UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC. et al., Plaintiffs, **ROBERT F. KENNEDY, JR.**, in his official capacity as Secretary of Health and Human Services, U.S. Department of Health and Human Services, and **MEHMET OZ**, in his official capacity as Administrator, Centers for Medicare and Medicaid Services, Defendants.	Case No. 1:25-cv-00693 (TNM)

JOINT APPENDIX OF ADMINISTRATIVE RECORD CITATIONS

In accordance with U.S. District Court for the District of Columbia Local Rule 7(n), the parties file this Joint Appendix containing copies of those portions of the Administrative Record cited in their respective briefs.

Date: June 23, 2025

Respectfully submitted,

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1	Excerpt of CTR. FOR MEDICARE AND MEDICAID SERVICES, MEDICARE 2025 PART C & D STAR RATINGS TECHNICAL NOTES ("2025 Technical Notes").	A.R. 09
2	Excerpt of 2025 Technical Notes.	A.R. 13
3	Excerpt of 2025 Technical Notes.	A.R. 18
4	Excerpt of 2025 Technical Notes.	A.R. 20–115
5	Excerpt of 2025 Technical Notes.	A.R. 125
6	Excerpt of 2025 Technical Notes.	A.R. 134–35
7	Excerpt of 2025 Technical Notes.	A.R. 161–62
8	Excerpt of CTRS. FOR MEDICARE AND MEDICAID SERVICES, MA & PDP QUALITY ASSURANCE PROTOCOLS & TECHNICAL SPECIFICATIONS ("CAHPS Technical Notes")	A.R. 265
9	Excerpt of CAHPS Technical Notes	A.R. 328
10	Excerpt of CAHPS Technical Notes	A.R. 332–33
11	Excerpt of CAHPS Technical Notes	A.R. 338
12	Excerpt of CAHPS Technical Notes	A.R. 809
13	Excerpt of CAHPS Technical Notes	A.R. 824
14	2025 Star Ratings Calculations for H2261, September 6, 2025	A.R. 1135–36
15	2025 Star Ratings Calculations for H2230, September 6, 2025	A.R. 1138–39
16	2025 Star Ratings Calculations for H2261, December 9, 2024	A.R. 1143–44
17	2025 Star Ratings Calculations for H2230, December 9, 2024	A.R. 1146–47

18	H2230 2024 Case-mix CAHPS Spreadsheet	A.R. 1178–80
19	H2230 2024 Means Tests CAHPS Spreadsheet	A.R. 1181–85
20	H2261 2024 Case-mix CAHPS Spreadsheet	A.R. 1186–88
21	H2261 2024 Means Tests CAHPS Spreadsheet	A.R. 1189–93
22	Informal Hearing Officer's Decision	A.R. 1194–96
23	De-identified Contract Level Data[1]	A.R. 1197

1 Defendants intend to file the native document including the de-identified contract level data cited in the parties' briefs directly with the Court.

CERTIFICATE OF SERVICE

I hereby certify that on June 23, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Lesley Reynolds
Lesley C. Reynolds

Introduction

CMS created the Part C & D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period. We refer to them as the '2025 Medicare Part C & D Star Ratings' because they are posted prior to the 2025 open enrollment period.

This document describes the methodology for creating the Part C & D Star Ratings displayed on the Medicare Plan Finder (MPF) at http://www.medicare.gov/ and posted on the CMS website at http://go.cms.gov/partcanddstarratings. A Glossary of Terms used in this document can be found in Attachment R.

The Star Ratings data are also displayed in the Health Plan Management System (HPMS). In HPMS, the data can be found by selecting: "Quality and Performance," then "Performance Metrics," then "Reports," then "Star Ratings and Display Measures," then "Star Ratings" for the report type, and "2025" for the report period. See Attachment S: Health Plan Management System Module Reference for descriptions of the HPMS pages.

The Star Ratings Program is consistent with the "Meaningful Measures" framework which focuses on measures related to person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. With Meaningful Measures 2.0, CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives of care. The Star Ratings include measures applying to the following five broad categories:

- Outcomes: Outcome measures reflect improvements in a beneficiary's health and are central to assessing quality of care.
- Intermediate outcomes: Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary's health status. Diabetes Care – Blood Sugar Controlled is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with diabetes.
- Patient experience: Patient experience measures reflect beneficiaries' perspectives of the care they received.
- Access: Access measures reflect processes and issues that could create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
- Process: Process measures capture the health care services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status.

Note on References to the 2024 Star Ratings

Throughout these technical notes, previous year and 2024 Star Ratings refer to the recalculated 2024 Star Ratings and cut points which were recalculated using the published 2023 Star Ratings cut points to determine the guardrails for 2024 Star Ratings (i.e., Tukey outliers were not removed from the 2023 Star Ratings measure scores when determining cut points).

Differences between the 2024 Star Ratings and 2025 Star Ratings

There have been several changes between the 2024 Star Ratings and the 2025 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details

Sources of the Star Ratings Measure Data

The 2025 Star Ratings include a maximum of 9 domains comprised of a maximum of 42 measures.

- MA-Only contracts are measured on 5 domains with a maximum of 30 measures.
- PDPs are measured on 4 domains with a maximum of 12 measures.
- MA-PD contracts are measured on all 9 domains with a maximum of 42 measures, 40 of which are unique measures. Two of the measures are shown in both Part C and Part D so that the results for a MA-PD contract can be compared to an MA-Only contract or a PDP contract. Only one instance of those two measures is used in calculating the overall rating. The two duplicated measures are Complaints about the Health/Drug Plan (CTM) and Members Choosing to Leave the Plan (MCLP).

For a health and/or drug plan to be included in the Part C & D Star Ratings, they must have an active contract with CMS to provide health and/or drug services to Medicare beneficiaries. All of the data used to rate the plans are collected through normal contractual requirements or directly from CMS systems. Information about Medicare Advantage contracting can be found at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html and Prescription Drug Coverage contracting at: https://www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/index.html. The data used in the Star Ratings come from four categories of data sources which are shown in Figure 2.

Figure 2: The Four Categories of Data Sources

Improvement Measures

Unlike the other Star Rating measures which are derived from data sources external to the Star Ratings, the Part C and Part D improvement measures are derived through comparisons of a contract's current and prior year measure scores. For a measure to be included in the improvement calculation the measure must not have had a significant specification change during those years. The Part C improvement measure includes only Part C measure scores and the Part D improvement measure includes only Part D measure scores. The measures and formulas for the improvement measure calculations are found in Attachment I. If a scaled reduction is applied to the Part C appeals measure in the previous year, the associated appeals measures will not be included in the Health Plan Quality Improvement measure.

The numeric results of these calculations are not publicly posted; only the measure ratings are reported publicly. Further, to receive a Star Rating in the improvement measures, a contract must have measure scores for both years in at least half of the required measures used to calculate the Part C improvement or Part D improvement measures. Improvement scores are not calculated for reconfigured regional contracts until data is available for the reconfigured structure from both years. Improvement scores are not calculated for consolidated contracts in their first year. Table 4 presents the minimum number of measure scores required to receive a rating for the improvement measures.

Guardrails are used to cap the amount of increase or decrease in measure cut point values from one year to the next. Specifically, each 1 to 5 star level cut point is compared to the prior year's value and capped at an increase or decrease of at most 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or at most 5 percent of the prior year's restricted score range for measures not having a 0 to 100 scale (restricted range cap). The final capped cut points after comparing each 1 through 5 star level cut point to the prior year's values are used for assigning measure stars.

B. Relative Distribution and Significance Testing (CAHPS)

This method is applied to determine valid star cut points for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars, a contract's CAHPS measure score needs to be ranked at least at the 80th percentile and be statistically significantly higher than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error above the 80th percentile. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and be statistically significantly lower than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error below the 15th percentile.

Methodology for Calculating Stars at the Domain Level

A domain rating is the average, unweighted mean, of the domain's measure stars. To receive a domain rating, a contract must meet or exceed the minimum number of rated measures required for the domain. The minimum number of rated measures required for a domain is determined based on whether the total number of measures in the domain for a contract type is odd or even:

- If the total number of measures that comprise the domain for a contract type is odd, divide the number of measures in the domain by two and round the quotient to the next whole number.
    - Example: If the total number of measures required in a domain for a contract type is 3, the value 3 is divided by 2. The quotient, in this case 1.5, is then rounded to the next whole number. To receive a domain rating, the contract must have a Star Rating for at least 2 of the 3 required measures.
- If the total number of measures that comprise the domain for a contract type is even, divide the number of measures in the domain by two and add one to the quotient.
    - Example: If the total number of measures required in a domain for a contract type is 6, the value 6 is divided by 2. In this example, 1 is then added to the quotient of 3. To receive a domain rating, the contract must have a Star Rating for at least 4 of the 6 required measures.

Table 5 details the minimum number of rated measures required for a domain rating by contract type.

- If the total number of measures required for the organization type is odd, divide the number by two and round it to a whole number.
    - Example: if there are 13 required Part D measures for the organization, 13 / 2 = 6.5, when rounded the result is 7. The contract needs at least 7 measures with ratings out of the 13 total measures to receive a Part D summary rating.
- If the total number of measures required for the organization type is even, divide the number of measures by two.
    - Example: if there are 30 required Part C measures for the organization, 30 / 2 = 15. The contract needs at least 15 measures with ratings out of the 30 total measures to receive a Part C summary rating.

Table 6 shows the minimum number of rated measures required by each contract type to receive a summary rating.

Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Part C summary	11 of 22	13 of 26	15 of 29	9 of 17	13 of 25	N/A	13 of 26
Part D summary	5 of 10*	6 of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 5 out of 9measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

For MA-PDs to receive an overall rating, the contract must have stars assigned to both the Part C and Part D summary ratings. If an MA-PD contract has only one of the two required summary ratings, the overall rating will show as "Not enough data available."

The overall rating for a MA-PD contract is calculated using a weighted average of the Part C and Part D measure stars. The weights assigned to each measure are shown in Attachment G.

There are a total of 42 measures (30 in Part C, 12 in Part D) in the 2025 Star Ratings. The following two measures are contained in both the Part C and D measure lists:

- Complaints about the Health/Drug Plan (CTM)
- Members Choosing to Leave the Plan (MCLP)

These measures share the same data source, so CMS includes only one instance of each of these two measures in the calculation of the overall rating. In addition, the Part C and D improvement measures are not included in the count for the minimum number of measures. Therefore, a total of 38 distinct measures plus the two improvement measures are used in the calculation of the overall rating.

The minimum number of rated measures required for an overall MA-PD rating is determined using the same methodology as for the Part C and D summary ratings. Table 7 provides the minimum number of rated measures required for an overall Star Rating by contract type.

Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Overall Rating	15 of 30*	18 of 35	19 of 38	12 of 24	N/A	N/A	18 of 35*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 15 out of 29 measures to receive an overall rating.

The overall and summary Star Ratings are calculated based on the measures required to be collected and reported for the contract type being offered for the Star Ratings year. For example, the 2025 Star Ratings are calculated for the 2025 contract year using data primarily from measurement year 2023. If a contract offered a SNP PBP in measurement year 2023, but is no longer offering a SNP PBP for the 2025 contract year, the 2025 Star Ratings exclude the SNP-only measures and the contract is rated as ‘‘Coordinated Care Plan without SNP.’’

Completing the Summary and Overall Rating Calculations

There are two adjustments made to the results of the summary and overall calculations described above. First, to reward consistently high performance, CMS utilizes both the mean and the variance of the measure stars to differentiate contracts for the summary and overall ratings. If a contract has both high and stable relative performance, a reward factor is added to the contract's ratings. Details about the reward factor can be found in the section entitled "Applying the Reward Factor." Second, the summary and overall ratings include a Categorical Adjustment Index (CAI) factor, which is added to or subtracted from a contract's summary and overall ratings. Details about the CAI can be found in the section entitled "Categorical Adjustment Index (CAI)."

The summary and overall rating calculations are run twice, once including the improvement measures and once without including the improvement measures. Based on a comparison of the results of these two calculations a decision is made as to whether the improvement measures are to be included in calculating a contract's final summary and overall ratings. Details about the application of the improvement measures can be found in the section entitled "Applying the Improvement Measure(s)."

Lastly, standard rounding rules are applied to convert the results of the final summary and overall ratings calculations into the publicly reported Star Ratings. Details about the rounding rules are presented in the section "Rounding Rules for Summary and Overall Ratings."

Applying the Improvement Measure(s)

The Part C Improvement Measure - Health Plan Quality Improvement (C27) and the Part D Improvement Measure - Drug Plan Quality Improvement (D04) were introduced earlier in this document in the section entitled "Improvement Measures." The measures and formulas for the improvement measures can be found in Attachment I. This section discusses whether and how to apply the improvement measures in calculating a contract's final summary and overall ratings.

Since high performing contracts have less room for improvement and consequently may have lower ratings on these measure(s), CMS has developed the following rules to not penalize contracts receiving 4 or more stars for their highest rating.

MA-PD Contracts

1. There are separate Part C and Part D improvement measures (C27 & D04) for MA-PD contracts.
   a. C27 is used in calculating the Part C summary rating of an MA-PD contract.
   b. D04 is used in calculating the Part D summary rating for an MA-PD contract.
   c. Both improvement measures will be used when calculating the overall rating in step 3.
2. Calculate the overall rating for MA-PD contracts without including either improvement measure.
3. Calculate the overall rating for MA-PD contracts with both improvement measures included.
4. If an MA-PD contract in step 2 has 4 or more stars, compare the two overall ratings. If the rating in step 3 is less than the value in step 2, use the overall rating from step 2; otherwise use the result from step 3.
5. For all other MA-PD contracts, use the overall rating from step 3.

MA-Only Contracts

1. Only the Part C improvement measure (C27) is used for MA-Only contracts.
2. Calculate the Part C summary rating for MA-Only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-Only contracts with the Part C improvement measure.
4. If an MA-Only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2; otherwise use the result from step 3.
5. For all other MA-Only contracts, use the Part C summary rating from step 3.

PDP Contracts

1. Only the Part D improvement measure (D04) is used for PDP contracts.
2. Calculate the Part D summary rating for PDP contracts without including the improvement measure.
3. Calculate the Part D summary rating for PDP contracts with the Part D improvement measure.
4. If a PDP contract in step 2 has 4 or more stars, compare the two Part D summary ratings. If the rating in step 3 is less than the value in step 2, use the Part D summary rating from step 2; otherwise use the result from step 3.
5. For all other PDP contracts, use the Part D summary rating from step 3.

Applying the Reward Factor

The following represents the steps taken to calculate and include the reward factor (r-Factor) in the Star Ratings summary and overall ratings. These calculations are performed both with and without the improvement measures included.

- Calculate the mean and the variance of all of the individual quality and performance measure stars at the contract level.
  - The mean is equal to the summary or overall rating before the reward factor is applied, which is calculated as described in the section entitled “Weighting of Measures.”
  - Using weights in the variance calculation accounts for the relative importance of measures in the reward factor calculation. To incorporate the weights shown in Attachment G into the variance calculation of the available individual performance measures for a given contract, the steps are as follows:

- Subtract the summary or overall star from each performance measure's star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
- Sum these results; call this 'SUMWX.'
- Set n equal to the number of individual performance measures available for the given contract.
- Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.
- The weighted variance for the given contract is calculated as: n * SUMWX / (W * (n-1)). For the complete formula, please see Attachment H: Calculation of Weighted Star Rating and Variance Estimates.

- Categorize the variance into three categories:
  - low (0 to < 30th percentile),
  - medium (≥ 30th to < 70th percentile) and
  - high (≥ 70th percentile)
- Develop the reward factor as follows:
  - r-Factor = 0.4 (for contract w/ low variance & high mean (mean ≥ 85th percentile))
  - r-Factor = 0.3 (for contract w/ medium variance & high mean (mean ≥ 85th percentile))
  - r-Factor = 0.2 (for contract w/ low variance & relatively high mean (mean ≥ 65th & < 85th percentile))
  - r-Factor = 0.1 (for contract w/ medium variance & relatively high mean (mean ≥ 65th & < 85th percentile))
  - r-Factor = 0.0 (for all other contracts)

Tables 8 and 9 show the final threshold values used in reward factor calculations for the 2025 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	65th	3.703125	3.666667	3.535714	3.646465
With	85th	4.014493	4.000000	4.035714	3.949495
Without	65th	3.707692	3.718750	3.687500	3.662921
Without	85th	4.044118	4.062500	4.173913	3.977528

Table 9: Variance Thresholds

Improvement	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	30th	0.820452	0.742679	0.847865	0.828220
With	70th	1.275376	1.268610	1.533170	1.240423
Without	30th	0.807024	0.654297	0.717578	0.795388
Without	70th	1.256410	1.210645	1.508203	1.216635

Categorical Adjustment Index (CAI)

CMS has implemented an analytical adjustment called the Categorical Adjustment Index (CAI). The CAI is a factor that is added to or subtracted from a contract's Overall and/or Summary Star Ratings to adjust for the

average within-contract disparity in performance for Low Income Subsidy/Dual Eligible (LIS/DE) beneficiaries and disabled beneficiaries. The CAI value (factor) depends on the contract's percentage of beneficiaries with LIS/DE and the contract's percentage of beneficiaries with disabled status. These adjustments are performed both with and without the improvement measures included. The value of the CAI varies by the contract's percentage of beneficiaries with LIS/DE and disability status.

The CAI values use data collected for the 2024 Star Ratings. To calculate the CAI, case-mix adjustment is applied to all clinical Star Rating measure scores that are not adjusted for SES using a beneficiary-level logistic regression model with contract fixed effects and beneficiary-level indicators of LIS/DE and disability status, similar to the approach currently used to adjust CAHPS patient experience measures. However, unlike CAHPS case-mix adjustment, the only adjusters are LIS/DE and disability status. Adjusted measure scores are then converted to measure stars using the 2024 rating year measure cutoffs and used to calculate Adjusted Overall and Summary Star Ratings. Unadjusted Overall and Summary Star Ratings are also determined for each contract.

