UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

CLOVER INSURANCE COMPANY,

Plaintiff,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

Case No. 2:25-cv-142

CERTIFICATION AND INDEX

I, Elizabeth Goldstein, Director, Division of Consumer Assessment and Plan Performance, Medicare Drug Benefit and C & D Data Group, Center for Medicare, Centers for Medicare & Medicaid Services ("CMS"), United States Department of Health and Human Services, certify that, to the best of my knowledge, the materials listed in the accompanying index comprise true and correct copies of the materials comprising the Administrative Record in the above-captioned case.

Executed this 8th day of April, 2026, in Baltimore, Maryland.

Elizabeth H. Goldstein -S Digitally signed by Elizabeth H. Goldstein -S
Date: 2026.04.08 12:10:22 -04'00'

Elizabeth Goldstein
Director
Division of Consumer Assessment and Plan Performance
Medicare Drug Benefit and C & D Data Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Administrative Record – Clover v. Department of Health and Human Services, et al.

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From: CMS PartC&DStarRatings
To: Robert Davis
Cc: wendy.richey@cloverhealth.com; CMS PartC&DStarRatings
Subject: RE: Med adherence star rating inquiry
Date: Monday, January 13, 2025 1:49:02 PM

Hi Robert,

Based on PQA's current methodology, it does not account for medication discontinuations.

If you have more questions regarding this, please reach out to the PQA at www.pqaalliance.org/tech-assist-form since the PQA is the measure steward who developed the measures.

Best,
Part C & D Star Ratings

From: Robert Davis <robert.davis@cloverhealth.com>
Sent: Friday, December 13, 2024 4:37 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: wendy.richey@cloverhealth.com
Subject: Re: Med adherence star rating inquiry

Good afternoon and thank you for such a prompt response. For clarification, does the highlighted language below mean that a bene cannot be excluded although the prescriber changed the prescription? Or can they be excluded? Thanks.

Thank you for your email. Please feel free to refer to the Patient Safety Analysis Adherence (ADH) Measures Report User Guide available on the Help Documents page of the Patient Safety Analysis Web Portal. Please note that the current methodology does not account for discontinuation of medications.

On Fri, Dec 13, 2024 at 2:31 PM CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov> wrote:

> Hi Robert,
>
> Thank you for your email. Please feel free to refer to the Patient Safety Analysis Adherence (ADH) Measures Report User Guide available on the Help Documents page of the Patient Safety Analysis Web Portal. Please note that the current methodology does not account for discontinuation of medications.
>
> Additionally, per section 2 'Measure Overview' of the General Report User Guide, all

Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy quality Alliance (PQA). Should you have further questions regarding the methodology for calculating the Adherence measures, please consult PQA's Web Page or contact them at www.pqaalliance.org/tech-assist-form. Upon submission, you will receive a confirmation of your request with an associated request ID number for easy referencing. Feel free to check out PQA's website for frequently asked questions as well.

Thanks,
Part C & D Star Ratings

From: Robert Davis <robert.davis@cloverhealth.com>
Sent: Thursday, December 12, 2024 1:22 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: wendy.richey@cloverhealth.com
Subject: Med adherence star rating inquiry

Good morning. We have an inquiry requesting clarification on excluding a member from a measure due to a change in the prescription as initially prescribed. We have a member in our plan who was prescribed Jardiance by a cardiologist for heart failure without the comorbidity of diabetes. The cardiologist later discontinued the medication after two fills and switched the member to Entresto (the change is supported by medical records). Our interpretation of the Stars technical manual for measure D08 is that since this member received 2 fills of Jardiance, they would be included in the denominator for measure D08, despite not having a diabetes diagnosis. This would cause a failure in the measure because the cardiologist discontinued Jardiance and thus the member stopped filling it. Is our understanding correct, or should the member be excluded given Jardiance was prescribed for its alternate clinical indication of heart failure? If exclusion is possible, how might we pursue that? Also, can this be applied to similar situations? Thanks.

Robert Davis
Senior Director, Compliance
Clover Health
201-320-0506

From:	CMS PartC&DStarRatings
To:	Cheree Pasalakis
Cc:	Vivian Meras; Cynthia Alexander; Cameron Pringle; CMS PartC&DStarRatings; PatientSafety; CMS PartC&DStarRatings
Subject:	RE: February Med Adherence Appeal
Date:	Thursday, February 20, 2025 11:16:45 AM

Dear Cheree,

In our communication with Part D sponsors regarding the December 2024 and January 2025 Patient Safety Reports Release, we let sponsors know that the statin medications that were commercially available after the July 2024 NDC Value Sets were not used in the Patient Safety Reports.

All Patient Safety measures are calculated using the Pharmacy Quality Alliance (PQA) measure specifications and Value Sets. Per Section 3.1 'Medication and Diagnosis Codes List' of the General User Guides (PS-General-YOS2024-Report-Guide-Apr-2024), the codes list is available with the contract report packages and in the 'Help Documents' section of the Patient Safety Analysis Web Portal. The PQA developed and owns the value sets.

The PQA comprehensively produces three value sets for a given measurement year: the first version is published in February of the measurement year, then updated in July of the measurement year, and finalized in February of the subsequent year. Therefore, for a given measurement year, three PQA Value Sets are used to calculate the Patient Safety measure rates. For example, in measurement year 2024, the first version of the PQA Value Sets for the measurement year 2024 were published in February 2024, updated in July 2024, and will be finalized in February 2025. Between NDC list updates, sponsors may observe differences between their internal monitoring reports and the Patient Safety Reports, especially if applying more real-time NDC changes or capturing PDE data not yet submitted to or processed by CMS. The PQA Value Sets published in February 2025 will include all NDCs for products that were marketed from July 1, 2023, through December 31, 2024, and will be used to calculate the final measure rates for the measurement year 2024.

As a reminder, once we receive the updated February PQA Value Sets, the updated PQA Value Sets are incorporated into the Patient Safety reports in approximately 1-2 monthly reporting cycles.

If you are interested in us investigating your contract further, please provide us with detailed information about the issue or request. A secure submission window will be opened in the Patient Safety Analysis Web Portal once we receive the following information **only**:

- **Contract Number**:
- **Patient Safety Report** (e.g. June 2024 Reports):
- **Year of Service** (e.g. YOS 2024):

- **Patient Safety Measure** (e.g. Star Ratings Adherence):
- **Description of the Inquiry**:

Your request will be reviewed in its entirety and if appropriate, a secure submission window will be opened in the Patient Safety Analysis Web Portal, and we will provide you with further instructions on how to submit your data.

Due to our security policy, we want to remind you not to send any PII/PHI information through email, only via the secure submission window in the Patient Safety Analysis Web Portal.

Thank you,
Part C & D Star Ratings

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Wednesday, February 19, 2025 3:19 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Vivian Meras <vivian.meras@cloverhealth.com>; Cynthia Alexander <cynthia.alexander@vendors.cloverhealth.com>; Cameron Pringle <cameron.pringle@cloverhealth.com>
Subject: February Med Adherence Appeal

Good afternoon,

The attached letter is our appeal request for February Med Adherence. We tried to upload via the Acumen portal but could not get the letter to upload successfully. We request your review and consideration.

Thank you.

Clover Health

February 13, 2025

To whom it may concern,

As a representative of Clover Health, I am writing related to the most recent published Acumen member details regarding the Statin and Diabetes measure data. Clover has done an internal evaluation of the members that we see in our 2024 medication statin & diabetes adherence measures that were most recently calculated at 80% PDC that in the Acumen member details do not have these members calculating at 80%. In particular, I am looking to highlight a set of members that we feel have missed claims based on new drug NDCs that have come to market since the latest drug list refresh. Our analysis indicates that there are ~4,740 members that would change from below 80% PDC (non-adherent) to above 80% PDC reporting as adherent in December. These members who are below 80% PDC in Acumen and above 80% in our internal audit all have an under-reported amount of Statin and Diabetes claims with the NDCs listed below.

4,735 members in the Statin measure using the additional NDCs:

NDC	DESCRIPTION
70710177200	ATORVASTATIN CALCIUM TAB 40 MG
70710177509	ATORVASTATIN CALCIUM TAB 20 MG
43598009805	ATORVASTATIN CALCIUM TAB 10 MG
70710177000	ATORVASTATIN CALCIUM TAB 80 MG
62135069290	ROSUVASTATIN CALCIUM TAB 20 MG
43598010105	ATORVASTATIN CALCIUM TAB 40 MG
43598010305	ATORVASTATIN CALCIUM TAB 80 MG
69097078912	PRAVASTATIN SODIUM TAB 20 MG

69097079112	PRAVASTATIN SODIUM TAB 40 MG
70710177500	ATORVASTATIN CALCIUM TAB 20 MG
43598009905	ATORVASTATIN CALCIUM TAB 20 MG
70710177700	ATORVASTATIN CALCIUM TAB 10 MG
62135069190	ROSUVASTATIN CALCIUM TAB 10 MG

4 members that should be passing in the diabetes measure using the below NDCs:

NDC	**DESCRIPTION**
68094080450	METFORMIN HCL TAB ER 24HR 750
00480366722	LIRAGLUTIDE SOLN PEN-INJECTOR
00480366720	LIRAGLUTIDE SOLN PEN-INJECTOR
68094048060	METFORMIN HCL TAB 1000 MG

We would be happy to provide evidence of these claims to ensure these members are correctly reported in Acumen. Please advise how we should proceed to get these members evaluated.

Thank you,

Cameron Pringle

From: Mareyba Fawad
To: Cheree Pasalakis
Cc: Cameron Pringle; Vivian Meras; Robert Davis; CMS PartC&DStarRatings; PatientSafety
Subject: RE: Hospice Med Adherence Appeal
Date: Wednesday, April 2, 2025 12:23:45 PM

Hello Cheree,

Thank you for your inquiry. We reviewed the responses you provided below in your previous email. The ICD-10 code Z51.5 that you have specified is an ICD-10 code for palliative care. Per Section 2.1.3 'Measure Exclusions' of the Star Ratings and Display Page Adherence (ADH) Measures User Guide (PS-SR-ADH-YOS2024-Report-Guide-Apr-2024 and PS-DPM-ADH-YOS2024-Report-Guide-Apr-2024) available with the contract report packages and on the Help Documents page of the Patient Safety Analysis Web Portal, palliative care is not an exclusion criterion for the ADH measures. Medicare Part D beneficiaries are excluded from the ADH measures' denominator if they have elected to receive hospice care with at least one day of hospice coverage during the measurement period. Please note that hospice coverage ~~information~~ is determined based on the hospice coverage start and end dates sourced from the Common Medicare Environment (CME) data, rather than the Common Working File (CWF) or the Encounter Data System (EDS), which uses ICD-10 codes.

If you have further questions, please feel free to reach out.

Best,
Acumen, LLC.

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Monday, March 31, 2025 11:18 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>; Vivian Meras <vivian.meras@cloverhealth.com>; Robert Davis <robert.davis@cloverhealth.com>
Subject: Hospice Med Adherence Appeal

Good afternoon,
We are requesting your review of the below information. Thank you.

- **Contract Number**: H1541
- **Patient Safety Report:** December report
- **Year of Service:** YOS 2024
- **Patient Safety Measure:** Star Ratings Adherence for DM, Star Ratings Adherence for RAS, Star Ratings Adherence for Statins
- **Description of the Inquiry**:

  Clover has done an internal evaluation of the members that we see in our 2024 medication adherence measures and we believe there are at least 56 members that are currently included in our patient safety report but should

be excluded based on their utilization of Hospice care (yet are not indicated as hospice on our monthly membership report). In particular, the evidence shows that these members have utilized hospice care (through documentation of a hospice care ICD-10 code Z51.5 as recognized by CMS). Therefore, at least 56 members should be excluded from our patient safety measures based on our December 2024 reporting.

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From: CMS PartC&DStarRatings
To: Cheree Pasalakis
Cc: PatientSafety; Cameron Pringle; Vivian Meras; Robert Davis; CMS PartC&DStarRatings
Subject: RE: Injectable Statin Appeal - H5141
Date: Tuesday, May 27, 2025 11:50:00 AM

Hi Cheree,

We will forward your email with your measure specification concerns to the Pharmacy Quality Alliance (PQA). The Part D Patient Safety measures are developed and endorsed by the PQA through a consensus-based process. The measures are calculated based on the PQA measure specifications and Value Sets. Updates to measure specifications are also vetted through the PQA's processes.

To make changes to the Parts C and D Star Ratings measure specifications, as codified at §§ 422.164(d)(2), and 423.184(d)(2), substantive updates (that is, changes) must be proposed and finalized through rulemaking in advance of the measurement period. CMS uses the Advance Notice and Rate Announcement process to announce non-substantive measure updates during or in advance of the measurement period as described at §§ 422.164(d)(1) and 423.184(d)(1) and to initially solicit feedback on substantive measure updates. If the PQA finalizes measure changes and issues its documentation, CMS will follow these steps as outlined in regulation to update Stars Ratings measures.

Best,
Part C & D Star Ratings

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Friday, May 16, 2025 9:45 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: PatientSafety <PatientSafety@acumenllc.com>; Cameron Pringle <cameron.pringle@cloverhealth.com>; Vivian Meras <vivian.meras@cloverhealth.com>; Robert Davis <robert.davis@cloverhealth.com>
Subject: Re: Injectable Statin Appeal - H5141

Good morning,
Thank you for your response. We are happy to discuss these issues with PQA, and please feel free to share our email with them.

But while PQA may have helped design these measures, CMS adopts (or does not adopt) the measures as CMS deems appropriate. Because CMS is responsible for these measures, we have raised (and continue to maintain) these challenges with CMS.

We would appreciate a response to our concerns, as the identified members should

have been excluded under CMS's own standards and guidance, as well as governing law--as explained in our April 2025 letter. We reserve all rights.

Thank you.

On Wed, Apr 30, 2025 at 1:03 PM CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov> wrote:

> Hi Cheree,
>
> Thank you for reaching out to us. Please review Section 2.1 Measure Specifications of the Adherence Measures User Guide, available in the Help Documents section of the PS Web Portal, for more details on the methodology for calculating the Adherence Measure's rates. Please note that the current methodology does not account for medication discontinuations.
>
> Additionally, per section 2 'Measure Overview' of the General Report User Guide, all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance (PQA). Should you have further questions regarding the methodology for calculating the Adherence measures, please consult PQA's Web Page or contact them at www.pqaalliance.org/tech-assist-form. Upon submission, you will receive a confirmation of your request with an associated request ID number for easy referencing. Feel free to check out PQA's website for frequently asked questions as well.
>
> Can we share your email with the PQA?
>
> Please let us know if you have any additional questions.
>
> Best,
> Part C & D Star Ratings
>
> ---
>
> **From:** Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
> **Sent:** Wednesday, April 30, 2025 10:45 AM
> **To:** CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; PatientSafety <PatientSafety@acumenllc.com>
> **Cc:** Cameron Pringle <cameron.pringle@cloverhealth.com>; Vivian Meras <vivian.meras@cloverhealth.com>; Robert Davis <robert.davis@cloverhealth.com>
> **Subject:** Injectable Statin Appeal - H5141
>
> Good morning,

We are requesting your review of the below information. Thank you.

