



Medicare 2016 Part C & D Display Measure Technical Notes

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Document Change Log:

Previous Version	Description of Change	Revision Date
-	Initial Release of the 2016 Display Measure Technical Notes	12/17/2015

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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. 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 2016, CMS is

- Transitioning one Star Rating measures to display:
 - a. Improving Bladder Control (Part C)
- Reintroducing five display measures
 - a. Call Center Hold Time 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

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
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@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 2015 Technical Specifications Volume 2, page 177	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC02 - Call Answer Timeliness

Title	Description
HEDIS Label: Call Answer Timeliness (CAT)	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 251	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC03 - Antidepressant Medication Management (6 months)

Title	Description
HEDIS Label: Antidepressant Medication Management (AMM)	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 168	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC04 - Continuous Beta Blocker Treatment

Title	Description
HEDIS Label: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 138	
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	

Title	Description
	(denominator) and who received persistent beta-blocker treatment for six months after discharge (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2014 - 12/31/2014
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

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

Title	Description
	HEDIS Label: Annual Monitoring for Patients on Persistent Medication (MPM)
Measure Reference:	NCQA HEDIS 2015 Technical Specifications Volume 2, page 202
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:	01/01/2014 - 12/31/2014
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC06 - Osteoporosis Testing

Title	Description
	HEDIS Label: Osteoporosis Testing in Older Women (OTO)
Measure Reference:	NCQA HEDIS 2014 Specifications for The Medicare Health Outcomes Survey Volume 6, page 37
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).
Exclusions:	None listed.
Data Source:	HEDIS / HOS
Data Source Description:	Cohort 15 Follow-up Data collection (2014) and Cohort 17 Baseline data collection (2014).
	HOS Survey Question 52: Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel or finger.
Data Time Frame:	04/18/2014 - 07/31/2014
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC07 - 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 2015 Technical Specifications Volume 2, page 114
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),

Title	Description
	who received appropriate spirometry testing to confirm the diagnosis (numerator).
Data Source:	HEDIS
Data Time Frame:	01/01/2014 - 12/31/2014
General Trend:	Higher is better
Data Display:	Percentage with no decimal point

Measure: DMC08 - Doctors who Communicate Well

Title	Description
	<p>Metric: This case mix adjusted composite measure is used to assess how well doctors communicate. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.</p> <p>CAHPS Survey Questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none"> • In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? • In the last 6 months, how often did your personal doctor listen carefully to you? • In the last 6 months, how often did your personal doctor show respect for what you had to say? • In the last 6 months, how often did your personal doctor spend enough time with you? <p>Data Source: CAHPS</p> <p>Data Time Frame: 02/15/2015 - 05/31/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DMC09 - Call Center – Beneficiary Hold Time

Title	Description
	<p>Metric: This measure is defined as the average time spent on hold by the call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the “Customer Service for Current Members – Part C” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part C contract beneficiary customer service call center, divided by the number of eligible calls made to the Part C contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.</p> <p>Exclusions: Data were not collected from contracts that cover U.S territories, 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.</p> <p>Data Source: Call Center</p> <p>Data Source Description: Call Center surveillance monitoring data collected by CMS. The “Customer Service for Current Members – Part C” phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.</p> <p>Data Time Frame: 01/19/2015 - 07/03/2015</p>

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

Measure: DMC10 - 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 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: 02/15/2015 - 05/31/2015	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC11 - Access to Primary Care Doctor Visits

Title	Description
HEDIS Label: Adults' Access to Preventive/Ambulatory Health Services	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 233	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	
Compliance Standard: 85%	

Measure: DMC12 - Calls Disconnected When Customer Calls Health Plan

Title	Description
Metric: This measure is defined as the number of calls unexpectedly dropped by the sponsor while the call surveyor was navigating the IVR or connected with a customer service representative (CSR) divided by the total number of calls made to the phone number associated with the contract.	
Exclusions: Data were not collected from contracts that cover U.S territories, 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.	
Data Source: Call Center	
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 Time Frame: 01/19/2015 - 07/03/2015	

