Medicare
2015 Part C & D
Display Measure
Technical Notes

Updated – 11/20/2014

Document Change Log:

Previous Version	Description of Change	Revision Date
-	Release of the final 2015 Display Measure Technical Notes	11/20/2014

Table of Contents

General

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

These display measures are not part of the Star Ratings. Display measures may have been transitioned from the Star Ratings. These can also be new measures being tested before inclusion into the Star Ratings. Lastly, some measures are displayed for informational purposes only. As indicated in the 2015 Call Letter, CMS will give advance notice if display measures are being considered for inclusion to the Star Ratings. Data for display page measures will continue to be collected and monitored, and poor scores on display measures are subject to compliance actions by CMS.

For 2015, CMS is

- Transitioning two Star Rating measures to display:
    a. Breast Cancer Screening
    b. Beneficiary Access and Performance Problems
- Introducing four display areas:
    a. CAHPS measures about contact from a doctor's office, health plan, pharmacy, or prescription drug plan (Part C)
    b. CAHPS Health Information Technology measures (Part C)
    c. Transition Monitoring (Part D)
    d. Disenrollment Reasons (Part C and D)
- Dropping measures:
    a. Call Center Hold Time, Information Accuracy and Disconnection measures (Part C and D)

Contact Information

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

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

Part C Display Measure Details

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

HEDIS Label:	Follow-Up After Hospitalization for Mental Illness (FUH)
Measure Reference:	NCQA HEDIS 2014 Technical Specifications Volume 2, page 181
Metric:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2013 - 12/31/2013
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC02 - Call Answer Timeliness

HEDIS Label:	Call Answer Timeliness (CAT)
Measure Reference:	NCQA HEDIS 2014 Technical Specifications Volume 2, page 248
Metric:	The percentage of calls received by the organization's member services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.
Data Source:	HEDIS
Data Time Frame:	01/01/2013 - 12/31/2013
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC03 - Antidepressant Medication Management (6 months)

HEDIS Label:	Antidepressant Medication Management (AMM)
Measure Reference:	NCQA HEDIS 2014 Technical Specifications Volume 2, page 172
Metric:	The percentage of members 18 years of age and older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2013 - 12/31/2013
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC04 - Continuous Beta Blocker Treatment

HEDIS Label:	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Measure Reference:	NCQA HEDIS 2014 Technical Specifications Volume 2, page 139
Metric:	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI (denominator) and who received persistent beta-blocker treatment for six months after discharge (numerator).
Data Source:	HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC05 - Appropriate Monitoring of Patients Taking Long-term Medications

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

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 198

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

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC06 - Osteoporosis Testing

HEDIS Label: Osteoporosis Testing in Older Women (OTO)

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 219

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

Data Source: HEDIS / HOS

Data Time Frame: 04/18/2013 - 07/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC07 - Testing to Confirm Chronic Obstructive Pulmonary Disease

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

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 112

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

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC08 - Doctors who Communicate Well

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

CAHPS Survey Questions (question numbers vary depending on survey type):

• In the last 6 months, how often did your personal doctor 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?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC09 - Pneumonia Vaccine

Metric: The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator). CAHPS Survey Question (question number varies depending on survey type):

• Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from a flu shot. It is also called the pneumococcal vaccine.

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC10 - Access to Primary Care Doctor Visits

HEDIS Label: Adults' Access to Preventive/Ambulatory Health Services

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 230

Metric: The percentage of members 20 years and older (denominator) who had an ambulatory or preventive care visit during the measurement year (numerator).

Exclusions: None listed.