The 2024 measures used in the 2025 CAI adjustment calculations are:

- Breast Cancer Screening (Part C)
- Colorectal Cancer Screening (Part C)
- Annual Flu Vaccine (Part C)
- Monitoring Physical Activity (Part C)
- Osteoporosis Management in Women who had a Fracture (Part C)
- Diabetes Care – Eye Exam (Part C)
- Diabetes Care – Blood Sugar Controlled (Part C)
- Controlling Blood Pressure (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (Part C)
- Medication Reconciliation Post-Discharge (Part C)
- Plan All-Cause Readmissions (Part C)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)
- Transitions of Care (Part C)
- Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (Part C)
- Medication Adherence for Diabetes Medication (Part D)
- Medication Adherence for Hypertension (RAS antagonists) (Part D)
- Medication Adherence for Cholesterol (Statins) (Part D)
- MTM Program Completion Rate for CMR (Part D)
- Statin Use in Patients with Diabetes (SUPD) (Part D)

To determine the value of the CAI, contracts are first divided into an initial set of categories based on the combination of a contract's LIS/DE and disability percentages. For the adjustment for the overall and summary ratings for MA-Only and MA-PD contracts, the initial groups are formed by the ten groups of LIS/DE and quintiles of disability, thus resulting in 50 initial categories. For PDPs, the initial groups are formed using quartiles for both LIS/DE and disability. The mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts in each initial category are determined and examined. The initial categories are collapsed to form final adjustment groups. The CAI values are the mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts within each final adjustment group. Separate CAI values are computed for the overall and summary

ratings, and the rating-specific CAI value is the same for all contracts that fall within the same final adjustment category.

The categorization of contracts into final adjustment categories for the CAI relies on both the use of a contract's percentages of LIS/DE and disabled beneficiaries. Categories were chosen to enforce monotonicity. Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI. Details regarding the methodology for the Puerto Rico model are provided in Attachment O.

Tables 10 and 11 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the determination of the CAI values for the Overall Rating. For example, if a contract's percentage of LIS/DE beneficiaries is 13.60%, the contract's LIS/DE initial group would be L4. The upper limit for each initial category is only included for the highest categories (L10 and D5), and the upper limit is equal to 100% for both of these categories.

Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.130891
2	6.130891 to less than 9.037945
3	9.037945 to less than 13.131086
4	13.131086 to less than 18.030927
5	18.030927 to less than 25.257942
6	25.257942 to less than 35.188560
7	35.188560 to less than 50.161404
8	50.161404 to less than 79.983090
9	79.983090 to less than 100.000000
10	100.000000

Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.607385
2	14.607385 to less than 21.923598
3	21.923598 to less than 31.057866
4	31.057866 to less than 44.050502
5	44.050502 to 100.000000

Table 12 provides the description of each of the final adjustment categories and the associated value of the CAI per category for the overall rating.

Table 12: Final Adjustment Categories and CAI Values for the Overall Rating

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1- L2 L1	D1 D2	-0.058127
2	L1- L2 L2-L3 L3	D3 D2 D1	-0.033597
3	L4-L6 L4-L5	D1 D2	-0.014802
4	L1-L5 L3-L6 L6-L7 L7-L8	D4-D5 D3 D2 D1	0.002506
5	L6-L7 L7-L9 L8 L9-L10	D4-D5 D3 D2 D1-D2	0.045230
6	L8 L9-L10 L10	D4-D5 D4 D3	0.064707
7	L9	D5	0.112056
8	L10	D5	0.134761

Tables 13 and 14 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the initial categories for the determination of the CAI values for the Part C summary.

Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 5.855856
2	5.855856 to less than 8.734793
3	8.734793 to less than 12.640171
4	12.640171 to less than 17.492877
5	17.492877 to less than 24.793782
6	24.793782 to less than 34.766754
7	34.766754 to less than 49.936168
8	49.936168 to less than 79.344262
9	79.344262 to less than 100.000000
10	100.000000

Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.372597
2	14.372597 to less than 21.743800
3	21.743800 to less than 30.716563
4	30.716563 to less than 44.001563
5	44.001563 to 100.000000

Table 15 provides the description of each of the final adjustment categories for the Part C summary and the associated value of the CAI for each final adjustment category.

Table 15: Final Adjustment Categories and CAI Values for the Part C Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.037897
2	L2 L1-L2	D1 D2-D3	-0.025930
3	L3-L4	D1-D2	-0.013018
4	L5-L8 L5-L7 L3-L7 L1-L5	D1 D2 D3 D4-D5	0.004257
5	L6-L7	D4-D5	0.023880
6	L8 L9-10 L9	D2-D5 D1-D2 D3	0.038923
7	L9 L10	D4-D5 D3-D4	0.078480
8	L10	D5	0.094759

Tables 16 and 17 provide the range of the percentages that correspond to the LIS/DE initial groups and the disability quintiles for the initial categories for the determination of the CAI values for the Part D summary rating for MA-PDs.

Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.229975
2	6.229975 to less than 9.567309
3	9.567309 to less than 14.176508
4	14.176508 to less than 19.916254
5	19.916254 to less than 27.960199
6	27.960199 to less than 40.979534
7	40.979534 to less than 59.964116
8	59.964116 to less than 91.207503
9	91.207503 to less than 100.000000
10	100.000000

Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.987453
2	14.987453 to less than 22.882693
3	22.882693 to less than 32.500000
4	32.500000 to less than 45.560408
5	45.560408 to 100.000000

Table 18 provides the description of each of the final adjustment categories for the MA-PD Part D summary and the associated values of the CAI for each final adjustment category.

Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L4 L1	D1 D2	-0.048532
2	L2-L4	D2	-0.031119
3	L1-L5 L5-L8 L9-L10	D3 D1-D2 D1	-0.002424
4	L1-L6 L6-L8	D4-D5 D3	0.022709
5	L7-L8 L9-L10	D4-D5 D2-D4	0.074098
6	L9-L10	D5	0.126344

Tables 19 and 20 provide the range of the percentages that correspond to the LIS/DE and disability quartiles for the initial categories for the determination of the CAI values for the PDP Part D summary. Quartiles are used for both dimensions due to the limited number of PDPs as compared to MA-PD contracts.

Table 19: Categorization of Contract's Members into Quartiles of LIS/DE for the PDP Part D Summary

LIS/DE Quartile	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 1.542070
2	1.542070 to less than 3.159360
3	3.159360 to less than 8.410224
4	8.410224 to 100.000000

Table 20: Categorization of Contract's Members into Quartiles of Disability for the PDP Part D Summary

Disability Quartile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 6.593595
2	6.593595 to less than 10.621062
3	10.621062 to less than 14.589481
4	14.589481 to 100.000000

Table 21 provides the description of each of the final adjustment categories for the PDP Part D summary and the associated value of the CAI per final adjustment category. Note that the CAI values for the PDP Part D summary are different from the CAI values for the MA-PD Part D summary. There are three final adjustment categories for the PDP Part D summary.

Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary

Final Adjustment Category	LIS/DE Quartile	Disability Quartile	CAI Value
1	L1-L2	D1-D2	-0.230036
2	L1-L3 L3-L4	D3-D4 D1-D2	-0.081240
3	L4	D3-D4	0.004293

Calculation Precision

CMS and its contractors have always used software called SAS (an integrated system of software products provided by SAS Institute Inc.) to perform the calculations used in producing the Star Ratings. For all measures, except the improvement measures, the precision used in scoring the measure is indicated next to the label "Data Display" within the detailed description of each measure. The improvement measures are discussed below. The domain ratings are the unweighted average of the star measures and are rounded to the nearest integer.
The improvement measures, summary, and overall ratings are calculated with at least six digits of precision after the decimal whenever the data allow it. The HEDIS measure scores have two digits of precision after the decimal. All other measures have at least six digits of precision when used in the improvement calculation.

Contracts may request a contract-specific calculation spreadsheet which emulates the actual SAS calculations from the Star Ratings mailbox during the second plan preview.

It is not possible to replicate CMS's calculations exactly due to factors including, but not limited to: using published measure data from sources other than CMS's Star Rating program which use different rounding rules, and exclusion of some contracts' ratings from publicly-posted data (e.g., terminated contracts).

Rounding Rules for Measure Scores

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using traditional rounding rules. These are standard "round to nearest" rules prior to cut point analysis. To obtain a value with the specified level of precision, the single digit following the level of precision will be rounded. If the digit to be rounded is 0, 1, 2, 3 or 4, the value

is rounded down, with no adjustment to the preceding digit. If the digit to be rounded is 5, 6, 7, 8 or 9, the value is rounded up, and a value of one is added to the preceding digit. After rounding, all digits after the specified level of precision are removed. If rounding to a whole number, the digit to be rounded is in the first decimal place. If the digit in the first decimal place is below 5, then after rounding the whole number remains unchanged and fractional parts of the number are deleted. If the digit in the first decimal place is 5 or greater, then the whole number is rounded up by adding a value of 1 and fractional parts of the number are deleted. For example, a measure listed with a Data Display of "Percentage with no decimal point" that has a value of 83.499999 rounds down to 83, while a value of 83.500000 rounds up to 84.

Rounding Rules for Summary and Overall Ratings

The results of the summary and overall calculations are rounded to the nearest half star (i.e., 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0). Table 22 summarizes the rounding rules for converting the Part C and D summary and overall ratings into the publicly reported Star Ratings.

Table 22: Rounding Rules for Summary and Overall Ratings

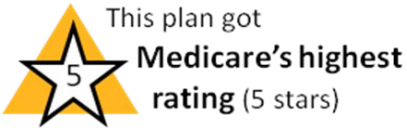
Raw Summary / Overall Score	Final Summary / Overall Rating
≥ 0.000000 and < 0.250000	0
≥ 0.250000 and < 0.750000	0.5
≥ 0.750000 and < 1.250000	1.0
≥ 1.250000 and < 1.750000	1.5
≥ 1.750000 and < 2.250000	2.0
≥ 2.250000 and < 2.750000	2.5
≥ 2.750000 and < 3.250000	3.0
≥ 3.250000 and < 3.750000	3.5
≥ 3.750000 and < 4.250000	4.0
≥ 4.250000 and < 4.750000	4.5
≥ 4.750000 and ≤ 5.000000	5.0

For example, a summary or overall rating of 3.749999 rounds down to a rating of 3.5, and a rating of 3.750000 rounds up to rating of 4. That is, a score would need to be at least halfway between 3.5 and 4 (having a minimum value of 3.750000) in order to obtain the higher rating of 4.

Methodology for Calculating the High Performing Icon

A contract may receive a high performing icon as a result of its performance on the Parts C and/or D measures. The high performing icon is assigned to an MA-Only contract for achieving a 5-star Part C summary rating, a PDP contract for a 5-star Part D summary rating, and an MA-PD contract for a 5-star overall rating. Figure 3 shows the high performing icon used in the MPF:

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past two years (i.e., the 2023, 2024, and 2025 Star Ratings). If the contract had any combination of Part C and/or Part D summary ratings of 2.5 or lower in all three years of data, it is marked with a low performing icon (LPI). A contract must have a rating in either Part C and/or Part D for all three years to be considered for this icon.

Figure 4 shows the low performing contract icon used in the MPF:

Figure 4: The Low Performing Icon

Table 23 shows example contracts which would receive an LPI.

Table 23: Example LPI Contracts

Contract/Rating	Rated As	2023 C	2024 C	2025 C	2023 D	2024 D	2025 D	LPI Awarded	LPI Reason
HAAAA	MA-PD	2	2.5	2.5	3	3	3	Yes	Part C
HBBBB	MA-PD	3	3	3	2.5	2	2.5	Yes	Part D
HCCCC	MA-PD	2.5	3	3	3	2.5	2.5	Yes	Part C or D
HDDDD	MA-PD	3	2.5	3	2.5	3	2.5	Yes	Part C or D
HEEEE	MA-PD	2.5	2	2.5	2	2.5	2.5	Yes	Part C and D
HFFFF	MA-Only	2.5	2	2.5	-	-	-	Yes	Part C
SAAAA	PDP	-	-	-	2.5	2.5	2	Yes	Part D

Mergers, Novations, and Consolidations

This section covers how the Star Ratings are affected by mergers, novation and consolidations. To ensure a common understanding, we begin by defining each of the terms.

- Merger: when two (or more) companies join together to become a single business. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to Medicare beneficiaries. After the merger, all of those individual contracts with CMS are still intact, only the ownership changes in each of the contracts to the name of the new single business. Mergers can occur at any time during a contract year.
- Novation: when one company acquires another company. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to beneficiaries. After the novation, all of those individual contracts with CMS are still intact. The owner's names of the contracts acquired are changed to the new owner's name. Novations can occur at any time during the contract year.

- Consolidation: when an organization/sponsor that has at least two contracts with CMS for offering health and/or drug services to beneficiaries combines multiple contracts into a single contract with CMS. Consolidations occur only at the change of the contract year. The one or more contracts that will no longer exist at contract year's end are known as the consumed contracts. The contract that will still exist is known as the surviving contract and all of the beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract.

Mergers and novations do not change the ratings earned by an individual contract in any way.

For a merger or novation, the only change is the company listed as owning the contract; there is no change in contract structure, so the Star Ratings earned by the contract remains with them until the next rating cycle. This includes any High Performing or Low Performing icons earned by any of the contracts.

Consolidations become effective the first day of the calendar year. The Star Ratings are released the previous October so they are available when open enrollment begins. In the first year following a consolidation, the measure values used in calculating the Star Ratings of the surviving contract will be based on the enrollment-weighted mean of all contracts in the consolidation (see Attachment B). The surviving contract's ratings are posted publicly, used in determining QBP ratings, and included in the Past Performance Analysis.

Reliability Requirement for Low-enrollment Contracts

HEDIS measures for contracts whose enrollment as of July 2023 was at least 500 but less than 1,000 will be included in the Star Ratings in 2025 when the contract-specific measure score reliability is equal to or greater than 0.7. The reliability calculations are implemented using SAS PROC MIXED as documented on pages 31-32 of the report "The Reliability of Provider Profiling – A Tutorial," available at https://www.rand.org/pubs/technical_reports/TR653.html.

The within-contract variance for the Transitions of Care composite measure utilizes a different formula than other HEDIS pass/fail measures because it is an average of four component measures. First, the binomial variances and standard deviations (i.e. the square root of a variance term), as discussed in the report "The Reliability of Provider Profiling – A Tutorial", are calculated for each of the four component measures. Next, pairwise correlations are computed among the four component measures. Pairwise covariance terms among the four component measures are calculated by multiplying the respective pairwise correlation and two items' standard deviations together. The final within-contract variance for the Transitions of Care composite measure is computed by summing the four variance terms and each pairwise covariance term multiplied by 2.0.

Special Needs Plan (SNP) Data

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP). Further details on SNP plans can be found in the glossary, Attachment R.

CMS has included three SNP-specific measures in the 2025 Star Ratings. The Part C 'Special Needs Plan Care Management' measure is based on data reported by contracts through the Medicare Part C Reporting Requirements. The two Part C 'Care for Older Adults' measures are based on HEDIS data. The data for all of these measures are reported at the plan benefit package (PBP) level, while the Star Ratings are reported at the contract level.

The methodology used to combine the PBP data to the contract level is different between the two data sources. The Part C Reporting Requirements data are summed into a contract-level rate after excluding PBPs that do not map to any PBP offered by the contract in the calendar year for which the Reporting Requirements data underwent data validation. The HEDIS data are summed into a contract-level rate as long as the contract will be offering a SNP PBP in the Star Ratings year.

The two methodologies used to combine the PBP data within a contract for these measures are described further in Attachment E.

Star Ratings and Marketing

Plan sponsors must ensure the Star Ratings document and all marketing of Star Ratings information is compliant with CMS's Medicare Marketing Guidelines. Failure to follow CMS's guidance may result in compliance action against the contract. The Medicare Marketing Guidelines were issued as Chapters 2 and 3 of the Prescription Drug Benefit Manual and the Medicare Managed Care Manual, respectively. Please direct questions about marketing Star Ratings information to your Account Manager.

Contact Information

The contact below can assist you with various aspects of the Star Ratings.

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

If you have questions or require information about the specific subject areas associated with the Star Ratings 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
- Compliance Activity Module issues (Part C): PartCCompliance@cms.hhs.gov
- Compliance Activity Module issues (Part D): PartD_Monitoring@cms.hhs.gov
- Demonstration (Medicare-Medicaid Plan) Ratings: mmcocapsmodel@cms.hhs.gov
- Disenrollment Reasons Survey: DisenrollSurvey@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- HPMS Access issues: HPMS_Access@cms.hhs.gov
- HPMS Help Desk (all other HPMS issues): HPMS@cms.hhs.gov
- Marketing: marketing@cms.hhs.gov
- Part C Compliance Activity issues: PartCCompliance@cms.hhs.gov
- Part D Compliance Activity issues: PartD_Monitoring@cms.hhs.gov
- Plan Reporting (Part C): Partcplanreporting@cms.hhs.gov
- Plan Reporting (Part D): Partd-planreporting@cms.hhs.gov
- Plan Reporting Data Validation (Part C & D): PartCandD_Data_Validation@cms.hhs.gov

- QBP Ratings and Appeals questions: QBPAppeals@cms.hhs.gov
- QBP Payment or Risk Analysis questions: riskadjustment@cms.hhs.gov

Framework and Definitions for the Domain and Measure Details Section

This page contains the formatting framework and definition of each sub-section that is used to describe the domain and measure details on the following pages.

Domain: The name of the domain to which the measures following this heading belong

Measure: The measure ID and common name of the ratings measure

Title	Description
Label for Stars:	The label that appears with the stars for this measure on Medicare.gov.
Label for Data:	The label that appears with the numeric data for this measure on HPMS and CMS.gov.
Description:	The English language description shown for the measure on Medicare.gov. The text in this sub-section has been prepared to aid beneficiaries' understanding of the nature and the purpose of the measure. We strongly encourage any public-facing explanation of the measure to use this description.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS-HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS are unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Statistical Method:	The methodology used for assigning stars in this measure; see the section entitled "Methodology for Assigning Part C and Part D Measure Star Ratings" for an explanation of each of the possible entries in this sub-section.
Improvement Measure:	Indicates whether this measure is included in the improvement measure.
CAI Usage:	Indicates if the measure is used in the Categorical Adjustment Index calculation.
Case-Mix Adjusted:	Indicates if the data are case mix adjusted prior to being used for the Star Ratings.

