Medicare Part C and Part D Measure
Instructions for Findings Data Collection Form for Data Validation Contractors

August 26, 2010

DRAFT

Prepared by:
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice

TABLE OF CONTENTS

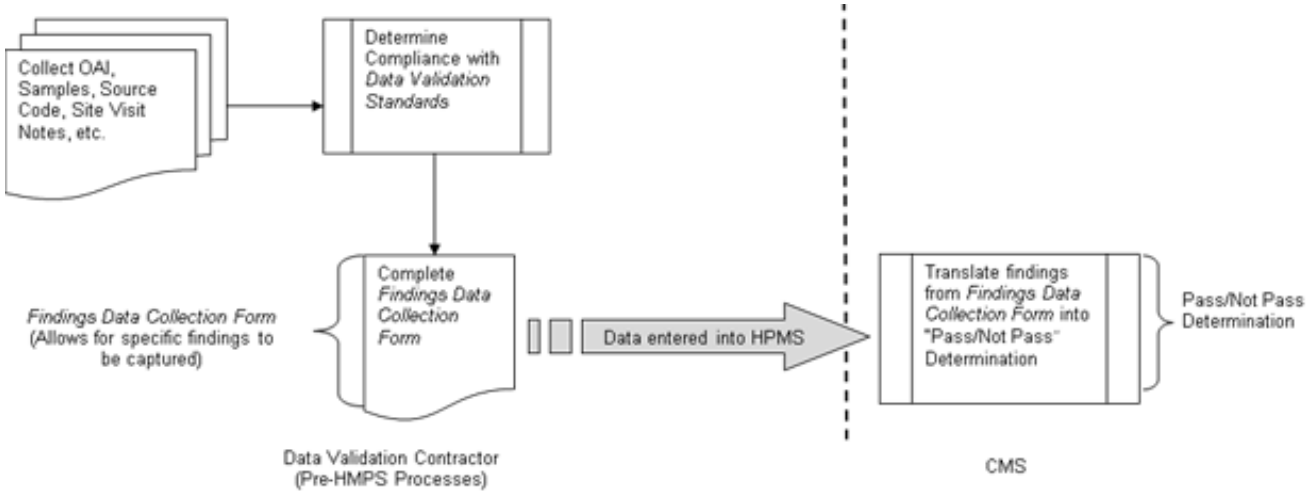
1.0 INTRODUCTION

1.1 Overview of Findings Data Collection Form and Evaluation Process

The Findings Data Collection Form is a tool for reviewers to record their validation findings for each contract included in the scope of the review. The form mirrors the content of the Data Validation Standards document, but allows the reviewer to record notes, data sources referenced, and findings for the different standards and criteria specified for a given measure.

Using the Findings Data Collection Form, the reviewers will conduct the review and record measure-level, and in some cases data element-level, findings for each measure's standards. Once the findings have been finalized, the reviewer will share the findings with the organization and then submit the completed Findings Data Collection Form to CMS, who will evaluate the measure- or data element-level findings for each measure's standards to derive an overall "Pass" or "Not Pass" determination. An overview of this process is depicted in Figure 1 below.

Figure 1: Overview of Findings Data Collection Process and Pass/Not Pass Determination



1.2 Recording Findings at the Measure Level or the Measure's Data Element Level

While most data validation standards and criteria are assessed at the measure-level (e.g., Standard 1, a review of source documents indicating that all source documents accurately capture required data fields and are properly documented), some are assessed at the data element-level (e.g., Standard 2e examines each data element for compliance with measure-specific criteria). Depending on the level of assessment for each standard and criteria, reviewers will record results in the Findings Data Collection Form at the measure-level or at the measure's data element-level.

The standards and criteria that involve data element-level reviews are Standards 2.e and 3.a, specifically, as they assess the accuracy of reported results that may vary across data elements reported by the organization. When assessing data at the element-level for Standards 2.e and 3.a, reviewers should always refer to the measure-specific criteria for these standards in their evaluation. Standard 3.b applies only to the data measures or data elements that are reported to CMS via data file upload (i.e., not manual data entry into HPMS). For example, Standard 3.b is applicable to data elements B1 and B2 from the Part D "Retail, Home Infusion, and Long-Term Care Pharmacy Access" measure because these elements are reported as a data file upload; Standard 3.b is not applicable to any of the data elements for the Part C and Part D "Plan Oversight of Agents" measure because this measure requires manual, direct data entry into HPMS.