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Compliance Standard: 85%

Measure: DMC11 - Special Needs Plan (SNP) Care Management

Metric: This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new enrollees (Element 13.1) and the number of enrollees eligible for an annual HRA (Element 13.2). The numerator for this measure is the sum of the number of initial HRAs performed on new enrollees (Element 13.3) and the number of annual reassessments performed (Element 13.4). The equation for calculating the SNP Care Management Assessment Rate is:

[Number of initial HRAs performed on new enrollees (Element 13.3) + Number of

annual reassessments performed (Element 13.4)] / [Number of new enrollees (Element 13.1) + Number of enrollees eligible for an annual HRA (Element 13.2)]

Exclusions: Contracts and PBPs with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2013) are excluded and listed as “No data available”.

SNP Care Management Assessment Rates are not provided for contracts that did not score at least 95% on data validation for the SNP Care Management reporting section. Rates are also not provided for contracts that scored 95% or higher on data validation for the SNP Care Management reporting section but that were not compliant with data validation standards/sub-standards for any the following SNP Care Management data elements:

- Number of new enrollees (Element 13.1)
- Number of enrollees eligible for an annual HRA (Element 13.2)
- Number of initial HRAs performed on new enrollees (Element 13.3)
- Number of annual reassessments performed (Element 13.4)

Contracts excluded from the SNP Care Management Assessment Rates due to data validation issues are shown as “CMS identified issues with this plan's data”.

Additionally, contracts must have 30 or more enrollees in the denominator [Number of new enrollees (Element 13.1) + Number of enrollees eligible for an annual HRA (Element 13.2) ≥ 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available.”

Data Source: Part C Plan Reporting

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

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

General Trend: Higher is better

Data Display: Percentage with 1 decimal point

Measure: DMC12 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

HEDIS Label: Pharmacotherapy Management of COPD Exacerbation

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 114

Metric: The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed a systemic corticosteroid within 14 days of the event.

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC13 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

HEDIS Label: Pharmacotherapy Management of COPD Exacerbation

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 114

Metric: The percentage of COPD exacerbations for members 40 years of age and older who

had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event.

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC14 - Initiation of Alcohol or other Drug Treatment

HEDIS Label: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 236

Metric: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC15 - Engagement of Alcohol or other Drug Treatment

HEDIS Label: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 236

Metric: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC16 - Reminders for Appointments

Metric: The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about appointments (numerator). CAHPS Survey Questions (question numbers vary depending on survey type):

• In the last 6 months, did anyone from a doctor's office or your health plan contact you to remind you to make appointments for tests or treatment?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC17 - Reminders for Immunizations

Metric: The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about getting immunizations (numerator). CAHPS Survey Questions (question numbers vary depending on survey type):

• In the last 6 months, did anyone from a doctor's office or your health plan contact you to remind you to get a flu shot or other immunization?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC18 - Reminders for Screening Tests

Metric: The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about getting a screening test (numerator). CAHPS Survey Questions (question numbers vary depending on survey type):

• In the last 6 months, did anyone from a doctor's office or your health plan contact you to remind you about screening tests such as breast cancer or colorectal cancer screening?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC19 - Computer Used during Office Visits

Metric: The percentage of sampled Medicare enrollees (denominator) who reported their doctor used a computer or handheld device during an office visit (numerator). CAHPS Survey Questions (question numbers vary depending on survey type):

• Doctors may use computers or handheld devices during an office visit to do things like look up your information or order prescription medicines. In the last 6 months, did your personal doctor use a computer or handheld device during any of your visits?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC20 - Computer Use by Doctor Helpful

Metric: This case-mix adjusted measure is used to assess how helpful providers' computer use is. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score is the percentage of sampled Medicare enrollees (denominator) who reported that their doctor's use of a computer or handheld device was helpful "a lot" or "a little".

CAHPS Survey Questions (question numbers vary depending on survey type):

• During your visits in the last 6 months, was your personal doctor's use of a computer or handheld device helpful to you?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC21 - Computer Use Made Talking with Doctor Easier

Metric: This case-mix adjusted measure is used to assess whether providers' computer use made talking harder or easier. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score is the percentage of sampled Medicare enrollees (denominator) who reported that their doctor's use of a computer or handheld device made talking to them easier.