- **Contract Number**: H5141
- **Patient Safety Report:** April Patient Safety Report
- **Year of Service:** 2024
- **Patient Safety Measure:** D10 - Medication **Adherence** for Cholesterol (**Statins**)
- **Description of the Inquiry**: Following an internal review, we have identified a subset of members currently included in this measure. Based on clinical documentation and treatment history, the patients' medical providers appropriately transitioned them from statin therapy to non-statin lipid-lowering agents, including PCSK9 inhibitors such as evolocumab (Repatha), inclisiran (Leqvio) and alirocumab (Praluent). These members have discontinued statins for clinically supported reasons, as directed by their physicians, including documented intolerance or inadequate therapeutic response, and have instead been prescribed PCSK9 inhibitors.

Clover Health

To whom it may concern,

On behalf of Clover Health, I am writing to formally appeal the inclusion of certain members in the latest 2024 patient safety report (published on April 1st), specifically within the Statin medication adherence measure.

Following an internal review, we have identified a subset of members currently included in this measure. Based on clinical documentation and treatment history, the patients' medical providers appropriately transitioned them from statin therapy to non-statin lipid-lowering agents, including PCSK9 inhibitors such as evolocumab (Repatha), inclisiran (Leqvio) and alirocumab (Praluent). These members have discontinued statins for clinically supported reasons, as directed by their physicians, including documented intolerance or inadequate therapeutic response, and have instead been prescribed PCSK9 inhibitors. Not only is such discontinuation of statins medically appropriate or necessary in accordance with current ACC/AHA guidelines, CMS methodology in the Technical Specifications recognizes the importance of such discontinuation under Measure D08 - Medication Adherence for Diabetes Medications. Labeling the measure as "Taking Diabetes as Directed," CMS stresses, "One of the most important ways people with diabetes can manage their health is by taking their medication *as directed*."[1] (Emphasis added). Therefore, the measure should include only "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." (Emphasis added).[2]

Here, the members' physicians "directed" them not to take statins and therefore did not provide a "prescription" for statins. Thus, these members should not be included in the measure. But contrary to CMS' own description for "Medication Adherence for Diabetes Medications," the statin adherence measure relied on Part D claims data for statins without accounting for members who receive appropriate alternative therapy via Part D injectables not on the PQA list. As a result, these members were inaccurately classified as non-adherent despite continuing to receive lipid-lowering treatment that meets the clinical specifications of the measure.

Moreover, it is important to emphasize that these patients' providers determined that Part D-administered injectables were more appropriate for the patients. Thus, for these patients to have continued on statin therapy would have been medically unnecessary (and perhaps

[1] https://www.cms.gov/files/document/mmpperformancedatatechnotes.pdf.
[2] https://www.cms.gov/files/document/mmpperformancedatatechnotes.pdf.

harmful) not to mention unduly costly. Given the voluminous statutes, CMS regulations and guidance on medical necessity, patient harm, and undue cost, the medication adherence measure certainly does not require patients to receive medically unnecessary (and inappropriate) treatments.

Summary of Affected Members Based on Clinically Appropriate Statin Replacement Therapy:

- Statin Measure: 91 members with documented PCSK9 escalation from a statin therapy that was not effective in controlling their cholesterol

Clinical Rationale:

- Statin intolerance (e.g., myalgia, liver enzyme elevations) is a well-established clinical reason for discontinuing statin therapy, as recognized in the 2018 ACC/AHA Multisociety Cholesterol Management Guidelines.

- PCSK9 inhibitors (e.g., Repatha, Praluent) are recommended for patients who are unable to tolerate statins or who do not achieve adequate LDL-C reduction with statins alone (ACC/AHA, 2018).

- Continuation of statin therapy despite intolerance may expose patients to increased risk of adverse events, including severe muscle-related side effects and liver toxicity, without proportional benefit.

We appreciate your consideration of this appeal and respectfully request that CMS exclude such members from the Statin adherence measure. We would be happy to provide a list of members and supporting documentation of PCSK9 use as a follow up.

Sincerely,

Dr. Shelly Gupta
Chief Medical Officer
Clover Health

From: Ketcham, Michelle (CMS/CM)
To: Will Chang; Duran, Vanessa (CMS/CM)
Subject: RE: Patient Safety Measures- D10, D08, and D09
Date: Wednesday, July 30, 2025 12:37:49 PM

Hello Will,

Yes, we are in receipt of your correspondence. Vanessa is on vacation until next week. I will connect with Vanessa after she returns, and then we will follow up on your request.

Thank you,
Michelle

Michelle B. Ketcham, PharmD, MBA | Director, Division of Clinical and Operational Performance (DCOP) | Medicare Drug Benefit and C&D Data Group (MDBG) | Centers for Medicare & Medicaid Services (CMS) | U.S. Department of Health and Human Services (DHHS) | Phone 410.786.3371

From: Will Chang <william.chang@cloverhealth.com>
Sent: Tuesday, July 29, 2025 1:08 PM
To: Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>; Ketcham, Michelle (CMS/CM) <michelle.ketcham@cms.hhs.gov>
Subject: Fwd: Patient Safety Measures- D10, D08, and D09

This message was sent securely using Zix®

Dear Ms. Duran and Dr. Ketcham,

On behalf of Clover Health, I respectfully request a meeting to discuss the calculation of the 2026 Star Ratings, specifically the data used to calculate the Medication Adherence measures. We believe the current calculation does not include data needed to accurately reflect the methodology as written, which specifies that beneficiaries should take their medication "as directed" by their physician, and that the data should include only members with a prescription for a diabetes medication.

It is also important to emphasize that these patients' providers determined that these medications were no longer appropriate for the patients. Thus, for these patients to have continued on therapy would have been medically unnecessary (and perhaps harmful) not to mention unduly costly.

We greatly appreciate your time and are available to meet at your convenience, though if possible we respectfully request that the meeting is held prior to the first plan preview period.

We attach the most recent correspondence for your reference, which CMS confirmed receipt of.

Regards,
Will Chang
Vice President and Deputy General Counsel

---------- Forwarded message ---------
From: **Cheree Pasalakis** <cheree.pasalakis@cloverhealth.com>
Date: Fri, Jun 13, 2025 at 9:37 AM

Subject: Patient Safety Measures- D10, D08, and D09
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>, PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>, Robert Davis <robert.davis@cloverhealth.com>, Will Chang <william.chang@cloverhealth.com>, <vanessa.duran@cms.hhs.gov>, <elizabeth.goldstein@cms.hhs.gov>, Shelly Gupta <shelly.gupta@cloverhealth.com>

Good morning,

We are requesting your review of the below and attached information. Thank you.

- **Contract Number**: H5141
- **Patient Safety Report:** May Patient Safety Report
- **Year of Service:** 2024
- **Patient Safety Measure:** D10 - Medication **Adherence** for Cholesterol (**Statins**), D08 - Medication Adherence for diabetes medications, D09 Medication Adherence for Hypertension (RAS antagonists)
- **Description of the Inquiry**:

On behalf of Clover Health, we respectfully reiterate our ongoing challenge to CMS's decision to include certain members in the latest 2024 patient safety report (published on April 1st)--within Measure D10, Medication Adherence for Cholesterol (Statins). In addition, we respectfully challenge CMS's decision to include certain members within Measure D08, Medication Adherence for Diabetes Medication and Measure D09, Medication Adherence for Hypertension (RAS antagonists).

As explained in Clover Health's April 30, 2025 letter, it is inappropriate for Measure D10 to penalize plans with members who have discontinued statins for medically appropriate reasons. It is also inappropriate for Measures D08 and D09 to penalize plans with members who have discontinued diabetes medications or RAS antagonists for medically appropriate reasons. The doctors of these members or CMS's own guidance has determined that continuing statins, diabetes medications, or RAS antagonists would have been medically unnecessary and perhaps harmful for the members–not to mention unduly costly. Given the voluminous statutes, CMS regulations, and guidance on medical necessity, patient harm, and undue cost, Star Ratings measures cannot–and should not–require medically unnecessary and inappropriate treatments in order to achieve compliance under those measures.

In your April 30, 2025 response, CMS did not address–let alone dispute–the substantive merits of our challenge. Instead, CMS simply says "that the current methodology does not account for medication discontinuations" and "all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance." CMS then directs us to the Pharmacy Quality Alliance (PQA) to address our challenges.

Respectfully, CMS's reliance on the measures is arbitrary, capricious, and otherwise not in accordance with law. And while CMS may consult and adopt measures developed by PQA, under the Medicare Act and the Administrative Procedure Act, CMS must ensure that any adopted measure design is methodologically sound and non-arbitrary. In short, CMS is legally responsible for Measures D08, D09, and D10 (and other Star

Ratings measures). CMS cannot avoid that responsibility by pointing us to PQA.

Under CMS's Medicare 2025 Part C & D Star Ratings Technical Notes, federal law, and other applicable authorities, CMS must exclude the members identified in our prior letter as well as the additional members identified in this letter for at least four independent reasons.

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Excel File Produced in Native Format

05.A Exhibit A w_o PHI.xlsx

This document contains confidential, commercial proprietary information or confidential personnel or medical files exempt from disclosure under Exemptions 4 and 6 of FOIA.

Clover Health

May 21, 2025

To whom it may concern,

On behalf of Clover Health, we respectfully reiterate our ongoing challenge to CMS's decision to include certain members in the latest 2024 patient safety report (published on April 1st)--within Measure D10, Medication Adherence for Cholesterol (Statins).[1] In addition, we respectfully challenge CMS's decision to include certain members within Measure D08, Medication Adherence for Diabetes Medication and Measure D09, Medication Adherence for Hypertension (RAS antagonists).

As explained in Clover Health's April 30, 2025 letter, it is inappropriate for Measure D10 to penalize plans with members who have discontinued statins for medically appropriate reasons.[2] It is also inappropriate for Measures D08 and D09 to penalize plans with members who have discontinued diabetes medications or RAS antagonists for medically appropriate reasons. The doctors of these members or CMS's own guidance has determined that continuing statins, diabetes medications, or RAS antagonists would have been medically unnecessary and perhaps harmful for the members–not to mention unduly costly. Given the voluminous statutes, CMS regulations, and guidance on medical necessity, patient harm, and undue cost, Star Ratings measures cannot–and should not–require medically unnecessary and inappropriate treatments in order to achieve compliance under those measures.

In your April 30, 2025 response, CMS did not address–let alone dispute–the substantive merits of our challenge.[3] Instead, CMS simply says "that the current methodology does not account for medication discontinuations" and "all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance."[4] CMS then directs us to the Pharmacy Quality Alliance (PQA) to address our challenges.[5]

Respectfully, CMS's reliance on the measures is arbitrary, capricious, and otherwise not in accordance with law.[6] And while CMS may consult and adopt measures developed by PQA, under the Medicare Act and the Administrative Procedure Act, CMS must ensure that any adopted measure design is

[1] *See* Exhibit A for members who should have been excluded. PHI has been withheld, including supporting documentation containing, among other things, patient medical information. We can make the PHI available to CMS upon request.

[2] *See* Exhibit B.

[3] *See* Exhibit C.

[4] *See* Exhibit C.

[5] *See* Exhibit C.

[6] 5 U.S.C. § 706(2)(A).

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methodologically sound and non-arbitrary. In short, CMS is legally responsible for Measures D08, D09, and D10 (and other Star Ratings measures). CMS cannot avoid that responsibility by pointing us to PQA.

Under CMS's Medicare 2025 Part C & D Star Ratings Technical Notes, federal law, and other applicable authorities, CMS must exclude the members identified in our prior letter as well as the additional members identified in this letter for at least four independent reasons.

First, as set forth in the supporting clinical documentation and our prior letter, at least 293 members were directed by their physicians *not* to take statins.[7] At least 218 members were directed by their physicians *not* to take diabetes medication.[8] And at least 222 members were directed by their physicians *not* to take RAS antagonists.[9]

CMS has repeatedly made clear that, to be included in Measures D10 (statins), D09 (RAS antagonists), and D08 (diabetes medication), the members must "[t]ak[e] ... medication *as [d]irected*."[10] Describing each of those measures,, CMS has stressed, "One of the most important ways people with [diabetes, high blood pressure, or high cholesterol] can manage their health is by taking medication *as directed*. The plan, doctor, and the member can work together to do this."[11] Here, the plan, doctor, and the member did exactly as CMS had instructed.

The supporting documentation shows that the doctors of the identified 733 members directed them not to take statins, RAS antagonists, or diabetes medication for clinical reasons, including intolerance or inadequate therapeutic response.[12] And the plan supported that treatment "as directed." Therefore, under CMS's Technical Notes, these members should have been excluded under Measures D08, D09, and D10. CMS's failure to do so is unlawful: "For an agency to say one thing[,] . . . and do another . . . is the essence of arbitrary action."[13]

Second, at least 393 members were *no longer* prescribed statins, diabetes medication, or RAS antagonists at a certain point during the measurement period–because their doctors determined that continuing such therapy would be medically inappropriate.[14] And CMS Technical Notes for Measure D10 "Metric" states, "This measure is defined as the percent of Medicare Part D beneficiaries 18 years and

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[7] *See* Exhibit A.

[8] *See* Exhibit A.

[9] *See* Exhibit A.

[10] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 92, 95, 98 (emphasis added).

[11] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 92, 95, 98 (emphasis added).

[12] *See* Exhibit A.

[13] *Pub. Citizen v. Heckler*, 653 F. Supp. 1229, 1237 (D.D.C. 1986).

[14] *See* Exhibit A.

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older who adhere to their *prescribed* drug therapy for" diabetes medications, RAS antagonists, or statin cholesterol medications.[15]

Regarding the members at issue, the supporting documentation shows that their doctors ceased prescribing diabetes medications, RAS antagonists, or statins for clinical reasons. Therefore, under CMS's Technical Notes, at least 393 members should have been excluded under Measures D08, D09, and D10. CMS's failure to do so is unlawful, because "an '[u]nexplained inconsistency' in agency policy is 'a reason for holding an interpretation to be an arbitrary and capricious change from agency practice.'"[16]

Third, Measure D10 fails to incorporate exclusions that CMS has for Measure C16 - Statin Therapy for Patients with Cardiovascular Disease. Statin therapy for patients with cardiovascular disease (Measure C16) is a subset of statin therapy for cholesterol (Measure D10). Therefore, the exclusions that apply to the latter (Measure D10) should include, *at the very least*, the same exclusions that apply to the former (Measure C16).

Yet CMS failed to do so. For Measure C16, there are at least *eleven* exclusions, including but not limited to Cirrhosis, end stage renal disease (ESRD), Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.[17] By contrast, measure D10 has only *two* exclusions.[18] Among other conditions, Measure D10 does not exclude Cirrhosis, ESRD, Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.

There is no legitimate basis (clinical or otherwise) for this discrepancy. For example, a patient who has Cirrhosis generally should not be on statins regardless of whether the therapy is for cardiovascular disease or cholesterol. And such discrepancies are unlawful, because "an agency must treat similar cases in a similar manner unless it can provide a legitimate reason for failing to do so."[19] CMS has not–because it cannot–do so.

Without this unlawful discrepancy whereby Measure D10 arbitrarily and capriciously fails to include the exclusions in Measure C16, at least 666 members should be excluded.[20]

Fourth, under federal law and longstanding CMS regulations and guidance, Medicare beneficiaries should not receive medically unnecessary care.[21] In the case of each of the identified members, their

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[15] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 92, 95, 98 (emphasis added).

[16] *See Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016).

[17] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 56-57.

[18] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 99.

[19] *See Bracco Diagnostics, Inc. v. Shalala*, 963 F. Supp. 20, 27 (D.D.C. 1997).

[20] *See* Exhibit A.

[21] *See, e.g.*, 18 U.S.C. section 1349; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf at 5 (CMS explaining that "Medicare fraud include[s] … [k[nowingly ordering medically necessary … services for patients.").