The remaining data validation standards and criteria (i.e., Standards 1, 4, 5, 6, 7) will involve measure-level reviews only, as they assess organization processes that are not likely to vary at the data element-level. For example, Standard 4 assesses policies and procedures for periodic data system updates; an organization will most likely have these policies and procedures in place for an entire measure, as opposed to having them in place for only certain data elements. As a result, recording findings at the measure-level for Standard 4 is sufficient.

1.3 Structure of Findings Data Collection Form

Each Part C and Part D measure's Findings Data Collection Form is included in a corresponding file. The content in each measure's form mirrors the Data Validation Standards, and includes space for the reviewer to record data sources, review results, and findings for a given standard. Reviewers should only complete areas displayed in white for data sources, review results and findings. Areas displayed in grey are not applicable and should not be completed. In the "Data Sources and Review Results:" column, the reviewer will enter the review results and/or data sources used for each standard or sub-standard. Next to this column, in the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N". The reviewers can also quickly reference the appropriate data element details provided in Section 4.0.

2.0 APPENDIX: DATA ELEMENTS FOR PART C AND PART D MEASURES

2.1 Part C Measure Data Elements

2.1.1 Benefit Utilization

Table 1: Data Elements for Benefit Utilization

Element Number	Data Elements for Benefit Utilization Measure
1.1	CMS issued contract number
1.2	Plan Benefit Package (PBP) ID
1.3	Number of member months for enrollees who had access to the Inpatient Facility service under their plan benefit package during the reporting period
1.4	Unique number of plan enrollees who used the Inpatient Facility service
1.5	Appropriate code to identify how you capture utilization data for Inpatient Facility services
1.6	Total number of Inpatient Facility services used by plan enrollees during the period
1.7	Reimbursement amount from the plan to providers for Inpatient Facility services used during the period
1.8	Total cost sharing paid by members directly to providers for Inpatient Facility services used during the period
1.9	Total payments made to providers for Inpatient Facility services covered under original Medicare
1.10	Cost sharing that would be required for covered Inpatient Facility services using original Medicare requirements
1.11	Number of member months for enrollees who had access to the Skilled Nursing Facility service under their plan benefit package during the reporting period
1.12	Unique number of plan enrollees who used the Skilled Nursing Facility service
1.13	Appropriate code to identify how you capture utilization data for Skilled Nursing Facility services
1.14	Total number of Skilled Nursing Facility services used by plan enrollees during the period
1.15	Reimbursement amount from the plan to providers for Skilled Nursing Facility services used during the period
1.16	Total cost sharing paid by members directly to providers for Skilled Nursing Facility services used during the period
1.17	Total payments made to providers for Skilled Nursing Facility services covered under original Medicare
1.18	Cost sharing that would be required for covered Skilled Nursing Facility services using original Medicare requirements
1.19	Number of member months for enrollees who had access to the Home Health service under their plan benefit package during the reporting period
1.20	Unique number of plan enrollees who used the Home Health service
1.21	Code to identify how you capture utilization data for Home Health services
1.22	Total number of Home Health services used by plan enrollees during the period
1.23	Reimbursement amount from the plan to providers for Home Health services used during the period
1.24	Total cost sharing paid by members directly to providers for Home Health services used during the period
1.25	Total payments made to providers for Home Health services covered under original Medicare
1.26	Cost sharing that would be required for covered Home Health services using original Medicare requirements
1.27	Number of member months for enrollees who had access to the Ambulance service under their plan benefit package during the reporting period