CAHPS Survey Questions (question numbers vary depending on survey type):

• During your visits in the last 6 months, did your personal doctor's use of a computer or handheld device make it harder or easier for you to talk to him or her?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMC22 - Breast Cancer Screening

HEDIS Label: Breast Cancer Screening (BCS)

Measure Reference: NCQA HEDIS 2014 Technical Specifications Volume 2, page 77

Metric: The percentage of female MA enrollees ages 50 to 74 (denominator) who had one or more mammograms during the measurement year or the 15 months prior to the measurement year (numerator).

Exclusions: (optional) Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies. Refer to NCQA HEDIS 2014 Technical Specifications Volume 2, page 82, Table BCS-B for codes to identify exclusions.

Contracts that reported HEDIS 2014, whose enrollment was less than 1,000 as of the July 2012 enrollment report were excluded from this measure.

Data Source: HEDIS

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with no decimal point

Part D Display Measure Details

Measure: DMD01 - Timely Receipt of Case Files for Appeals

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

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

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

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

Exclusions: None

Data Source: IRE

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

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

Data Time Frame: 01/01/2014 - 06/30/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD02 - Timely Effectuation of Appeals

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

Numerator = The number of appeals that were effectuated timely.

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

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

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

Data Source: IRE

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

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

of decision notification.

Data Time Frame: 01/01/2014 - 06/30/2014

General Trend: Higher is better

Data Display: Percentage with 2 decimal points

Measure: DMD03 - Drug-Drug Interactions

Metric: This measure is defined as the percent of Medicare Part D beneficiaries who received a prescription for a target medication during the measurement period and who were dispensed a prescription for a contraindicated medication with or subsequent to the initial prescription.

Numerator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication with at least one day overlap with a contraindicated medication.

Denominator = Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication.

This is calculated as: [(Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication with at least one day overlap with a contraindicated medication)/(Number of member-years of beneficiaries enrolled during the measurement period who were dispensed a target medication)]*100.

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

Data Source: PDE data

Data Source Description: The Drug-Drug Interaction (DDI) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2013-December 31, 2013, and processed by June 30, 2014. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes.

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Percentage with 1 decimal point

Measure: DMD04 - Diabetes Medication Dosing

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

Numerator = Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose.

Denominator = Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed at least one prescription of an

oral hypoglycemic.

This is calculated as: [(Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose) / (Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed at least one prescription of an oral hypoglycemic)]*100.

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

Data Source: PDE data

Data Source Description: The Diabetes Medication Dosing (DMD) measure is adapted from the measure concept that was first developed by the Pharmacy Quality Alliance (PQA). The data for this measure come from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare for dates of service from January 1, 2013-December 31, 2013, and processed by June 30, 2014. Only final action PDE claims are used to calculate the patient safety measures. PDE adjustments made post-reconciliation were not reflected in this measure. The measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists will be posted along with these technical notes.

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Percentage with 2 decimal points

Measure: DMD05 - Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website

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

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

Denominator = Total number of pricing data submissions

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

Exclusions: None.

Data Source: CMS Administrative Data

Data Time Frame: 10/01/2013 - 09/30/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD06 - MPF – Stability

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

The stability price index uses final prescription drug event (PDE) data to assess changes in prices over the contract year. It is defined as the average change in price of a specified basket of drugs each quarter. A basket of drugs defined by quarter 1 PDEs is priced using quarter 1 average prices for each drug first. The same basket is then priced using quarter 2 average prices. The stability price index from quarter 1 to

quarter 2 is calculated as the total price of the basket using the quarter 2 average prices divided by the total price of same basket using quarter 1 average prices. This same process is repeated using a quarter 2 basket of drugs to compute the quarter 2 to quarter 3 price index and a quarter 3 basket of drugs to compute the quarter 3 to quarter 4 price index. The overall stability price index is the average of the price index from quarter 1 to 2, quarter 2 to 3, and quarter 3 to 4. A price index of 1 indicates a plan had no increase in prices from the beginning to the end of the year. A stability index smaller than 1 indicates that prices decreased, while an index greater than 1 indicates that prices increased.