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doctors determined that statin therapy would be medically unnecessary, and in some cases, cause patient harm. Under well-established law, CMS Star Ratings cannot require illegal or harmful therapy (in violation of federal statute and CMS guidance) in order to satisfy a medication adherence measure.[22]

In CMS's April 30, 2025 response to our similar challenges regarding Measure D10, CMS directed us to bring such challenges to PQA. While we understand that CMS often bases its Star Rating measures on the measure steward's specifications (for example, PQA) for each measure, ultimately under both the Medicare Act and the Administrative Procedure Act, it is CMS's obligation to ensure that measure design–inlcuding D08, D09, and D10–is methodologically sound and non-arbitrary.[23]

* * *

For the above reasons, Clover Health continues to challenge CMS's use of the measure and respectfully asks that CMS rescind the measure, unless and until it is appropriately modified to exclude members who have discontinued statins for clinically supported reasons. We appreciate your consideration of this challenge and respectfully request that CMS exclude such members from Measures D08, D09, and D10. We reserve all rights.

Sincerely,

Dr. Shelly Gupta
Chief Medical Officer
Clover Health

Will Chang
Vice President and Deputy General Counsel
Clover Health

CC: Vanessa Duran, vanessa.duran@cms.hhs.gov
Elizabeth Goldstein, elizabeth.goldstein@cms.hhs.gov

[22] *See* SSA § 1801 (prohibiting federal interference with or control over the practice of medicine); *see also Mylan Lab'ys Ltd. v. U.S. Food & Drug Admin.*, 910 F. Supp. 2d 299, 306 (D.D.C. 2012) (agencies cannot act "inconsistent with the statutory mandate" or "frustrate[s] the policy that Congress sought to implement.").

[23] *See* Social Security Act (SSA) § 1852(e); *see also id.* §§ 1853(o), 1856(b).

CMS Response:

CMS has reviewed Clover Health's concerns. CMS is unable to make an ad hoc methodology change to account for medication discontinuation or to add additional exclusions after the measurement year for the three Medication Adherence measures. For the Medicare Part C & D Star Ratings program, we cannot make substantive changes to measure specifications without rigorous measure development, testing, and rulemaking processes ahead of the measurement period. As codified at 42 CFR §§ 422.164(d)(2) and 423.184(d)(2), substantive updates (that is, changes) must be proposed and finalized through rulemaking in advance of the measurement period and only after we have solicited feedback through the Advance Notice and Rate Announcement process. In addition, we must announce any non-substantive measure updates through the Advance Notice and Rate Announcement process during or in advance of the measurement period as described at 42 CFR §§ 422.164(d)(1) and 423.184(d)(1). Therefore, we are limited as to when measure specification updates can be implemented. At this time, we are unable to implement changes to measure specifications for the 2026 Star Ratings (measurement year 2024), including the changes to the Medication Adherence measures requested by Clover Health. Moreover, to the extent Clover Health seeks one-off, post-hoc exceptions or adjustments to the measure specifications to be applied solely to its plans, we cannot grant that request, as the inconsistent application of measure specifications would erode measure validity across the Part D Star Ratings program.

Furthermore, the current measure specifications for the Part D Medication Adherence measures are appropriate to assess and promote evidence-based medication adherence, while also taking discontinuation into account to the extent feasible. If a patient discontinues the target medication due to intolerance or adverse effects, they may appear non-adherent for the remainder of the measurement year. However, in subsequent years, if the patient has no further claims for the target medication, they are excluded from the denominator and no longer impact the measure. Accordingly, any discontinuation due to intolerance has only a transient effect on measure calculations. This design ensures that clinical appropriateness and shared decision-making are preserved, without compromising the integrity of the adherence metric.

Also, as a reminder, the Proportion of Days Covered (PDC) threshold is 80% (in other words, CMS does not expect 100% adherence). As we noted in the contract year (CY) 2019 Medicare Advantage and Part D final rule (83 FR 16553), the 80% compliance threshold reflects the potential for changes in therapy, including medication discontinuation.

Additionally, as we explained in the CY 2019 Medicare Advantage and Part D final rule (83 FR 16553), incorporating medication discontinuation into the Part D Medication Adherence measures would raise significant data integrity concerns. We do not currently have beneficiary-level medication discontinuation data, and there is a lack of standardized data sources for supporting clinical documentation, such as electronic medical record (EMR) care notes. Furthermore, there is a lack of standardized access to this type of data across different Part D plan sponsors, including stand-alone Prescription Drug Plans (PDPs), which do not have access to medical records. If Part D sponsors were to attempt to collect the data, it is unclear how sponsors could implement sufficient

internal controls to meet audit standards necessary to ensure the quality of the data. A standardized data source is required for CMS to validate and verify that the beneficiary discontinued the medication based on a provider's direction. Based on the HPMS memorandum dated May 11, 2012, which addresses the prohibition on submitting Prescription Drug Event (PDE) data for non-Part D prescriptions due to concerns related to beneficiary privacy protections and data validation, and the HPMS memorandum dated April 23, 2013, regarding the May 2013 updates to the Drug Data Processing System, we cannot accept supplemental data. Accepting non-standardized and unvalidated data could potentially lead to data integrity issues.

Without verification using a standardized data source across all plans that CMS can appropriately validate, Part D Star Ratings measures are at risk of potential gaming. It is imperative that CMS apply consistent standards and methodology across all Part D plan sponsors to avoid gamification and data integrity issues, which could undermine the reliability of plan ratings. In addition, the requested adjustments could risk incentivizing plans and providers to discontinue indicated therapy due to adherence concerns to improve performance, undermining the measure intent.

Furthermore, the exclusions utilized in the Part C Statin Therapy for Patients with Cardiovascular Disease (SPC) measure are applied based on a different set of data sources than those applicable to the Medication Adherence for Cholesterol (Statins) measure. The Medication Adherence for Cholesterol (Statins) measure was developed for use in the Part D Star Ratings using administrative PDE data to identify the eligible population because PDPs have limited to no access to medical claims. In contrast, the SPC measure is a Part C measure that aligns with the broader Healthcare Effectiveness Data and Information Set (HEDIS) ecosystem. HEDIS measures require calculation by certified vendors and allow use of broader data sources beyond administrative data, including clinical and other data sources.

Finally, we note that Clover Health is not uniquely impacted by the Medication Adherence measure specifications. Medication discontinuation may occur for beneficiaries across all Part D contracts. The Star Ratings methodology for assigning stars for the Medication Adherence measures is not based on predetermined or static cut points but is based on a clustering methodology using scores from all contracts (stratified by MA-PDs and PDPs) at the end of the measurement year. Star Ratings are assigned based on a contract's performance relative to other contracts, and measure specifications are applied consistently to all Part D sponsors.

CMS PartC&DStarRatings

From: CMS PartC&DStarRatings
Sent: Wednesday, April 30, 2025 2:03 PM
To: Cheree Pasalakis; PatientSafety
Cc: Cameron Pringle; Vivian Meras; Robert Davis; CMS PartC&DStarRatings; CMS PartC&DStarRatings
Subject: RE: Injectable Statin Appeal - H5141

Hi Cheree,

Thank you for reaching out to us. Please review Section 2.1 Measure Specifications of the Adherence Measures User Guide, available in the Help Documents section of the PS Web Portal, for more details on the methodology for calculating the Adherence Measure's rates. Please note that the current methodology does not account for medication discontinuations.

Additionally, per section 2 'Measure Overview' of the General Report User Guide, all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance (PQA). Should you have further questions regarding the methodology for calculating the Adherence measures, please consult PQA's Web Page or contact them at www.pqaalliance.org/tech-assist-form. Upon submission, you will receive a confirmation of your request with an associated request ID number for easy referencing. Feel free to check out PQA's website for frequently asked questions as well.

Can we share your email with the PQA?

Please let us know if you have any additional questions.

Best,
Part C & D Star Ratings

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Wednesday, April 30, 2025 10:45 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>; Vivian Meras <vivian.meras@cloverhealth.com>; Robert Davis <robert.davis@cloverhealth.com>
Subject: Injectable Statin Appeal - H5141

Good morning,
We are requesting your review of the below information. Thank you.

- **Contract Number**: H5141
- **Patient Safety Report:** April Patient Safety Report
- **Year of Service:** 2024
- **Patient Safety Measure:** D10 - Medication **Adherence** for Cholesterol (**Statins**)
- **Description of the Inquiry**: Following an internal review, we have identified a subset of members currently included in this measure. Based on clinical documentation and treatment history, the patients' medical providers appropriately transitioned them from statin therapy to non-statin lipid-lowering agents, including PCSK9 inhibitors such as evolocumab (Repatha),

inclisiran (Leqvio) and alirocumab (Praluent). These members have discontinued statins for clinically supported reasons, as directed by their physicians, including documented intolerance or inadequate therapeutic response, and have instead been prescribed PCSK9 inhibitors.

From: CMS PartC&DStarRatings
To: Cheree Pasalakis
Cc: Jaye Johnston; Will Chang; Wendy Richey; Jamie Reynoso; Kim Williams; CMS PartC&DStarRatings
Subject: RE: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010
Date: Wednesday, August 13, 2025 3:29:33 PM

We noticed in your attachments that you provided enrollee names. As is stated in our Plan Preview memo, no PHI should be sent through email. Please delete these files from your system. If you need to provide PHI, as stated you need to request a secure means for transferring the information.

Below we provide feedback about each of the case numbers in your email regarding the Part C appeals measures.

Case 1-13931154263- When your plan submitted the case file to Maximus, there was not sufficient information about the WOL date issue. Thank you for providing additional information and Maximus will change the appeal request date to 3/28/24. In the future, please try to make these requests earlier if your plan incorrectly entered the appeal receipt date.

Case 1-14156837886- No changes will be made. There is no evidence of an issue with the signature date in the case file sent to Maximus. The WOL has a date stamp of when the plan received this via fax that explicitly states 2/1/24 at 16:20:11. This was a valid WOL as per the documentation sent to Maximus so we see no issues to correct.

1-14575068066- It looks like your plan entered the wrong date when the case was submitted to Maximus. We are having Maximus update the date to 8/22/2024.

1-14506371416- This case was submitted nearly a month after the first one that you claim is a duplicate. This is an expedited appeal, and it is very common for a patient to request multiple appeals for the same item/service if their clinical circumstances change. It also does not look like you requested a reopening of this case. No changes are being made to this case.

1-14506371416- Your plan submitted this case as an expedited appeal and no changes can be made to change the appeal priority. For this appeal your plan notes that this is an expedited request in multiple places in the file submitted to maximus.

1-14595402316- Reopening decisions do not impact the timeliness measure. Reopenings are not related to the timeliness calculations. Reopenings only affect Reviewing Appeals Decisions measure, not the Plan Makes Timely Decisions measure.

1-14385393292- Maximus does not have medical records related to this case so no updates can be made.

For all of the cases related to re-openings, Clover did not request a reopening within 180 days of the Maximus decision. It appears that Clover is saying on their own initiative that they reopened the cases while the appeals were being processed. Clover is not able to reopen a decision after they receive an appeal request. Please see the below citation.

42 CFR § 405.980(a)(4) – When a party has filed a valid request for an appeal of an initial determination, redetermination, reconsideration, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen an issue on a claim that is under appeal until all appeal rights for that issue are exhausted. Once the appeal rights for the issue have been exhausted, the contractor, QIC, ALJ or attorney adjudicator, or Council may reopen as set forth in this section.

We also checked the dates related to the below cases and corrections are in red.

- **1-13664105851** - Initial Determination denial on January 18, 2024 (Attachment O); reopening by Clover to approve coverage on January 22, 2024 (Attachment A; *see also* Attachment T).
    - Initial denial on December 26, 2023; Plan received appeal request on January 17, 2024; plan forwarded to Maximus on January 19, 2024
- **1-13814982651** - Initial determination denial on February 21, 2024 (Attachment P); reopening by Clover to approve coverage on March 25, 2024 (Attachment D; *see also* Attachment U).
    - Initial determination denied on January 25, 2024; plan received appeal request on February 14, 2024; plan forwarded to Maximus on March 4, 2024
- **1-13976245156** - Initial determination denial on April 18, 2024 (Attachment Q); reopening by Clover to approve coverage on April 22, 2024 (Attachment F; *see also* Attachment V).
    - Initial determination denied on April 12, 2024; plan received appeal request on April 17, 2024; plan forwarded to Maximus on April 19, 2024
- **1-14005223730** - Initial determination denial on April 29, 2024 (Attachment R); reopening by Clover to approve coverage on May 1, 2024 (Attachment F; *see also* Attachment W).
    - Initial determination denied on April 26, 2024; plan received appeal request on April 26, 2024; plan forwarded to Maximus on April 29, 2024

- **1-14173810816** - Initial determination denial on June 5, 2024 (Attachment S); reopening by Clover to approve coverage on August 13, 2024 (Attachment J; *see also* Attachment X).
    - Initial determination denied on February 16, 2024; plan received appeal request on April 13, 2024; plan forwarded to Maximus on June 09, 2024
- **1-14196773261** - Initial determination denial on June 16, 2024 (Attachment N); reopening by Clover to approve coverage on July 7, 2024 (Attachment L; *see also* Attachment Y).
    - Initial determination denied on June 4, 2024; plan received appeal request on June 13, 2024; plan forwarded to Maximus on June 16, 2024

Part C and D Star Ratings Team

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Tuesday, August 12, 2025 7:15 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jaye Johnston <jaye.johnston@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Wendy Richey <wendy.richey@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>
Subject: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

This message was sent securely using Zix®

Good afternoon,
Attached is our appeal documentation for plan preview #1. Thank you in advance for your review and consideration.

Cheree Pasalakis
Manager, Compliance
615.426.5531

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From: CMS CallCenterMonitoring
To: Wendy Richey
Cc: Cheree Pasalakis; CMS PartC&DStarRatings; Jaye Johnston; Will Chang; Jamie Reynoso; Kim Williams
Subject: RE: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010
Date: Thursday, August 14, 2025 12:48:58 PM
Attachments: ~WRD0567.jpg
image001.png

Good afternoon,

Thank you for reaching out with your questions. We have completed our review and found the following.

Your plan IVR was presenting a message that stated the call center was closed. CMS also noted being asked to leave a message with the closed message on several calls. Your plan agrees that your IVR was presenting a message that the call center was closed. The results remain as is

Thank you again for reaching out with your questions.

Very respectfully,

Call Center Monitoring Team
Medicare Drug Benefit and C&D Data Group (MDBG)
CallCenterMonitoring@cms.hhs.gov

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From: Wendy Richey <wendy.richey@cloverhealth.com>
Sent: Tuesday, August 12, 2025 9:29 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Jaye Johnston <jaye.johnston@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>
Subject: Re: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

This message was sent securely using Zix®

Thank you. Appreciate your quick response. Have a great evening

Wendy Richey
Medicare Compliance Officer
Clover Health
551-225-2014



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On Tue, Aug 12, 2025 at 8:15 PM CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov> wrote:

> Good evening,
>
> Thank you for reaching out with your questions. We will review and be in touch.
>
> Very respectfully,
>
> **Call Center Monitoring Team**
> Medicare Drug Benefit and C&D Data Group (MDBG)
> CallCenterMonitoring@cms.hhs.gov

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From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Tuesday, August 12, 2025 7:15 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jaye Johnston <jaye.johnston@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Wendy Richey <wendy.richey@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>
Subject: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

This message was sent securely using Zix®

Good afternoon,
Attached is our appeal documentation for plan preview #1. Thank you in advance for your review and consideration.