Element Number	Data Elements for Benefit Utilization Measure
1.28	Unique number of plan enrollees who used the Ambulance service
1.29	Code to identify how you capture utilization data for Ambulance services
1.30	Total number of Ambulance services used by plan enrollees during the period
1.31	Reimbursement amount from the plan to providers for Ambulance services used during the period
1.32	Total cost sharing paid by members directly to providers for Ambulance services used during the period
1.33	Total payments made to providers for Ambulance services covered under original Medicare
1.34	Cost sharing that would be required for covered Ambulance services using original Medicare requirements
1.35	Number of member months for enrollees who had access to the DME/Prosthetics/Supplies service under their plan benefit package during the reporting period
1.36	Unique number of plan enrollees who used the DME/Prosthetics/Supplies service
1.37	Appropriate code to identify how you capture utilization data for DME/Prosthetics/Supplies services
1.38	Total number of DME/Prosthetics/Supplies services used by plan enrollees during the period
1.39	Reimbursement amount from the plan to providers for DME/Prosthetics/Supplies services used during the period
1.40	Total cost sharing paid by members directly to providers for DME/Prosthetics/Supplies services used during the period
1.41	Total payments made to providers for DME/Prosthetics/Supplies services covered under original Medicare
1.42	Cost sharing that would be required for covered DME/Prosthetics/Supplies services using original Medicare requirements
1.43	Number of member months for enrollees who had access to the OP Facility – Emergency service under their plan benefit package during the reporting period
1.44	Unique number of plan enrollees who used the OP Facility – Emergency service
1.45	Appropriate code to identify how you capture utilization data for OP Facility – Emergency services
1.46	Total number of OP Facility – Emergency services used by plan enrollees during the period
1.47	Reimbursement amount from the plan to providers for OP Facility – Emergency services used during the period
1.48	Total cost sharing paid by members directly to providers for OP Facility – Emergency services used during the period
1.49	Total payments made to providers for OP Facility – Emergency services covered under original Medicare
1.50	Cost sharing that would be required for covered OP Facility – Emergency services using original Medicare requirements
1.51	Number of member months for enrollees who had access to the OP Facility – Surgery service under their plan benefit package during the
1.52	Unique number of plan enrollees who used the OP Facility – Surgery service
1.53	Appropriate code to identify how you capture utilization data for OP Facility – Surgery services
1.54	Total number of OP Facility – Surgery services used by plan enrollees during the period
1.55	Reimbursement amount from the plan to providers for OP Facility – Surgery services used during the period
1.56	Total cost sharing paid by members directly to providers for OP Facility – Surgery services used during the period
1.57	Total payments made to providers for OP Facility – Surgery services covered under original Medicare
1.58	Cost sharing that would be required for covered OP Facility – Surgery services using original Medicare requirements
1.59	Number of member months for enrollees who had access to the OP Facility – Other service under their plan benefit package during the reporting period
1.60	Unique number of plan enrollees who used the OP Facility – Other service
1.61	Code to identify how you capture utilization data for OP Facility – Other services
1.62	Total number of OP Facility – Other services used by plan enrollees during the period

Element Number	Data Elements for Benefit Utilization Measure
1.63	Reimbursement amount from the plan to providers for OP Facility – Other services used during the period
1.64	Total cost sharing paid by members directly to providers for OP Facility – Other services used during the period
1.65	Total payments made to providers for OP Facility – Other services covered under original Medicare
1.66	Cost sharing that would be required for covered OP Facility – Other services using original Medicare requirements
1.67	Number of member months for enrollees who had access to the Professional service under their plan benefit package during the reporting period
1.68	Unique number of plan enrollees who used the Professional service
1.69	Code to identify how you capture utilization data for Professional services
1.70	Total number of Professional services used by plan enrollees during the period
1.71	Reimbursement amount from the plan to providers for Professional services used during the period
1.72	Total cost sharing paid by members directly to providers for Professional services used during the period
1.73	Total payments made to providers for Professional services covered under original Medicare
1.74	Cost sharing that would be required for covered Professional services using original Medicare requirements
1.75	Number of member months for enrollees who had access to the Part B Rx service under their plan benefit package during the reporting period
1.76	Unique number of plan enrollees who used the Part B Rx service
1.77	Code to identify how you capture utilization data for Part B Rx services
1.78	Total number of Part B Rx services used by plan enrollees during the period
1.79	Reimbursement amount from the plan to providers for Part B Rx services used during the period
1.80	Total cost sharing paid by members directly to providers for Part B Rx services used during the period
1.81	Total payments made to providers for Part B Rx services covered under original Medicare
1.82	Cost sharing that would be required for covered Part B Rx services using original Medicare requirements
1.83	Number of member months for enrollees who had access to the Other Medicare Part B service under their plan benefit package during the reporting period
1.84	Unique number of plan enrollees who used the Other Medicare Part B service
1.85	Code to identify how you capture utilization data for Other Medicare Part B services
1.86	Total number of Other Medicare Part B services used by plan enrollees during the period
1.87	Reimbursement amount from the plan to providers for Other Medicare Part B services used during the period
1.88	Total cost sharing paid by members directly to providers for Other Medicare Part B services used during the period
1.89	Total payments made to providers for Other Medicare Part B services covered under original Medicare
1.90	Cost sharing that would be required for covered Other Medicare Part B services using original Medicare requirements
1.91	Number of member months for enrollees who had access to the Transportation service under their plan benefit package during the reporting period
1.92	Unique number of plan enrollees who used the Transportation service
1.93	Code to identify how you capture utilization data for Transportation services
1.94	Total number of Transportation services used by plan enrollees during the period
1.95	Reimbursement amount from the plan to providers for Transportation services used during the period
1.96	Total cost sharing paid by members directly to providers for Transportation services used during the period
1.97	Number of member months for enrollees who had access to the Dental service under their plan benefit package during the reporting period