Title	Description
General Trend: Lower is better	
Data Display: Percentage with 2 decimal points	
Compliance Standard: 5%	

Measure: DMC13 - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid

Title	Description
HEDIS Label: Pharmacotherapy Management of COPD Exacerbation	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 116	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC14 - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator

Title	Description
HEDIS Label: Pharmacotherapy Management of COPD Exacerbation	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 116	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC15 - Initiation of Alcohol or other Drug Treatment

Title	Description
HEDIS Label: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 239	
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: 01/01/2014 - 12/31/2014	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMC16 - Engagement of Alcohol or other Drug Treatment

Title	Description
	HEDIS Label: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	Measure Reference: NCQA HEDIS 2015 Technical Specifications Volume 2, page 239
	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: 01/01/2014 - 12/31/2014
	General Trend: Higher is better
	Data Display: Percentage with no decimal point

Measure: DMC17 - Reminders for Appointments

Title	Description
	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):
	<ul style="list-style-type: none">• 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: 02/15/2015 - 05/31/2015
	General Trend: Higher is better
	Data Display: Percentage with no decimal point

Measure: DMC18 - Reminders for Immunizations

Title	Description
	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):
	<ul style="list-style-type: none">• 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: 02/15/2015 - 05/31/2015
	General Trend: Higher is better
	Data Display: Percentage with no decimal point

Measure: DMC19 - Reminders for Screening Tests

Title	Description
	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):
	<ul style="list-style-type: none">• 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: 02/15/2015 - 05/31/2015
	General Trend: Higher is better
	Data Display: Percentage with no decimal point

Measure: DMC20 - Computer Used during Office Visits

Title	Description
	<p>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):</p> <ul style="list-style-type: none">• 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? <p>Data Source: CAHPS</p> <p>Data Time Frame: 02/15/2015 - 05/31/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DMC21 - Computer Use by Doctor Helpful

Title	Description
	<p>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".</p> <p>CAHPS Survey Questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none">• During your visits in the last 6 months, was your personal doctor's use of a computer or handheld device helpful to you? <p>Data Source: CAHPS</p> <p>Data Time Frame: 02/15/2015 - 05/31/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DMC22 - Computer Use Made Talking with Doctor Easier

Title	Description
	<p>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.</p> <p>CAHPS Survey Questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none">• 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? <p>Data Source: CAHPS</p> <p>Data Time Frame: 02/15/2015 - 05/31/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DMC23 - Improving Bladder Control

Title	Description
	HEDIS Label: Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS 2014 Specifications for The Medicare Health Outcomes Survey Volume 6, page 29
Metric:	The percentage of Medicare members 65 years of age or older who reported having a urine leakage problem in the past six months (denominator) and who received treatment for their current urine leakage problem (numerator).
Exclusions:	None listed.
Data Source:	HEDIS / HOS
Data Source Description:	Cohort 15 Follow-up Data collection (2014) and Cohort 17 Baseline data collection (2014).
	HOS Survey Question 42: Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?
Data Time Frame:	04/18/2014 - 07/31/2014
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

Title	Description
	<p>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.)</p> <p>Numerator = The number of case files requested that were received in the required time frame.</p> <p>Denominator = The number of case files requested by the IRE.</p> <p>This is calculated as: $[(\text{The number of case files received in the required timeframe}) / (\text{The number of case files requested by the IRE})] * 100.$</p> <p>Exclusions: None</p> <p>Data Source: IRE</p> <p>Data Source Description: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.</p> <p>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.</p> <p>Data Time Frame: 01/01/2015 - 06/30/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DMD02 - Timely Effectuation of Appeals

Title	Description
	<p>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.).</p> <p>Numerator = The number of appeals that were effectuated timely.</p> <p>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.</p> <p>This is calculated as: $[(\text{The number of appeals that were effectuated timely}) / (\text{The number of dispositions that required effectuation})] * 100.$</p> <p>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.</p> <p>Data Source: IRE</p> <p>Data Source Description: Data were obtained from the IRE contracted by CMS for Part D reconsiderations.</p> <p>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</p>