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

100 – ((stability index – 1) x 100).

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

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

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

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Rate with no decimal point

Measure: DMD07 - Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews

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

Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period.

Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries that meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries that were in hospice at any point during the reporting period are excluded.

A beneficiary's MTM eligibility, receipt of CMRs, etc. are determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. A beneficiary must meet the inclusion criteria for the contract to be included in the

contract's CMR rate. A beneficiary that is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates.

Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/ or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.

MTM eligibility rates are also provided as an attachment to these technical notes as additional information. Analyses have not found a correlation between a sponsor's rate of MTM program eligibility and the CMR completion rate.

Exclusions: A contract must have 31 or more beneficiaries meeting the denominator criteria to have a calculated rate. Contracts with fewer than 31 beneficiaries meeting the denominator criteria are listed as "Plan too small to be measured."

Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2014), or that were not required to participate in data validation are listed as "Plan not required to report measure."

Rates are not calculated for contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section. Rates are also not calculated for contracts that scored 95% or higher on data validation for the MTM program section but were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements:

- Met the specified targeting criteria per CMS – Part D requirements (Element G)
- Date of MTM program enrollment (Element J)
- Date met the specified targeting criteria per CMS – Part D requirements (Element K)
- Data of MTM program opt-out, if applicable (Element L)
- Received annual CMR with written summary in CMS standardized format (Element P)
- Date(s) of CMR(s) with written summary in CMS standardized format (Element R)

These contracts excluded from the measure due to data validation issues are shown as "Data issues found."

Data Source: Part D Plan Reporting

Data Source Description: Data were reported by contracts to CMS per the Part D Reporting Requirements through the Health Plan Management System (HPMS). Validation of these data was performed retrospectively during the 2014 Data Validation cycle. The Enrollment Database was used to identify beneficiaries in hospice and to calculate eligibility rates.

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Percentage with 1 decimal point

Measure: DMD08 - Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes

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

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

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

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

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

* See Notes under Data Source for definition of LTI

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

Data Source: PDE data, Enrollment data, Minimum Date Set((MDS) Assessments

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

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

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

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

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Percentage with 2 decimal points

Measure: DMD09 - Getting Information from Drug Plan

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

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

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD10 - Plan Submitted Higher Prices for Display on MPF

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

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

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

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

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

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

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

	• PDE must be for retail pharmacy (pharmacies marked retail and mail order/HI/LTC are excluded)
Data Source:	PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span
Data Time Frame:	01/01/2013 - 09/30/2013
General Trend:	Higher is better
Data Display:	Rate with no decimal point

Measure: DMD11 - Transition monitoring - failure rate for drugs within classes of clinical concern

Metric:	The numbers of failures (numerator) were divided by the number of claims sampled (denominator) to calculate an overall compliance score. If the number of failures resulted in more than a 10% failure rate, CMS determined that an overall compliance failure occurred for this area.
Exclusions:	Contracts with fewer than 15 claims sampled; Contracts not listed in active status in HPMS; MMPs that did not have a January 2014 start date; Contracts that are involved in other transition oversight activities; Contracts that do not offer Part D coverage or did not utilize a formulary.
Data Source:	Part D Sponsor, PDE data and HPMS approved formularies
Data Source Description:	Data was obtained from the Part D Sponsor, PDE data, and HPMS approved formulary extracts.
Data Time Frame:	January 1 – 21, 2014
General Trend:	Lower is better
Data Display:	Percentage with 1 decimal point
Compliance Standard:	>10%