Element Number	Data Elements for Benefit Utilization Measure
1.98	Unique number of plan enrollees who used the Dental service
1.99	Code to identify how you capture utilization data for Dental services
1.100	Total number of Dental services used by plan enrollees during the period
1.101	Reimbursement amount from the plan to providers for Dental services used during the period
1.102	Total cost sharing paid by members directly to providers for Dental services used during the period
1.103	Number of member months for enrollees who had access to the Vision service under their plan benefit package during the reporting period
1.104	Unique number of plan enrollees who used the Vision service
1.105	Code to identify how you capture utilization data for Vision services
1.106	Total number of Vision services used by plan enrollees during the period
1.107	Reimbursement amount from the plan to providers for Vision services used during the period
1.108	Total cost sharing paid by members directly to providers for Vision services used during the period
1.109	Number of member months for enrollees who had access to the Hearing service under their plan benefit package
1.110	Unique number of plan enrollees who used the Hearing service
1.111	Code to identify how you capture utilization data for Hearing services
1.112	Total number of Hearing services used by plan enrollees during the period
1.113	Reimbursement amount from the plan to providers for Hearing services used during the period
1.114	Total cost sharing paid by members directly to providers for Hearing services used during the period
1.115	Number of member months for enrollees who had access to the Health & Education service under their plan benefit package during the reporting period
1.116	Unique number of plan enrollees who used the Health & Education service
1.117	Code to identify how you capture utilization data for Health & Education services
1.118	Total number of Health & Education services used by plan enrollees during the period
1.119	Reimbursement amount from the plan to providers for Health & Education services used during the period
1.120	Total cost sharing paid by members directly to providers for Health & Education services used during the period
1.121	Number of member months for enrollees who had access to the Other (Non-Covered) service under their plan benefit package during the reporting period
1.122	Unique number of plan enrollees who used the Other (Non-Covered) service
1.123	Code to identify how you capture utilization data for Other (Non-Covered) services
1.124	Total number of Other (Non-Covered) services used by plan enrollees during the period
1.125	Reimbursement amount from the plan to providers for Other (Non-Covered) services used during the period
1.126	Total cost sharing paid by members directly to providers for Other (Non-Covered) services used during the period
1.127	Number of member months for enrollees who had access to the Medical services under their plan benefit package during the reporting period
1.128	Unique number of plan enrollees who used the Medical services
1.129	Reimbursement amount from the plan to providers for Medical services used during the period
1.130	Total cost sharing paid by members directly to providers for Medical services used during the period
1.131	Total payments made to providers for Medical services covered under original Medicare
1.132	Cost sharing that would be required for covered Medical services using original Medicare requirements

Element Number	Data Elements for Benefit Utilization Measure
1.133	Total number of enrollees under the plan during the reporting period
1.134	Number of member months during the reporting period
1.135	Dollar figure representing premiums collected over the course of the entire reporting period for this plan
1.136	Dollar figure representing CMS revenue collected under the plan over the course of the entire reporting period inclusive of rebates applied to A/B services
1.137	Dollar figure representing CMS rebates for A and B Services under the plan over the course of the entire reporting period
1.138	Dollar figure representing reserves for outstanding claims from the reporting period

2.1.2 Procedure Frequency

Table 2: Procedure Frequency

Element Number	Data Elements for Procedure Frequency Measure
2.1*	Number of Enrollees receiving Cardiac Catheterization
2.2	Number of Enrollees receiving Open Coronary Angioplasty
2.3	Number of Enrollees receiving PTCA or Coronary Atherectomy with CABG
2.4	Number of Enrollees receiving PTCA or Coronary Atherectomy with insertion of drug-eluting coronary artery stent(s)
2.5	Number of Enrollees receiving PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent(s)
2.6	Number of Enrollees receiving PTCA or Coronary Atherectomy without insertion of coronary artery stent
2.7*	Number of Enrollees receiving Total Hip Replacement
2.8*	Number of Enrollees receiving Total Knee Replacement
2.9	Number of Enrollees receiving Bone Marrow Transplant
2.10	Number of Enrollees receiving Heart Transplant
2.11	Number of Enrollees receiving Heart/Lung Transplant
2.12	Number of Enrollees receiving Kidney Transplant
2.13	Number of Enrollees receiving Liver Transplant
2.14	Number of Enrollees receiving Lung Transplant
2.15	Number of Enrollees receiving Pancreas Transplant
2.16	Number of Enrollees receiving Pancreas/Kidney Transplant
2.17*	Number of Enrollees receiving CABG
2.18	Number of Enrollees receiving Gastric Bypass
2.19	Number of Enrollees receiving Excision or Destruction of Lesion or Tissue of Lung (with cancer diagnosis as specified)
2.20*	Number of Enrollees receiving Excision of Large Intestine (with cancer diagnosis as specified)
2.21*	Number of Enrollees receiving Mastectomy (with cancer diagnosis as specified)
2.22*	Number of Enrollees receiving Lumpectomy (with cancer diagnosis as specified)