Cheree Pasalakis
Manager, Compliance
615.426.5531

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transmission is illegal under the law. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY ME IMMEDIATELY BY A REPLY E-MAIL OR PHONE AND PERMANENTLY DELETE THE ORIGINAL E-MAIL AND ANY ATTACHMENTS FROM ALL STORAGE DEVICES WITHOUT RETAINING A COPY. THANK YOU.

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HPMS Appeal – 2026 Plan Preview: Measures D08 (Medication Adherence for Diabetes Medication), D09 (Medication Adherence for Hypertension: RAS antagonists), D10 (Medication Adherence for Cholesterol: Statins)

Contract No.(s): H5141

Executive Summary:

Clover Health (Contract No.: H5141) respectfully objects to CMS's inclusion of certain members in the calculation of Clover Health's performance on Measures D08 (Medication Adherence for Diabetes Medication), D09 (Medication Adherence for Hypertension: RAS antagonists), and D10 (Medication Adherence for Cholesterol: Statins). These medication adherence measures improperly include members who have discontinued the applicable medications for clinically appropriate reasons.

CMS's failure to exclude such members from these measures is contrary to law, arbitrary and capricious, an abuse of discretion, and otherwise unlawful in violation of the Administrative Procedure Act (APA). This failure materially harms Clover Health, and is projected to lower Measure performance for D08 from 85.5% to 84.5%, for D09 from 86.1% to 85.5%, and for D10 from 83.5% to 81.8%. Clover Health has previously raised objections to these measures. On August 5, 2025, CMS provided a response indicating that it cannot implement the corrective actions requested by Clover Health because, in CMS's view, the agency "cannot make substantive changes to measure specifications" without notice-and-comment rulemaking or otherwise grant "post-hoc exceptions or adjustments."[1]

We understand CMS's August 5, 2025, response to mean that the agency believes that further administrative review of Clover's objections is unavailable through the Star Rating and QBP appeal processes—including for purposes of administrative appeal under 42 C.F.R. § 422.260.[2]

---

1 CMS Response at 1 (Aug. 5, 2025) (*See* Appendix A).

2 *See also* 42 C.F.R. § 422.260(c)(3)(ii) ("An administrative review cannot be requested for the following: the methodology for calculating the star ratings (including the calculation of the overall star ratings); cut-off points for determining measure thresholds; the set of measures included in the star rating system; and the methodology for determining QBP determinations

This document and its appendices contain confidential, commercial proprietary information or confidential personnel or medical files exempt from disclosure under Exemptions 4 and 6 of FOIA.

However, we submit this appeal for the avoidance of doubt and to reserve all rights related to challenge of CMS's determination of Clover Health's measure scores for the three medication adherence measures: D08, D09, and D10.

Background:

Clover has documented evidence of three different types of impact to these measures that are appropriate clinical care, but CMS does not take into account how medication adherence is currently documented.

1. Patients had their regimen changed based on directions that their physician deemed clinically appropriate (e.g., a pause in regimen due to intolerance, a reduction in dose not followed through into pharmacy claims, or a pause due to "control of the condition")
2. Discontinuation of the therapy as a result of the physicians judgement that occurred after the patient had received two prescriptions that year
3. Documented intolerance / allergy and / or adverse reaction to statins that are allowed as exclusions as part of the C16 statin measure (e.g., myalgia, myositis, rhabdomyalgia)

The impact of these measures can be summarized in the following table of unique member counts (note that there are overlaps in members between these identified discrepancies / exclusions):

Measure for contract H5141	**1. As directed**	**2. Discontinued**	**3. C16 equivalent exclusion**
D08 - Diabetes	218	115	
D09 - Hypertension	222	34	

for low enrollment contracts and new MA plans."); *Scan Health Plan v. HHS*, No. 1:23-CV-3910 (CJN), 2024 WL 2815789, at *4 n.3 (D.D.C. June 3, 2024).

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D10 - Cholesterol	293	244	666

Data Discrepancy:

Clover reiterates the following concerns, which were previously raised in detailed objections submitted to the agency on April 30, 2025 and June 13, 2025.[3]

First, CMS has improperly treated 733 cases as non-adherent across the three medication adherence measures (D08, D09, and D010), where the clinical documentation shows that the applicable medications were discontinued because their treating clinician directed the patient to discontinue his or her course of treatment:

- **D08 (Medication Adherence for Diabetes Medication)**: 218 members where medication was discontinued because the members were directed by their physician to discontinue diabetes medication.
- **D09 (Medication Adherence for Hypertension: RAS antagonists)**: 222 members where RAS antagonists were discontinued because the members were directed by their physician to discontinue such medication.
- **D10 (Medication Adherence for Cholesterol: Statins)**: 293 patients where statins were discontinued at the physicians' direction (e.g., due to documented PCSK9 escalation from a statin therapy that was not effective in controlling their cholesterol).[4]

By treating these cases as non-adherent, CMS has artificially deflated Clover Health's Part D medication adherence measure scores. CMS's 2026 Star Ratings Technical Notes make clear that these measures test the percentage of patients "who adhere" to a prescribed drug therapy.[5] Where a course of treatment has been discontinued at the direction of a patient's physician, adherence to the treatment regimen requires *discontinuing* the therapy. In other words, Clover Health cannot be penalized for medication "non-adherence" where a patient's physician

[3] Clover Health also incorporates by reference all arguments raised in its prior submissions, which (as noted) are included in Appendix A.

[4] *See* Appendix B (supporting clinical documentation).

[5] 2026 Medicare Part C & D Star Ratings Technical Notes 96 (Measure D08), 99 (Measure D09), 101 (Measure D10).

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directs that it is medically appropriate to discontinue the course of treatment and a patient adheres to this treatment direction.

CMS's prior Technical Notes were even more explicit. The 2025 Star Ratings Technical Notes expressly required taking of medications "*as directed*."[6] The unexplained removal of this language from CMS's 2026 Star Ratings Technical Notes only further reinforces the arbitrariness of the agency's position. CMS cannot reverse its policy of tracking use of medication "as directed" through *sub silentio* deletions of guidance language. A basic premise of both administrative law and due process is that if an agency is changing its policies it must "acknowledge that it is in fact changing its position and "show that there are good reasons for the new policy."[7]

Second, for 393 cases, the applicable medical records show that the members were no longer prescribed statins, diabetes medication, or RAS antagonists at a certain point during the measurement period–because their doctors determined that continuing such therapy would be medically inappropriate.[8] These cases should be excluded because CMS's Technical Notes describing each of these measures make clear that the measures only include plan members "with a prescription" for the applicable medication.[9] This is further reinforced by language in the Technical Instructions making clear that the metric tracks patients "who adhere to their *prescribed* medications," which facially excludes patients who no longer have prescriptions.[10]

Third, CMS's measure design is arbitrary and capricious because CMS fails to incorporate relevant exclusions in the three Part D medication adherence measures that are included in other, similar measures. For example, Measure C19 (statin therapy for patients with cardiovascular disease) incorporates a series of exclusions for, among other things, cirrhosis, end stage renal disease (ESRD), Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year—but similar exclusions are not included in Measure D10 (Medication Adherence for Cholesterol: Statins). In fact, Measure D10 only has two exclusions—whereas

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6 2025 Medicare Part C & D Star Ratings Technical Notes 92 (Measure D08), 95 (Measure D09), 98 (Measure D10), *available at* https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf.

7 *FCC v. Fox Television Stations, Inc.*, 132 S.Ct. 2307, 2315–16 (2012).

8 *See* Appendix A.

9 *See* 2026 Medicare Part C & D Star Ratings Technical Notes at 96 (D08), 99 (D09), 101 (D10).

10 *See id.* at 96 (D08), 99 (D09), 101 (D10) (emphasis added).

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Measure C16 incorporates fully *eleven* separate exclusions.[11] There is no valid clinical or other basis for such differential treatment, and CMS's failure to incorporate comparable exclusions is arbitrary and capricious. A basic premise of administrative law is that agencies must treat "similar cases in a similar manner," unless there is a legitimate and statutorily relevant basis for failing to do so.[12]

Fourth, CMS's approach is inconsistent with Medicare policy. In the first place, it interferes with clinical decision-making in contravention of federal law.[13] It is also inconsistent with CMS's long-standing policy prohibiting medically unnecessary care.[14]

Evidence of Data Discrepancy:

Clover includes at **Appendix A** copies of all prior submissions by Clover Health objecting to CMS's medication adherence measures and copies of CMS's responses—including CMS's most recent August 5, 2025 response. Clover includes at **Appendix B** as supporting evidence of CMS's erroneous treatment of the impacted cases.

Has this issue been raised to CMS/NCQA already this year? If so, what was their response?:

Clover Health has previously raised its concerns to CMS, and CMS has previously indicated that it is unable to make the adjustments requested by Clover Health. As noted, Clover

Commented [1]: HL NOTE: Do we have other documentation of the underlying records beyond what it previously submitted?

The spreadsheet that was previously sent to CMS is just a summary of what Clover says the medical records reflect. Do we want to provide additional documentation beyond?

Commented [2R1]: HL NOTE: Also: The previous submission redacted the member IDs—but that means there no mechanism to verify the accuracy of what we're saying. Does Clover want to submit unredacted versions?

(We included the FOIA disclaimer assuming they may want to consider doing so)

Commented [3R1]: We will submit the unredacted version. We have the original records and the tie to them that we can share. It is a significant amount of data and so the summary would be easier to submit prior to them

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11 *Compare id.* 59-60 (measure C19 exclusions—including for, among other things, cirrhosis; myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year; member death; member palliative care; member hospice, ESRD diagnosis or dialysis; pregnancy, in vitro fertilization, etc.) *with id.* at 103 (measure D10 exclusions for hospice and ESRD diagnosis or dialysis coverage).

12 *Bracco Diagnostics, Inc. v. Shalala*, 963 F. Supp. 20, 27 (D.D.C. 1997).

13 Social Security Act (SSA) § 1801 (prohibiting federal interference with or control over the practice of medicine); *see also Mylan Lab'ys Ltd. v. U.S. Food & Drug Admin.*, 910 F. Supp. 2d 299, 306 (D.D.C. 2012) (agencies cannot act "inconsistent with the statutory mandate" or "frustrate[s] the policy that Congress sought to implement.").

14 *See, e.g.*, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf at 5 (CMS explaining that "Medicare fraud include[s] … [k[nowingly ordering medically necessary … services for patients.").

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provides complete copies of our prior submissions to CMS and CMS's responses in **Appendix A.**

Why should CMS change the manner in which it calculates these medication adherence measures?:

It would be arbitrary, capricious, and otherwise unlawful for CMS to continue to apply its medication adherence measures without excluding cases where a patient's course of treatment was discontinued by the patient's treating physician. Clover Health notes the following in reply to CMS's August 5, 2025 response.

First, CMS suggests that current measure specifications are "appropriate" because "any discontinuation due to intolerance has only a transient effect on measure calculations," i.e., it only impacts scoring for the measurement year in which the medication is discontinued and not future years.[15] This rationale is illogical. Star Rating performance is always "transient," in the sense that Star Ratings are updated every year based on data from the latest measurement year. CMS's reasoning would permit the agency to use unlimited bad data in any given year—because that data would *always* be replaced in the subsequent year. Such an outcome "entirely fails to consider an important aspect of the problem," because it completely disregards the impact of using erroneous data from a given measurement year on a plan's Star Ratings *during the performance year.*[16] It also disregards that new clinical discontinuances will constantly be occurring. As a consequence, the flaws in the measure data will never truly be transient; new errors will continually be introduced each new measurement year to replace the errors in the prior measurement year.

An"as directed" approach[17] could address this issue–if it actually requires consideration of data demonstrating that patients took/or ceased taking their drugs based on the directives of the patients' physicians (e.g., instructions to discontinue the drug or a termination of the

15 CMS Response at 1 (Appendix A).

16 *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 US 29, 43 (1983).

17 As discussed above, although CMS has silently removed this term in the 2026 Technical Notes–the instructions continue to incorporate this idea through the language stating that the measure only tracks patients "who adhere" to a prescribed course of treatment. *See also* 2026 Medicare Part C & D Star Ratings Technical Notes 96 (Measure D08), 99 (Measure D09), 101 (Measure D10).

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prescription). But CMS' position appears to be that, contrary to the plain language of its own program instruction, CMS does *not* consider whether patients took their drugs "as directed," and thus the true flaw is with CMS's *methodology*—which persists beyond any particular measurement year.

Second, CMS suggests that the drug adherence measures' "80% compliance threshold reflects the potential for changes in therapy, including medication discontinuation."[18] This response misses the point: No matter what threshold is applied, CMS's measure design fails to distinguish between medically appropriate discontinuations and genuine nonadherence. A lower threshold does not change the fact that plans can be penalized when patients follow their prescriber's instructions. In other words, the implication that an 80% compliance threshold is reasonable because CMS "could have" set a 100% compliance threshold relies on a false comparison: Both thresholds are arbitrary because they result in plans being penalized for factors wholly outside of their control, including for discontinuances that were indisputably clinically appropriate. Clover Health also emphasizes that the 80% compliance threshold does not offset the range of discontinuances that can occur for reasons outside of Clover Health's control. In Clover Health's case, medically appropriate decisions (including discontinuations) and documented statin intolerance alone account for fully 8% of all cases being considered to be "non-adherent" by CMS. More specifically, it accounts for 8% of the "non-adherence" identified by CMS for Measure D08, 4% of the "non-adherence" identified for Measure D09, and 11% of the "non-adherence" identified for Measure D10.

At bottom, CMS's 80% threshold is arbitrary and capricious. It is wholly unrealistic and inadequate to account for clinically appropriate medication discontinuances and other reasons why there could be instances of patient non-adherence that are outside of plans' control. For example, compliance will be different depending on numerous factors, including when the patient first started on the drug during the year and when the discontinuation occurred or when the physician ceased prescribing the drug. An arbitrary 80 percent threshold is just that–arbitrary. CMS nowhere (including in the regulatory materials) accounts for these commonly understood realities of prescribing drugs and when things (such a discontinuation) may occur.

Rather than attempting to obscure material differences with a blunt, indifferent "compliance threshold," CMS must actually attempt to assess the facts that bear on plans' quality. Any

[18] CMS Response at 1 (Appendix A).

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other approach risks penalizing plans for failing to provide medically *unnecessary* care or for the conduct of independent third parties.[19]

As is documented below, the 80% threshold does not appropriately account for patients that have had their medications discontinued, directed by their physician to change behavior or have reactions to a statin as the average PDC for these patients is significantly below 80%

	1. As directed	**2. Discontinued**	**3. C16 equivalent exclusion**
D08 - Diabetes	64%	62%	N/a
D09 - Hypertension	71%	63%	N/a
D10 - Cholesterol	60%	60%	63%

Third, CMS asserts "data integrity concerns."[20] The agency also states that not all Part D plans may collect medical records and "if Part D sponsors were to attempt to collect the data, it is unclear how sponsors could implement sufficient internal controls to meet audit standards," and expresses concern about "potential gaming" if there is no mechanism to audit or otherwise verify such data.[21] Nothing prevents a plan from collecting medical records relevant to its processed claims. Moreover, "[t]o the extent that a [Part D plan (PDP)] offered by a PDP sponsor maintains medical records or other health information regarding Part D enrollees, the PDP sponsor must meet the same requirements regarding confidentiality and accuracy of enrollee records as MA organizations offering MA plans must currently meet under 42 CFR 422.118."[22] CMS also regularly validates claims on the basis of such medical records through auditing and other claims; for example, this is standard practice across all of Medicare fee-for-service.[23]

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19 *See generally Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 940 (D.C. Cir. 1991) ("Impossible requirements imposed by an agency are perforce unreasonable.").