Title	Description
Weighting Category:	The weighting category of this measure.
Weighting Value:	The numeric weight for this measure in the summary and overall rating calculations.
Meaningful Measure Area:	Contains the area where this measure fits into the Meaningful Measure Framework.
CMIT #:	The CMS Measure Inventory Tool (CMIT) is the repository of record for information about the measures which CMS uses to promote healthcare quality and quality improvement.
Data Display:	The format used to the display the numeric data on Medicare.gov
Reporting Requirements:	Table indicating which organization types are required to report the measure. “Yes” for organizations required to report; “No” for organizations not required to report.
Cut Points:	Table containing the cut points used in the measure. For non-CAHPS measures, excluding new measures and measures with substantive specification changes that have been in the Part C and D Star Ratings for three years or less, the cut points are after the application of Tukey outlier deletion, mean resampling, and guardrails. New measures and measures with substantive specification changes that have been in the Part C and D Star Ratings program for three years or less, and the Health Plan Quality Improvement and Drug Plan Quality Improvement measure cut points are after the application of Tukey outlier deletion and mean resampling. For CAHPS measures, the table contains the base group cut points which are used prior to the final star assignment rules being applied.

Part C Domain and Measure Details

See Attachment C for the national averages of individual Part C measures.

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines

Measure: C01 - Breast Cancer Screening

Title	Description
Label for Stars:	Breast Cancer Screening
Label for Data:	Breast Cancer Screening
Description:	Percent of female plan members aged 52-74 who had a mammogram during the past two years.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 606
Metric:	The percentage of women MA enrollees 50 to 74 years of age (denominator) as of December 31 of the measurement year who had a mammogram to screen for breast cancer in the past two years (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members in hospice or using hospice services any time during the measurement period. • Members receiving palliative care any time during the measurement period. • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: – At least two indications of frailty with different dates of service during the measurement period. – At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, or nonacute inpatient encounters or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. • Members receiving palliative care during the measurement year • Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: – Bilateral mastectomy. – Unilateral mastectomy with a bilateral modifier (same procedure). – Two unilateral mastectomies found in clinical data with a bilateral modifier (same procedure).

Title	Description
	– History of bilateral mastectomy. • Any combination of the following that indicate a mastectomy on both the left and right side on the same or on different dates of service: –Unilateral mastectomy with a right-side modifier (same procedure). – Unilateral mastectomy with a left-side modifier (same procedure). – Absence of the left breast. – Absence of the right breast. – Left unilateral mastectomy. – Right unilateral mastectomy. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00093-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 53 %	>= 53 % to < 67 %	>= 67 % to < 75 %	>= 75 % to < 82 %	>= 82 %

Measure: C02 - Colorectal Cancer Screening

Title	Description

Label for Stars: Colorectal Cancer Screening

Label for Data: Colorectal Cancer Screening

Description: Percent of plan members aged 50-75 who had appropriate screening for colon cancer.

HEDIS Label: Colorectal Cancer Screening (COL)

Measure Reference: NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 102

Metric: The percentage of MA enrollees aged 50 to 75 (denominator) as of December 31 of the measurement year who had appropriate screenings for colorectal cancer (numerator).

Primary Data Source: HEDIS Patient-level Data

Data Source Category: Health and Drug Plans

Exclusions: • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
• Members 66 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness during the measurement year. Members must meet both of the frailty and advanced illness criteria to be excluded:

1. – At least two indications of frailty with different dates of service during the measurement year.
2. – Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
   – At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges. Visit type need not be the same for the two visits.
   – At least one acute inpatient encounter with an advanced illness diagnosis.
   – At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim.
   – A dispensed dementia medication.

• (Required) Exclude members who meet any of the following criteria:
– Members who had colorectal cancer or a total colectomy any time during the member's history through December 31 of the measurement year.
– Members receiving palliative care during the measurement year.
– Members in hospice or using hospice services during the measurement year.

Title	Description

– Members receiving palliative care during the measurement year.
– Members who died during the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00139-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 53 %	>= 53 % to < 65 %	>= 65 % to < 75 %	>= 75 % to < 83 %	>= 83 %

Measure: C03 - Annual Flu Vaccine

Title	Description
Label for Stars:	Yearly Flu Vaccine
Label for Data:	Yearly Flu Vaccine
Description:	Percent of plan members who got a vaccine (flu shot).
Metric:	The percentage of sampled Medicare enrollees (denominator) who received an influenza vaccination (numerator).
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question number varies depending on survey type): • Have you had a flu shot since July 1, 2023?
Data Source Category:	Survey of Enrollees
General Notes:	This measure is not case-mix adjusted. CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00259-01-C-PARTC
Data Display:	Percentage with no decimal place

Title	Description

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 61	>= 61 to < 65	>= 65 to < 71	>= 71 to < 76	>= 76

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C04 - Monitoring Physical Activity

Title	Description

Label for Stars: Monitoring Physical Activity

Label for Data: Monitoring Physical Activity

Description: Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.

HEDIS Label: Physical Activity in Older Adults (PAO)

Measure Reference: NCQA HEDIS Measurement Year 2022 Specifications for the Medicare Health Outcomes Survey Volume 6, page 36

Metric: The percentage of sampled Medicare members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase or maintain their level exercise or physical activity (numerator).

Primary Data Source: HEDIS-HOS

Data Source Description: Cohort 24 Follow-up Data collection (2023) and Cohort 26 Baseline data collection (2023).

HOS Survey Question 42: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.

HOS Survey Question 43: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Data Source Category: Survey of Enrollees

Exclusions: Members who responded "I had no visits in the past 12 months" to Question 42 are excluded from results calculations for Question 43. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.

Data Time Frame: 07/17/2023 – 11/01/2023

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00450-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 41 %	>= 41 % to < 47 %	>= 47 % to < 52 %	>= 52 % to < 60 %	>= 60 %

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C05 - Special Needs Plan (SNP) Care Management

Title	Description
Label for Stars:	Members Whose Plan Did an Assessment of Their Health Needs and Risks
Label for Data:	Members Whose Plan Did an Assessment of Their Health Needs and Risks
Description:	Percent of members whose plan did an assessment of their health needs and risks in the past year. The results of this review are used to help the member get the care they need. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
Metric:	This measure is defined as the percent of eligible Special Needs Plan (SNP) enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new enrollees due for an Initial HRA (Element A) and the number of enrollees eligible for an annual reassessment HRA (Element B). The numerator for this measure is the sum of the number of initial HRAs performed on new enrollees (Element C) and the number of annual reassessments performed on enrollees eligible for a reassessment (Element F). The equation for calculating the SNP Care Management Assessment Rate is: [Number of initial HRAs performed on new enrollees (Element C) + Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)] / [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual reassessment HRA (Element B)]
Primary Data Source:	Part C Plan Reporting
Data Source Description:	Data reported by contracts to CMS per the 2023 Part C Reporting Requirements. Validation for data performed during the 2024 Data Validation cycle (data pulled June 2023). Validation of these data was performed retrospectively during the 2024 data validation cycle (deadline June 15, 2024 and data validation results pulled July 2024).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts and PBPs with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as “No data available.” SNP Care Management Assessment Rates are not provided for contracts that did not score at least 95% on data validation for the SNP Care Management reporting section or were not compliant with data validation standards/sub-standards for any of the following SNP Care Management data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation. • Number of new enrollees due for an initial HRA (Element A) • Number of enrollees eligible for an annual reassessment HRA (Element B) • Number of initial HRAs performed on new enrollees (Element C)

Title	Description
	• Number of annual reassessments performed on enrollees eligible for reassessment (Element F) Contracts excluded from the SNP Care Management Assessment Rates due to data validation issues are shown as “CMS identified issues with this plan's data.” Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select “Monitoring,” then “Plan Reporting Data Validation.” Select the appropriate contract year. Select the PRDVM Reports. Select “Score Detail Report.” Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov. Additionally, contracts must have 30 or more enrollees in the denominator [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual HRA (Element B) ≥ 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available.”
General Notes:	More information about the data used to calculate this measure can be found in Attachment E. The Part C reporting requirement fields listed below are not used in calculating this measure: • Data Element D Number of initial HRA refusals • Data Element E Number of initial HRAs where SNP is unable to reach new enrollees • Data Element G Number of annual reassessment refusals • Data Element H Number of annual reassessments where SNP is unable to reach enrollee
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions

Title	Description
CMIT #:	00685-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 46 %	>= 46 % to < 62 %	>= 62 % to < 76 %	>= 76 % to < 89 %	>= 89 %

Measure: C06 - Care for Older Adults – Medication Review

Title	Description
Label for Stars:	Yearly Review of All Medications and Supplements Being Taken
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 115
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2023 SNP Comprehensive Report were excluded from this measure. Exclude members in hospice or using hospice services or who died any time during the measurement year.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2023 – 12/31/2023

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00110-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 53 %	>= 53 % to < 80 %	>= 80 % to < 92 %	>= 92 % to < 98 %	>= 98 %

Measure: C07 - Care for Older Adults – Pain Assessment

Title	Description
Label for Stars:	Yearly Pain Screening or Pain Management Plan
Label for Data:	Yearly Pain Screening or Pain Management Plan
Description:	Percent of plan members who had a pain screening at least once during the year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 115

Title	Description
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2023 SNP Comprehensive Report were excluded from this measure. Exclude members in hospice or using hospice services or who died any time during the measurement year.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00111-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 60 %	>= 60 % to < 81 %	>= 81 % to < 92 %	>= 92 % to < 96 %	>= 96 %

Measure: C08 - Osteoporosis Management in Women who had a Fracture

Title	Description
Label for Stars:	Osteoporosis Management
Label for Data:	Osteoporosis Management
Description:	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.
HEDIS Label:	Osteoporosis Management in Women Who Had a Fracture (OMW)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 232
Metric:	The percentage of woman MA enrollees 67 - 85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD. • Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD. • Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the IESD. • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. • Members who received palliative care any time during the intake period through the end of the measurement year. • Members 67 years of age and older as of December 31 of the measurement year who meet either of the following: – Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Members living long-term in an institution any time during the measurement year. • Members 67-80 years of age as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded: • At least two indications of frailty with different dates of service during the intake period through the end of the measurement year. • Any of the following during the measurement year or the year prior to the measurement year: • At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. • At least one acute inpatient encounter with an advanced illness diagnosis. • At least on acute inpatient discharge with an advanced illness diagnosis on the discharge claim.

Title	Description

• A dispenses dementia medication.
• Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the intake period through the end of the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 27 %	>= 27 % to < 39 %	>= 39 % to < 52 %	>= 52 % to < 71 %	>= 71 %

Measure: C09 - Diabetes Care – Eye Exam

Title	Description
Label for Stars:	Eye Exam to Check for Damage from Diabetes
Label for Data:	Eye Exam to Check for Damage from Diabetes
Description:	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
HEDIS Label:	Eye Exam for Patients with Diabetes (EED)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 203
Metric:	The percentage of diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with both frailty and advanced illness during the measurement year. Members must meet both the following frailty and advanced illness criteria to be excluded: • At least two indications of frailty with different dates of service during the measurement year. • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. o At least one acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. o A dispensed dementia medication. • (Required) Exclude members who meet any of the following criteria: – Members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year. – Members in hospice or using hospice services any time during the measurement year.

Title	Description

– Members who died any time during the measurement year.
– Members receiving palliative care any time during the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00203-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 57 %	>= 57 % to < 70 %	>= 70 % to < 77 %	>= 77 % to < 83 %	>= 83 %

Measure: C10 - Diabetes Care – Blood Sugar Controlled

Title	Description
Label for Stars:	Plan Members with Diabetes whose Blood Sugar is Under Control
Label for Data:	Plan Members with Diabetes whose Blood Sugar is Under Control
Description:	Percent of plan members with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees age 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with both frailty and advanced illness during the measurement year. Members must meet both the following frailty and advanced illness criteria to be excluded: • At least two indications of frailty with different dates of service during the measurement year. • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. o At least one acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. o A dispensed dementia medication. • (Required) Exclude members who meet any of the following criteria: – Members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Title	Description

– Members in hospice or using hospice services any time during the measurement year.
– Members who died any time during the measurement year.
– Members receiving palliative care any time during the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00204-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 49 %	>= 49 % to < 72 %	>= 72 % to < 84 %	>= 84 % to < 90 %	>= 90 %

Measure: C11 - Controlling Blood Pressure

Title	Description
Label for Stars:	Controlling Blood Pressure
Label for Data:	Controlling Blood Pressure
Description:	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 152
Metric:	The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded: • At least two indications of frailty with different dates of service during the measurement year. • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. • At least one acute inpatient encounter with an advanced illness diagnosis. • At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. • A dispensed dementia medication. • (Required) Exclude members who meet any of the following criteria: – • Members with evidence of end-stage renal

Title	Description

disease (ESRD), dialysis, nephrectomy, or kidney transplant any time during the member's history on or prior to December 31 of the measurement year.

- • Members receiving palliative care during the measurement year.
- • Members with a diagnosis of pregnancy during the measurement year.
- • Members in hospice or using hospice services any time during the measurement year.
- • Members who died any time during the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcomes Measure

Weighting Value: 3

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00167-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 69 %	>= 69 % to < 74 %	>= 74 % to < 80 %	>= 80 % to < 85 %	>= 85 %

Measure: C12 - Reducing the Risk of Falling

Title	Description
Label for Stars:	Reducing the Risk of Falling
Label for Data:	Reducing the Risk of Falling
Description:	Percent of plan members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Specifications for the Medicare Health Outcomes Survey Volume 6, page 38
Metric:	The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 24 Follow-up Data collection (2023) and Cohort 26 Baseline data collection (2023). HOS Survey Question 44: A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? HOS Survey Question 45: Did you fall in the past 12 months? HOS Survey Question 46: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 47: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 44 or Question 47 are excluded from results calculations. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/17/2023 – 11/01/2023
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Safety
CMIT #:	00646-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 50 %	>= 50 % to < 56 %	>= 56 % to < 63 %	>= 63 % to < 73 %	>= 73 %

Measure: C13 - Improving Bladder Control

Title	Description
Label for Stars:	Improving Bladder Control
Label for Data:	Improving Bladder Control
Description:	Percent of plan members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.
HEDIS Label:	Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Specifications for the Medicare Health Outcomes Survey Volume 6, page 33
Metric:	The percentage of Medicare members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 24 Follow-up Data collection (2023) and Cohort 26 Baseline data collection (2023).

Title	Description
	HOS Survey Question 38: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 41: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? Member choices must be as follows to be included in the denominator: • Q38 = "Yes." • Q41 = "Yes" or "No." The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider. Member choice must be as follows to be included in the numerator: • Q41 = "Yes."
Data Source Category:	Survey of Enrollees
Exclusions:	Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/17/2023 – 11/01/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00378-01-C-PARTC
Data Display:	Percentage with no decimal place

Title	Description

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 39 %	>= 39 % to < 44 %	>= 44 % to < 48 %	>= 48 % to < 52 %	>= 52 %

Measure: C14 - Medication Reconciliation Post-Discharge

Title	Description
Label for Stars:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Label for Data:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Description:	This shows the percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.
HEDIS Label:	Medication Reconciliation Post-Discharge (MRP)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 330
Metric:	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Members in hospice or using hospice services any time during the measurement year. Members who died any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00441-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 42 %	>= 42 % to < 57 %	>= 57 % to < 73 %	>= 73 % to < 87 %	>= 87 %

Measure: C15 - Plan All-Cause Readmissions

Title	Description
Label for Stars:	Readmission to a Hospital within 30 Days of Being Discharged (more stars are better because it means fewer members are being readmitted)
Label for Data:	Readmission to a Hospital within 30 Days of Being Discharged (lower percentages are better because it means fewer members are being readmitted)
Description:	Percent of plan members aged 18 and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This “risk-adjustment” helps make the comparisons between plans fair and meaningful.)
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 498
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average

Title	Description
	is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment F: Calculating Measure C15: Plan All-Cause Readmissions (18+) for the complete formula, example calculation and National Average Observation value used to complete this measure.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Members with a principal diagnosis of pregnancy on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period on the discharge claim. (Required) Exclude members in hospice or using hospice services any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was less than 150.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	Yes
Weighting Category:	Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Admissions and Readmissions to Hospitals

Title	Description

CMIT #: 00561-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 14 %	> 12 % to <= 14 %	> 10 % to <= 12 %	> 8 % to <= 10 %	<= 8 %

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description

Label for Stars: The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol

Label for Data: The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol

Description: This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs. Health plans can help make sure their members are prescribed medications that are more effective for them.

HEDIS Label: Statin Therapy for Patients with Cardiovascular Disease (SPC)

Measure Reference: NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 168

Metric: The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: Exclude members who meet any of the following criteria:
• Pregnancy during the measurement year or year prior to the measurement year.
• In vitro fertilization in the measurement year or year prior to the measurement year.
• Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year.
• ESRD or dialysis during the measurement year or the year prior to the measurement year.
• Cirrhosis during the measurement year or the year prior to the measurement year.
• Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.
• Members in hospice or using hospice services any time during the measurement year.
• Members who died any time during the measurement year.
• Members receiving palliative care any time during the measurement year.
• Members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

Title	Description
	– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded: – At least two indications of frailty with different dates of service during the measurement year. – Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): 1. At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits, virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. 2. At least one acute inpatient encounter with an advanced illness diagnosis. 3. At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. 4. A dispensed dementia medication. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00700-01-C-PARTC

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 81 %	>= 81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %

Measure: C17 - Transitions of Care

Title	Description
Label for Stars:	After hospital stay, members receive information and care they need
Label for Data:	After hospital stay, members receive information and care they need
Description:	This rating is based on the percent of plan members who got follow-up care after a hospital stay. Follow-up care includes: getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 330
Metric:	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). If the admission dates and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. Required exclusions: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.

Title	Description

Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00729-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 44 %	>= 44 % to < 52 %	>= 52 % to < 63 %	>= 63 % to < 77 %	>= 77 %

Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Title	Description
Label for Stars:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Label for Data:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Description:	This rating is based on the percent of plan members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 340
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays. 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place Required exclusions: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00263-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 39 %	>= 39 % to < 53 %	>= 53 % to < 60 %	>= 60 % to < 69 %	>= 69 %

Domain: 3 - Member Experience with Health Plan

Measure: C19 - Getting Needed Care

Title	Description
Label for Stars:	Ease of Getting Needed Care and Seeing Specialists
Label for Data:	Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. 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.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Title	Description
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00293-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 77	>= 77 to < 79	>= 79 to < 82	>= 82 to < 83	>= 83

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C20 - Getting Appointments and Care Quickly

Title	Description
Label for Stars:	Getting Appointments & Care Quickly
Label for Data:	Getting Appointments & Care Quickly (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how quickly members get appointments and care.
Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. 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.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00292-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 80	>= 80 to < 82	>= 82 to < 84	>= 84 to < 86	>= 86

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C21 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. 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.
Primary Data Source:	CAHPS
Data Source Description:	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

Title	Description

information or help you needed?