Element Number	Data Elements for Procedure Frequency Measure
2.23*	Number of Enrollees receiving Prostatectomy (with cancer diagnosis as specified)

* For organizations that report these data elements in HEDIS, then it is appropriate for the contract to report "0" for these data elements, and data validation for these elements is not required.

2.1.3 Serious Reportable Adverse Events (SRAEs)

Table 3: Serious Reportable Adverse Events (SRAEs)

Element Number	Data Elements for Serious Reportable Adverse Events (SRAEs) Measure (includes SRAEs and HACs)
3.1	Number of total surgeries
3.2	Number of surgeries on wrong body part
3.3	Number of surgeries on wrong patient
3.4	Number of wrong surgical procedures on a patient
3.5	Number of surgeries with post-operative death in normal health patient
3.6	Number of surgeries with foreign object left in patient after surgery
3.7	Number of Air Embolism events
3.8	Number of Blood Incompatibility events
3.9	Number of Stage III & IV Pressure Ulcers
3.10	Number of fractures
3.11	Number of dislocations
3.12	Number of intracranial injuries
3.13	Number of crushing injuries
3.14	Number of burns
3.15	Number of Vascular Catheter-Associated Infections
3.16	Number of Catheter-Associated UTIs
3.17	Number of Manifestations of Poor Glycemic Control
3.18	Number of SSI (Mediastinitis) after CABG
3.19	Number of SSI after certain Orthopedic Procedures
3.20	Number of SSI following Bariatric Surgery for Obesity
3.21	Number of DVT and pulmonary embolism following certain orthopedic procedures

2.1.4 Provider Network Adequacy

Table 4: Provider Network Adequacy

Element Number	Data Elements for Provider Network Adequacy Measure
4.1 – 4.6	Number of PCPs in network on first day of reporting period by PCP type - General Medicine (4.1), Family Medicine (4.2), Internal Medicine (4.3), Obstetricians (4.4), Pediatricians (4.5), State Licensed Nurse Practitioners (4.6)
4.7 – 4.12	Number of PCPs in network continuously through reporting period by PCP type - General Medicine (4.7), Family Medicine (4.8), Internal Medicine (4.9), Obstetricians (4.10), Pediatricians (4.11), State Licensed Nurse Practitioners (4.12)
4.13 – 4.18	Number of PCPs added to network during reporting period by PCP type - General Medicine (4.13), Family Medicine (4.14), Internal Medicine (4.15), Obstetricians (4.16), Pediatricians (4.17), State Licensed Nurse Practitioners (4.18)
4.19 – 4.24	Number of PCPs accepting new patients at start of reporting period by PCP type - General Medicine (4.19), Family Medicine (4.20), Internal Medicine (4.21), Obstetricians (4.22), Pediatricians (4.23), State Licensed Nurse Practitioners (4.24)
4.25 – 4.30	Number of PCPs accepting new patients at end of reporting period by PCP type - General Medicine (4.25), Family Medicine (4.26), Internal Medicine (4.27), Obstetricians (4.28), Pediatricians (4.29), State Licensed Nurse Practitioners (4.30)
4.31 – 4.36	Number of PCPs in network on last day of reporting period by PCP type - General Medicine (4.31), Family Medicine (4.32), Internal Medicine (4.33), Obstetricians (4.34), Pediatricians (4.35), State Licensed Nurse Practitioners (4.36)
4.37 – 4.46	Number of specialists/facilities in network on first day of reporting period by specialist/facility type - Hospitals (4.37), Home Health Agencies (4.38), Cardiologist (4.39), Oncologist (4.40), Pulmonologist (4.41), Endocrinologist (4.42), Skilled Nursing Facilities (4.43), Rheumatologist (4.44), Ophthalmologist (4.45), Urologist (4.46)
4.47 – 4.56	Number of specialists in network continuously through reporting period by specialist/facility type - Hospitals (4.47), Home Health Agencies (4.48), Cardiologist (4.49), Oncologist (4.50), Pulmonologist (4.51), Endocrinologist (4.52), Skilled Nursing Facilities (4.53), Rheumatologist (4.54), Ophthalmologist (4.55), Urologist (4.56)
4.57 – 4.66	Number of specialists added during reporting period by specialist/facility type - Hospitals (4.57), Home Health Agencies (4.58), Cardiologist (4.59), Oncologist (4.60), Pulmonologist (4.61), Endocrinologist (4.62), Skilled Nursing Facilities (4.63), Rheumatologist (4.64), Ophthalmologist (4.65), Urologist (4.66)
4.67 – 4.76	Number of specialists accepting new patients at start of reporting period by specialist/facility type - Hospitals (4.67), Home Health Agencies (4.68), Cardiologist (4.69), Oncologist (4.70), Pulmonologist (4.71), Endocrinologist (4.72), Skilled Nursing Facilities (4.73), Rheumatologist (4.74), Ophthalmologist (4.75), Urologist (4.76)
4.77 – 4.86	Number of specialists accepting new patients at end of reporting period by specialist/facility type - Hospitals (4.77), Home Health Agencies (4.78), Cardiologist (4.79), Oncologist (4.80), Pulmonologist (4.81), Endocrinologist (4.82), Skilled Nursing Facilities (4.83), Rheumatologist (4.84), Ophthalmologist (4.85), Urologist (4.86)
4.87 – 4.96	Number of specialists in network on last day of reporting period by specialist/facility type - Hospitals (4.87), Home Health Agencies (4.88), Cardiologist (4.89), Oncologist (4.90), Pulmonologist (4.91), Endocrinologist (4.92), Skilled Nursing Facilities (4.93), Rheumatologist (4.94), Ophthalmologist (4.95), Urologist (4.96)