Measure: DMD12 - Transition monitoring - failure rate for all other drugs

Metric:	The numbers of failures (numerator) were divided by the number of claims sampled (denominator) to calculate an overall compliance score. If the number of failures resulted in more than a 20% failure rate, CMS determined that an overall compliance failure occurred for this area.
Exclusions:	Contracts with fewer than 15 claims sampled; Contracts not listed in active status in HPMS; MMPs that did not have a January 2014 start date; Contracts that are involved in other transition oversight activities; Contracts that do not offer Part D coverage or did not utilize a formulary.
Data Source:	Part D Sponsor, PDE data and HPMS approved formularies
Data Source Description:	Data was obtained from the Part D Sponsor, PDE data, and HPMS approved formulary extracts.
Data Time Frame:	January 1 – 21, 2014
General Trend:	Lower is better
Data Display:	Percentage with 1 decimal point
Compliance Standard:	>20%

Measure: DMD13 - Reminders to Fill prescriptions

Metric: The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about filling or refilling a prescription (numerator). CAHPS Survey Questions (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?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DMD14 - Reminders to Take Medications

Metric: The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about taking medications as directed (numerator). CAHPS Survey Questions (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?

Data Source: CAHPS

Data Time Frame: 02/15/2014 - 05/31/2014

General Trend: Higher is better

Data Display: Percentage with no decimal point

Measure: DME01 - Enrollment Timeliness

Metric:	Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date Denominator = The total number of plan generated enrollment transactions submitted to CMS Calculation = [(The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date) / (The total number of plan generated enrollment transactions submitted to CMS)] * 100
Exclusions:	1. Contracts with 25 or fewer enrollment submissions during the measurement period, when summed. 2. Election Types: ICEP, IEP, IEP2 and AEP. 3. Employer/Union enrollments. 4. 1876 Cost Contract MA-only members. 5. Special Needs Plans. 6. Transaction Reply Codes 1-5 (TRC1, TRC2, TRC3, TRC4, TRC5) equal to any of the below: TRC's: ('001', '002', '003', '004', '006', '007', '008', '009', '019', '020', '032', '033', '034', '035', '036', '037', '038', '039', '042', '044', '045', '048', '056', '060', '062', '102', '103', '104', '105', '106', '107', '108', '109', '110', '114', '116', '122', '123', '124', '126', '127', '128', '129', '130', '133', '139', '156', '157', '162', '166', '169', '176', '184', '196', '200', '201', '202', '203', '211', '220', '257', '258', '263', '600', '601', '602', '603', '605', '611') TRCs are defined in the Plan Communication Users Guide Appendix Table I-2.
Data Source:	Medicare Advantage and Prescription Drug System (MARx)
Data Source Description:	The data timeframe is the monthly enrollment files for January - July, 2014, which represents submission dates of 01/01/2014 - 07/31/2014.
Data Time Frame:	01/01/2014 - 07/31/2014
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DME02 - Grievance Rate

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. Part D grievances reported in the "CMS issues" category (Element G: CMS issues grievances) are excluded from the Total Grievances count.
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 terminate date on or before the deadline to submit data validation results to CMS (June 30, 2014) are listed as "Plan not required to report measure." Rates are not calculated for contracts that did not score at least 95% on data

validation for the Grievances reporting section(s). Rates are also not calculated for contracts that scored 95% or higher on data validation for Grievance section(s) but that were not compliant with data validation standards/sub-standards for at least one of the following Grievance data elements:

Part C (MA only and MA-PDs)
• Fraud grievances (Element 5.1)
• Enrollment/disenrollment grievances (Element 5.2)
• Benefit package grievances (Element 5.3)
• Access grievances (Element 5.4)
• Marketing grievances (Element 5.5)
• Customer service grievances (Element 5.6)
• Privacy issue grievances (Element 5.7)
• Quality of care grievances (Element 5.8)
• Appeals grievances (Element 5.9)
• Other grievances (Element 5.10)

Part D (PDPs and MA-PDs)
• Enrollment, plan benefits, or pharmacy access – Total number of grievances (Element A)
• Customer Service – Total number of grievances (Element C)
• Coverage determinations and Redeterminations process – Total number of grievances (Element E)
• Other – Total number of grievances (Element I)

These contracts excluded from the measure due to data validation issues are shown as "Data issues found."