- In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?
- In the last 6 months, how often were the forms from your health plan easy to fill out?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2024 – 06/2024

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00181-01-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 88	>= 88 to < 89	>= 89 to < 91	>= 91 to < 92	>= 92

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C22 - Rating of Health Care Quality

Title	Description
Label for Stars:	Members' Rating of Health Care Quality
Label for Data:	Members' Rating of Health Care Quality (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Metric:	This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. 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.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00642-01-C-PARTC

Title	Description
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 84	>= 84 to < 85	>= 85 to < 87	>= 87 to < 88	>= 88

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C23 - Rating of Health Plan

Title	Description
Label for Stars:	Members' Rating of Health Plan
Label for Data:	Members’ Rating of Health Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the health plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their health plan. 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.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes

Title	Description
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters. Person-Centered Care
CMIT #:	00643-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 84	>= 84 to < 86	>= 86 to < 88	>= 88 to < 89	>= 89

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: C24 - Care Coordination

Title	Description
Label for Stars:	Coordination of Members' Health Care Services
Label for Data:	Coordination of Members' Health Care Services (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

Title	Description
	• In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00106-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	Yes	No	Yes

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 84	>= 84 to < 85	>= 85 to < 87	>= 87 to < 88	>= 88

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Domain: 4 - Member Complaints and Changes in the Health Plan's Performance

Measure: C25 - Complaints about the Health Plan

Title	Description
Label for Stars:	Complaints about the Health Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of complaints filed with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2023 complaints made by the June 28, 2024 deadline are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTC
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 1.39	> 0.76 to <= 1.39	> 0.37 to <= 0.76	> 0.12 to <= 0.37	<= 0.12

Measure: C26 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2023–December 31, 2023 (numerator) divided by all members enrolled in the contract at any time during 2023 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data

Title	Description
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2023 and 12/31/2023 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4

Title	Description
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 36 %	> 24 % to <= 36 %	> 17 % to <= 24 %	> 8 % to <= 17 %	<= 8 %

Measure: C27 - Health Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Health Plan's Performance
Label for Data:	Improvement (if any) in the Health Plan's Performance
Description:	This shows how much the health plan's performance improved or declined from one year to the next. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2024 and 2025 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2024 and 2025 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment H contains the formulas used to calculate the improvement measure and lists indicating which measures were used.

Title	Description
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00300-01-C-PARTC
Data Display:	Not Applicable

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< -0.179809	>= -0.179809 to < 0	>= 0 to < 0.174445	>= 0.174445 to < 0.421057	>= 0.421057

Domain: 5 - Health Plan Customer Service

Measure: C28 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Stars:	Health Plan Makes Timely Decisions about Appeals
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	This rating shows how fast a plan sends information for an independent review.
Metric:	Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and appeals not evaluated by the IRE because plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Not Evaluated by the IRE Because Plan Agreed to Cover])) * 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is "Not enough data available." Dismissed appeals (except appeals not evaluated by the IRE because plan agreed to cover) and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) + [Appeals Not Evaluated by the IRE Because Plan Agreed to Cover]) - [Late] Note: Appeals Not Evaluated by the IRE Because Plan Agreed to Cover were formerly called Dismissed Because Plan Agreed to Cover. When reviewing IRE data from the Maximus appeals website found at http://www.medicareappeal.com/AppealSearch and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

Title	Description

Previous Field Name	Current Field Name
Upheld	Unfavorable
Overturn	Favorable
Partially Overturn	Partially favorable

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 4

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00562-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 69 %	>= 69 % to < 85 %	>= 85 % to < 95 %	>= 95 % to < 99 %	>= 99 %

Measure: C29 - Reviewing Appeals Decisions

Title	Description

Label for Stars: Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer

Label for Data: Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer

Description: This rating shows how often an independent reviewer found the health plan's decision to deny coverage to be reasonable.

Title	Description
Metric:	Percent of appeals where a plan‘s decision was “upheld” by the Independent Review Entity (IRE) (numerator) out of all the plan‘s appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: ([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2024, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2024 are not reflected in these data and the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is “Not enough data available.” Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00652-01-C-PARTC

Title	Description

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 78 %	>= 78 % to < 92 %	>= 92 % to < 96 %	>= 96 % to < 99 %	>= 99 %

Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description

Label for Stars: Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan

Label for Data: Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan

Description: Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.

Metric: The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes.

Primary Data Source: Call Center

Data Source Description: Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.

Data Source Category: Data Collected by CMS Contractors

Exclusions: Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MAOs, MA-PDs, and MMPs under sanction.

General Notes: Specific questions about Call Center Monitoring and requests for detail data should be directed to CallCenterMonitoring@cms.hhs.gov.

Data Time Frame: 02/2024 – 05/2024

General Trend: Higher is better

Statistical Method: Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	No adjustment for 2022 or 2023 disasters.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00096-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	No	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 46 %	>= 46 % to < 69 %	>= 69 % to < 93 %	>= 93 % to < 100 %	100 %

Part D Domain and Measure Details

See Attachment C for the national averages of individual Part D measures.

Domain: 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MA-PDs, PDPs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to CallCenterMonitoring@cms.hhs.gov.
Data Time Frame:	02/2024 – 05/2024
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access

Title	Description

Weighting Value: 4

Major Disaster: No adjustment for 2022 or 2023 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
No	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 40 %	>= 40 % to < 74 %	>= 74 % to < 90 %	>= 90 % to < 100 %	100 %
PDP	< 70 %	>= 70 % to < 85 %	>= 85 % to < 98 %	>= 98 % to < 100 %	100 %

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance

Measure: D02 - Complaints about the Drug Plan

Title	Description
Label for Stars:	Complaints about the Drug Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Drug Plan (number of complaints for every 1,000 members). (Lower numbers are better because it means fewer complaints.)
Description:	Rate of complaints filed with Medicare about the drug plan.
Metric:	Rate of complaints about the drug plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2023 complaints made by the June 28, 2024 deadline are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTD
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 1.39	> 0.76 to <= 1.39	> 0.37 to <= 0.76	> 0.12 to <= 0.37	<= 0.12
PDP	> 0.32	> 0.2 to <= 0.32	> 0.11 to <= 0.2	> 0.04 to <= 0.11	<= 0.04

Measure: D03 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2023–December 31, 2023 (numerator) divided by all members enrolled in the contract at any time during 2023 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)

Title	Description
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2023 and 12/31/2023 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure

Title	Description
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 36 %	> 24 % to <= 36 %	> 17 % to <= 24 %	> 8 % to <= 17 %	<= 8 %
PDP	> 22 %	> 16 % to <= 22 %	> 9 % to <= 16 %	> 5 % to <= 9 %	<= 5 %

Measure: D04 - Drug Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Drug Plan's Performance
Label for Data:	Improvement (If any) in the Drug Plan's Performance
Description:	This shows how much the drug plan's performance has improved or declined from one year to the next year. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2024 and 2025 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2024 and 2025 Star Ratings
Data Source Category:	Star Ratings

Title	Description

Exclusions: Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.

General Notes: Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Improvement Measure

Weighting Value: 5

Major Disaster: Includes only measures which have data from both years.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00224-01-C-PARTD

Data Display: Not Applicable

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< -0.218869	>= -0.218869 to < 0	>= 0 to < 0.242468	>= 0.242468 to < 0.496603	>= 0.496603
PDP	< -0.282500	>= -0.282500 to < 0	>= 0 to < 0.273334	>= 0.273334 to < 0.576667	>= 0.576667

Domain: 3 - Member Experience with the Drug Plan

Measure: D05 - Rating of Drug Plan

Title	Description
Label for Stars:	Members' Rating of Drug Plan
Label for Data:	Members' Rating of Drug Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the prescription drug plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. 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.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care

Title	Description
CMIT #:	00641-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	No	Yes	Yes

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	< 84	>= 84 to < 86	>= 86 to < 87	>= 87 to < 89	>= 89
PDP	< 79	>= 79 to < 82	>= 82 to < 85	>= 85 to < 87	>= 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Measure: D06 - Getting Needed Prescription Drugs

Title	Description
Label for Stars:	Ease of Getting Prescriptions Filled When Using the Plan
Label for Data:	Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.
Metric:	This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. 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.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better

Title	Description

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 4

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00294-01-C-PARTD

Data Display: Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	No	No	Yes	Yes

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	< 87	>= 87 to < 88	>= 88 to < 90	>= 90 to < 91	>= 91
PDP	< 86	>= 86 to < 87	>= 87 to < 89	>= 89 to < 90	>= 90

These technical notes show the base group cut points for CAHPS measures; please see the Attachment K for the CAHPS Methodology for final star assignment rules.

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder (MPF) website. Higher scores are better because they mean the plan provided more accurate prices.
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than MPF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than MPF) / (Total number of PDEs). The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index and claim percentage index as: 0.5 x (100 – ((accuracy index – 1) x 100)) + 0.5 x ((1 – claim percentage index) x 100).
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data used in this measure are obtained from a number of sources: MPF Pricing Files and PDE data are the primary data sources. The PDE data were submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023- September 30, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the measure. If the PDE edit is informational, and therefore does not result in the PDE being rejected, then the PDE is used. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used.
Data Source Category:	Data Collected by CMS Contractors

Title	Description
Exclusions:	A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria: • If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. • Drug must appear in formulary file and in MPF pricing file • PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug
General Notes:	Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2023 – 09/30/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00452-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	100
PDP	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	100

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description
Label for Stars:	Taking Diabetes Medication as Directed
Label for Data:	Taking Diabetes Medication as Directed
Description:	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The plan, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug,* a *sulfonylurea drug,* a *thiazolidinedione drug*, a *DPP-4 inhibitor,* a *GIP/GLP-1 receptor agonist*, a *meglitinide drug,* or an *SGLT2 inhibitor*. Plan members who take insulin are not included.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GIP/GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then

Title	Description
	the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS’s migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • In hospice • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode,

Title	Description

reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).

The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings, and stays in SNFs. The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments.

When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 87 %	>= 87 % to < 91 %	>= 91 %
PDP	< 85 %	>= 85 % to < 87 %	>= 87 % to < 89 %	>= 89 % to < 93 %	>= 93 %

Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Stars:	Taking Blood Pressure Medication as Directed
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACEI (angiotensin converting enzyme inhibitor)*, an *ARB (angiotensin receptor blocker),* or a *direct renin inhibitor drug*.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the PQA. See the medication list for this measure. The Part D Medication Adherence rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted to the CMS DDPS and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two

Title	Description
	prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the CME, the EDB, and the CWF, and the EDS. The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and SNF stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • In hospice • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings, and stays in SNFs. The discharge date is included as an adjustment day for IP/SNF stays.

Title	Description
	Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00437-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 83 %	>= 83 % to < 87 %	>= 87 % to < 90 %	>= 90 % to < 92 %	>= 92 %
PDP	< 87 %	>= 87 % to < 89 %	>= 89 % to < 90 %	>= 90 % to < 92 %	>= 92 %

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Stars:	Taking Cholesterol Medication as Directed
Label for Data:	Taking Cholesterol Medication as Directed
Description:	Percent of plan members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their statin medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the PQA. See the medication list for this measure. The Medication Adherence rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to the CMS DDPS and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.

Title	Description
	Additional data sources include the CME, the EDB, the CWF, and the EDS. The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, IP and SNF stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • In hospice • ESRD diagnosis or dialysis coverage dates
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings, and stays in SNFs. The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.

Title	Description
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00435-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 89 %	>= 89 % to < 93 %	>= 93 %
PDP	< 86 %	>= 86 % to < 88 %	>= 88 % to < 89 %	>= 89 % to < 92 %	>= 92 %

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Stars:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.

Title	Description
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are only included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. The date of enrollment is counted towards the 60 days but the opt-out date is not. A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days or received a CMR if enrolled for less than 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract. Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2023 Part D Reporting Requirements (data pulled June 2024). Validation of these data was performed retrospectively during the 2024 data validation cycle (deadline June 15, 2024 and data validation results pulled July 2024). Additionally, the Medicare Enrollment Database (EDB) from the Integrated Data Repository (CME IDRC) is used to identify beneficiaries in hospice (data pulled June 2024).
Data Source Category:	Health and Drug Plans

Title	Description
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as “Not required to report.” MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any of the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation. • MBI Number (Element B) • Date of MTM program enrollment (Element H) • Met the specified targeting criteria per CMS – Part D requirements (Element I) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element K) • Received annual CMR with written summary in CMS standardized format (Element O) • Date(s) of CMR(s) (Element P) MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as “CMS identified issues with this plan's data.” See Attachment N for more details on the MTM CMR completion rate measure scoring methodology. Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select “Monitoring,” then “Plan Reporting Data Validation.” Select the appropriate contract year. Select the PRDVM Reports. Select “Score Detail Report.” Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMS at HPMS_Access@cms.hhs.gov. Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "Not enough data available".
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure

Title	Description
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00454-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 57 %	>= 57 % to < 77 %	>= 77 % to < 89 %	>= 89 % to < 93 %	>= 93 %
PDP	< 30 %	>= 30 % to < 55 %	>= 55 % to < 68 %	>= 68 % to < 80 %	>= 80 %

Measure: D12 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Stars:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills on unique dates of service during the measurement period (denominator). Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year or end of the enrollment episode. The SUPD measure is adapted from the measure concept that was developed and endorsed by the PQA. See the medication list for this measure. The SUPD measure is calculated using the NDC lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.

Title	Description
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS DDPS and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023 – December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term “final action” PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the CME, the EDB, the CWF, and the EDS. The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS’s migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify diagnoses based on ICD-10-CM codes.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • Rhabdomyolysis and myopathy • Pregnancy, Lactation, and fertility • Cirrhosis • Pre-Diabetes • Polycystic Ovary Syndrome
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given

Title	Description

episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode.

The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).

Data Time Frame: 01/01/2023 – 12/31/2023

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Yes	Yes	Yes	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 81 %	>= 81 % to < 86 %	>= 86 % to < 89 %	>= 89 % to < 93 %	>= 93 %
PDP	< 80 %	>= 80 % to < 83 %	>= 83 % to < 85 %	>= 85 % to < 87 %	>= 87 %

CAHPS Case-Mix Adjustment

The CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include administrative age, dual eligibility status, low-income subsidy (LIS) indicator, and use of Asian language survey, and self-reported education, general health status, mental health status, and proxy usage status. The tables below include the case-mix variables and show the case-mix coefficients for each of the CAHPS measures included in the Star Ratings. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to otherwise similar people with the baseline value for that characteristic (e.g. reference group), on the original scale of the item or composite, as presented in plan reports. The reference group for each characteristic will have a coefficient value of zero.

For example, for the Part C measure "Rating of Health Plan," the model coefficient for "age 75-79" is 0.0511, indicating that respondents in that age range tend to score their plans 0.0511 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, respondents who had a proxy help aside from answering for them tend to respond 0.0850 points lower on this item than otherwise similar respondents without proxy help. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who had proxy help will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. Item-level coefficients are presented below separately for each composite. For more detailed information on the application of CAHPS case-mix adjustment, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items

Predictor	Get appointment with specialist	Easy to get care
Age: 64 or under	0.0576	-0.0150
Age: 65 – 69	-0.0251	-0.0157
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0043	0.0207
Age: 80 – 84	0.0083	-0.0005
Age: 85 and older	0.0364	0.0224
Education: Less than an 8th grade education	0.0136	-0.0402
Education: Some high school	-0.0119	0.0065
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.0661	-0.0536
Education: College graduate	-0.0921	-0.0552
Education: More than a bachelor's degree	-0.1588	-0.0844
General health rating: excellent	0.1392	0.0480
General health rating: very good	0.0816	0.0596
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0612	-0.0669
General health rating: poor	-0.0762	-0.1168
Mental health rating: excellent	0.1772	0.1754
Mental health rating: very good	0.0943	0.0933
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0630	-0.0547
Mental health rating: poor	-0.1618	-0.1287
Proxy helped	-0.0084	0.0039
Proxy answered	0.0104	0.0574
Medicaid dual eligible	0.0075	0.0107
Low-income subsidy (LIS)	-0.0226	0.0136
Asian survey language	-0.0145	0.0455

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
C01	Breast Cancer Screening	HEDIS	01/01/2023 – 12/31/2023
C02	Colorectal Cancer Screening	HEDIS	01/01/2023 – 12/31/2023
C03	Annual Flu Vaccine	CAHPS	03/2024 – 06/2024
C04	Monitoring Physical Activity	HEDIS-HOS	07/17/2023 – 11/01/2023
C05	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2023 – 12/31/2023
C06	Care for Older Adults – Medication Review	HEDIS	01/01/2023 – 12/31/2023
C07	Care for Older Adults – Pain Assessment	HEDIS	01/01/2023 – 12/31/2023
C08	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2023 – 12/31/2023
C09	Diabetes Care – Eye Exam	HEDIS	01/01/2023 – 12/31/2023
C10	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2023 – 12/31/2023
C11	Controlling Blood Pressure	HEDIS	01/01/2023 – 12/31/2023
C12	Reducing the Risk of Falling	HEDIS-HOS	07/17/2023 – 11/01/2023
C13	Improving Bladder Control	HEDIS-HOS	07/17/2023 – 11/01/2023
C14	Medication Reconciliation Post-Discharge	HEDIS	01/01/2023 – 12/31/2023
C15	Plan All-Cause Readmission	HEDIS	01/01/2023 – 12/31/2023
C16	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2023 – 12/31/2023
C17	Transitions of Care	HEDIS	01/01/2023 – 12/31/2023
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2023 – 12/31/2023
C19	Getting Needed Care	CAHPS	03/2024 – 06/2024
C20	Getting Appointments and Care Quickly	CAHPS	03/2024 – 06/2024
C21	Customer Service	CAHPS	03/2024 – 06/2024
C22	Rating of Health Care Quality	CAHPS	03/2024 – 06/2024
C23	Rating of Health Plan	CAHPS	03/2024 – 06/2024
C24	Care Coordination	CAHPS	03/2024 – 06/2024
C25	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2023 – 12/31/2023
C26	Members Choosing to Leave the Plan	MBDSS	01/01/2023 – 12/31/2023
C27	Health Plan Quality Improvement	Star Ratings	Not Applicable
C28	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2023 – 12/31/2023
C29	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2023 – 12/31/2023
C30	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2024 – 05/2024

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

Contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measure to be eligible to receive a rating in that improvement measure.