2.1.5 Grievances (Part C)

Table 5: Grievances

Element Number	Data Elements for Grievances (Part C) Measure
5.1	Number of Grievances for Fraud and Abuse
5.2	Number of Grievances for Enrollment/Disenrollment Access/Benefit package
5.3	Number of Grievances for Marketing
5.4	Number of Grievances for Confidentiality/Privacy
5.5	Number of Grievances for Quality of Care
5.6	Number of Expedited Grievances
5.7	Number of Grievances for Other

2.1.6 Organization Determinations/Reconsiderations

Table 6: Organization Determinations/Reconsiderations

Element Number	Data Elements for Organization Determinations/ Reconsiderations Measure
6.1	Number of Organization Determinations – Fully Favorable
6.2	Number of Organization Determinations – Partially Favorable
6.3	Number of Organization Determinations – Adverse
6.4	Number of Reconsiderations – Fully Favorable
6.5	Number of Reconsiderations – Partially Favorable
6.6	Number of Reconsiderations – Adverse

2.1.7 Employer Group Plan Sponsors (Part C)

Table 7: Employer Group Plan Sponsors (Part C)

Element Number	Data Elements for Employer Group Plan Sponsors (Part C) Measure
7.1	Employer Legal Name
7.2	Employer DBA Name
7.3	Employer Federal Tax ID
7.4	Employer Address
7.5	Type of Group Sponsor (employer, union, trustees of a fund)

Element Number	Data Elements for Employer Group Plan Sponsors (Part C) Measure
7.6	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
7.7	Type of Contract (insured, ASO, other)
7.8	Employer Plan Year Start Date
7.9	Current Enrollment

2.1.8 Plan Oversight of Agents (Part C)

Table 8: Plan Oversight of Agents

Element Number	Data Elements for Plan Oversight of Agents (Part C) Measure
12.1	Total number of agents
12.2	Number of agents investigated based on complaints
12.3	Number of agents receiving disciplinary actions based on complaints
12.4	Number of complaints reported to State by MAO or Cost contractor
12.5	Number of agents whose selling privileges were revoked by the plan based on conduct or discipline
12.6	Number of agent-assisted enrollments

2.1.9 Special Needs Plans (SNPs) Care Management

Table 9: Special Needs Plans (SNPs) Care Management

Element Number	Data Elements for Special Needs Plans (SNPs) Care Management Measure
13.1	Number of new enrollees
13.2	Number of enrollees eligible for an annual reassessment
13.3	Number of initial assessments performed on new enrollees during reporting period
13.4	Number of annual reassessments performed on enrollees eligible for a reassessment