Title	Description
	making payments, timely is defined as payment being made within 30 calendar days of decision notification.
Data Time Frame:	01/01/2015 - 06/30/2015
General Trend:	Higher is better
Data Display:	Percentage with 2 decimal points

Measure: DMD03 - Calls Disconnected When Customer Calls Drug Plan

Title	Description
	<p>Metric: This measure is defined as the number of calls unexpectedly dropped by the sponsor while the call surveyor was navigating the IVR or connected with a customer service representative (CSR) divided by the total number of calls made to the phone number associated with the contract.</p> <p>Exclusions: Data were not collected from contracts that cover U.S. territories, 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.</p> <p>Data Source: Call Center</p> <p>Data Source Description: Call Center surveillance monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored. This measure is based on calls to the current enrollee call center.</p> <p>Data Time Frame: 01/19/2015 - 07/03/2015</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with 2 decimal points</p> <p>Compliance Standard: 5%</p>

Measure: DMD04 - Call Center – Beneficiary Hold Time

Title	Description
	<p>Metric: This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the “Customer Service for Current Members – Part D” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract beneficiary customer service call center divided by the number of eligible calls made to the Part D contract beneficiary customer service call center. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.</p> <p>Exclusions: Data were not collected from contracts that cover U.S. territories, 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.</p> <p>Data Source: Call Center</p> <p>Data Source Description: Call center monitoring data collected by CMS. The “Customer Service for Current Members – Part D” phone number associated with each contract was monitored.</p> <p>Data Time Frame: 01/19/2015 - 07/03/2015</p> <p>General Trend: Lower is better</p>

Title	Description
Data Display: Time	
Compliance Standard: 2:00	

Measure: DMD05 - Drug-Drug Interactions

Title	Description
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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, 2014-December 31, 2014, and processed by June 30, 2015. 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: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Data Display: Percentage with 1 decimal point

Measure: DMD06 - Diabetes Medication Dosing

Title	Description
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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, sulfonylureas, 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.

Title	Description
	<p>This is calculated as: $[(\text{Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed a dose of an oral hypoglycemic higher than the daily recommended dose}) / (\text{Number of member-years of beneficiaries 18 years and older enrolled during the measurement period who were dispensed at least one prescription of an oral hypoglycemic})] * 100$.</p> <p>Exclusions: A percentage is not calculated for contracts with 30 or fewer beneficiary member years (in the denominator).</p> <p>Data Source: PDE data</p> <p>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, 2014-December 31, 2014, and processed by June 30, 2015. 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.</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with 2 decimal points</p>

Measure: DMD07 - Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website

Title	Description
	<p>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.</p> <p>Numerator = Number of pricing data file submissions that do not result in suppression of pricing data on www.medicare.gov</p> <p>Denominator = Total number of pricing data submissions</p> <p>This is calculated as: $[(\text{Number of pricing data file submissions that do not result in suppression of pricing data on } \text{www.medicare.gov}) / (\text{Total number of pricing data submissions})] * 100$.</p> <p>Exclusions: None.</p> <p>Data Source: CMS Administrative Data</p> <p>Data Time Frame: 10/01/2014 - 09/30/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DMD08 - MPF – Stability

Title	Description
Metric: This measure evaluates stability in a plan's point of sale prices.	
<p>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.</p> <p>To convert the index into the stability score, we use the formula below. The score is rounded to the nearest whole number.</p> $100 - ((\text{stability index} - 1) \times 100).$ <p>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:</p> <ul style="list-style-type: none">• 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 <p>Data Source: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span</p> <p>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</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Higher is better</p> <p>Data Display: Rate with no decimal point</p>	

Measure: DMD09 - Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes

Title	Description
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:	
<ul style="list-style-type: none">• 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,	

Title	Description
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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 Data 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: 01/01/2014 - 12/31/2014

General Trend: Lower is better

Data Display: Percentage with 2 decimal points

Measure: DMD10 - Getting Information from Drug Plan

Title	Description
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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?