20 CMS Response at 1 (Appendix A).

21 *Id.* at 1–2.

22 Medicare Prescription Drug Policy Manual, ch. 5 § 80.

23 *See* Medicare Program Integrity Manual, ch. 1 § 1.3 (describing contractor medical record reviews, as well as other program integrity reviews).

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Ultimately, any "data integrity concern" is a problem of CMS's own creation. It is CMS's responsibility to ensure that it has the ability to validate data submitted by plans.[24] CMS cannot create a requirement and then foreclose plans from submitting data to show that they have complied with the requirement. Doing so is the very definition of arbitrary and capricious.[25]

Fourth, CMS also asserts that the Part D medication adherence measures differ from certain other Medicare Advantage measures that incorporate more robust exclusions—because the Part D and Medicare Advantages measures rely on different data sources and have different data integrity controls. This response again disregards that *CMS* is the entity that is ultimately responsible for adopting sound, reliable, and non-arbitrary Star Rating measures—including by selecting appropriate data sources and validation metrics.[26] CMS has shown that it is able to develop or adopt appropriate measure designs in the Medicare Advantage context. Nothing precludes CMS from doing the same in the Part D measure context, and CMS's failure to do so is arbitrary and capricious.[27]

Fifth, and finally, CMS asserts that "Clover Health is not uniquely impacted by the Medication Adherence measure specifications" and that "Star Ratings are assigned based on a contract's performance relative to other contracts."[28] This rationale fails on its face. CMS's approach necessarily harms some plans more than others–depending on their membership mix, and there is no indication that CMS ever gave due consideration or weight to this concern.[29] CMS's failure to do so is arbitrary and capricious: Not only does CMS's approach "entirely fail[] to consider as important aspect of the problem" intended to be solved by a quality comparison

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24 *See generally* SSA §§ 1851(d), 1852(e), 1853(o), 1854(b)(1)(C), 1860D–1(c)).

25 *See Motor Vehicle Mfrs. Assn. of United States, Inc.*, 463 US at 43 (agencies cannot ignore evidence that runs counter to the agency's position or ignore an important aspect of the problem that it purports to be addressing).

26 *See generally* SSA §§ 1851(d), 1852(e), 1853(o), 1854(b)(1)(C), 1860D–1(c)).

27 *See generally Bracco Diagnostics, Inc.*, 963 F. Supp. at 27; *see also* discussion above regarding a comparison of Measure C19 (statin therapy for patients with cardiovascular disease) vs. Measure D10 (Medication Adherence for Cholesterol: Statins).

28 CMS Response at 2.

29 *See also, e.g.*, 83 Fed. Reg. 16,440, 15,553, Tbl. 3D (Apr. 16, 2018) (no meaningful discussion of disparate impacts based on plan demographics—except for a cursory discussion of standalone PDPs).

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system, but it also undermines Congress's intent in requiring CMS to establish a system for making valid quality comparisons between different plans.[30]

Recommended CMS Action:
Consistent with the foregoing, CMS should exclude the impacted cases from its D08, D09, and D10 medication adherence measures.

30 *See Motor Vehicle Mfrs. Assn. of United States, Inc.*, 463 US at 43.

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Appendix B

---------- Forwarded message ---------
From: **Cheree Pasalakis** <cheree.pasalakis@cloverhealth.com>
Date: Wed, Apr 30, 2025 at 10:44 AM
Subject: Injectable Statin Appeal - H5141
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>, PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>, Vivian Meras <vivian.meras@cloverhealth.com>, Robert Davis <robert.davis@cloverhealth.com>

Good morning,
We are requesting your review of the below information. Thank you.

- **Contract Number**: H5141
- **Patient Safety Report:** April Patient Safety Report
- **Year of Service:** 2024
- **Patient Safety Measure:** D10 - Medication **Adherence** for Cholesterol (**Statins**)
- **Description of the Inquiry**: Following an internal review, we have identified a subset of members currently included in this measure. Based on clinical documentation and treatment history, the patients' medical providers appropriately transitioned them from statin therapy to non-statin lipid-lowering agents, including PCSK9 inhibitors such as evolocumab (Repatha), inclisiran (Leqvio) and alirocumab (Praluent). These members have discontinued statins for clinically supported reasons, as directed by their physicians, including documented intolerance or inadequate therapeutic response, and have instead been prescribed PCSK9 inhibitors.

One attachment • Scanned by Gmail Security Sandbox



Clover Health

To whom it may concern,

On behalf of Clover Health, I am writing to formally appeal the inclusion of certain members in the latest 2024 patient safety report (published on April 1st), specifically within the Statin medication adherence measure.

Following an internal review, we have identified a subset of members currently included in this measure. Based on clinical documentation and treatment history, the patients' medical providers appropriately transitioned them from statin therapy to non-statin lipid-lowering agents, including PCSK9 inhibitors such as evolocumab (Repatha), inclisiran (Leqvio) and alirocumab (Praluent). These members have discontinued statins for clinically supported reasons, as directed by their physicians, including documented intolerance or inadequate therapeutic response, and have instead been prescribed PCSK9 inhibitors. Not only is such discontinuation of statins medically appropriate or necessary in accordance with current ACC/AHA guidelines, CMS methodology in the Technical Specifications recognizes the importance of such discontinuation under Measure D08 - Medication Adherence for Diabetes Medications. Labeling the measure as "Taking Diabetes as Directed," CMS stresses, "One of the most important ways people with diabetes can manage their health is by taking their medication *as directed*."[1] (Emphasis added). Therefore, the measure should include only "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." (Emphasis added).[2]

Here, the members' physicians "directed" them not to take statins and therefore did not provide a "prescription" for statins. Thus, these members should not be included in the measure. But contrary to CMS' own description for "Medication Adherence for Diabetes Medications," the statin adherence measure relied on Part D claims data for statins without accounting for members who receive appropriate alternative therapy via Part D injectables not on the PQA list. As a result, these members were inaccurately classified as non-adherent despite continuing to receive lipid-lowering treatment that meets the clinical specifications of the measure.

Moreover, it is important to emphasize that these patients' providers determined that Part D-administered injectables were more appropriate for the patients. Thus, for these patients to have continued on statin therapy would have been medically unnecessary (and perhaps

[1] https://www.cms.gov/files/document/mmpperformancedatatechnotes.pdf.
[2] https://www.cms.gov/files/document/mmpperformancedatatechnotes.pdf.

harmful) not to mention unduly costly. Given the voluminous statutes, CMS regulations and guidance on medical necessity, patient harm, and undue cost, the medication adherence measure certainly does not require patients to receive medically unnecessary (and inappropriate) treatments.

Summary of Affected Members Based on Clinically Appropriate Statin Replacement Therapy:

- Statin Measure: 91 members with documented PCSK9 escalation from a statin therapy that was not effective in controlling their cholesterol

Clinical Rationale:

- Statin intolerance (e.g., myalgia, liver enzyme elevations) is a well-established clinical reason for discontinuing statin therapy, as recognized in the 2018 ACC/AHA Multisociety Cholesterol Management Guidelines.

- PCSK9 inhibitors (e.g., Repatha, Praluent) are recommended for patients who are unable to tolerate statins or who do not achieve adequate LDL-C reduction with statins alone (ACC/AHA, 2018).

- Continuation of statin therapy despite intolerance may expose patients to increased risk of adverse events, including severe muscle-related side effects and liver toxicity, without proportional benefit.

We appreciate your consideration of this appeal and respectfully request that CMS exclude such members from the Statin adherence measure. We would be happy to provide a list of members and supporting documentation of PCSK9 use as a follow up.

Sincerely,

Dr. Shelly Gupta
Chief Medical Officer
Clover Health

---------- Forwarded message ---------
From: **CMS PartC&DStarRatings** <PartCandDStarRatings@cms.hhs.gov>
Date: Wed, Apr 30, 2025 at 2:03 PM
Subject: RE: Injectable Statin Appeal - H5141
To: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>, PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>, Vivian Meras <vivian.meras@cloverhealth.com>, Robert Davis <robert.davis@cloverhealth.com>, CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Hi Cheree,

Thank you for reaching out to us. Please review Section 2.1 Measure Specifications of the Adherence Measures User Guide, available in the Help Documents section of the PS Web Portal, for more details on the methodology for calculating the Adherence Measure's rates. Please note that the current methodology does not account for medication discontinuations.

Additionally, per section 2 'Measure Overview' of the General Report User Guide, all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance (PQA). Should you have further questions regarding the methodology for calculating the Adherence measures, please consult PQA's Web Page or contact them at www.pqaalliance.org/tech-assist-form. Upon submission, you will receive a confirmation of your request with an associated request ID number for easy referencing. Feel free to check out PQA's website for frequently asked questions as well.

Can we share your email with the PQA?

Please let us know if you have any additional questions.

Best,
Part C & D Star Ratings

Clover

Fwd: Patient Safety Measures- D10, D08, and D09

2 messages

---------- Forwarded message ---------
From: **Cheree Pasalakis** <cheree.pasalakis@cloverhealth.com>
Date: Fri, Jun 13, 2025 at 9:37 AM
Subject: Patient Safety Measures- D10, D08, and D09
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>, PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>, Robert Davis <robert.davis@cloverhealth.com>, Will Chang <william.chang@cloverhealth.com>, <vanessa.duran@cms.hhs.gov>, <elizabeth.goldstein@cms.hhs.gov>, Shelly Gupta <shelly.gupta@cloverhealth.com>

Good morning,
We are requesting your review of the below and attached information. Thank you.

- **Contract Number**: H5141
- **Patient Safety Report:** May Patient Safety Report
- **Year of Service:** 2024
- **Patient Safety Measure:** D10 - Medication **Adherence** for Cholesterol (**Statins**), D08 - Medication Adherence for diabetes medications, D09 Medication Adherence for Hypertension (RAS antagonists)
- **Description of the Inquiry**:

On behalf of Clover Health, we respectfully reiterate our ongoing challenge to CMS's decision to include certain members in the latest 2024 patient safety report (published on April 1st)--within Measure D10, Medication Adherence for Cholesterol (Statins). In addition, we respectfully challenge CMS's decision to include certain members within Measure D08, Medication Adherence for Diabetes Medication and Measure D09, Medication Adherence for Hypertension (RAS antagonists).

As explained in Clover Health's April 30, 2025 letter, it is inappropriate for Measure D10 to penalize plans with members who have discontinued statins for medically appropriate reasons. It is also inappropriate for Measures D08 and D09 to penalize plans with members who have discontinued diabetes medications or RAS antagonists for medically appropriate reasons. The doctors of these members or CMS's own guidance has determined that continuing statins, diabetes medications, or RAS antagonists would have been medically unnecessary and perhaps harmful for the members–not to mention unduly costly. Given the voluminous statutes, CMS regulations, and guidance on medical necessity, patient harm, and undue cost, Star Ratings measures cannot–and should not–require medically unnecessary and inappropriate treatments in order to achieve compliance under those measures.

In your April 30, 2025 response, CMS did not address–let alone dispute–the substantive merits of our challenge. Instead, CMS simply says "that the current methodology does not account for medication discontinuations" and "all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance." CMS then directs us to the Pharmacy Quality Alliance (PQA) to address our challenges.

Respectfully, CMS's reliance on the measures is arbitrary, capricious, and otherwise not in accordance with law. And while CMS may consult and adopt measures developed by PQA, under the Medicare Act and the Administrative Procedure Act, CMS must ensure that any adopted measure design is methodologically sound and non-arbitrary. In short, CMS is legally responsible for Measures D08, D09, and D10 (and other Star Ratings measures). CMS cannot avoid that responsibility by pointing us to PQA.

Under CMS's Medicare 2025 Part C & D Star Ratings Technical Notes, federal law, and other applicable authorities, CMS must exclude the members identified in our prior letter as well as the additional members identified in this letter for at least four independent reasons.

2 attachments

Exhibit A w_o PHI.xlsx
56K

May 2025 Omnibus Appeal.docx
686K

---------- Forwarded message ---------
From: **CMS PartC&DStarRatings** <PartCandDStarRatings@cms.hhs.gov>
Date: Tue, Aug 5, 2025 at 11:23AM
Subject: RE: Patient Safety Measures- D10, D08, and D09
To: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>, Robert Davis <robert.davis@cloverhealth.com>, Will Chang <william.chang@cloverhealth.com>, Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>, Goldstein, Elizabeth (CMS/CM) <Elizabeth.Goldstein@cms.hhs.gov>, Shelly Gupta <shelly.gupta@cloverhealth.com>, CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Hello,

Please review the attached response from CMS Part C & D Star Ratings.

Thank you
Part C & D Star Ratings

CMS Response:

CMS has reviewed Clover Health's concerns. CMS is unable to make an ad hoc methodology change to account for medication discontinuation or to add additional exclusions after the measurement year for the three Medication Adherence measures. For the Medicare Part C & D Star Ratings program, we cannot make substantive changes to measure specifications without rigorous measure development, testing, and rulemaking processes ahead of the measurement period. As codified at 42 CFR §§ 422.164(d)(2) and 423.184(d)(2), substantive updates (that is, changes) must be proposed and finalized through rulemaking in advance of the measurement period and only after we have solicited feedback through the Advance Notice and Rate Announcement process. In addition, we must announce any non-substantive measure updates through the Advance Notice and Rate Announcement process during or in advance of the measurement period as described at 42 CFR §§ 422.164(d)(1) and 423.184(d)(1). Therefore, we are limited as to when measure specification updates can be implemented. At this time, we are unable to implement changes to measure specifications for the 2026 Star Ratings (measurement year 2024), including the changes to the Medication Adherence measures requested by Clover Health. Moreover, to the extent Clover Health seeks one-off, post-hoc exceptions or adjustments to the measure specifications to be applied solely to its plans, we cannot grant that request, as the inconsistent application of measure specifications would erode measure validity across the Part D Star Ratings program.

Furthermore, the current measure specifications for the Part D Medication Adherence measures are appropriate to assess and promote evidence-based medication adherence, while also taking discontinuation into account to the extent feasible. If a patient discontinues the target medication due to intolerance or adverse effects, they may appear non-adherent for the remainder of the measurement year. However, in subsequent years, if the patient has no further claims for the target medication, they are excluded from the denominator and no longer impact the measure. Accordingly, any discontinuation due to intolerance has only a transient effect on measure calculations. This design ensures that clinical appropriateness and shared decision-making are preserved, without compromising the integrity of the adherence metric.

Also, as a reminder, the Proportion of Days Covered (PDC) threshold is 80% (in other words, CMS does not expect 100% adherence). As we noted in the contract year (CY) 2019 Medicare Advantage and Part D final rule (83 FR 16553), the 80% compliance threshold reflects the potential for changes in therapy, including medication discontinuation.

Additionally, as we explained in the CY 2019 Medicare Advantage and Part D final rule (83 FR 16553), incorporating medication discontinuation into the Part D Medication Adherence measures would raise significant data integrity concerns. We do not currently have beneficiary-level medication discontinuation data, and there is a lack of standardized data sources for supporting clinical documentation, such as electronic medical record (EMR) care notes. Furthermore, there is a lack of standardized access to this type of data across different Part D plan sponsors, including stand-alone Prescription Drug Plans (PDPs), which do not have access to medical records. If Part D sponsors were to attempt to collect the data, it is unclear how sponsors could implement sufficient

internal controls to meet audit standards necessary to ensure the quality of the data. A standardized data source is required for CMS to validate and verify that the beneficiary discontinued the medication based on a provider's direction. Based on the HPMS memorandum dated May 11, 2012, which addresses the prohibition on submitting Prescription Drug Event (PDE) data for non-Part D prescriptions due to concerns related to beneficiary privacy protections and data validation, and the HPMS memorandum dated April 23, 2013, regarding the May 2013 updates to the Drug Data Processing System, we cannot accept supplemental data. Accepting non-standardized and unvalidated data could potentially lead to data integrity issues.