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2024 and 2025.

For measures where a higher score is better:

$$\text{Improvement Change Score} = \text{Score in 2025} - \text{Score in 2024}$$

For measures where a lower score is better:

$$\text{Improvement Change Score} = \text{Score in 2024} - \text{Score in 2025}$$

An eligible measure was defined as a measure for which a contract was scored in both the 2024 and 2025 Star Ratings, and there were no significant measure specification changes or a regional contract reconfiguration for which only contract data is available from the original contract in one or both years.

For each measure, significant improvement or decline between Star Ratings years 2024 and 2025 was determined by a two-sided t-test at the 0.05 significance level:

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} > 1.96\text{, then YES = significant improvement}$$

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} < -1.96\text{, then YES = significant decline}$$

Hold Harmless Provision for Individual Measures: If a contract demonstrated statistically significant decline (at the 0.05 significance level) on an attainment measure for which they received five stars during both the current contract year and the prior contract year, then this measure will be counted as showing no significant change. Measures that are held harmless as described here will be considered eligible for the improvement measure. Net improvement is calculated for each class of measures (e.g., outcome, access, and process) by subtracting the number of significantly declined measures from the number of significantly improved measures.

$$\text{Net Improvement} = \text{Number of significantly improved measures} - \text{Number of significantly declined measures}$$

The improvement measure score is calculated for Parts C and D separately by taking a weighted sum of net improvement divided by the weighted sum of the number of eligible measures.

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 4

Process measure: Weight of 1

Specific weights for each measure, which may deviate from the general scheme above are described in Attachment G. When the weight of an individual measure changes over the two years of data used, the newer weight value is used in the improvement calculation.

$$\text{Improvement Measure Score} = \frac{\text{Net\_Imp\_Process} + 3 * \text{Net\_Imp\_Outcome} + 4 * \text{Net\_Imp\_PtExp}}{\text{Elig\_Process} + 3 * \text{Elig\_Outcome} + 4 * \text{Elig\_PtExp}}$$

Net_Imp_Process = Net improvement for process measures
Net_Imp_Outcome = Net improvement for outcome and intermediate outcome measures
Net_Imp_PtExp = Net improvement for patient experience/complaints and access measures
Elig_Process = Number of eligible process measures
Elig_Outcome = Number of eligible outcome and intermediate outcome measures
Elig_PtExp = Number of eligible patient experience/complaints and access measures

The improvement measure score is converted into a Star Rating using the clustering method. Conceptually, the clustering algorithm identifies the "gaps" in the data and creates cut points that result in the creation of five categories (one for each Star Rating) such that scores of contracts in the same score category (Star Rating) are as similar as possible, and scores of contracts in different categories are as different as possible. Improvement scores of 0 (equivalent to no net change on the attainment measures included in the improvement measure calculation) will be centered at 3 stars when assigning the improvement measure Star Rating. Then, the remaining contracts are split into two groups and clustered: 1) improvement scores less than zero receive one or two stars on the improvement measure and 2) improvement scores greater than or equal to zero receive 3, 4, or 5 stars.

General Standard Error Formula

Because a contract's score on a given measure in one year is not independent of its score in the next year, the standard error for the improvement change score for each measure is calculated using the standard approach for estimating the variance of the difference between two variables that may not be independent. In particular, the standard error of the improvement change score is calculated using the formula:

$$\sqrt{se(Y_{i2})^2 + se(Y_{i1})^2 - 2 * Cov(Y_{i2}, Y_{i1})}$$

Using measure C01 as an example, the change score standard error is:

$se(Y_{i2})$ Represents the 2025 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2024 standard error for contract i on measure C01

Y_{i2} Represents the 2025 rate for contract i on measure C01

Y_{i1} Represents the 2024 rate for contract i on measure C01

cov Represents the covariance between Y_{i2} and Y_{i1} computed using the correlation across all contracts observed at both time points (2025 and 2024). In other words:

$$cov(Y_{i2}, Y_{i1}) = se(Y_{i2}) * se(Y_{i1}) * Corr(Y_{i2}, Y_{i1})$$

where the correlation $Corr(Y_{i2}, Y_{i1})$ is assumed to be the same for all contracts and is computed using data for all contracts for which both years' measure scores are available and not excluded by the disaster policy. This assumption is needed because only one score is observed for each contract in each year; therefore, it is not possible to compute a contract-specific correlation.

Improvement Change Score Standard Error Numerical Example

For measure C03, contract A:

$se(Y_{i2})$ = 2.805

$se(Y_{i1})$ = 3.000

$Corr(Y_{i2}, Y_{i1})$ = 0.901

Relative Distribution and Significance Testing (CAHPS) Methodology

The CAHPS measures are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses. See Attachment A for the case-mix adjusters. The percentile cut points for base groups are defined by current-year distribution of case-mix adjusted contract means. Percentile cut points are rounded to the nearest integer on the 0-100 reporting scale, and each base group includes those contracts whose rounded mean score is at or above the lower limit and below the upper limit. The number of stars assigned is determined by the position of the contract mean score relative to percentile cutoffs from the distribution of contract weighted mean scores from all contracts (which determines the base group); statistical significance of the difference of the contract mean from the national mean along with the direction of the difference; the statistical reliability of the estimate (based on the ratio of sampling variation for each contract mean to between-contract variation); and the standard error of the mean score. All statistical tests, including comparisons involving standard errors, are computed using unrounded scores.

CAHPS reliability calculation details are provided under the section header, "MA & PDP CAHPS Between-Contract Variances for Reported Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings. Tables K-8 and K-9 contain the rules applied to determine the final CAHPS measure star value.

Table K-8: CAHPS Star Assignment Rules

Star	Criteria for Assigning Star Ratings
1	A contract is assigned one star if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is lower than the 15th percentile; AND (b) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) below the 15th percentile.
2	A contract is assigned two stars if it does not meet the one-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is lower than the 30th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is lower than the 15th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score and below the 60th percentile.
3	A contract is assigned three stars if it meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 30th percentile and lower than the 60th percentile, AND it is not statistically significantly different from the national average CAHPS measure score; OR (b) its average CAHPS measure score is at or above the 15th percentile and lower than the 30th percentile, AND the reliability is low, AND the score is not statistically significantly lower than the national average CAHPS measure score; OR (c) its average CAHPS measure score is at or above the 60th percentile and lower than the 80th percentile, AND the reliability is low, AND the score is not statistically significantly higher than the national average CAHPS measure score.
4	A contract is assigned four stars if it does not meet the five-star criteria and meets at least one of these three criteria: (a) its average CAHPS measure score is at or above the 60th percentile and the measure does not have low reliability; OR (b) its average CAHPS measure score is at or above the 80th percentile and the measure has low reliability; OR (c) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score and above the 30th percentile.
5	A contract is assigned five stars if both criteria (a) and (b) are met plus at least one of criteria (c) and (d): (a) its average CAHPS measure score is at or above the 80th percentile; AND (b) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score; (c) the reliability is not low; OR (d) its average CAHPS measure score is more than one standard error (SE) above the 80th percentile.

Administration of the MA & PDP CAHPS Survey

The MA & PDP CAHPS Survey is conducted with a sample of Medicare enrollees who are at least 18 years of age and currently enrolled in an MA contract or PDP for six months or more, and who live in the United States. Efforts are made by CMS to exclude enrollees who are known to be institutionalized at the time of the sample draw. The MA & PDP CAHPS Survey is administered using a single data collection protocol of web-mail-phone. The data collection protocol includes:

- A pre-notification letter
- An email or letter invitation to a web survey
- A web survey reminder email
- Up to two survey mailings to non-respondents to the web survey
- Telephone follow-up to non-respondents to the web and mail surveys

Prior to 2011, CMS paid for all data collection activities and contracted with a single survey vendor for data collection. Beginning in 2011, CMS required all MA and PDP contracts with at least 600 enrollees as of July the previous year to contract with approved MA & PDP CAHPS Survey vendors to collect and report MA & PDP CAHPS Survey data. Collection of MA & PDP CAHPS Survey data follows a specific data collection timeline and protocol established by CMS. Beginning with 2012 MA & PDP CAHPS Survey administration, CMS required all MA organizations, 1876 cost contracts, and Part D sponsors with 600 or more enrollees as of July the previous year to contract with approved MA & PDP CAHPS Survey vendors to collect and report MA & PDP CAHPS Survey data. Medicare-Medicaid plans (MMP) began fielding the survey in 2015.

The MA & PDP CAHPS Survey is conducted at the contract level. CMS will select the sample and provide the approved survey vendors with separate sample files for each Medicare contract. The MA & PDP CAHPS Survey is conducted on an annual basis. CMS will continue to implement the Medicare CAHPS Survey for enrollees in FFS Medicare.

Public Reporting and Use of the 2024 MA & PDP CAHPS Survey Data

The MA & PDP CAHPS Survey produces comparable data on the enrollee's experience of care that allow objective and meaningful comparisons between MA and PDP contracts on domains that are important to consumers. The survey results are publicly reported by CMS for each contract in the Medicare & You Handbook published each fall and on the Medicare Plan Finder website (www.medicare.gov). The survey results are used by enrollees to assist in their selection of an MA or PDP contract. The public and research community can use survey results to assess Medicare program performance. In addition, contracts can use survey results to identify areas for quality improvement. Medicare administrators and policymakers also rely on the use of measures to manage the program; devise, implement, and monitor quality improvement efforts; and make policy decisions. Beginning in 2012, the CAHPS data have been included in the Star Ratings for MA Quality Bonus Payments. CMS will also continue to make the FFS Medicare CAHPS measures available to the general public.

IX. DATA ANALYSIS AND PUBLIC REPORTING

Overview

This section describes the public reporting of the 2024 survey results in the Medicare & You Handbook, in the Medicare Plan Finder website (www.medicare.gov), the reports prepared for plans, and the data analysis of the MA & PDP CAHPS Survey conducted by CMS. It also provides a discussion of data analyses that survey vendors may conduct for plans. Survey results for the 2023 MA & PDP CAHPS Survey will be available in the fall of 2024.

Reporting

Public Reporting of 2024 MA & PDP CAHPS Survey Data

MA & PDP CAHPS Survey data are publicly reported by contract (MA and PDP) and state (FFS). Limited information from the MA & PDP CAHPS Survey is published in the Medicare & You Handbook and additional measures are included on the Medicare Plan Finder website (www.medicare.gov) each fall. The survey data can also be found on CMS's website at https://go.cms.gov/partcanddstarratings. Public reporting of the survey results is designed to create incentives for contracts to improve their quality of care and also serves to enhance public accountability in healthcare by increasing the transparency of the quality of care provided by Medicare contracts. The measures derived from the surveys are used by enrollees to help choose an MA or PDP plan. Medicare administrators and policymakers also rely on the measures to manage the program; devise, implement, and monitor quality improvement efforts; and make policy decisions.

Additional Reporting of 2024 Medicare CAHPS Data to Plans

Official CAHPS preview reports will be emailed to Medicare Compliance Officers in late August 2024. In addition to these preview reports, CMS provides each MA and PDP contract that participates in the MA & PDP CAHPS Survey a more detailed report that summarizes that contract's survey results and compares contract scores to state and national-level benchmarks. Each plan report also compares the contract's CAHPS scores to those from FFS enrollees, as well as to other MA or PDP contracts within the contract's market area. Official CAHPS plan reports will be provided via email to Medicare Compliance Officers in late fall 2024.

In addition to the global ratings, individual items, and composite measures, the reports to plans include a response rate for the plan. The response rate reported to plans includes all surveys used in analysis divided by the total eligible sample. If survey vendors want to replicate this response rate for the purposes of internal client reporting, CMS recommends the following as a close approximation of that rate: include completed (code 10) and partially completed (code 31) surveys in the numerator, divided by the denominator of total sample minus all ineligible enrollees. Ineligible enrollees include sample cases with a final disposition of Institutionalized (code 11), Deceased (code 20), Mentally or Physically Unable to Respond (code 24), and Excluded From Survey (code 40).

When calculating the response rate, code 34 (incomplete or blank survey returned) is **not** included in the numerator, but **is** included in the total sample component of the denominator.

Data Cleaning Prior to Case-Mix Adjustment

A forward-cleaning approach is used for editing and cleaning survey data. This approach uses responses to the "screener" (or gate) items to control how subsequent items within the questionnaire are treated, such as setting responses to a missing value or retaining the original response. Under this forward data cleaning approach, screener items that were initially unanswered are **not** updated or back-filled based on responses to subsequent items.

Data are cleaned using the following forward-cleaning conventions and guidelines:

- Survey items that contain multiple responses (double-grid) when only one response is allowed are set to "M – Missing"
- If a screener question is blank, but there are data in the dependent questions, those data are used in analysis and the screener is recorded as "M – Missing"
- If the response to a screener question is valid, but the respondent violates the skip instruction by answering dependent questions that should have been skipped, the response to the screener question is retained and the responses for the dependent questions are set to "M – Missing" (with the exception of Customer Service, item 3 as referenced above)
- Embedded screener questions (a skip pattern within a skip pattern) are treated in the same way as a primary screener question. The embedded skip pattern is evaluated first, followed by the primary skip pattern.

Special missing value codes are assigned to recoded questionnaire variables to indicate the type of missing data.

Case-Mix Adjustment and Weighting

Certain respondent characteristics, such as education, are not under the control of the health plan, but are related to the sampled enrollee's survey responses. To ensure that comparisons between contracts reflect differences in performance rather than differences in case-mix, CMS adjusts for such respondent characteristics when comparing contracts in preview reports and public reporting.

In general, for example, individuals with less education and those who report better general and mental health provide more positive ratings and reports of care. The case-mix model used for analyzing MA & PDP CAHPS Survey data includes the following variables (each of which has mutually exclusive categories):

- Education
- Self-reported general health status
- Self-reported mental health status
- Proxy completion of the survey or other proxy assistance
- Dual eligibility*; Low income subsidy but not dual eligibility*
- Age* (calculated as the difference between survey finalization year and year of birth)
- Asian (Chinese, Korean, Tagalog, and Vietnamese) language survey completion

** Note: CMS Administrative Data*

Although proxy reporting has contributed very weakly to differences in contract means, it has been retained as an adjustor to allay concerns that are occasionally voiced about the effects of proxy responses on scores.

Case-mix adjustment is implemented via linear regression models predicting CAHPS measures from case-mix adjustors and contract indicators. In these models, missing case-mix adjustors are imputed as the contract mean. Adjusted means represent the mean that would be obtained for a given contract if the average of the case-mix variables for that contract was equal to the national average across all contracts.[2]

Respondent data for each contract are weighted by the ratio of survey-eligible enrollment in the contract to respondents. Some MA contracts include both one or more plans with a Part D benefit and one or more MA-Only plans; these two subgroups are therefore differentially weighted in scoring and case-mix calculations for Part C (MA) measures in such contracts. See "Sample Selection and Eligibility Criteria" for additional information. For the applicable contracts, these weights are necessary to reproduce official scores on Part C measures.

The following three components are needed for case-mix adjustment at the contract level:

- Weighted contract means for each case-mix variable for respondents who answered the item being adjusted
- Weighted national means for each case-mix variable for respondents who answered the item being adjusted
- Individual-level coefficients for each case-mix variable in the model predicting individual responses, conditional on contract indicator variables

Vendors have the data to calculate the first component. CMS now supplies the second and third components annually.

Note: Each of these components is based only on respondents who answered the corresponding CAHPS items.

The formula used to calculate a case-mix adjusted score is as follows: Adjusted Score = Raw Score – Net Adjustment. The net adjustment is the sum of a series of products. Each product is, for a single case-mix adjusted variable, calculated as follows: (Contract Mean – National Mean) * Coefficient.

[2] Consequently, the national mean of contract means for any rating or report is unchanged by case-mix adjustment.

CAHPS reliability calculation details are provided in the document, "https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/2020-instructions-for-analyzing-data.pdf."

Defining Market Areas

Each contract's "market area" is determined by comparing its county-level survey samples with those of every other MA or PDP contract. Another contract is included in the report contract's market area for comparison if there is an overlap of at least five percent of the report contract's enrollment and vice-versa (the other contract must also have at least five percent of its enrollment in the report contract's county). Private Fee-for-Service (PFFS) MA contracts, which typically have multi-state if not national enrollment, are not included in the market area definition. However, enrollees in PFFS MA contracts are included in the national and state benchmarks.

Survey Vendor Analysis of MA & PDP CAHPS Survey Data

CMS-calculated results for the MA & PDP CAHPS Survey are the official survey results. CMS will continue to provide MA & PDP contracts with reports that contain information that can be used for quality improvement purposes (including information related to market and service area as described above). However, a survey vendor may analyze the survey data to provide contracts with additional information that contracts can use for quality improvement purposes as long as **the vendor suppresses any report or display of data that includes cell sizes with fewer than 11 observations.** No cell sizes under 11 can be displayed in any cross tabulations, frequency distributions, tables, Excel files, or other reporting mechanisms. This guidance also applies to reporting response rates. Intervention or follow-up with low scoring individuals is not permitted. Survey vendors should ensure that contracts recognize that these survey vendor analyses are **not** official survey results and should **only** be used for quality improvement purposes. Survey vendors may provide contracts with preliminary survey data that the survey vendor develops specifically for the contract. As a result, the survey vendor scores may differ slightly from the official CMS results. When providing contracts with preliminary survey data, survey vendors must communicate to contracts that the survey vendor scores are **not** the official CMS scores. **All reports provided to the contracts must include a statement on each page that vendor results are unofficial and are for the contract's internal quality improvement purposes only, whether paper or electronic report format. The statement must be printed in a minimum 14-point font size.**

In addition, survey vendors will not be able to provide enrollee -level datasets to their contracts, as these data could be used to identify an individual, which would violate the guarantee of confidentiality that CMS provides all survey respondents. For example, survey vendors may **not** provide contracts with names of enrollees selected for the survey, or provide contracts their full enrollee file with names of sampled enrollees removed. Survey vendors must not use any MA & PDP CAHPS survey data, whether preliminary or final results, for any purpose beyond client reports for quality improvement purposes. Survey results may not be published on public facing websites or in marketing materials. Findings may not be shared beyond quality improvement reports to clients. Vendor marketing materials should be limited to the vendor's role in data collection activities and may not state or imply that the vendor can improve a client's Star Ratings**.**

15. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

16. In the last 6 months, how often did your personal doctor spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

17. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

- ☐ 0 Worst personal doctor possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best personal doctor possible

18. In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

19. In the last 6 months, did your personal doctor order a blood test, x-ray or other test for you?

- ☐ Yes
- ☐ No →**If No, Go to Question 22**

20. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

21. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

24. May the Medicare Program follow up with you to learn more about your health care, or to invite you to a group discussion or interview on topics related to health care?