Title	Description
	<ul style="list-style-type: none"> • 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: 02/15/2015 - 05/31/2015	
General Trend: Higher is better	
Data Display: Percentage with no decimal point	

Measure: DMD11 - Call Center – Pharmacy Hold Time

Title	Description
	<p>Metric: This measure is defined as the average time spent on hold by a call surveyor following the navigation of the Interactive Voice Response (IVR) or Automatic Call Distributor (ACD) system and prior to reaching a live person for the “Pharmacy Technical Help Desk” phone number associated with the contract. This measure is calculated by taking the sum of the total time (mm:ss) it takes for a caller to reach a Customer Service Representative (CSR) for all eligible calls made to that Part D contract pharmacy technical help desk divided by the number of eligible calls made to the Part D contract pharmacy technical help desk. For calls in which the caller terminated the call due to being on hold for greater than 10 minutes prior to reaching a live person, the hold time applied is truncated to 10:00 minutes. Note that total time excludes the time navigating the IVR/ACD system and thus measures only the time the caller is placed into the “hold” queue.</p> <p>Exclusions: Data were not collected from contracts that cover U.S. territories, 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers.</p> <p>Data Source: Call Center</p> <p>Data Source Description: Call center data collected by CMS. The Pharmacy Technical Help Desk phone number associated with each contract was monitored.</p> <p>Data Time Frame: 01/18/2015 - 07/02/2015</p> <p>General Trend: Lower is better</p> <p>Data Display: Time</p> <p>Compliance Standard: 2:00</p>

Measure: DMD12 - Plan Submitted Higher Prices for Display on MPF

Title	Description
	<p>Metric: This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract’s score is based on the accuracy index.</p> <p>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.</p> <p>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.</p>

Title	Description
	<p>The index is computed as: $(\text{Total amount that PF is higher than PDE} + \text{Total PDE cost}) / (\text{Total PDE cost}).$</p> <p>The best possible accuracy index is 1. An index of 1 indicates that a plan did not have PDE prices less than MPF prices.</p> <p>A contract's score is computed using its accuracy index as: $100 - ((\text{accuracy index} - 1) \times 100).$</p> <p>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:</p> <ul style="list-style-type: none"> • 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) <p>Data Source: PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span</p> <p>Data Time Frame: 01/01/2014 - 09/30/2014</p> <p>General Trend: Higher is better</p> <p>Data Display: Rate with no decimal point</p>

Measure: DMD13 - Transition monitoring - failure rate for drugs within classes of clinical concern

Title	Description
	<p>Metric: The numbers of failures (numerator) were divided by the number of claims sampled (denominator) to calculate an overall compliance score.</p> <p>If the number of failures resulted in more than a 10% failure rate, CMS determined that an overall compliance failure occurred for this area.</p> <p>Exclusions: Contracts with fewer than 15 claims sampled; Contracts not listed in active status in HPMS; MMPs that did not have a start date on or before January 2015; Contracts that are involved in other transition oversight activities; Contracts that do not offer Part D coverage or did not utilize a formulary.</p> <p>Data Source: Part D Sponsor, PDE data, CME data and HPMS approved formularies</p> <p>Data Source Description: Data was obtained from the Part D Sponsor, PDE data, CME data and HPMS approved formulary extracts.</p> <p>Data Time Frame: January 4 – 24, 2015</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with 1 decimal point</p> <p>Compliance Standard: >10%</p>

Measure: DMD14 - Transition monitoring - failure rate for all other drugs

Title	Description
	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 start date on or before January 2015; 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, CME data, and HPMS approved formularies
	Data Source Description: Data was obtained from the Part D Sponsor, PDE data, CME data, and HPMS approved formulary extracts.
	Data Time Frame: January 4 – 24, 2015
	General Trend: Lower is better
	Data Display: Percentage with 1 decimal point
	Compliance Standard: >20%

Measure: DMD15 - 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 Questions (question numbers vary depending on survey type):
	<ul style="list-style-type: none">• In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?
	Data Source: CAHPS
	Data Time Frame: 02/15/2015 - 05/31/2015
	General Trend: Higher is better
	Data Display: Percentage with no decimal point