Without verification using a standardized data source across all plans that CMS can appropriately validate, Part D Star Ratings measures are at risk of potential gaming. It is imperative that CMS apply consistent standards and methodology across all Part D plan sponsors to avoid gamification and data integrity issues, which could undermine the reliability of plan ratings. In addition, the requested adjustments could risk incentivizing plans and providers to discontinue indicated therapy due to adherence concerns to improve performance, undermining the measure intent.

Furthermore, the exclusions utilized in the Part C Statin Therapy for Patients with Cardiovascular Disease (SPC) measure are applied based on a different set of data sources than those applicable to the Medication Adherence for Cholesterol (Statins) measure. The Medication Adherence for Cholesterol (Statins) measure was developed for use in the Part D Star Ratings using administrative PDE data to identify the eligible population because PDPs have limited to no access to medical claims. In contrast, the SPC measure is a Part C measure that aligns with the broader Healthcare Effectiveness Data and Information Set (HEDIS) ecosystem. HEDIS measures require calculation by certified vendors and allow use of broader data sources beyond administrative data, including clinical and other data sources.

Finally, we note that Clover Health is not uniquely impacted by the Medication Adherence measure specifications. Medication discontinuation may occur for beneficiaries across all Part D contracts. The Star Ratings methodology for assigning stars for the Medication Adherence measures is not based on predetermined or static cut points but is based on a clustering methodology using scores from all contracts (stratified by MA-PDs and PDPs) at the end of the measurement year. Star Ratings are assigned based on a contract's performance relative to other contracts, and measure specifications are applied consistently to all Part D sponsors.

Excel File Excluded Because It Contains Protected Health Information

Exhibit A w_ PHI.xlsx

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Clover Health

May 21, 2025

To whom it may concern,

On behalf of Clover Health, we respectfully reiterate our ongoing challenge to CMS's decision to include certain members in the latest 2024 patient safety report (published on April 1st)--within Measure D10, Medication Adherence for Cholesterol (Statins).[1] In addition, we respectfully challenge CMS's decision to include certain members within Measure D08, Medication Adherence for Diabetes Medication and Measure D09, Medication Adherence for Hypertension (RAS antagonists).

As explained in Clover Health's April 30, 2025 letter, it is inappropriate for Measure D10 to penalize plans with members who have discontinued statins for medically appropriate reasons.[2] It is also inappropriate for Measures D08 and D09 to penalize plans with members who have discontinued diabetes medications or RAS antagonists for medically appropriate reasons. The doctors of these members or CMS's own guidance has determined that continuing statins, diabetes medications, or RAS antagonists would have been medically unnecessary and perhaps harmful for the members–not to mention unduly costly. Given the voluminous statutes, CMS regulations, and guidance on medical necessity, patient harm, and undue cost, Star Ratings measures cannot–and should not–require medically unnecessary and inappropriate treatments in order to achieve compliance under those measures.

In your April 30, 2025 response, CMS did not address–let alone dispute–the substantive merits of our challenge.[3] Instead, CMS simply says "that the current methodology does not account for medication discontinuations" and "all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance."[4] CMS then directs us to the Pharmacy Quality Alliance (PQA) to address our challenges.[5]

Respectfully, CMS's reliance on the measures is arbitrary, capricious, and otherwise not in accordance with law.[6] And while CMS may consult and adopt measures developed by PQA, under the Medicare Act and the Administrative Procedure Act, CMS must ensure that any adopted measure design is

[1] *See* Exhibit A for members who should have been excluded. PHI has been withheld, including supporting documentation containing, among other things, patient medical information. We can make the PHI available to CMS upon request.

[2] *See* Exhibit B.

[3] *See* Exhibit C.

[4] *See* Exhibit C.

[5] *See* Exhibit C.

[6] 5 U.S.C. § 706(2)(A).

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methodologically sound and non-arbitrary. In short, CMS is legally responsible for Measures D08, D09, and D10 (and other Star Ratings measures). CMS cannot avoid that responsibility by pointing us to PQA.

Under CMS's Medicare 2025 Part C & D Star Ratings Technical Notes, federal law, and other applicable authorities, CMS must exclude the members identified in our prior letter as well as the additional members identified in this letter for at least four independent reasons.

First, as set forth in the supporting clinical documentation and our prior letter, at least 293 members were directed by their physicians *not* to take statins.[7] At least 218 members were directed by their physicians *not* to take diabetes medication.[8] And at least 222 members were directed by their physicians *not* to take RAS antagonists.[9]

CMS has repeatedly made clear that, to be included in Measures D10 (statins), D09 (RAS antagonists), and D08 (diabetes medication), the members must "[t]ak[e] ... medication *as [d]irected*."[10] Describing each of those measures,, CMS has stressed, "One of the most important ways people with [diabetes, high blood pressure, or high cholesterol] can manage their health is by taking medication *as directed*. The plan, doctor, and the member can work together to do this."[11] Here, the plan, doctor, and the member did exactly as CMS had instructed.

The supporting documentation shows that the doctors of the identified 733 members directed them not to take statins, RAS antagonists, or diabetes medication for clinical reasons, including intolerance or inadequate therapeutic response.[12] And the plan supported that treatment "as directed." Therefore, under CMS's Technical Notes, these members should have been excluded under Measures D08, D09, and D10. CMS's failure to do so is unlawful: "For an agency to say one thing[,] . . . and do another . . . is the essence of arbitrary action."[13]

Second, at least 393 members were *no longer* prescribed statins, diabetes medication, or RAS antagonists at a certain point during the measurement period–because their doctors determined that continuing such therapy would be medically inappropriate.[14] And CMS Technical Notes for Measure D10 "Metric" states, "This measure is defined as the percent of Medicare Part D beneficiaries 18 years and

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[7] *See* Exhibit A.

[8] *See* Exhibit A.

[9] *See* Exhibit A.

[10] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 92, 95, 98 (emphasis added).

[11] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 92, 95, 98 (emphasis added).

[12] *See* Exhibit A.

[13] *Pub. Citizen v. Heckler*, 653 F. Supp. 1229, 1237 (D.D.C. 1986).

[14] *See* Exhibit A.

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older who adhere to their *prescribed* drug therapy for" diabetes medications, RAS antagonists, or statin cholesterol medications.[15]

Regarding the members at issue, the supporting documentation shows that their doctors ceased prescribing diabetes medications, RAS antagonists, or statins for clinical reasons. Therefore, under CMS's Technical Notes, at least 393 members should have been excluded under Measures D08, D09, and D10. CMS's failure to do so is unlawful, because "an '[u]nexplained inconsistency' in agency policy is 'a reason for holding an interpretation to be an arbitrary and capricious change from agency practice.'"[16]

Third, Measure D10 fails to incorporate exclusions that CMS has for Measure C16 - Statin Therapy for Patients with Cardiovascular Disease. Statin therapy for patients with cardiovascular disease (Measure C16) is a subset of statin therapy for cholesterol (Measure D10). Therefore, the exclusions that apply to the latter (Measure D10) should include, *at the very least*, the same exclusions that apply to the former (Measure C16).

Yet CMS failed to do so. For Measure C16, there are at least *eleven* exclusions, including but not limited to Cirrhosis, end stage renal disease (ESRD), Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.[17] By contrast, measure D10 has only *two* exclusions.[18] Among other conditions, Measure D10 does not exclude Cirrhosis, ESRD, Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.

There is no legitimate basis (clinical or otherwise) for this discrepancy. For example, a patient who has Cirrhosis generally should not be on statins regardless of whether the therapy is for cardiovascular disease or cholesterol. And such discrepancies are unlawful, because "an agency must treat similar cases in a similar manner unless it can provide a legitimate reason for failing to do so."[19] CMS has not–because it cannot–do so.

Without this unlawful discrepancy whereby Measure D10 arbitrarily and capriciously fails to include the exclusions in Measure C16, at least 666 members should be excluded.[20]

Fourth, under federal law and longstanding CMS regulations and guidance, Medicare beneficiaries should not receive medically unnecessary care.[21] In the case of each of the identified members, their

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[15] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 92, 95, 98 (emphasis added).

[16] *See Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016).

[17] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 56-57.

[18] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, at 99.

[19] *See Bracco Diagnostics, Inc. v. Shalala*, 963 F. Supp. 20, 27 (D.D.C. 1997).

[20] *See* Exhibit A.

[21] *See, e.g.*, 18 U.S.C. section 1349; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf at 5 (CMS explaining that "Medicare fraud include[s] … [k[nowingly ordering medically necessary … services for patients.").

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doctors determined that statin therapy would be medically unnecessary, and in some cases, cause patient harm. Under well-established law, CMS Star Ratings cannot require illegal or harmful therapy (in violation of federal statute and CMS guidance) in order to satisfy a medication adherence measure.[22]

In CMS's April 30, 2025 response to our similar challenges regarding Measure D10, CMS directed us to bring such challenges to PQA. While we understand that CMS often bases its Star Rating measures on the measure steward's specifications (for example, PQA) for each measure, ultimately under both the Medicare Act and the Administrative Procedure Act, it is CMS's obligation to ensure that measure design–inlcuding D08, D09, and D10–is methodologically sound and non-arbitrary.[23]

* * *

For the above reasons, Clover Health continues to challenge CMS's use of the measure and respectfully asks that CMS rescind the measure, unless and until it is appropriately modified to exclude members who have discontinued statins for clinically supported reasons. We appreciate your consideration of this challenge and respectfully request that CMS exclude such members from Measures D08, D09, and D10. We reserve all rights.

Sincerely,

Dr. Shelly Gupta
Chief Medical Officer
Clover Health

Will Chang
Vice President and Deputy General Counsel
Clover Health

CC: Vanessa Duran, vanessa.duran@cms.hhs.gov
Elizabeth Goldstein, elizabeth.goldstein@cms.hhs.gov

[22] *See* SSA § 1801 (prohibiting federal interference with or control over the practice of medicine); *see also Mylan Lab'ys Ltd. v. U.S. Food & Drug Admin.*, 910 F. Supp. 2d 299, 306 (D.D.C. 2012) (agencies cannot act "inconsistent with the statutory mandate" or "frustrate[s] the policy that Congress sought to implement.").

[23] *See* Social Security Act (SSA) § 1852(e); *see also id.* §§ 1853(o), 1856(b).

Clover Health

Request for Reconsideration of Measure: C28 Complaints about the Health Plan

Contract:

Clover Health (contracts H5141 and H8010) respectfully requests review and removal of certain 2024 Complaints about the Health Plan (CTMs) for purposes of calculating our 2026 Star Rating for measure: C28 Complaints About the Health Plan. Clover Health is being inaccurately penalized by CMS for issues that are outside of the plan's control and which require CMS' assistance to resolve. By seeking to penalize Clover for issues that are outside of the plan's control and that require CMS intervention to address, the agency has "failed to consider an important aspect of the problem," and has thereby failed to satisfy the Administrative Procedure Act's (APA's) requirements of reasoned decision-making. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

Data Discrepancy:

Complaints listed in Table B, attached, should not be counted against the plan negatively. For contract year 2024, Clover respectfully requests that a total 45 CTMs (H5141= 41 CTMs, H8010=4 CTMs) be removed from the calculation of Clover Health's 2026 Star Ratings. These fall into different categories but most share a common characteristics such as:

- Loss of Medicare Entitlement (Loss of Part A and or B coverage)
- LEP (Late Enrollment Penalty)
- CMS Facilitated Enrollment/Disenrollment (Enrollments/Disenrollments effectuated by CMS)
- Duplicate Complaint (2 complaints received for the same issue)
- No prior contact to health plan prior to filing a CTM with CMS

As noted, a common element across all these CTMs is that they involve issues outside of the plan's control that would require CMS' intervention or assistance to address or resolve. CMS has previously refused to reclassify the loss of entitlement, LEP, and SSA CTMs because CMS maintains that the plan is expected to communicate with the beneficiary and assist the member *before* the member contacts 1-800-Medicare. But the model communications the beneficiary receives about loss of entitlement, LEP, and SSA come directly from CMS and clearly instruct the beneficiary to contact 1-800 Medicare with any questions. CMS states,

"Remember, Medicare limits how and when you can make changes to your coverage. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048."

Many members, therefore, contact 1-800 Medicare before notifying the plan of the issue. Given this context, it is not possible for the plan to intervene before the beneficiary calls 1-800 Medicare - and thus, it is not possible for the plan to avoid a CTM.

Has this Issue Previously Been Raised with CMS/NCQA This Year? If so, what was their response?:

Clover Health has previously requested that these cases not count against the health plan following the CTM Updated Guidance on Standard Operating Procedures (SOP) for the Complaints Tracking Module. CMS original response to the Plan request that CTMs be removed is found in the table below in the column labeled, Table B, "Original CMS Response".

Why should CMS change it and what does Clover believe our rate/score to be?:

Overall, classifying these complaints as CTMs misrepresents the nature of these member complaints. The root cause of these complaints is not the *plan's* behavior. Rather, these complaints arise because of actions by CMS(or the Social Security Administration). As explained above, given the communications sent by CMS to members, it is also impossible for the plan to intervene prior to the complaint being filed. Incorporating these complaints into STAR ratings severely and unfairly penalizes plans for issues that are entirely outside of the plan's control and that would require CMS assistance to address. Clover ascertains that removing the below CTMs would change the final H8010 and H5141 Star Measure Rate as detailed in Table A, *"Clover Calculated CTM Rate Reflecting CTMs Removed"*.

- H5141: Removal of 41 CTMs
- H8010: Removal of 4 CTMs

Table A: CMS Plan Preview C25 CTM Rate vs. Recalculated C25 CTM Rate

Contract	Total Number of Complaints	Complaint Average Enrollment	CMS Plan Preview 1 Rate	Revised Number of Complaints with CTMs removed	Complaint Average Enrollment	Clover Calculated CTM Rate Reflecting CTMs Removed
H5141	214	76,781	0.23	173	76,781	0.18
H8010	16	3,575	0.37	12	3,575	0.28

File Excluded Because It Contains Protected Health Information

Table B.pdf

Clover Health – Faulty CMS Test Calls Foreign Language Interpreter and TTY Availability Subject: Request for Recalculation of C33 and D01 Measure Score for Contracts H5141 and H8010

Executive Summary

Clover Health respectfully requests that CMS exclude five (5) test calls–resulting in unsuccessful outcomes–conducted between April 1–3, 2025 from the calculation of Stars measure C33 ("Call Center – Foreign Language Interpreter and TTY Availability") and D01 ("Call Center – Foreign Language Interpreter and TTY Availability"). These calls were erroneously marked as plan unsuccessful despite Clover Health's compliance with applicable CMS protocols. The failures arose solely because CMS test callers prematurely disconnected before the protocol-mandated routing to a live representative could occur—a procedural error on the part of the callers, not Clover Health.