- ☐ Yes
- ☐ No

25. Did someone help you complete this survey?

- ☐ Yes
- ☐ No → **Thank you. Please return the completed survey in the postage-paid envelope.**

26. How did that person help you? Please mark one or more.

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

Thank you.

Please return the completed survey in the postage-paid envelope.

[SURVEY VENDOR RETURN ADDRESS FOR MAIL PROCESSING]

Contract Name: _____

[OPTIONAL]
You may also know your plan by one of the following:

H2261 Overall

As of 5/9/2025

Contract: H2261 Contract Type: Local & Regional CCP w/o SNP					Calculation Without Improvement					
Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.										
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	82	5	1	5	3.662921	1.337079	1.787780	1.787780
	HEDIS	**C02: Colorectal Cancer Screening**	78	4	1	4	3.662921	0.337079	0.113622	0.113622
	CAHPS	**C03: Annual Flu Vaccine**	80	5	1	5	3.662921	1.337079	1.787780	1.787780
	HEDIS / HOS	**C04: Monitoring Physical Activity**	51	3	1	3	3.662921	-0.662921	0.439464	0.439464
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	38	2	1	2	3.662921	-1.662921	2.765306	2.765306
	HEDIS	**C09: Diabetes Care – Eye Exam**	80	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	87	4	3	12	3.662921	0.337079	0.113622	0.340867
	HEDIS	**C11: Controlling Blood Pressure**	77	3	3	9	3.662921	-0.662921	0.439464	1.318393
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	53	2	1	2	3.662921	-1.662921	2.765306	2.765306
	HEDIS / HOS	**C13: Improving Bladder Control**	41	2	1	2	3.662921	-1.662921	2.765306	2.765306
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	73	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C15: Plan All-Cause Readmissions**	5	5	3	15	3.662921	1.337079	1.787780	5.363341
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	90	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C17: Transitions of Care**	72	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	63	4	1	4	3.662921	0.337079	0.113622	0.113622
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	80	3	4	12	3.662921	-0.662921	0.439464	1.757857
	CAHPS	**C20: Getting Appointments and Care Quickly**	83	3	4	12	3.662921	-0.662921	0.439464	1.757857
	CAHPS	**C21: Customer Service**	92	5	4	20	3.662921	1.337079	1.787780	7.151121
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.662921	-1.662921	2.765306	11.061225
	CAHPS	**C23: Rating of Health Plan**	86	2	4	8	3.662921	-1.662921	2.765306	11.061225
	CAHPS	**C24: Care Coordination**	86	3	4	12	3.662921	-0.662921	0.439464	1.757857
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.03	5	4	20	3.662921	1.337079	1.787780	7.151121
	MBDSS	**C26: Members Choosing to Leave the Plan**	7	5	4	20	3.662921	1.337079	1.787780	7.151121
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	**Not used in this Calculation**					
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	100	5	4	20	3.662921	1.337079	1.787780	7.151121
	IRE	**C29: Reviewing Appeals Decisions**	100	5	4	20	3.662921	1.337079	1.787780	7.151121
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.662921	1.337079	1.787780	7.151121
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.662921	0.337079	0.113622	0.454489
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.03	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	7	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	5	**Not used in this Calculation**					
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.662921	-1.662921	2.765306	11.061225
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.662921	-1.662921	2.765306	11.061225
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.662921	-0.662921	0.439464	0.439464
	PDE data	**D08: Medication Adherence for Diabetes Medications**	89	4	3	12	3.662921	0.337079	0.113622	0.340867
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	91	4	3	12	3.662921	0.337079	0.113622	0.340867
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	90	4	3	12	3.662921	0.337079	0.113622	0.340867
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	74	2	1	2	3.662921	-1.662921	2.765306	2.765306
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.662921	-1.662921	2.765306	2.765306
Rated Like MA-PD	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**				**89** Sum of weights	**326** Sum of weights * stars	**3.662921** Calculated Summary Mean			**119.887640** Sum of weighted squared diffs
	2022 Major Disaster % 0									
	2023 Major Disaster % 0									

New Measure(s)	With	With
Improvement	Without	With
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.662921	3.747475
CAI Value	-0.033597	-0.033597
Final Summary	3.629324	3.713878
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

35 # eligible measures

1.386671 Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

Without Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.795388
70th	1.216635
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.662921
85th	3.977528

H2261 Overall

As of 5/9/2025

Contract: H2261 Contract Type: Local & Regional CCP w/o SNP Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.					Calculation With Improvement					
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	82	5	1	5	3.747475	1.252525	1.568819	1.568819
	HEDIS	**C02: Colorectal Cancer Screening**	78	4	1	4	3.747475	0.252525	0.063769	0.063769
	CAHPS	**C03: Annual Flu Vaccine**	80	5	1	5	3.747475	1.252525	1.568819	1.568819
	HEDIS / HOS	**C04: Monitoring Physical Activity**	51	3	1	3	3.747475	-0.747475	0.558719	0.558719
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	38	2	1	2	3.747475	-1.747475	3.053669	3.053669
	HEDIS	**C09: Diabetes Care – Eye Exam**	80	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	87	4	3	12	3.747475	0.252525	0.063769	0.191307
	HEDIS	**C11: Controlling Blood Pressure**	77	3	3	9	3.747475	-0.747475	0.558719	1.676157
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	53	2	1	2	3.747475	-1.747475	3.053669	3.053669
	HEDIS / HOS	**C13: Improving Bladder Control**	41	2	1	2	3.747475	-1.747475	3.053669	3.053669
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	73	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C15: Plan All-Cause Readmissions**	5	5	3	15	3.747475	1.252525	1.568819	4.706457
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	90	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C17: Transitions of Care**	72	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	63	4	1	4	3.747475	0.252525	0.063769	0.063769
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	CAHPS	**C20: Getting Appointments and Care Quickly**	83	3	4	12	3.747475	-0.747475	0.558719	2.234876
	CAHPS	**C21: Customer Service**	92	5	4	20	3.747475	1.252525	1.568819	6.275276
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.747475	-1.747475	3.053669	12.214676
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4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.03	5	4	20	3.747475	1.252525	1.568819	6.275276
	MBDSS	**C26: Members Choosing to Leave the Plan**	7	5	4	20	3.747475	1.252525	1.568819	6.275276
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	5	20	3.747475	0.252525	0.063769	0.318844
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	100	5	4	20	3.747475	1.252525	1.568819	6.275276
	IRE	**C29: Reviewing Appeals Decisions**	100	5	4	20	3.747475	1.252525	1.568819	6.275276
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.747475	1.252525	1.568819	6.275276
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.747475	0.252525	0.063769	0.255076
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.03	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	7	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	5	5	25	3.747475	1.252525	1.568819	7.844094
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.747475	-1.747475	3.053669	12.214676
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.747475	-1.747475	3.053669	12.214676
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.747475	-0.747475	0.558719	0.558719
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	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	90	4	3	12	3.747475	0.252525	0.063769	0.191307
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	74	2	1	2	3.747475	-1.747475	3.053669	3.053669
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.747475	-1.747475	3.053669	3.053669

Rated Like	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**		**99**	**371**	**3.747475**		**128.686869**
MA-PD	**2022 Major Disaster %**	**0**					
	2023 Major Disaster %	**0**					
			Sum of weights	**Sum of weights * stars**	**Calculated Summary Mean**		**Sum of weighted squared diffs**

New Measure(s) Improvement	**With Without**	**With With**
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.662921	3.747475
CAI Value	-0.033597	-0.033597
Final Summary	3.629324	3.713878
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

37
 # eligible measures

1.335975
Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

With Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.828220
70th	1.240423
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.646465
85th	3.949495

H2230 Overall

As of 5/9/2025

Contract: H2230 **Contract Type: Local & Regional CCP w/o SNP**

Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.

Domain	Primary Data Source	Quality Measure	Score	Star	Calculation Without Improvement: Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	84	5	1	5	3.595506	1.404494	1.972603	1.972603
	HEDIS	**C02: Colorectal Cancer Screening**	81	4	1	4	3.595506	0.404494	0.163615	0.163615
	CAHPS	**C03: Annual Flu Vaccine**	81	5	1	5	3.595506	1.404494	1.972603	1.972603
	HEDIS / HOS	**C04: Monitoring Physical Activity**	53	4	1	4	3.595506	0.404494	0.163615	0.163615
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	47	3	1	3	3.595506	-0.595506	0.354627	0.354627
	HEDIS	**C09: Diabetes Care – Eye Exam**	83	5	1	5	3.595506	1.404494	1.972603	1.972603
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	85	4	3	12	3.595506	0.404494	0.163615	0.490846
	HEDIS	**C11: Controlling Blood Pressure**	80	4	3	12	3.595506	0.404494	0.163615	0.490846
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	49	1	1	1	3.595506	-2.595506	6.736651	6.736651
	HEDIS / HOS	**C13: Improving Bladder Control**	48	4	1	4	3.595506	0.404494	0.163615	0.163615
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	68	3	1	3	3.595506	-0.595506	0.354627	0.354627
	HEDIS	**C15: Plan All-Cause Readmissions**	6	5	3	15	3.595506	1.404494	1.972603	5.917810
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	88	4	1	4	3.595506	0.404494	0.163615	0.163615
	HEDIS	**C17: Transitions of Care**	67	4	1	4	3.595506	0.404494	0.163615	0.163615
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	64	4	1	4	3.595506	0.404494	0.163615	0.163615
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	79	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**C20: Getting Appointments and Care Quickly**	81	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**C21: Customer Service**	91	4	4	16	3.595506	0.404494	0.163615	0.654462
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**C23: Rating of Health Plan**	87	3	4	12	3.595506	-0.595506	0.354627	1.418510
	CAHPS	**C24: Care Coordination**	85	2	4	8	3.595506	-1.595506	2.545639	10.182558
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.04	5	4	20	3.595506	1.404494	1.972603	7.890414
	MBDSS	**C26: Members Choosing to Leave the Plan**	2	5	4	20	3.595506	1.404494	1.972603	7.890414
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	**Not used in this Calculation**					
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	99	5	4	20	3.595506	1.404494	1.972603	7.890414
	IRE	**C29: Reviewing Appeals Decisions**	98	4	4	16	3.595506	0.404494	0.163615	0.654462
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.595506	1.404494	1.972603	7.890414
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.595506	0.404494	0.163615	0.654462
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.04	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	2	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	3	**Not used in this Calculation**					
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.595506	-1.595506	2.545639	10.182558
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.595506	-0.595506	0.354627	0.354627
	PDE data	**D08: Medication Adherence for Diabetes Medications**	88	4	3	12	3.595506	0.404494	0.163615	0.490846
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	92	5	3	15	3.595506	1.404494	1.972603	5.917810
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	89	4	3	12	3.595506	0.404494	0.163615	0.490846
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	77	3	1	3	3.595506	-0.595506	0.354627	0.354627
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.595506	-1.595506	2.545639	2.545639

Rated Like MA-PD	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**		**89** Sum of weights	**320** Sum of weights * stars	**3.595506** Calculated Summary Mean	**127.438202** Sum of weighted squared diffs
	2022 Major Disaster % **0**					
	2023 Major Disaster % **0**					

New Measure(s) Improvement	With Without	With With
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.595506	3.585859
CAI Value	-0.058127	-0.058127
Final Summary	3.537379	3.527732
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

35 # eligible measures

1.474004 Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

Without Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.795388
70th	1.216635
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.662921
85th	3.977528

H2230 Overall

As of 5/9/2025

Contract: H2230 Contract Type: Local & Regional CCP w/o SNP Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.					Calculation With Improvement					
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	84	5	1	5	3.585859	1.414141	1.999795	1.999795
	HEDIS	**C02: Colorectal Cancer Screening**	81	4	1	4	3.585859	0.414141	0.171513	0.171513
	CAHPS	**C03: Annual Flu Vaccine**	81	5	1	5	3.585859	1.414141	1.999795	1.999795
	HEDIS / HOS	**C04: Monitoring Physical Activity**	53	4	1	4	3.585859	0.414141	0.171513	0.171513
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	47	3	1	3	3.585859	-0.585859	0.343231	0.343231
	HEDIS	**C09: Diabetes Care – Eye Exam**	83	5	1	5	3.585859	1.414141	1.999795	1.999795
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	85	4	3	12	3.585859	0.414141	0.171513	0.514538
	HEDIS	**C11: Controlling Blood Pressure**	80	4	3	12	3.585859	0.414141	0.171513	0.514538
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	49	1	1	1	3.585859	-2.585859	6.686667	6.686667
	HEDIS / HOS	**C13: Improving Bladder Control**	48	4	1	4	3.585859	0.414141	0.171513	0.171513
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	68	3	1	3	3.585859	-0.585859	0.343231	0.343231
	HEDIS	**C15: Plan All-Cause Readmissions**	6	5	3	15	3.585859	1.414141	1.999795	5.999384
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	88	4	1	4	3.585859	0.414141	0.171513	0.171513
	HEDIS	**C17: Transitions of Care**	67	4	1	4	3.585859	0.414141	0.171513	0.171513
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	64	4	1	4	3.585859	0.414141	0.171513	0.171513
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	79	2	4	8	3.585859	-1.585859	2.514949	10.059795
	CAHPS	**C20: Getting Appointments and Care Quickly**	81	2	4	8	3.585859	-1.585859	2.514949	10.059795
	CAHPS	**C21: Customer Service**	91	4	4	16	3.585859	0.414141	0.171513	0.686051
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.585859	-1.585859	2.514949	10.059795
	CAHPS	**C23: Rating of Health Plan**	87	3	4	12	3.585859	-0.585859	0.343231	1.372923
	CAHPS	**C24: Care Coordination**	85	2	4	8	3.585859	-1.585859	2.514949	10.059795
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.04	5	4	20	3.585859	1.414141	1.999795	7.999179
	MBDSS	**C26: Members Choosing to Leave the Plan**	2	5	4	20	3.585859	1.414141	1.999795	7.999179
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	5	20	3.585859	0.414141	0.171513	0.857564
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	99	5	4	20	3.585859	1.414141	1.999795	7.999179
	IRE	**C29: Reviewing Appeals Decisions**	98	4	4	16	3.585859	0.414141	0.171513	0.686051
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.585859	1.414141	1.999795	7.999179
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.585859	0.414141	0.171513	0.686051
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.04	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	2	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	3	5	15	3.585859	-0.585859	0.343231	1.716154
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.585859	-1.585859	2.514949	10.059795
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.585859	-1.585859	2.514949	10.059795
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.585859	-0.585859	0.343231	0.343231
	PDE data	**D08: Medication Adherence for Diabetes Medications**	88	4	3	12	3.585859	0.414141	0.171513	0.514538
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	92	5	3	15	3.585859	1.414141	1.999795	5.999384
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	89	4	3	12	3.585859	0.414141	0.171513	0.514538
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	77	3	1	3	3.585859	-0.585859	0.343231	0.343231
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.585859	-1.585859	2.514949	2.514949

Rated Like	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**		**99**	**355**	**3.585859**		**130.020202**
MA-PD	**2022 Major Disaster %**	**0**					
	2023 Major Disaster %	**0**	**Sum of weights**	**Sum of weights * stars**	**Calculated Summary Mean**		**Sum of weighted squared diffs**

New Measure(s)	**With**	**With**
Improvement	**Without**	**With**
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.595506	3.585859
CAI Value	-0.058127	-0.058127
Final Summary	3.537379	3.527732
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

37
 # eligible measures

1.349817
Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

With Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.828220
70th	1.240423
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.646465
85th	3.949495

H2261 Overall

As of 5/9/2025

Contract: H2261 Contract Type: Local & Regional CCP w/o SNP					Calculation Without Improvement					
Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.										
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	82	5	1	5	3.662921	1.337079	1.787780	1.787780
	HEDIS	**C02: Colorectal Cancer Screening**	78	4	1	4	3.662921	0.337079	0.113622	0.113622
	CAHPS	**C03: Annual Flu Vaccine**	80	5	1	5	3.662921	1.337079	1.787780	1.787780
	HEDIS / HOS	**C04: Monitoring Physical Activity**	51	3	1	3	3.662921	-0.662921	0.439464	0.439464
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	38	2	1	2	3.662921	-1.662921	2.765306	2.765306
	HEDIS	**C09: Diabetes Care – Eye Exam**	80	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	87	4	3	12	3.662921	0.337079	0.113622	0.340867
	HEDIS	**C11: Controlling Blood Pressure**	77	3	3	9	3.662921	-0.662921	0.439464	1.318393
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	53	2	1	2	3.662921	-1.662921	2.765306	2.765306
	HEDIS / HOS	**C13: Improving Bladder Control**	41	2	1	2	3.662921	-1.662921	2.765306	2.765306
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	73	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C15: Plan All-Cause Readmissions**	5	5	3	15	3.662921	1.337079	1.787780	5.363341
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	90	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C17: Transitions of Care**	72	4	1	4	3.662921	0.337079	0.113622	0.113622
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	63	4	1	4	3.662921	0.337079	0.113622	0.113622
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	80	3	4	12	3.662921	-0.662921	0.439464	1.757857
	CAHPS	**C20: Getting Appointments and Care Quickly**	83	3	4	12	3.662921	-0.662921	0.439464	1.757857
	CAHPS	**C21: Customer Service**	92	5	4	20	3.662921	1.337079	1.787780	7.151121
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.662921	-1.662921	2.765306	11.061225
	CAHPS	**C23: Rating of Health Plan**	86	2	4	8	3.662921	-1.662921	2.765306	11.061225
	CAHPS	**C24: Care Coordination**	86	3	4	12	3.662921	-0.662921	0.439464	1.757857
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.03	5	4	20	3.662921	1.337079	1.787780	7.151121
	MBDSS	**C26: Members Choosing to Leave the Plan**	7	5	4	20	3.662921	1.337079	1.787780	7.151121
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	**Not used in this Calculation**					
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	100	5	4	20	3.662921	1.337079	1.787780	7.151121
	IRE	**C29: Reviewing Appeals Decisions**	100	5	4	20	3.662921	1.337079	1.787780	7.151121
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.662921	1.337079	1.787780	7.151121
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.662921	0.337079	0.113622	0.454489
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.03	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	7	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	5	**Not used in this Calculation**					
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.662921	-1.662921	2.765306	11.061225
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.662921	-1.662921	2.765306	11.061225
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.662921	-0.662921	0.439464	0.439464
	PDE data	**D08: Medication Adherence for Diabetes Medications**	89	4	3	12	3.662921	0.337079	0.113622	0.340867
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	91	4	3	12	3.662921	0.337079	0.113622	0.340867
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	90	4	3	12	3.662921	0.337079	0.113622	0.340867
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	74	2	1	2	3.662921	-1.662921	2.765306	2.765306
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.662921	-1.662921	2.765306	2.765306
Rated Like MA-PD	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**				**89** Sum of weights	**326** Sum of weights * stars	**3.662921** Calculated Summary Mean			**119.887640** Sum of weighted squared diffs
	2022 Major Disaster % 0									
	2023 Major Disaster % 0									