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 2014 Data Validation cycle.

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Rate with 2 decimal points

Measure: DME03 - Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only)

Metric: "Problems Getting Needed Care, Coverage, and Cost Information" is a composite of the following survey questions (question numbers vary depending on survey type):
(a) Did you leave the plan because you were frustrated by the plan's approval process for care, tests, or treatment?
(b) Did you leave the plan because you had problems getting the care, tests, or treatment you needed?
(c) Did you leave the plan because you had problems getting the plan to pay a claim?
(d) Did you leave the plan because it was hard to get information from the plan -- like which health care services were covered or how much a specific test or treatment would cost?

Each of these questions asked about a reason for disenrollment that was related to the beneficiary's experiences with getting needed health care services and cost information and getting claims paid for these services. Scores range from 0 to 100 and a lower mean indicates that problems getting needed care, coverage and cost information reasons were endorsed less frequently by disenrollees from your contract.

Exclusions: Contracts with less than 30 responses are excluded.

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 Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Rate with no decimal point

Measure: DME04 - Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)

Metric: "Problems with Coverage of Doctors and Hospitals" is a composite of the following survey questions (question numbers vary depending on survey type):
(a) Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan?
(b) Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan?

Each of these questions asked about a reason for disenrollment that was related to the coverage of doctors and hospitals by the plan. Scores range from 0 to 100 and a lower mean indicates that problems with coverage of doctors and hospitals reasons were endorsed less frequently by disenrollees from your contract.

Exclusions: Contracts with less than 30 responses are excluded.

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 Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Rate with no decimal point

Measure: DME05 - Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)

Metric: "Financial Reasons for Disenrollment" is a composite of the following survey questions (question numbers vary depending on survey type):
(a) Did you leave the plan because the monthly fee that the health plan charges to provide coverage for health care and prescription medicines went up?
(b) Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up?
(c) Did you leave the plan because you found a health plan that costs less?
(d) Did you leave the plan because a change in your personal finances meant you could no longer afford the plan?

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

Exclusions: Contracts with less than 30 responses are excluded.

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 Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Rate with no decimal point

Measure: DME06 - Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)

Metric: "Problems with Prescription Drug Benefits and Coverage" is a composite of the following survey questions (question numbers vary depending on survey type):
(a) Did you leave the plan because they changed the list of prescription medicines they cover?
(b) Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed?
(c) Did you leave the plan because you had problems getting the medicines your doctor prescribed?
(d) Did you leave the plan because it was difficult to get brand name medicines?
(e) Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers?

Each of these questions asked about a reason for disenrollment that was related to prescription drug benefits and coverage. Scores range from 0 to 100 and a lower mean indicates that problems with prescription drug benefits and coverage reasons were endorsed less frequently by disenrollees from your contract.

Exclusions: Contracts with less than 30 responses are excluded.

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 Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Rate with no decimal point

Measure: DME07 - Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP)

Metric: "Problems Getting Information about Prescription Drugs" a composite of the following survey questions (question numbers vary depending on survey type):
(a) Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription?
(b) Did you leave the plan because it was hard to get information from the plan -- like which prescription medicines were covered or how much a specific medicine would cost?
(c) Did you leave the plan because you were unhappy with how the plan handled a question or complaint?
(d) Did you leave the plan because you could not get the information or help you

needed from the plan?
(e) Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

Each of these questions asked about a reason for disenrollment that was related to the beneficiary's experiences with getting information about prescription drugs. Scores range from 0 to 100 and a lower mean indicates that problems with getting information about prescription drug reasons were endorsed less frequently by disenrollees from your contract.