Measure: DMD16 - 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 Questions (question numbers vary depending on survey type):
	<ul style="list-style-type: none">• In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you were taking medications as directed?
	Data Source: CAHPS
	Data Time Frame: 02/15/2015 - 05/31/2015
	General Trend: Higher is better
	Data Display: Percentage with no decimal point

Common Part C & D Display Measure Details

Measure: DME01 - Enrollment Timeliness

Title	Description
	<p>Metric: Numerator = The number of plan generated enrollment transactions submitted to CMS within 7 calendar days of the application date</p> <p>Denominator = The total number of plan generated enrollment transactions submitted to CMS</p> <p>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</p> <p>Exclusions: 1. Contracts with 25 or fewer enrollment submissions during the measurement period, when summed.</p> <p>2. Election Types: ICEP, IEP, IEP2 and AEP.</p> <p>3. Employer/Union enrollments.</p> <p>4. 1876 Cost Contract MA-only members.</p> <p>5. Special Needs Plans.</p> <p>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.</p> <p>Data Source: Medicare Advantage and Prescription Drug System (MARx)</p> <p>Data Source Description: The data timeframe is the monthly enrollment files for January - June, 2015, which represents submission dates of 01/01/2015 - 06/30/2015.</p> <p>Data Time Frame: 01/01/2015 - 06/30/2015</p> <p>General Trend: Higher is better</p> <p>Data Display: Percentage with no decimal point</p>

Measure: DME02 - Grievance Rate

Title	Description
	<p>Metric: This measure is defined as the number of grievances filed with the health plan per 1,000 enrollees per month.</p> <p>Numerator = (Quarter 1 Total Grievances + Quarter 2 Grievances + Quarter 3 Grievances + Quarter 4 Grievances) * 1,000 * 30</p> <p>Denominator = Average Enrollment * Number of days in period</p> <p>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.</p> <p>Exclusions: Part C grievances reported in the "CMS issues" category (Element 5.10: CMS issues grievances) are excluded from the Total Grievances count.</p> <p>Part D grievances reported in the "CMS issues" category (Element T: CMS issues grievances) are excluded from the Total Grievances count.</p> <p>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</p>

Title	Description
	<p>measured.”</p> <p>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.”</p> <p>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:</p> <p>Part C (MA only and MA-PDs)</p> <ul style="list-style-type: none"> • 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 5.11) <p>Part D (PDPs and MA-PDs)</p> <ul style="list-style-type: none"> • 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) <p>These contracts excluded from the measure due to data validation issues are shown as “Data issues found.”</p> <p>Data Source: Part C & D Plan Reporting</p> <p>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.</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Lower is better</p> <p>Data Display: Rate with 2 decimal points</p>

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

Title	Description
	<p>Metric: “Problems Getting Needed Care, Coverage, and Cost Information” is a composite of the following survey questions (question numbers vary depending on survey type):</p> <p>(a) Did you leave the plan because you were frustrated by the plan’s approval process for care, tests, or treatment?</p> <p>(b) Did you leave the plan because you had problems getting the care, tests, or treatment you needed?</p> <p>(c) Did you leave the plan because you had problems getting the plan to pay a claim?</p>

Title	Description
	<p>(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?</p> <p>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.</p> <p>Exclusions: Contracts with less than 30 responses are excluded.</p> <p>Data Source: Disenrollment Reasons Survey</p> <p>Data Source Description: Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal point</p>

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

Title	Description
	<p>Metric: "Problems with Coverage of Doctors and Hospitals" is a composite of the following survey questions (question numbers vary depending on survey type):</p> <p>(a) Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan?</p> <p>(b) Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan?</p> <p>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.</p> <p>Exclusions: Contracts with less than 30 responses are excluded.</p> <p>Data Source: Disenrollment Reasons Survey</p> <p>Data Source Description: Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal point</p>

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

Title	Description
	<p>Metric: "Financial Reasons for Disenrollment" is a composite of the following survey questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none">(a) Did you leave the plan because the monthly 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? <p>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.</p> <p>Exclusions: Contracts with less than 30 responses are excluded.</p> <p>Data Source: Disenrollment Reasons Survey</p> <p>Data Source Description: Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal point</p>