2.2 Part D Measure Data Elements

2.2.1 Retail, Home Infusion, and Long Term Care Pharmacy Access

Table 10: Retail, Home Infusion, and Long Term Care Pharmacy Access

Element Number	Data Elements for Retail, Home Infusion, and Long Term Care Pharmacy Access Measure
A1	Percentage of Medicare beneficiaries living within 2 miles of a retail network pharmacy in urban areas of a Contract's service area (by State for PDPs and regional PPOs, and by service area for local MA-PD plans) as of the last day of the reporting period specified above
A2	Percentage of Medicare beneficiaries living within 5 miles of a retail network pharmacy in suburban areas (by State for PDPs and regional PPOs, and by service area for local MA-PD plans) as of the last day of the reporting period specified above
A3	Percentage of Medicare beneficiaries living within 15 miles of a retail network pharmacy in rural areas (by State for PDPs and regional PPOs, and by service area for local MA-PD plans) as of the last day of the reporting period specified above
A4	The number of contracted retail pharmacies in a Contract's service area (by State for PDPs and regional PPOs, and by service area for local MA-PD plans) as of the last day of the reporting period specified above
B1	A list of contracted HI network pharmacies into HPMS as of the last day of the reporting period specified above
B2	A list of contracted LTC network pharmacies into HPMS as of the last day of the reporting period specified above
C1	Number of prescriptions provided by all pharmacies owned and operated by the plan
C2	Number of prescriptions provided at all pharmacies contracted by the plan
D1	Number of prescriptions provided by retail pharmacies owned and operated by the plan
D2	Number of prescriptions provided at all retail pharmacies contracted by the plan

2.2.2 Medication Therapy Management Programs

Table 11: Medication Therapy Management Programs

Element Number	Data Elements for Medication Therapy Management Programs Measure
A	The total number of beneficiaries identified to be eligible for, and automatically enrolled in, the MTMP during the specified time period above
B	The total number of beneficiaries who opted-out of enrollment in the MTMP during the time period specified above. This should be a longitudinally cumulative total, and be a subset of the number of beneficiaries identified to be eligible for, and were automatically enrolled in, the MTMP in the specified time period.
C	The number of beneficiaries who opted-out of enrollment in the MTMP due to death at any time during the specified time period above. This should be a subset of the total number of beneficiaries who opted-out of enrollment in the MTMP in the specified time period.
D	The number of beneficiaries who opted-out of enrollment in the MTMP due to disenrollment from the Plan at any time during the specified time period above. This should be a subset of the total number of beneficiaries who opted-out of enrollment in the MTMP in the specified time period.
E	The number of beneficiaries who opted-out of enrollment in the MTMP at their request at any time during the specified time period above. This should be a subset of the total number of beneficiaries who opted-out of enrollment in the MTMP in the specified time period.

Element Number	Data Elements for Medication Therapy Management Programs Measure
F	The number of beneficiaries who opted-out of enrollment in the MTMP for a reason not specified in data elements C-E during the specified time period above. This should be a subset of the total number of beneficiaries who opted-out of enrollment in the MTMP in the specified time period.
G	For beneficiaries enrolled in the MTMP at any time during the specified time period above, provide the prescription cost of all covered* Part D medications on a per MTMP beneficiary per month basis.
H	For beneficiaries enrolled in the MTMP at any time during the specified time period above, provide the number of covered* Part D 30-day equivalent prescriptions on a per MTMP beneficiary per month basis. This should be a numeric field.
I	For beneficiaries enrolled in the MTMP at any time during the specified time period above, the number of beneficiaries offered a comprehensive medication review
J	For beneficiaries enrolled in the MTMP at any time during the specified time period above, the number of beneficiaries who received a comprehensive medication review
II (a)	Contract Number
II (b)	HICN or RRB Number
II (c)	Beneficiary first name
II (d)	Beneficiary middle initial
II (e)	Beneficiary last name
II (f)	Beneficiary date of birth
II (g)	LTC Enrollment
II (h)	Date of MTMP enrollment
II (i)	Date of MTMP opt-out, if applicable
II (j)	Reason participant opted-out of MTMP (Death; Disenrollment from Plan; Request by beneficiary; or Other). Required if Date of MTMP opt-out is applicable.
II (k)	Received annual comprehensive medication review
II (l)	Date of annual comprehensive medication review, if applicable
II (m)	Number of targeted medication reviews
II (n)	Number of prescriber interventions
II (o)	Number of changes to drug therapy made as a result of MTM interventions. Changes include dosage changes, therapeutic or generic substitutions, and discontinuation of therapy.