Clover Health requests that CMS exclude a total of 5 impacted calls from scoring--3 from Measure C33 and 2 from D01 for Contracts H5141 and H8010, which would result in the following changes:

- H5141
  - C33 would go from 94 percent (60/64) compliance to 98 percent compliance (60/61)
  - D01 would go from 94 percent (60/64) compliance to 97 percent compliance (60/62)
- H8010
  - C33 would go from 94 percent (60/64) compliance to 98 percent compliance (60/61)
  - D01 would go from 94 percent (60/64) compliance to 97 percent compliance (60/62)

Each of the test calls at issue was made while Clover's call center was fully operational, and live representatives were available and standing by. While a temporary Interactive Voice Response (IVR) misconfiguration resulted in the incorrect playback of an English-language message during this window, Clover's IVR system was correctly configured to default to a live customer service representative (CSR) in the absence of an IVR selection–exactly as CMS mandates for non-English language testing.

Under CMS's own guidance, when IVR options are unavailable in the caller's language, callers must remain on the line without making a selection. CMS technical notes and December 2024 memorandum confirm that only calls that remain in the queue and are not routed to a representative may be counted as "unsuccessful due to time-outs." Further, when it comes to non-English speaking callers, CMS technical notes state:

> Finally, when testing interpreter availability, our callers are simulating the experience of a non-English-speaking caller, so if IVR instructions are not available in the language we are testing, we do not make an IVR selection because a non-English-

> speaking caller *could not understand what is being said and could not make that IVR selection.* For this reason, ensure your phone systems will default to a live customer service representative if no IVR selection is made, or voice command given.

Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes at 19 (Emphasis added).

CMS test callers prematurely terminated all five calls at issue–contrary to CMS's testing methodology. Accordingly, Clover Health urges CMS to exclude these calls from Stars scoring. Inclusion would not only be inconsistent with CMS policy, but would also constitute an arbitrary and capricious departure from agency standards.

Background

From April 1st to April 3rd, 2025, CMS test callers performed 5 test calls of Clover Health's call center to determine if a non-English speaking caller would be connected to a live representative within a certain period. Throughout that time, Clover Health's call center was open and representatives were available during business hours. Further, at all times, the phone system was operable in all respects, including the feature to default to a live operator if no IVR selection was made.

Clover Health acknowledges that, during the time period in question, it experienced a temporary misconfiguration within our contact center platform, Zoom Contact Center. This misconfiguration resulted in the wrong IVR script being played, causing the system to erroneously deliver an English-only closed message during normal hours of operation. In response to the misconfiguration, CMS test callers, simulating non-English speakers, disconnected from their test calls without waiting the CMS-mandated time period for calls of this nature. Of these 5 unsuccessful calls, 3 were associated with Measure C33 and 2 were associated with Measure D01, as set forth below:

Impacted Calls

The following CMS test calls were received during the wrong IVR message window and were marked unsuccessful due to the interviewer disconnecting the call. Unsuccessful calls according to the CMS' HPMS raw data database:

Measure	Contract ID	Case ID	Ts0 Date	Ts0 Time (Start Time)	Ts7 Time (When Test Caller Disconnected)	IVR Time (in seconds)
C33	H8010/H5141	C1300429	4/1/2025	12:13:00	12:19:39	339
	H8010/H5141	C1300515	4/1/2025	17:29:43	17:33:56	83
	H8010/H5141	C1301020	4/3/2025	17:36:04	17:37:37	22

D01	H8010/H5141	D1300838	4/2/2025	19:02:04	19:04:29	27
	H8010/H5141	D1300996	4/3/2025	14:05:10	14:05:49	17

The error in IVR messaging was manually updated on the morning of April 4, 2025, upon identification of the issue. Note, in three of the five calls, the test caller disconnected after less than 30 seconds. In another call, the test caller disconnected after less than a minute and a half. And the final caller disconnected after less than six minutes. So in all cases, the test caller remained on the line for significantly less than the ten minutes required by CMS's test call protocols and instructions.

Appeal Basis Narrative

Clover Health respectfully requests reconsideration of the 5 unsuccessful CMS test calls between April 1st - 3rd, 2025 associated with Contracts H5141 and H8010. These calls were marked as unsuccessful due to callers receiving a "closed" message and subsequently choosing to disconnect.

These test calls were not failures. The misconfigured IVR script should have had no impact on the 5 calls because they were testing access to foreign language interpretation, meaning that the purpose of the test was to determine whether Clover had required language protocols in place. Clover did.

The test callers violated CMS's own standards by discontinuing the foreign language interpretation test call based on an erroneous English-only IVR. According to CMS instructions, when a test caller simulates a non-English-speaking beneficiary and IVR instructions are not available in the language being tested, the caller **mus**t remain on the line to be routed to a live representative. That's because, according to CMS's own rules, "CMS telephone interviewers who are testing a language other than the primary language **will not make a selection** in the IVR system if the instruction is only in the primary language. **Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu**." December 5, 2024 Memorandum from Vanessa S. Duran, 2025 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies, at 7 (emphasis in original). In other words, a test caller simulating a non-English speaker is prohibited from interpreting or responding to English-only IVR messages. That same caller cannot reasonably interpret a 'closed' message in English.

Had the test callers stayed on the line, the callers would have been routed to a live operator. Instead, CMS' callers disconnected manually, which is inconsistent with CMS's stated expectations for how language line testing should be conducted when the test caller simulates a non-English speaker.

In conclusion, Clover Health complied with CMS's test instructions, whereas CMS's test callers departed from the agency's instructions. Clover Health had a live representative available to be connected in the mandated timeframe, including live representatives available for non-English speakers. Zoom's incorrect English-only recording was immaterial, as it did not impact the protocols

that the testers were supposed to follow for a test of the availability of foreign language interpretation services.

Because these test results were based on incomplete test calls, and the test callers violated CMS's own instructions, the results must be excluded from Stars scoring. Any other outcome would be arbitrary and capricious. "It is settled law that an agency ordinarily must follow its own policies and procedures." *Lobsters, Inc. v. Evans*, 346 F. Supp. 2d 340, 348 (D. Mass. 2004). "[A]n irrational departure from that policy" may therefore be "overturned as 'arbitrary, capricious, [or] an abuse of discretion.'" *INS v. Yueh-Shaio Yang*, 519 U.S. 26, 32 (1996).

Supporting Documentation

- 2025 Part C and Part D Call Center Monitoring
- 508_Technical_Notes_2025_07_03_Final

Citations:

Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes

"For non-TTY calls, callers will wait in the plan IVR or hold queues for up to 10 minutes each until a live person is available." The Hold queue is defined as the time spent on hold by the CMS caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person. After 10 minutes has expired, the system closes out the case and the CMS caller assigns a status code shown in the raw data."

"Interpreter availability: Defined as the ability of a caller to communicate with a person at the plan's call center and receive answers to questions in the caller's language. This must happen within eight minutes of reaching a live person. This occurs at the end of phase 3.

TTY functionality: Defined as the ability of a hearing and/or speech impaired caller using TTY being able to communicate with a live person and receive answers to questions at the plan's call center directly or via a relay operator within seven minutes. This occurs at the end of phase 3."

"Finally, when testing interpreter availability, our callers are simulating the experience of a non-English-speaking caller, so if IVR instructions are not available in the language we are testing, we do not make an IVR selection because a non-English-speaking caller could not understand what is being said and could not make that IVR selection. For this reason, ensure your phone systems will default to a live customer service representative if no IVR selection is made, or voice command given."

2025 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies - 2025 Part C and Part D Call Center Monitoring

Ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu. Every year CMS encounters plans that offer limited IVR options without a clear way to select the option to speak with a current member representative or a prospective beneficiary representative, and the IVR message cycles over and over without a live representative answering the telephone. This results in unsuccessful calls due to time-outs. Test your systems. When planning the IVR choices, ask yourself, "If I am calling to get information so I can decide if I want to enroll in this plan, is there an IVR option for me on this prospective beneficiary telephone number, even if I do not speak English (or other than the primary language in the area)?"

"In order to replicate a beneficiary's actual experience, ***CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the IVR system if the instruction is only in the primary language. Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.*** *If the IVR instruction is available in the language being tested, the test callers will make an*

appropriate IVR selection. For example, if the language being tested is French, and instruction is available in French in the IVR to select an option for French, the test caller will make that selection. (Please note that the primary language in Puerto Rico is Spanish and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)"



Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes

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Document Change Log

Previous Version	Description of Change	Revision Date
2008	Added purpose section, contact information, and expanded/clarified definitions	**5/15/2016**
2017	Revised call and measure outcomes and provided additional detail for performance metrics shown in HPMS for 2017, including unsuccessful calls.	**3/23/2017**
2019	Expanded sections for Purpose, Contact Information, and Understanding the Data. Added FAQs.	**6/30/2019**
2021	Revised language to match the Call Center Monitoring Memo, and expanded /clarified definitions	**7/20/2021**
2022	Revised based on 42 CFR 422.111(h) and 423.128(d)	**6/30/2022**
2024	Revised language around where calls originate. Minor format updates.	**6/05/2024**
2025	Edited for clarity, removed language that was duplicative, ambiguous, or superfluous	**6/18/2025**

Purpose

This document describes the Medicare Part C and Part D Call Center Monitoring metrics for the yearly Accuracy and Accessibility Study. All results are reported at the contract level.

Background

Each year, CMS issues an annual Call Center Monitoring Memo to all Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), Medicare Advantage-Prescription Drug Plans (MA-PDs), and Medicare-Medicaid Plans (MMPs) affected by the Call Center Monitoring studies it performs. The memo explains that the studies are for the purpose of monitoring the performance of plan sponsors' call centers with respect to the standards adopted to implement 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1). The annual memo describes the study and offers tips to help your organization be successful. The annual memo supersedes any definitions contained in this document.

In an effort to reduce the burden on plans by reducing the number of phone calls necessary for the Accuracy and Accessibility Study, CMS selects samples across *call centers* rather than basing this study on the phone number itself. In order to select these samples, we review the toll-free prospective beneficiary customer service phone numbers listed in HPMS for your Part C and Part D prospective customer service centers. CMS' monitoring contractor, then asks the compliance officer on record in HPMS to indicate if the customer service phone numbers route into the same or different call centers. The monitoring contractor then determines the number of distinct call centers indicated by the compliance officer and notes which phone numbers route to each unique call center. The contractor assigns a unique call center indicator to identify each call center for use in the study.

This study is conducted at the call center level by calling all toll-free prospective phone numbers for the Part C call center or the Part D call center. A simple random sample method is adopted for the Accuracy and Accessibility Study with eight different survey modes: English, Spanish, French, Vietnamese, Mandarin, Cantonese, Tagalog, and TTY. (These modes are announced each year inthe annual call center monitoring memo.) English is considered the native language we are testing for all states/territories except Puerto Rico, where Spanish is tested as the native language.

Although TTY services utilize a separate set of phone numbers, TTY is defined as one of the survey modes and it is treated like one of the languages from the sample design perspective. Therefore, TTY calls are a subset of the total sample. Since there is no TTY call center information, TTY sample size is first built at the unique TTY phone number level. For state relayphone numbers and other TTY lines that cover a large number of contracts, the sample is selected at the TTY/ LEP call center level to get sufficient sampling of these phone numbers and lines.

The metrics and compliance outcomes are posted in the HPMS at the conclusion of the study.The raw data, which is available by download from HPMS, show which accuracy questions were "assigned" to plans for each case/call. The call center indicator is also shown in the raw data. All plan-level results are "rolled up"and reported out to you in HPMS by contract ID.

Results are displayed for all MAOs, MA-PDs, PDPs, and MMPs. 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 (Programs for the All-Inclusive Care of the Elderly), MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers. Contracts with *only* SNPs are excluded from the accuracy measure of the Accuracy and Accessibility Study. Any plan under marketing and enrollment sanction is excluded from the

Accuracy and Accessibility Study until such sanction is released.

The following categories are reported within the HPMS Call Center Monitoring Part C and Part D Prospective Beneficiary Customer Support Performance Metrics sections: TTY functionality, interpreter availability/LEP, accuracy measures, results by language tested, unsuccessfulcalls, and Star Ratings. The TTY functionality and interpreter availability/LEP scores are combined for Star Ratings purposes but are shown in the Call Center Monitoring data only as they relate to the Accuracy and Accessibility Study. Inquiries about Star Ratings should be referred to the Part C & D Star Ratings Team.

Contact Information

The Call Center Monitoring resource mailbox can assist you with all aspects of Call Center Monitoring. Prior to results being posted CMS can assist with questions or concerns related to systems connectivity and urgent issues. After results are posted, CMS can assist with questions about individual calls. **Please include the following information along with your question/concern:**

- Contract ID
- Phone number on which the call was received
- Unique case ID found in the raw data or the date and time of the call including time zone
- If questioning a disconnected call, a full call log (screen shots alone are not sufficient), that confirms the disconnect did not occur on the plan side. Information should be provided to help CMS interpret any information that is provided. Audio files alone are not sufficient to determine a call disconnect

Please do not use secure email to communicate with us. This project never shares personally identifiable information. If you must send something in a secure fashion, please contact us at the email below first. Send your concerns to CallCenterMonitoring@cms.hhs.gov.

If you have questions or require information about other subject areas that overlap with Call Center Monitoring, please write to those contacts directly and cc the Call Center Monitoring mailbox.

- CMS Medicare Learning Network Team: MLNMattersTeam@cms.hhs.gov
- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

Performance Metrics Availability in HPMS

Detailed results (e.g., number of calls by language, number of questions answered correctly,number of completed calls by mode, etc.) will be available in the HPMS at the following paths: (https://hpms.cms.gov):

1. For Part C results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [choose date range for current study] > [enter the contract number].

2. For Part D results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [choose date range for current study] > [enter the contract

number].

Understanding the Data: Call Outcomes Compared to Measure Outcomes

Call outcomes and measure outcomes may differ, meaning you may have a call listed in the rawdata that reached a CSR, but none of the measures included in that call was successful. To help you understand your raw data and your results, please think about the separate phases of each call as shown below:

- Phase 1: Dial
- Phase 2: Connect
- Phase 3: Complete
- Phase 4: Ask

In phase 1 *(dial)*, the plan's toll-free or alternate toll-free (TTY) calling information, downloaded from HPMS, is dialed.

Phase 2 (*connect*) is when the caller reaches a live person. Reasons for unanswered calls may include (1) wrong number listed in HPMS; (2) prolonged wait times for a live person due to high call volumes at the plan; (3) center is closed at an inappropriate time; or (4) other reasons caused by the plan or the plan's phone carrier.

Regardless of mode of call scheduled (TTY, interpreter availability/LEP, or native language call) it will be scored as unsuccessful if we are not able to reach a live person. (CMS provides you with a data dictionary in HPMS. The data dictionary provides definitions for our numerical codes in the raw data. These codes explain the outcome for you.)

For non-TTY calls, callers will wait in the plan IVR or hold queues for up to 10 minutes each until a live person is available. If either timer expires before we reach a live person, the call is unsuccessful. This does not apply to TTY calls because the caller does not encounter an IVR or HOLD before reaching a live person.

If we reach a live person within the given time parameters, the call moves into phase 3 (*complete*) to ensure we are speaking with a customer service representative who can answer questions about the plan's benefits. If yes, the call is moved into phase 4 (*ask*) to ask the three accuracy questions.

At the conclusion of the study, CMS may take compliance action when a contract fails to meet any of the following requirements:

Interpreter availability: Defined as the ability of a caller to communicate with a person at the plan's call center and receive answers to questions in the caller's language. This must happen within eight minutes of reaching a live person. This occurs at the end of phase 3.

TTY functionality: Defined as the ability of a hearing and/or speech impaired caller using TTY being able to communicate with a live person and receive answers to questions at the plan's call center directly or via a relay operator within seven minutes. This occurs at the end of phase 3.

Accuracy: Accuracy of answers to questions about plan benefits allows for a maximum of seven

minutes for each of three questions. Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.