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

Title	Description
	<p>Metric: "Problems with Prescription Drug Benefits and Coverage" is a composite of the following survey questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none">(a) Did you leave the plan because they changed the list of prescription medicines they cover?(b) Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed?(c) Did you leave the plan because you had problems getting the medicines your doctor prescribed?(d) Did you leave the plan because it was difficult to get brand name medicines?(e) Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers? <p>Each of these questions asked about a 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.</p> <p>Exclusions: Contracts with less than 30 responses are excluded.</p> <p>Data Source: Disenrollment Reasons Survey</p> <p>Data Source Description: Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in</p>

Title	Description
	another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).
Data Time Frame: 01/01/2014 - 12/31/2014	
General Trend: Lower is better	
Data Display: Percentage with no decimal point	

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

Title	Description
	<p>Metric: "Problems Getting Information about Prescription Drugs" a composite of the following survey questions (question numbers vary depending on survey type):</p> <ul style="list-style-type: none"> (a) Did you leave the plan because you 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? <p>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.</p> <p>Exclusions: Contracts with less than 30 responses are excluded.</p> <p>Data Source: Disenrollment Reasons Survey</p> <p>Data Source Description: Survey of members who disenrolled from the contract during the measurement time frame with the following disenrollment reason codes: disenrollment reason codes: 11 - Voluntary Disenrollment through plan, 13 - Disenrollment because of enrollment in another Plan, 14 - Retroactive or 99 - Other (not supplied by beneficiary).</p> <p>Data Time Frame: 01/01/2014 - 12/31/2014</p> <p>General Trend: Lower is better</p> <p>Data Display: Percentage with no decimal point</p>

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 2016 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)	55%
DMC02	Call Answer Timeliness	82%
DMC03	Antidepressant Medication Management (6 months)	56%
DMC04	Continuous Beta Blocker Treatment	90%
DMC05	Appropriate Monitoring of Patients Taking Long-term Medications	91%
DMC06	Osteoporosis Testing	75%
DMC07	Testing to Confirm Chronic Obstructive Pulmonary Disease	36%
DMC08	Doctors who Communicate Well	91%
DMC09	Call Center – Beneficiary Hold Time	0:20
DMC10	Pneumonia Vaccine	69%
DMC11	Access to Primary Care Doctor Visits	95%
DMC12	Calls Disconnected When Customer Calls Health Plan	1.62%
DMC13	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	72%
DMC14	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	80%
DMC15	Initiation of Alcohol or other Drug Treatment	33%
DMC16	Engagement of Alcohol or other Drug Treatment	3%
DMC17	Reminders for Appointments	59%
DMC18	Reminders for Immunizations	45%
DMC19	Reminders for Screening Tests	39%
DMC20	Computer Used during Office Visits	85%
DMC21	Computer Use by Doctor Helpful	94%
DMC22	Computer Use Made Talking with Doctor Easier	53%
DMC23	Improving Bladder Control	35%

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

Measure ID	Measure Name	Average
DMD01	Timely Receipt of Case Files for Appeals	86%
DMD02	Timely Effectuation of Appeals	92.73%
DMD03	Calls Disconnected When Customer Calls Drug Plan	1.65%
DMD04	Call Center – Beneficiary Hold Time	0:20
DMD05	Drug-Drug Interactions	5.7%
DMD06	Diabetes Medication Dosing	0.66%
DMD07	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	100%
DMD08	MPF – Stability	99
DMD09	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	17.54%
DMD10	Getting Information from Drug Plan	82%
DMD11	Call Center – Pharmacy Hold Time	0:09
DMD12	Plan Submitted Higher Prices for Display on MPF	97
DMD13	Transition monitoring - failure rate for drugs within classes of clinical concern	2.0%
DMD14	Transition monitoring - failure rate for all other drugs	3.2%
DMD15	Reminders to Fill prescriptions	38%
DMD16	Reminders to Take Medications	22%

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	2.97
DME03	Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Information (MA-PD, MA-only)	17%
DME04	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-only)	26%
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)	11%
DME07	Disenrollment Reasons - Problems Getting Information about Prescription Drugs (MA-PD, PDP)	12%