2.2.3 Grievances (Part D)

Table 12: Grievances

Element Number	Data Elements for Grievances (Part D) Measure
A	Number of LIS beneficiaries who filed grievances
B	Number of non-LIS beneficiaries who filed grievances
C1	Number of grievances filed by LIS beneficiaries
C2	Number of grievances filed by LIS beneficiaries which the Sponsor provided timely notification of its decision
C3	Number of grievances filed by non-LIS beneficiaries

Element Number	Data Elements for Grievances (Part D) Measure
C4	Number of grievances filed by non-LIS beneficiaries which the Sponsor provided timely notification of its decision
D1	Number of Enrollment, Plan Benefits, or Pharmacy Access Grievances
D2	Number of Enrollment, Plan Benefits, or Pharmacy Access Grievances which the Sponsor provided timely notification of its decision
D3	Number of Customer Service Grievances
D4	Number of Customer Service Grievances which the Sponsor provided timely notification of its decision
D5	Number of Coverage determinations/Exceptions and Appeals process (e.g. untimely decisions) Grievances
D6	Number of Coverage determinations/Exceptions and Appeals process (e.g. untimely decisions) Grievances which the Sponsor provided timely notification of its decision
D7	Number of Other Grievances
D8	Number of Other Grievances which the Sponsor provided timely notification of its decision

2.2.4 Coverage Determinations and Exceptions

Table 13: Coverage Determinations and Exceptions

Element Number	Data Elements for Coverage Determinations and Exceptions Measure
A	The total number of pharmacy transactions in the time period above
B	Of the total reported in A, the number of pharmacy transactions rejected due to formulary restrictions, including non-formulary status, prior authorization requirements, step therapy, and quantity limits (QL). Rejections due to early refills should be excluded.
C	The total number of prior authorizations requested in the time period above
D	Of the total reported in C, the number approved
E	The total number of exceptions requested to the Plan's utilization management tools, e.g. prior authorization, quantity limits, or step therapy requirements, in the time period above
F	Of the total reported in E, the number approved
G	The number of tier exceptions requested in the time period above
H	Of the total reported in G, the number approved
I	The number of exceptions requested for non-formulary medications in the time period above
J	Of the total reported in I, the number approved

2.2.5 Appeals

Table 14: Appeals

Element Number	Data Elements for Appeals Measure
A	The total number of redeterminations made in the time period specified above
B	Of the total reported in A, the number resulting in full reversal of original coverage determination
C	Of the total reported in A, the number resulting in partial reversal of original coverage determination

2.2.6 Long-Term Care Utilization

Table 15: Long-Term Care Utilization

Element Number	Data Elements for Long-Term Care Utilization Measure
A	The total number of network LTC pharmacies in the service area (PDPs and regional PPOs will report for each state, MA-PDs will report for the service area)
B	The total number of network retail pharmacies in the service area (PDPs and regional PPOs will report for each state, MA-PDs will report for the service area)
C	The total number of beneficiaries in LTC facilities for whom Part D drugs have been provided under the Contract
D	For each network LTC pharmacy in the service area: a. LTC pharmacy name b. LTC pharmacy NPI c. Contract entity name of LTC pharmacy d. Chain code of LTC pharmacy e. Number of 31-day equivalent formulary prescriptions dispensed f. Number of 31-day equivalent non-formulary prescriptions dispensed g. Cost of formulary prescriptions h. Cost of non-formulary prescriptions
E	In aggregate, for all retail pharmacies in the service area: a. Number of 30-day equivalent formulary prescriptions dispensed b. Number of 30-day equivalent non-formulary prescriptions dispensed c. Cost of formulary prescriptions d. Cost of non-formulary prescriptions

2.2.7 Employer/Union-Sponsored Group Health Plan Sponsors (Part D)

Table 16: Employer/Union-Sponsored Group Health Plan Sponsors

Element Number	Data Elements for Employer/Union-Sponsored Group Health Plan Sponsors (Part D) Measure
A	Employer Legal Name
B	Employer DBA Name
C	Employer Federal Tax ID
D	Employer Address
E	Type of Group Sponsor (employer, union, trustees of a fund)
F	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
G	Type of Contract (insured, ASO, other)
H	Employer Plan Year Start Date
I	Current/Anticipated Enrollment

2.2.8 Plan Oversight of Agents (Part D)

Table 17: Plan Oversight of Agents

Element Number	Data Elements for Plan Oversight of Agents (Part D) Measure
A	Total number of agents
B	Number of agents investigated based on complaints
C	Number of agents receiving disciplinary actions from the Sponsor based on complaints
D	Number of complaints reported to State by MAO or Cost contractor
E	Number of agents whose selling privileges were revoked by the plan based on conduct or discipline
F	Number of agent-assisted enrollments