Exclusions: Contracts with less than 30 responses are excluded.

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 Time Frame: 01/01/2013 - 12/31/2013

General Trend: Lower is better

Data Display: Rate with no decimal point

Measure: DME08 - Beneficiary Access and Performance Problems

Metric: This measure is based on sanctions, civil monetary penalties (CMP) as well as 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). While CMS utilized a risk-based strategy to identify contracts for performance audits in 2013, compliance or other actions may be taken against contracts as a result of other issues or concerns being identified.

- 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 1/1/2014 or later are marked as "Plan too new to be measured".
  - All contracts with an effective date prior to 1/1/2014 begin with a score 100.
- Contracts placed under sanction anytime during the data time frame are reduced to a score of 0. This is separate from the deduction applied at the overall score level for contracts with more recent sanctions.
- The following deductions are taken from contracts whose score is above 0:
  - For each CMP with beneficiary impact related to access: 40 points.
  - 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 noncompliance, 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) + (NAHC * (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
NAHC = Number of Ad-Hoc CAPs
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

General Notes: Based on feedback from plans, this measure only includes the ad-hoc and compliance actions parts of the Beneficiary Access measure. The audit component of this measure is not included.

Data Source: CMS Administrative Data

Data Source Description: Ad hoc and compliance actions that occurred during the 12 month past performance review period between January 1, 2013 and December 31, 2013. For compliance actions, the date the action was issued is used when pulling the data from HPMS.

Data Time Frame: 01/01/2013 - 12/31/2013

General Trend: Higher is better

Data Display: Rate with no decimal point

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 2015 Display measures.

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)	54%
DMC02	Call Answer Timeliness	84%
DMC03	Antidepressant Medication Management (6 months)	54%
DMC04	Continuous Beta Blocker Treatment	90%
DMC05	Appropriate Monitoring of Patients Taking Long-term Medications	92%
DMC06	Osteoporosis Testing	74%
DMC07	Testing to Confirm Chronic Obstructive Pulmonary Disease	36%
DMC08	Doctors who Communicate Well	91%
DMC09	Pneumonia Vaccine	69%
DMC10	Access to Primary Care Doctor Visits	96%
DMC11	Special Needs Plan (SNP) Care Management	51.8%
DMC12	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	71%
DMC13	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	79%
DMC14	Initiation of Alcohol or other Drug Treatment	35%
DMC15	Engagement of Alcohol or other Drug Treatment	3%
DMC16	Reminders for Appointments	60%
DMC17	Reminders for Immunizations	47%
DMC18	Reminders for Screening Tests	40%
DMC19	Computer Used during Office Visits	82%
DMC20	Computer Use by Doctor Helpful	94%
DMC21	Computer Use Made Talking with Doctor Easier	53%
DMC22	Breast Cancer Screening	70%

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

Measure ID	Measure Name	Average
DMD01	Timely Receipt of Case Files for Appeals	87%
DMD02	Timely Effectuation of Appeals	94.04%
DMD03	Drug-Drug Interactions	6.1%
DMD04	Diabetes Medication Dosing	0.74%
DMD05	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	98%
DMD06	MPF – Stability	98
DMD07	Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews	21.0%
DMD08	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	19.85%
DMD09	Getting Information from Drug Plan	82%
DMD10	Plan Submitted Higher Prices for Display on MPF	97
DMD11	Transition monitoring - failure rate for drugs within classes of clinical concern	3.7%
DMD12	Transition monitoring - failure rate for all other drugs	7.3%
DMD13	Reminders to Fill prescriptions	38%
DMD14	Reminders to Take Medications	23%

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

Measure ID	Measure Name	Average
DME01	Enrollment Timeliness	95%
DME02	Grievance Rate	2.16
DME03	Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only)	15
DME04	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)	23
DME05	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-only, PDP)	28
DME06	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	10
DME07	Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP)	10
DME08	Beneficiary Access and Performance Problems	85