New Measure(s) Improvement	With Without	With With
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.662921	3.747475
CAI Value	-0.033597	-0.033597
Final Summary	3.629324	3.713878
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

35 # eligible measures

1.386671 Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

Without Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.795388
70th	1.216635
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.662921
85th	3.977528

H2261 Overall

As of 5/9/2025

Contract: H2261 Contract Type: Local & Regional CCP w/o SNP					Calculation With Improvement					
Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.										
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	82	5	1	5	3.747475	1.252525	1.568819	1.568819
	HEDIS	**C02: Colorectal Cancer Screening**	78	4	1	4	3.747475	0.252525	0.063769	0.063769
	CAHPS	**C03: Annual Flu Vaccine**	80	5	1	5	3.747475	1.252525	1.568819	1.568819
	HEDIS / HOS	**C04: Monitoring Physical Activity**	51	3	1	3	3.747475	-0.747475	0.558719	0.558719
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	38	2	1	2	3.747475	-1.747475	3.053669	3.053669
	HEDIS	**C09: Diabetes Care – Eye Exam**	80	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	87	4	3	12	3.747475	0.252525	0.063769	0.191307
	HEDIS	**C11: Controlling Blood Pressure**	77	3	3	9	3.747475	-0.747475	0.558719	1.676157
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	53	2	1	2	3.747475	-1.747475	3.053669	3.053669
	HEDIS / HOS	**C13: Improving Bladder Control**	41	2	1	2	3.747475	-1.747475	3.053669	3.053669
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	73	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C15: Plan All-Cause Readmissions**	5	5	3	15	3.747475	1.252525	1.568819	4.706457
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	90	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C17: Transitions of Care**	72	4	1	4	3.747475	0.252525	0.063769	0.063769
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	63	4	1	4	3.747475	0.252525	0.063769	0.063769
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	80	3	4	12	3.747475	-0.747475	0.558719	2.234876
	CAHPS	**C20: Getting Appointments and Care Quickly**	83	3	4	12	3.747475	-0.747475	0.558719	2.234876
	CAHPS	**C21: Customer Service**	92	5	4	20	3.747475	1.252525	1.568819	6.275276
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.747475	-1.747475	3.053669	12.214676
	CAHPS	**C23: Rating of Health Plan**	86	2	4	8	3.747475	-1.747475	3.053669	12.214676
	CAHPS	**C24: Care Coordination**	86	3	4	12	3.747475	-0.747475	0.558719	2.234876
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.03	5	4	20	3.747475	1.252525	1.568819	6.275276
	MBDSS	**C26: Members Choosing to Leave the Plan**	7	5	4	20	3.747475	1.252525	1.568819	6.275276
	Star Ratings	**C27: Health Plan Quality Improvement**	Medica re only	4	5	20	3.747475	0.252525	0.063769	0.318844
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	100	5	4	20	3.747475	1.252525	1.568819	6.275276
	IRE	**C29: Reviewing Appeals Decisions**	100	5	4	20	3.747475	1.252525	1.568819	6.275276
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.747475	1.252525	1.568819	6.275276
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.747475	0.252525	0.063769	0.255076
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.03	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	7	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medica re only	5	5	25	3.747475	1.252525	1.568819	7.844094
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.747475	-1.747475	3.053669	12.214676
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.747475	-1.747475	3.053669	12.214676
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.747475	-0.747475	0.558719	0.558719
	PDE data	**D08: Medication Adherence for Diabetes Medications**	89	4	3	12	3.747475	0.252525	0.063769	0.191307
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	91	4	3	12	3.747475	0.252525	0.063769	0.191307
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	90	4	3	12	3.747475	0.252525	0.063769	0.191307
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	74	2	1	2	3.747475	-1.747475	3.053669	3.053669
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.747475	-1.747475	3.053669	3.053669
Rated Like MA-PD	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**				**99** Sum of weights	**371** Sum of weights * stars	**3.747475** Calculated Summary Mean			**128.686869** Sum of weighted squared diffs
	2022 Major Disaster % 0									
	2023 Major Disaster % 0									

New Measure(s) Improvement	With Without	With With
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.662921	3.747475
CAI Value	-0.033597	-0.033597
Final Summary	3.629324	3.713878
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

37 # eligible measures

1.335975 Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

With Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.828220
70th	1.240423
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.646465
85th	3.949495

H2230 Overall

As of 5/9/2025

Contract: H2230 Contract Type: Local & Regional CCP w/o SNP					Calculation Without Improvement					
Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.										
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	84	5	1	5	3.595506	1.404494	1.972603	1.972603
	HEDIS	**C02: Colorectal Cancer Screening**	81	4	1	4	3.595506	0.404494	0.163615	0.163615
	CAHPS	**C03: Annual Flu Vaccine**	81	5	1	5	3.595506	1.404494	1.972603	1.972603
	HEDIS / HOS	**C04: Monitoring Physical Activity**	53	4	1	4	3.595506	0.404494	0.163615	0.163615
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	47	3	1	3	3.595506	-0.595506	0.354627	0.354627
	HEDIS	**C09: Diabetes Care – Eye Exam**	83	5	1	5	3.595506	1.404494	1.972603	1.972603
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	85	4	3	12	3.595506	0.404494	0.163615	0.490846
	HEDIS	**C11: Controlling Blood Pressure**	80	4	3	12	3.595506	0.404494	0.163615	0.490846
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	49	1	1	1	3.595506	-2.595506	6.736651	6.736651
	HEDIS / HOS	**C13: Improving Bladder Control**	48	4	1	4	3.595506	0.404494	0.163615	0.163615
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	68	3	1	3	3.595506	-0.595506	0.354627	0.354627
	HEDIS	**C15: Plan All-Cause Readmissions**	6	5	3	15	3.595506	1.404494	1.972603	5.917810
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	88	4	1	4	3.595506	0.404494	0.163615	0.163615
	HEDIS	**C17: Transitions of Care**	67	4	1	4	3.595506	0.404494	0.163615	0.163615
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	64	4	1	4	3.595506	0.404494	0.163615	0.163615
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	79	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**C20: Getting Appointments and Care Quickly**	81	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**C21: Customer Service**	91	4	4	16	3.595506	0.404494	0.163615	0.654462
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**C23: Rating of Health Plan**	87	3	4	12	3.595506	-0.595506	0.354627	1.418510
	CAHPS	**C24: Care Coordination**	85	2	4	8	3.595506	-1.595506	2.545639	10.182558
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.04	5	4	20	3.595506	1.404494	1.972603	7.890414
	MBDSS	**C26: Members Choosing to Leave the Plan**	2	5	4	20	3.595506	1.404494	1.972603	7.890414
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	**Not used in this Calculation**					
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	99	5	4	20	3.595506	1.404494	1.972603	7.890414
	IRE	**C29: Reviewing Appeals Decisions**	98	4	4	16	3.595506	0.404494	0.163615	0.654462
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.595506	1.404494	1.972603	7.890414
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.595506	0.404494	0.163615	0.654462
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.04	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	2	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	4	**Not used in this Calculation**					
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.595506	-1.595506	2.545639	10.182558
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.595506	-1.595506	2.545639	10.182558
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.595506	-0.595506	0.354627	0.354627
	PDE data	**D08: Medication Adherence for Diabetes Medications**	88	4	3	12	3.595506	0.404494	0.163615	0.490846
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	92	5	3	15	3.595506	1.404494	1.972603	5.917810
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	90	4	3	12	3.595506	0.404494	0.163615	0.490846
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	77	3	1	3	3.595506	-0.595506	0.354627	0.354627
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.595506	-1.595506	2.545639	2.545639

Rated Like	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**		**89**	**320**	**3.595506**		**127.438202**
MA-PD	**2022 Major Disaster %**	**0**	**Sum of weights**	**Sum of weights * stars**	**Calculated Summary Mean**		**Sum of weighted squared diffs**
	2023 Major Disaster %	**0**					

New Measure(s) Improvement	**With Without**	**With With**
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.595506	3.636364
CAI Value	-0.058127	-0.058127
Final Summary	3.537379	3.578237
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

35 # eligible measures

1.474004 Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

Without Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.795388
70th	1.216635
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.662921
85th	3.977528

H2230 Overall

As of 5/9/2025

Contract: H2230 Contract Type: Local & Regional CCP w/o SNP					Calculation With Improvement					
Contract Name: BCBS OF MASSACHUSETTS HMO BLUE, INC.										
Domain	**Primary Data Source**	**Quality Measure**	**Score**	**Star**	Weight	Weight * star	x bar	diff	diff squared	multiply by measure weight
Part C Measures										
1 - Staying Healthy: Screenings, Tests, and Vaccines	HEDIS	**C01: Breast Cancer Screening**	84	5	1	5	3.636364	1.363636	1.859503	1.859503
	HEDIS	**C02: Colorectal Cancer Screening**	81	4	1	4	3.636364	0.363636	0.132231	0.132231
	CAHPS	**C03: Annual Flu Vaccine**	81	5	1	5	3.636364	1.363636	1.859503	1.859503
	HEDIS / HOS	**C04: Monitoring Physical Activity**	53	4	1	4	3.636364	0.363636	0.132231	0.132231
2 - Managing Chronic (Long Term) Conditions	Plan Reporting	**C05: Special Needs Plan (SNP) Care Management**			**Plan not required to report measure**					
	HEDIS	**C06: Care for Older Adults – Medication Review**			**Plan not required to report measure**					
	HEDIS	**C07: Care for Older Adults – Pain Assessment**			**Plan not required to report measure**					
	HEDIS	**C08: Osteoporosis Management in Women who had a Fracture**	47	3	1	3	3.636364	-0.636364	0.404959	0.404959
	HEDIS	**C09: Diabetes Care – Eye Exam**	83	5	1	5	3.636364	1.363636	1.859503	1.859503
	HEDIS	**C10: Diabetes Care – Blood Sugar Controlled**	85	4	3	12	3.636364	0.363636	0.132231	0.396693
	HEDIS	**C11: Controlling Blood Pressure**	80	4	3	12	3.636364	0.363636	0.132231	0.396693
	HEDIS / HOS	**C12: Reducing the Risk of Falling**	49	1	1	1	3.636364	-2.636364	6.950415	6.950415
	HEDIS / HOS	**C13: Improving Bladder Control**	48	4	1	4	3.636364	0.363636	0.132231	0.132231
	HEDIS	**C14: Medication Reconciliation Post-Discharge**	68	3	1	3	3.636364	-0.636364	0.404959	0.404959
	HEDIS	**C15: Plan All-Cause Readmissions**	6	5	3	15	3.636364	1.363636	1.859503	5.578509
	HEDIS	**C16: Statin Therapy for Patients with Cardiovascular Disease**	88	4	1	4	3.636364	0.363636	0.132231	0.132231
	HEDIS	**C17: Transitions of Care**	67	4	1	4	3.636364	0.363636	0.132231	0.132231
	HEDIS	**C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	64	4	1	4	3.636364	0.363636	0.132231	0.132231
3 - Member Experience with Health Plan	CAHPS	**C19: Getting Needed Care**	79	2	4	8	3.636364	-1.636364	2.677687	10.710749
	CAHPS	**C20: Getting Appointments and Care Quickly**	81	2	4	8	3.636364	-1.636364	2.677687	10.710749
	CAHPS	**C21: Customer Service**	91	4	4	16	3.636364	0.363636	0.132231	0.528925
	CAHPS	**C22: Rating of Health Care Quality**	85	2	4	8	3.636364	-1.636364	2.677687	10.710749
	CAHPS	**C23: Rating of Health Plan**	87	3	4	12	3.636364	-0.636364	0.404959	1.619837
	CAHPS	**C24: Care Coordination**	85	2	4	8	3.636364	-1.636364	2.677687	10.710749
4 - Member Complaints and Improvement in the Health Plan's Performance	CTM	**C25: Complaints about the Health Plan**	0.04	5	4	20	3.636364	1.363636	1.859503	7.438013
	MBDSS	**C26: Members Choosing to Leave the Plan**	2	5	4	20	3.636364	1.363636	1.859503	7.438013
	Star Ratings	**C27: Health Plan Quality Improvement**	Medicare only	4	5	20	3.636364	0.363636	0.132231	0.661156
5 - Health Plan Customer Service	IRE	**C28: Plan Makes Timely Decisions about Appeals**	99	5	4	20	3.636364	1.363636	1.859503	7.438013
	IRE	**C29: Reviewing Appeals Decisions**	98	4	4	16	3.636364	0.363636	0.132231	0.528925
	Call Center	**C30: Call Center – Foreign Language Interpreter and TTY Availability**	100	5	4	20	3.636364	1.363636	1.859503	7.438013
Part D Measures										
1 - Drug Plan Customer Service	Call Center	**D01: Call Center – Foreign Language Interpreter and TTY Availability**	98	4	4	16	3.636364	0.363636	0.132231	0.528925
2 - Member Complaints and Improvement in the Drug Plan's Performance	CTM	**D02 Complaints about the Drug Plan**	0.04	5	**Counted in Part C**					
	MBDSS	**D03: Members Choosing to Leave the Plan**	2	5	**Counted in Part C**					
	Star Ratings	**D04: Drug Plan Quality Improvement**	Medicare only	4	5	20	3.636364	0.363636	0.132231	0.661156
3 - Member Experience with Drug Plan	CAHPS	**D05: Rating of Drug Plan**	84	2	4	8	3.636364	-1.636364	2.677687	10.710749
	CAHPS	**D06: Getting Needed Prescription Drugs**	87	2	4	8	3.636364	-1.636364	2.677687	10.710749
4 - Drug Pricing and Patient Safety	PDE & MPF Pricing Files	**D07: MPF Price Accuracy**	98	3	1	3	3.636364	-0.636364	0.404959	0.404959
	PDE data	**D08: Medication Adherence for Diabetes Medications**	88	4	3	12	3.636364	0.363636	0.132231	0.396693
	PDE data	**D09: Medication Adherence for Hypertension (RAS antagonists)**	92	5	3	15	3.636364	1.363636	1.859503	5.578509
	PDE data	**D10: Medication Adherence for Cholesterol (Statins)**	90	4	3	12	3.636364	0.363636	0.132231	0.396693
	Part D Plan Reporting	**D11: MTM Program Completion Rate for CMR**	77	3	1	3	3.636364	-0.636364	0.404959	0.404959
	PDE data	**D12: Statin Use in Persons with Diabetes (SUPD)**	85	2	1	2	3.636364	-1.636364	2.677687	2.677687
Rated Like MA-PD	**Local & Regional CCP w/o SNP needs at least 18 of 35 measures**				**99** Sum of weights	**360** Sum of weights * stars	**3.636364** Calculated Summary Mean			**128.909091** Sum of weighted squared diffs
	2022 Major Disaster % **0**									
	2023 Major Disaster % **0**									

New Measure(s) Improvement	With Without	With With
# Measures Needed	18	18
# Measures Scored	35	37
Variance Category	high	high
Reward Factor	0	0
Interim Summary	3.595506	3.636364
CAI Value	-0.058127	-0.058127
Final Summary	3.537379	3.578237
Overall Rating	3.5	3.5
Final Overall Rating	**3.5**	

37 # eligible measures

1.338282 Calculated Variance

- Categorize the variance into three categories:
  - o low (0 to < 30th percentile),
  - o medium (≥ 30th to < 70th percentile) and
  - o high (≥ 70th percentile and above)
- Develop the Reward Factor as follows:
  - o r-Factor = 0.4 (for contract w/low-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.3 (for contract w/medium-variability & high-mean (mean ≥ 85th percentile)
  - o r-Factor = 0.2 (for contract w/low-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.1 (for contract w/medium-variability & relatively high-mean (mean ≥ 65th & < 85th percentile)
  - o r-Factor = 0.0 (for other types of contracts)

With Improvement	
Variance Thresholds	
Percentile	**Overall Rating**
30th	0.828220
70th	1.240423
Performance Summary Thresholds	
Percentile	**Overall Rating**
65th	3.646465
85th	3.949495

Contract	Sponsor
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.
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[1]S - cell is suppressed per the requirement to suppress cells with counts of 1-10 observations.

X - cell is suppressed to prevent the exact inference of another cell with counts of 1-10 observations, per the rec

Predictor	Category	National	H2230
Age	Age: 64 or under	0.077872	
Age	Age: 65 - 69	0.179175	0.210634
Age	Age: 70 - 74	0.248507	0.347648
Age	Age: 75 - 79	0.222699	0.236196
Age	Age: 80 - 84	0.153716	0.139059
Age	Age: 85 and older	0.118030	
Education	Less than an 8th grade education	0.053270	
Education	Some high school	0.073535	
Education	High school graduate	0.308543	0.198420
Education	Some college	0.288263	0.281760
Education	College graduate	0.128953	0.229439
Education	More than a bachelor's degree	0.147437	0.267281
Health Status	General health rating: excellent	0.057780	0.136040
Health Status	General health rating: very good	0.267377	0.406759
Health Status	General health rating: good	0.400374	0.344950
Health Status	General health rating: fair	0.229523	
Health Status	General health rating: poor	0.044946	
Mental Health	Mental health rating: excellent	0.221873	0.351130
Mental Health	Mental health rating: very good	0.324968	0.364480
Mental Health	Mental health rating: good	0.299969	0.211535
Mental Health	Mental health rating: fair	0.130684	0.061572
Mental Health	Mental health rating: poor	0.022505	0.011283
Proxy	Proxy helped	0.071636	0.028982
Proxy	Proxy answered	0.033232	
Medicaid / LIS	Medicaid dual eligible	0.214697	0.039877
Medicaid / LIS	Low-income subsidy (LIS)	0.025223	
Asian Language	Asian Language	0.002469	0.000000
Total Adjustment, Original Scale			
Total Adjustment, 0 - 100 scale			

quirements to prevent exact inference of such cells.

