Rate	6.55	1.87
DME02	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-only)	18%	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)	22%	45%
DME05	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	10%	9%
DME06	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)	13%	6%
DME07	Beneficiary Access and Performance Problems	97	94

Attachment B: Calculating Measure DMC14: Hospitalization for Potentially Preventable Complications – Total ACSC (M/F Total)

All data is available in the CMS 2022 HEDIS® Public Use File (PUF)[3] 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):

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

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

$$NatAvgObs = Average\left(\left(\frac{ObservedCount_1}{NonOutlierMemberCount_1}\right) + \ldots + \left(\frac{ObservedCount_n}{NonOutlierMemberCount_n}\right)\right)$$

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:

Final Rate = OE x NatAvgObs x 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

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

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

$$NatAvgObs = 0.139245$$

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

Final Rate reported for Contract 1 = 139

The actual calculated National Observed Rate used in the 2023 display measures was 0.030808627274905.

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

Attachment C: Calculating Measure DMC21: Plan All-Cause Readmissions (18+)

All data are available in the CMS 2022 HEDIS® Public Use File (PUF)[4] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (18-64) indicator (IndicatorKey = 202025_20) and the PCR (65+) indicator (IndicatorKey = 202111_20).

For each contract, calculate the (18+) Denominator, ObservedCount, and ExpectedCount:

Denominator(18+) = Denominator(18-64) + Denominator(65+)

ObservedCount(18+) = ObservedCount(18-64) + ObservedCount(65+)

ExpectedCount(18+) = ExpectedCount(18-64) + ExpectedCount(65+)

Using these (18+) values, calculate the (18+) Observed-over-Expected ratio (OE):

$$OE(18+) = \left(\frac{ObservedCount(18+)}{ExpectedCount(18+)}\right)$$

And the national average of the (18+) Observed Rate:

$$NatAvgObs(18+) = Average\left(\left(\frac{ObservedCount(18+)_1}{Denominator(18+)_1}\right) + \ldots + \left(\frac{ObservedCount(18+)_n}{Denominator(18+)_n}\right)\right)$$

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) 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:

Final Rate(18+) = OE(18+) x NatAvgObs(18+) x 100

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	IndicatorKey	Denominator	ObservedCount	ExpectedCount
Contract 1	202025_20	214	8	12
Contract 1	202111_20	4,792	641	642
Contract 2	202025_20	225	12	7
Contract 2	202111_20	4,761	688	668
Contract 3	202025_20	573	31	35
Contract 3	202111_20	8,629	1,126	1,070
Contract 4	202025_20	12	0	1
Contract 4	202111_20	533	79	73

$$NatAvgObs = Average\left(\left(\frac{8+641}{214+4,792}\right) + \left(\frac{12+688}{225+4,761}\right) + \left(\frac{31+1,126}{573+8,629}\right) + \left(\frac{0+79}{12+533}\right)\right)$$

NatAvgObs = 0.135181

$$OE\ Contract\ 1 = \left(\frac{8+641}{12+642}\right) = 0.992355$$

[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

Final Rate Contract 1 = $0.992355 \times 0.135181 \text{ x } 100 = 13.41$

Final Rate reported for Contract 1 = 13%

The actual calculated National Observed Rate used in the 2023 display measures was 0.112740894267562.

Attachment D: Calculating Measure DMC22: Plan All-Cause Readmissions (18-64)

All data are available in the CMS 2022 HEDIS® Public Use File (PUF)[5] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (18-64) indicator (IndicatorKey = 202025_20).

For each contract, calculate the (18-64) Observed-over-Expected Ratio (OE):

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

Calculate the national average of the (18-64) Observed Rate:

$$NatAvgObs = Average\left(\left(\frac{ObservedCount_1}{Denominator_1}\right) + \ldots + \left(\frac{ObservedCount_n}{Denominator_n}\right)\right)$$

Where 1 through n are all contracts with a (18-64) Denominator larger than or equal to 150, and a (18-64) 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:

Final Rate = OE x NatAvgObs x 100

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	IndicatorKey	Denominator	ObservedCount	ExpectedCount
Contract 1	202025_20	4,792	641	642
Contract 2	202025_20	4,761	688	668
Contract 3	202025_20	8,629	1,126	1,070
Contract 4	202025_20	533	79	73

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

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

$$NatAvgObs = 0.139245$$

$$OE\ Contract\ 1 = \left(\frac{641}{642}\right) = 0.998442$$

Final Rate Contract 1 = 0.998442 × 0.139245 x 100 = 13.90

Final Rate reported for Contract 1 = 14%

The actual calculated National Observed Rate used in the 2023 display measures was 0.115639096165544.

[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

Attachment E: Calculating Measure DMC23: Plan All-Cause Readmissions (65+)

All data are available in the CMS 2022 HEDIS® Public Use File (PUF)[6] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (65+) indicator (IndicatorKey = 202111_20).

For each contract, calculate the (65+) Observed-over-Expected Ratio (OE):

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

Calculate the national average of the (65+) Observed Rate:

$$NatAvgObs = Average\left(\left(\frac{ObservedCount_1}{Denominator_1}\right) + \ldots + \left(\frac{ObservedCount_n}{Denominator_n}\right)\right)$$

Where 1 through n are all contracts with a (65+) Denominator larger than or equal to 150, and a (65+) 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:

Final Rate = OE x NatAvgObs x 100

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	IndicatorKey	Denominator	ObservedCount	ExpectedCount
Contract 1	202111_20	4,792	641	642
Contract 2	202111_20	4,761	688	668
Contract 3	202111_20	8,629	1,126	1,070
Contract 4	202111_20	533	79	73

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

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

$$NatAvgObs = 0.139245$$

$$OE\ Contract\ 1 = \left(\frac{641}{642}\right) = 0.998442$$

Final Rate Contract 1 = 0.998442 × 0.139245 x 100 = 13.90

Final Rate reported for Contract 1 = 14%

The actual calculated National Observed Rate used in the 2023 display measures was 0.111082183700204.

[6] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files