Difference (Cntrt-Nat)	Coefficient	Coeff * Diff	Small Cell Flag[1]
	-0.006074		S
0.031459	-0.013623	-0.000429	
0.099141		0	
0.013497	-0.004855	-0.000066	
-0.014657	-0.013277	0.000195	
	-0.010573		X
	-0.037549		S
	-0.009141		X
-0.110123		0	
-0.006503	-0.004797	0.000031	
0.100486	-0.016438	-0.001652	
0.119844	0.001654	0.000198	
0.078261	0.012246	0.000958	
0.139382	0.015388	0.002145	
-0.055424		0	
	-0.034644		X
	-0.052066		S
0.129256	0.085238	0.011018	
0.039512	0.044991	0.001778	
-0.088435		0	
-0.069112	-0.029950	0.002070	
-0.011222	-0.056365	0.000633	
-0.042655	0.000427	-0.000018	
	0.037464		S
-0.174819	-0.021892	0.003827	
	-0.009843		S
-0.002469	-0.147644	0.000365	
		0.029968	
		0.998917	

contract_number	sponsor	measure
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	coc_comp
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	md_medrecs
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	md_talkmeds
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	md_testcomb
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	r_md_getmngca
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	sp_mdinformd
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	cs_comp
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	cs_csgetinfo
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	cs_csrespect
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	pl_ezpaper
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	gcq_comp
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	ca_illasaw
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	ca_rtnasaw
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	gnc_comp
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	pl_getcare
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	sp_getappt
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	im_flu1last
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	pd_gneeded_comp
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	pd_ezrxmeds
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	pd_mailpharm
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	rate_care
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	rate_pdp
H2230	Blue Cross and Blue Shield of Massachusetts, Inc.	rate_plan

cahps_measure_description	usen	alln	original_range	mean_score_unadj
Coordination of Care (Comp)	1064	1279	1 to 4	85.763458
How often personal dr have medical records about your care	978	1279	1 to 4	95.057941
How often talk with personal dr about medicines taking	928	1279	1 to 4	83.548851
MD follows up test results and gives results as soon as needed	877	1279	1 to 4	86.621057
Get help from dr office to manage providers and services care	184	1279	1 to 3	
How often doctor seemed informed about care from specialist	804	1279	1 to 4	80.472637
Health Plan Customer Service (Comp)	1243	1279	1 to 4	91.911666
How often get needed information from customer service	488	1279	1 to 4	83.948087
How often Customer Service treat with courteous/respectful	491	1279	1 to 4	95.315682
How often health plan forms easy to fill out	1228	1279	1 to 4	96.471227
Get Care Quickly (Comp)	1025	1279	1 to 4	81.912581
Get care for illness as soon as wanted	405	1279	1 to 4	84.609053
Get appt for routine care as soon as wanted	927	1279	1 to 4	79.216109
Get Needed Care (Comp)	1262	1279	1 to 4	79.886003
How often easy to get needed care through health plan	1243	1279	1 to 4	81.255028
How often easy to get appointments with specialists	962	1279	1 to 4	78.516979
Flu Shot last year	1249	1279	0 to 1	81.024820
Getting Needed Prescription Drugs (Comp)	1199	1279	1 to 4	87.662692
Easy to get prescription medicines	1185	1279	1 to 4	87.482419
Get PD from mail or pharmacy	1142	1279	1 to 4	87.842966
Rate Health Care	1252	1279	0 to 10	86.325879
Rate Prescription Drug Plan	1241	1279	0 to 10	83.875907
Rate Health Plan	1248	1279	0 to 10	87.275641

mean_score_adj	contract_weight	variance_mean	variance_between	exact_reliability	reliability_cat
84.769086	184230.598124	0.351710	3.311952	0.904000	
94.059024					
82.521221					
85.022710					
80.472453					
91.494200	107822.044566	0.279486	3.575144	0.927494	
83.824121					
95.033907					
95.624572					
81.094307	65074.292416	0.652805	7.752602	0.922335	
83.701163					
78.487452					
78.770500	107724.335418	0.413196	8.070230	0.951294	
79.997290					
77.543709					
81.024820	61019.362783	1.230953	56.749662	0.978770	
86.993976	113684.593432	0.291831	3.270264	0.918073	
86.916249					
87.071702					
84.947766	61165.926505	0.192478	2.977384	0.939279	
84.464809	60628.526192	0.228018	5.144999	0.957562	
87.375158	60970.508210	0.150572	7.491712	0.980297	

delta	se_test	national_mean	t_statistic	t_test_significance	group_15_test
-1.460644	0.602988	86.229730	-2.422345	1	
1.345186	0.540423	90.149013	2.489137	3	
-2.363776	0.822315	83.458083	-2.874537	1	
-2.093758	0.654283	80.864258	-3.200080	1	
9.963826	1.135225	71.060994	8.776963	3	2
-2.689003	0.547405	89.682979	-4.912278	1	
-1.750845	0.447046	86.698611	-3.916475	1	
-3.606371	0.484329	88.071180	-7.446117	1	
-0.557058	0.396291	87.932216	-1.405679	2	

score_rounded	base_cutpoints	base_groups	stars
85	84, 85, 87, 88	3	2
91	88, 89, 91, 92	4	4
81	80, 82, 84, 86	2	2
79	77, 79, 82, 83	3	2
81	61, 65, 71, 76	5	5
87	87, 88, 90, 91	2	2
85	84, 85, 87, 88	3	2
84	84, 86, 87, 89	2	2
87	84, 86, 88, 89	3	3

Contract	Sponsor
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.
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[1]S - cell is suppressed per the requirement to suppress cells with counts of 1-10 observations.

X - cell is suppressed to prevent the exact inference of another cell with counts of 1-10 observations, per the rec

Predictor	Category	National	H2261
Age	Age: 64 or under	0.077872	0.020833
Age	Age: 65 - 69	0.179175	0.167892
Age	Age: 70 - 74	0.248507	0.357843
Age	Age: 75 - 79	0.222699	0.203431
Age	Age: 80 - 84	0.153716	0.111520
Age	Age: 85 and older	0.118030	0.138480
Education	Less than an 8th grade education	0.053270	0.033970
Education	Some high school	0.073535	0.035430
Education	High school graduate	0.308543	0.258673
Education	Some college	0.288263	0.293064
Education	College graduate	0.128953	0.197384
Education	More than a bachelor's degree	0.147437	0.181479
Health Status	General health rating: excellent	0.057780	0.080722
Health Status	General health rating: very good	0.267377	0.372977
Health Status	General health rating: good	0.400374	0.384101
Health Status	General health rating: fair	0.229523	0.143640
Health Status	General health rating: poor	0.044946	0.018560
Mental Health	Mental health rating: excellent	0.221873	0.251654
Mental Health	Mental health rating: very good	0.324968	0.369297
Mental Health	Mental health rating: good	0.299969	0.298567
Mental Health	Mental health rating: fair	0.130684	
Mental Health	Mental health rating: poor	0.022505	
Proxy	Proxy helped	0.071636	0.045845
Proxy	Proxy answered	0.033232	0.023525
Medicaid / LIS	Medicaid dual eligible	0.214697	0.082108
Medicaid / LIS	Low-income subsidy (LIS)	0.025223	
Asian Language	Asian Language	0.002469	0.000000
Total Adjustment, Original Scale			
Total Adjustment, 0 - 100 scale			

quirements to prevent exact inference of such cells.

Difference (Cntrt-Nat)	Coefficient	Coeff * Diff	Small Cell Flag[1]
-0.057039	-0.006074	0.000346	
-0.011283	-0.013623	0.000154	
0.109336		0	
-0.019268	-0.004855	0.000094	
-0.042197	-0.013277	0.000560	
0.020451	-0.010573	-0.000216	
-0.019299	-0.037549	0.000725	
-0.038106	-0.009141	0.000348	
-0.049870		0	
0.004802	-0.004797	-0.000023	
0.068431	-0.016438	-0.001125	
0.034042	0.001654	0.000056	
0.022942	0.012246	0.000281	
0.105600	0.015388	0.001625	
-0.016274		0	
-0.085883	-0.034644	0.002975	
-0.026386	-0.052066	0.001374	
0.029781	0.085238	0.002538	
0.044329	0.044991	0.001994	
-0.001402		0	
	-0.029950		X
	-0.056365		S
-0.025791	0.000427	-0.000011	
-0.009707	0.037464	-0.000364	
-0.132589	-0.021892	0.002903	
	-0.009843		S
-0.002469	-0.147644	0.000365	
		0.017331	
		0.577683	

contract_number	sponsor	measure
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	coc_comp
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	md_medrecs
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	md_talkmeds
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	md_testcomb
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	r_md_getmngca
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	sp_mdinformd
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	cs_comp
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	cs_csgetinfo
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	cs_csrespect
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	pl_ezpaper
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	gcq_comp
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	ca_illasaw
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	ca_rtnasaw
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	gnc_comp
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	pl_getcare
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	sp_getappt
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	im_flu1last
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	pd_gneeded_comp
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	pd_ezrxmeds
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	pd_mailpharm
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	rate_care
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	rate_pdp
H2261	Blue Cross and Blue Shield of Massachusetts, Inc.	rate_plan

cahps_measure_description	usen	alln	original_range	mean_score_unadj
Coordination of Care (Comp)	873	1073	1 to 4	86.886261
How often personal dr have medical records about your care	816	1073	1 to 4	95.383987
How often talk with personal dr about medicines taking	770	1073	1 to 4	83.333333
MD follows up test results and gives results as soon as needed	720	1073	1 to 4	85.833333
Get help from dr office to manage providers and services care	191	1073	1 to 3	89.005236
How often doctor seemed informed about care from specialist	628	1073	1 to 4	81.581741
Health Plan Customer Service (Comp)	1049	1073	1 to 4	92.541089
How often get needed information from customer service	399	1073	1 to 4	86.299081
How often Customer Service treat with courteous/respectful	404	1073	1 to 4	94.966997
How often health plan forms easy to fill out	1034	1073	1 to 4	96.357189
Get Care Quickly (Comp)	819	1073	1 to 4	83.657070
Get care for illness as soon as wanted	361	1073	1 to 4	85.687904
Get appt for routine care as soon as wanted	742	1073	1 to 4	81.626235
Get Needed Care (Comp)	1040	1073	1 to 4	80.974234
How often easy to get needed care through health plan	1028	1073	1 to 4	81.517510
How often easy to get appointments with specialists	758	1073	1 to 4	80.430959
Flu Shot last year	1051	1073	0 to 1	80.399619
Getting Needed Prescription Drugs (Comp)	996	1073	1 to 4	87.659067
Easy to get prescription medicines	984	1073	1 to 4	87.195122
Get PD from mail or pharmacy	943	1073	1 to 4	88.123012
Rate Health Care	1046	1073	0 to 10	85.879541
Rate Prescription Drug Plan	1040	1073	0 to 10	84.115385
Rate Health Plan	1040	1073	0 to 10	86.096154

mean_score_adj	contract_weight	variance_mean	variance_between	exact_reliability	reliability_cat
86.346443	37042.753961	0.326019	3.311952	0.910384	
94.806303					
83.032447					
85.025714					
87.789685					
81.559147					
92.287966	21775.212488	0.348271	3.575144	0.911233	
86.272972					
94.832752					
95.758174					
83.205873	13074.610438	0.683732	7.752602	0.918954	
85.147529					
81.264216					
80.231660	21170.674744	0.476012	8.070230	0.944302	
80.737554					
79.725766					
80.399619	12458.219012	1.499394	56.749662	0.974259	
87.122932	22842.043802	0.322263	3.270264	0.910296	
86.683760					
87.562104					
85.034726	12398.950606	0.225704	2.977384	0.929536	
84.493933	12327.828518	0.275252	5.144999	0.949218	
86.118791	12327.828518	0.192557	7.491712	0.974941	

delta	se_test	national_mean	t_statistic	t_test_significance	group_15_test
0.116713	0.582492	86.229730	0.200368	2	
2.138952	0.601533	90.149013	3.555836	3	2
-0.252211	0.842425	83.458083	-0.299387	2	
-0.632598	0.701815	80.864258	-0.901375	2	
9.338626	1.249701	71.060994	7.472686	3	2
-2.560047	0.575593	89.682979	-4.447668	1	
-1.663884	0.483518	86.698611	-3.441203	1	
-3.577247	0.531708	88.071180	-6.727836	1	
-1.813424	0.446739	87.932216	-4.059251	1	

score_rounded	base_cutpoints	base_groups	stars
86	84, 85, 87, 88	3	3
92	88, 89, 91, 92	5	5
83	80, 82, 84, 86	3	3
80	77, 79, 82, 83	3	3
80	61, 65, 71, 76	5	5
87	87, 88, 90, 91	2	2
85	84, 85, 87, 88	3	2
84	84, 86, 87, 89	2	2
86	84, 86, 88, 89	3	2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

April 14, 2025

Centers for Medicare & Medicaid Services
Hearing Officer Decision

In the Matter of: Informal Hearing Decision for Contracts H2230 and H2261

Dear Ms. Sullivan,

The following represents the hearing officer decision in response to Blue Cross and Blue Shield of Massachusetts (BCBSMA's) request for an informal hearing on the record for the 2025 Star Ratings and associated 2026 Quality Bonus Payment ("QBP") determination for contracts H2230 and H2261.

Introduction

Pursuant to 42 C.F.R. § 422.260, Medicare Advantage ("MA") organizations are provided an opportunity to request a reconsideration of a QBP determination. Should the MA organization receive an adverse reconsideration decision, the organization may request an informal hearing on the record. Administrative review may not be requested to contest the methodology for calculating the star ratings, the cut-off points for determining measure thresholds, the set of measures included in calculating star ratings, and the methodology for QBP determinations for low enrollment contracts or new MA plans. 42 C.F.R. § 422.260(c)(3)(ii). Informal hearing requests are limited to the measure(s) and value(s) that precipitated the request for reconsideration. 42 C.F.R. § 422.260(c)(2)(iii). Finally, the MA organization must provide clear and convincing evidence that CMS' calculations were incorrect. 42 C.F.R. § 422.260(c)(2)(v).

BCBSMA requested a reconsideration of its 2026 QBP determination and a decision was rendered by the CMS Reconsideration Official on January 31, 2025, which upheld the initial determination. BCBSMA has now requested an informal hearing, arguing that CMS erred in including case number D1800221 as a failed contact for measure D01 Center - Foreign Language Interpreter and TTY Availability.

Findings of Fact and Conclusions of Law

As iterated above, administrative review is limited to possible calculation errors or inaccuracies in the data utilized for determining star ratings. 42 C.F.R. § 422.260(c)(3)(ii). A reconsideration or informal hearing is not the proper venue for contesting the methodology or the set of measures included in calculating the star ratings. *Id*.

BCBSMA asserts that CMS improperly relied on its contractor's assessment and did not conduct an independent analysis regarding the disputed call. BCBSMA further asserted that CMS did not follow its own guidance requiring that the CMS caller ask an introductory question and that CMS' guidelines regarding second attempts to call are unclear and cannot be applied consistently.

BCBSMA does not dispute that CMS test caller reached the customer service representative and asked for a Cantonese interpreter and that the customer service representative forwarded the test caller to an interpreter. However, BCBSMA asserts that it has no evidence that the CMS contractor's test caller followed CMS guidance to ask the required introductory question and argues that CMS has not provided BCBSMA with any additional information regarding call D1800221, including CMS' recordings or transcripts of the call, despite BCBSMA's belief that such additional information should be maintained and available from CMS' contractor. In addition, BCBSMA believes that the CMS contractor should have called back to attempt this call a second time.

CMS disagreed with BCBSMA's assertions and maintained that it provided all information CMS has pertaining to the case number at issue, including the raw data, caller notes and the system-generated call log and further states that BCBSMA did not provide CMS a recording of the disputed call. CMS further maintained that there was initial communication with the customer service representative, after which an interpreter was conferenced and then the representative disconnected. The caller and interpreter continued communicating, with the interpreter suggesting that that caller call back. However, CMS maintains that the limited criteria under which a second call is required were not met in this instance.

BCBSMA is appealing the Reconsideration Official's decision to uphold H2230 and H2261's QBP determination and asks that asks that D1800221 be excluded from the denominator in the calculation of its D01 measure.

As the hearing officer for this request, I reviewed and considered all of the supporting details for the plan's informal hearing on the record request, including the QBP determination, the evidence and findings upon which the initial determination was based, and the additional information submitted by BCBSMA. I find that BCBSMA has not demonstrated by a clear and convincing evidence standard that CMS has erred in its determinations.

As noted above, regulations at 42 C.F.R. § 422.260(c)(2)(v) state that: The MA organization must prove by a preponderance of evidence that CMS' calculations of the measure(s) and value(s) in question were incorrect. The burden of proof is on the MA organization to prove an error was made in the calculation of the QBP status. Based on my review of all evidence, BCBSMA has not met that standard.

According to the Medicare 2025 Part C & D Star Ratings Technical Notes, the metric used for D01 is, in relevant part, "the number of completed contacts with the interpreter and TTY divided by the number of ***attempted*** contacts." (p. 80) (emphasis added) In the instance of the case number at issue, CMS provided evidence, through call logs and notes, that attempts were validly

made, yet contacts were not completed as outlined in the Technical Notes. BCBSMA did not prove by a preponderance of the evidence that CMS or the TTY operator disconnected the call.

Decision

The reconsideration official's determination is upheld and CMS will not change the QBP rating for H2230 and H2261. This decision is subject to review and modification by the CMS Administrator within 10 business days of issuance. If the Administrator does not review and issue a decision within 10 business days, this decision is final and binding on both the MA organization and CMS.

Sincerely,

Tiffany Swygert

Tiffany Swygert, CMS Hearing Officer
Deputy Director, Innovation & Financial Management
Office of Program Operations & Local Engagement

De-identified Contract Level Data

[Defendants intend to file the native document including the de-identified contract level data cited in the parties' briefs directly with the Court.]