The raw data will show outcomes for each test call placed. The raw data will include a numerical code for the call that also explains the call outcome. Refer to the data dictionary to help you decipher the numerical call outcome codes. The data dictionary is available for download in HPMS next to the link for the Raw Data at the bottom of the performance metrics pages. In addition to the raw data, HPMS will list the unsuccessful call in the performance metrics section as well as the reason why the call was unsuccessful.

Please be aware that certain outcome codes in the raw data imply **a call is completed.**

- **Code 295** indicates that the caller asked and received answers to all three accuracy questions.
- **Code 295.2** indicates a SNP call with phase 3 fulfilled and phase 4 excluded.
- **Code 290.x** *(where x is filled in with a number)* indicates that phase 4 began but for several reasons, one or more of the three accuracy questions were not answered. This most often occurs when the seven-minute timer expires during a question, or the call disconnects. This code indicates a positive outcome for the interpreter availability/LEP or TTY measure (phase 3), with the accuracy measure (phase 4) *partially* met. You can review the raw data for the individual call to determine if each question was answered and, if so, whether it answered accurately or inaccurately. The raw data also shows you if and when a timer expired for an accuracy question, meaning on the first, second, or third accuracy question. Recall that any unanswered question has a neutral impact on the plan's performance and is not cause for concern.

Performance Metrics

The performance metrics listed below correspond with column letters in the Call Center Performance Metrics tables in HPMS.

Total Number of all Monitoring Calls – This metric is the number of all monitoring calls, including interpreter availability/LEP, TTY, and native language calls.

Total Number of Completed Monitoring Calls - This metric includes the total number of completed LEP calls, completed TTY calls, and completed native language calls (codes 295,295.2, 290.x).

All Calls - Percentage of Completed Calls out of All Calls – This metric shows thepercentage of completed monitoring calls out of the total number of monitoring calls. This is not your Star Rating measure.

Unsuccessful Calls – This section shows the call weeks, which are the calendar weeks of theyear when the study was active. For example, week 1 is the first week in January. This study is normally active from approximately February through June. The chart includes a count of unsuccessful calls, the total number of unsuccessful calls during the study, and a call outcome description. For example, the reader may see an outcome description that states, "TTY seven-minute HOLD." This would imply that the CMS caller was on hold for longer than seven minutes when testing TTY

functionality, and therefore the call was unsuccessful, and thus the TTY measure was unsuccessful.

A call is classified as unsuccessful for any of the following reasons:

- Phone number was called but did not get answered after six rings.
- Survey could not continue; Call Center disconnected call (including hanging up).
- Survey could not continue; Call Center responded in Spanish only.
- Survey could not continue; call dropped before it rang six times.
- Survey could not continue; line did not accept incoming calls.
- Survey could not continue; message stated that the target number cannot be dialed from CMS caller area code.
- Survey could not continue; phone line problems.
- Survey could not continue; reached a number that was NOT the targeted call center (dueto incorrect phone number listed in HPMS).
- Survey could not continue; reached a system filtering inbound calls.
- Survey could not continue; reached Call Center voicemail.
- Survey could not continue; received a busy signal.
- Survey could not continue; technology barrier (e.g., received a computer modem/fax machine signal, beeper/pager number, etc.)
- Survey could not continue; received a message that an identification number was neededto continue.
- Survey could not continue; received a TYY device for the hearing impaired when callingvia telephone.
- Survey could not continue; received message that the Call Center was closed.
- Survey could not continue; CSR refused to answer question.
- Survey could not continue; CSR insists on member name, SSN, ID etc. to continue.
- Survey could not continue; CSR tells our caller to call back.
- Survey could not continue: CSR unable to answer questions about Medicare/Medicaid.
- Surveyor navigated the IVR for 10 minutes and call reached time limit.
- Surveyor was in the HOLD queue for 10 minutes and then call reached limit.
- Surveyor cannot connect to TTY operator.
- Surveyor can connect to TTY operator but cannot connect to the plan.
- Survey could not continue for other reasons*.

*When the classification "*Survey could not continue for other reasons*" is used, the CMS caller includes the reason in a descriptor field. Most commonly recorded reasons include:

- Disconnected number
- CSR Offers New Number to Call

Connected and Completed Calls by Language – This section shows the results by individual language. The languages tested were English, Spanish, French, Vietnamese, Mandarin, Cantonese, and Tagalog. HPMS displays the total number of monitoring calls, total number of connected calls,

total number of completed calls,and percentage of completed calls out of all calls.

Total Number of All Interpreter Availability/LEP Monitoring Calls – The metric shows the total number of monitoring calls placed to test interpreter availability.

Total Number of Completed Interpreter Availability/LEP Calls Out of All LEP Calls – This metric shows the total number of times that an attempt to confirm interpreter availabilitywas completed**.**

Percentage of Completed Interpreter Availability/LEP Calls Out of All LEP Calls – This metric shows the percentage of completed LEP calls out of the total number of all LEPmonitoring calls.

Total Number of TTY Monitoring Calls - This metric shows the total number ofmonitoring calls placed to test TTY functionality.

Total Number of Completed Calls to the organization TTY number - This metric showsthe total number of times that an attempt to confirm TTY functionality was completed.

Percentage of Completed Calls to the organization TTY number – This metric shows the percentage of completed TTY calls out of the total number of TTY monitoring calls.

Star Ratings Calculation - 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. The formula is as shown below.

$$\frac{\#\text{ Completed TTY calls} + \#\text{ Completed LEP calls}}{\#\text{ TTY calls} + \#\text{ LEP calls}}$$

For more info on Star Ratings: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

Accuracy - Total Number of Medicare Questions Answered – This metric shows the total number of times the Medicare accuracy questions were *answered* within seven minutes. If ananswer was not provided before the seven-minute timer expired during the monitoring call, it was not counted in this metric.

Accuracy - Total Number of Accurate Answers to all Medicare Questions – This metric shows the total number of times a CSR provided an accurate response to the accuracy question.

Accuracy - Percentage of Accurate Answers to all Medicare Questions – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered.

Foreign Language Accuracy Result – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered, when those questions were asked in a foreign language.

TTY Accuracy Result – This metric is the percentage of times that a Medicare question was answered accurately out of the total number of Medicare questions answered, when those questions were asked via TTY device.

Call Center Monitoring Definitions

Accuracy Questions – During the Accuracy and Accessibility Study, CMS callers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR provides an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to a general Medicare accuracy question. The percentage of accurate responses is calculated as the number of questions answered accurately divided by the total number of *answered* questions multiplied by 100. Note: If a CSR is unable to answer the question before the timer expires, the call ends without progressing to the next accuracy question (e.g., question number 2 or 3). The effect of atimed-out call during the accuracy measure is neutral to the plan, meaning the question was not answered accurately or inaccurately and therefore is not counted in the accuracy measure performance metric.

Connected Calls – Generally speaking, a call is considered "connected" when the CMS caller reaches a live person (or connects to the plan for TTY calls) in a timely manner. The measure is considered completed when that person confirms that they are able to assist the CMS caller with questions about Medicare Part C or Part D benefits in a timely manner.

Hold Time

During the Accuracy and Accessibility Study, the maximum hold time for waiting in an IVR orin the Hold queue is 10 minutes for non-TTY calls.

The Hold queue is defined as the time spent on hold by the CMS caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person. After 10 minutes has expired, the system closes out the case and the CMS caller assigns a status code shown in the raw data.

Interpreter Availability 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. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A call is considered **connected** when the CMS caller confirms that the call connects to the CSR. The measure is considered **completed** when contact has been established with an interpreter and the introductory question has been correctly answered within eight minutes of reaching a CSR. The CMS caller may also have moved on to asking the first of three general Medicare or plan- specific accuracy questions, but this is not required for consideration as a completed interpreter availability measure. The number of completed calls out of all foreign language calls is used for compliance as well as star ratings measures.

Limited English Proficiency (LEP) – The acronym LEP is used in the performance metricssection

of HPMS to indicate a call made to determine interpreter availability as part of the Accuracy and Accessibility Study.

LEP Hold Time is a code used to capture the time waiting for the interpreter. Each call is allotted eight minutes for this timer.

LEP Hold time begins after reaching a live customer service representative and ends after the CMS caller has confirmed that the CSR is available and able to assist in answering questions about Medicare Part C or Part D benefits.

Missing Data - When call data are not available for a contract, HPMS will display "N/A." Reasons for missing data include technical issues and other reasons for which calls cannot be made/connected.

Phone Numbers - *Prospective beneficiary customer service lines* are called for the Accuracy and Accessibility Study. Phone numbers used in the study were extracted from data provided by MAOs, MA-PDs, PDPs, and MMPs in HPMS for prospective Part C and Part D customer service lines. Customer service numbers were extracted at the plan level (i.e., HXXXX-001 or SXXXX-001). Extracts from HPMS are performed to update phone numbers on a weekly basis throughout this study.

Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the time zones for the regions in which they operate) for *prospective beneficiary* customer service lines. For example, if the same phone number serves plans in both New York and California, that number receives calls from 8:00 a.m. in New York until 8:00 p.m. in California. The calls made are distributed throughout the period of time the call center is required to be open. Statisticsfor any given contract typically include all calls made to phone numbers associated with the contract.

If any *beneficiary* customer service calls were made before the hour of 8:00 a.m. in the time zone of the contract's eastern-most service area or after 8:00 p.m. in the time zone of the western-most service area, they will be excluded from the analysis for that specific contract since the contractor is not expected to maintain call center operations at those times.

Time Data - All time data are provided in minutes and seconds in the format of MM:SS and are recorded in the Eastern Time Zone.

When reviewing the raw data, please remember to calculate the time difference between the East Coast and your plan's region(s).

TTY functionality 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. The calculation of this measure is the number of completed contacts with the CSR divided by the number of attempted contacts.

TTY Hold Time is a code used to capture the time waiting for the TTY operator. The TTY hold time is the time between reaching the plan, either via 711/state relay operator or connecting directly to a live CSR, and the time when a live CSR confirms he or she can assist with questions about

Medicare Part C or Part D benefits, and the confirmation was received on the tester's TTY device. The maximum allowable time for waiting for the TTY operator (TTY_HOLD) is seven minutes.

Raw Data
The raw data that supports these performance metrics is also available in HPMS in the Part C and Part D prospective beneficiary customer service performance metrics sections. Links to the raw data are displayed immediately below the performance metrics display. MAOs, MA-PDs, PDPs, and MMPs may download the data either in an Excel document for a single contract, or asa text-delimited file for all contracts under the parent organization ID.

Data Dictionary
A data dictionary is available for you to download via link in HPMS adjacent to the link for the raw data. The data dictionary provides an explanation for numerical codes shown in the raw data.

Frequently Asked Questions

Accuracy and Accessibility Study

Question: During what time of day do you place outbound monitoring calls for the Accuracy and Accessibility Study?

Answer: Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the local time zones for the regions in which they operate) for beneficiary customer service lines. For example, if the same phone number serves plans in both New York and California, the number receives test calls from CMS from 8:00 a.m. in New York until 8:00 p.m. in California.

Where multiple time zones are served by a single call center servicing multiple contract IDs, if any beneficiary customer service calls were made before the hour of 8:00 a.m. in the time zone of the contract's eastern-most service area or after 8:00 p.m. in the time zone of the western-most service area, the call will be *excluded* from the analyses for that specific contract since the contractor is not expected to maintain call center operations at those times.

Question: How are call center indicators assigned?

Answer: CMS' contractor emails the compliance officer and asks them to assign a letter (A, B,C for example) for each call center it operates. We do this late in the year prior to the study beginning the following year. The CMS contractor then further breaks down the sample by phone numbers, plan types, etc. and assigns indicators as necessary for call completion.

This process can become quite involved for large contracts that cover SNPs, non-SNPs, MMPs,and non-MMPs. If you are confused by the raw data for a large organization that covers many plan types, it may be best to send specific questions to CallCenterMonitoring@cms.hhs.gov and we will assist you.

Below are some generalities about our contractor's process:

- Calls made to phone numbers assigned to call center indicators dedicated to SNP plans may be handled differently. If an assigned call center indicator only includes phone numbers that are dedicated to SNP plans, there is no change. If a call center indicator includes phone numbers that are dedicated to SNP plans along with phone numbers that serve both SNP and non-SNP, at least one LEP or English call is made to the SNP-dedicated phone number. Please note that a contract with ONLY SNPs is exempt from the accuracy measure and CMS callers will not ask any accuracy questions on calls under these SNP-only contracts. Contracts with both SNP and non-SNP plans will be asked accuracy questions for the non-SNP plans and no accuracy questions are asked for the SNP plans. The results are rolled up to the contract level.
- Regarding how calls are applied, our contractor reviews the counties served by each plan type and the time zones served in those local service areas. (For example, some contracts will occasionally have counties that are split into two time zones. If two time zones are served, the call center is required to be open from 8 am to 8 pm in EACH local service area/time zone.) Calls are scheduled to be placed at appropriate times. The results of the calls are applied to every contract ID *assigned to the call center indicator* that is appropriate based upon the time

the call was actually placed.

To handle a call center which normally covers all SNPs, non-SNPs, MMPs, and non-MMP plans, our contractor needs extra steps and assumptions to make sure that it can minimize the number of calls to the plans. These assumptions are made, for example, for contracts with

1. Some phone numbers covering both SNPs and non-SNPs.
2. Some phone numbers covering either MMPs or non-MMPs.
3. Some phone numbers covering both MMPs and non-MMPs.

When a compliance office has indicated a call center is shared by SNP-only and non-SNP phone numbers, calls are distributed so that the SNP-only number receives at least one call a week. In this case, TTY calls are only made to non-SNP phone numbers. When a call center only uses SNP-only phone numbers, the call center can expect six calls per week, including TTY calls.

We will not ask any accuracy questions for SNP plans, so the call is considered complete when an interpreter is available and answers "Yes" to our introductory question. In contrast, for non- SNP plans we will also ask accuracy questions. Consequently, SNPs which share phone numberswith non-SNPs can also share interpreter availability/LEP performance metrics with the non- SNP plan (but NOT vice versa.)

As stated previously, this can be confusing for large organizations, so let us know if you needhelp by sending your contract ID and your question to CallCenterMonitoring@cms.hhs.gov.

Question: How many calls will we receive during the Accuracy and Accessibility Study?

Answer: Each year, CMS' contractor re-evaluates the number of calls needed for statistical significance in keeping with the margin of error for this study, so the examples below should only be used as an estimate of the volume of calls that could be received in any given year.

In 2025, you could expect to receive, on average, 96 calls ***per call center indicator***. This total comes from an average of 6 calls each week. Those 6 calls were comprised of one TTY test call, two native language calls, and three foreign language calls. In 2025, we placed *approximately* 96 calls per Part C call center indicator, and approximately 96 calls per Part D call center indicator, if you were a sponsor offering Part D services.

Recall that the Accuracy and Accessibility Study is conducted at the *call center* level, not the phone number level like the Timeliness Study. Our monitoring calls include the native language (Spanish in Puerto Rico; English elsewhere), TTY, and each of the six foreign languages that wetest. Note that a call center indicator could have many phone lines (e.g., 35 phone lines in 2025) associated with it and each call will be to a different phone number when there is more than one number for a call center indicator. Another thing to note is that one phone line can be associated with multiple plans.

Interpreter Availability Measure

Question: When do you release the languages for testing?

Answer: We announce the languages in our annual call center monitoring memo. We typically release this in December of the year prior to the study. The memo is announced via HPMS and is emailed to compliance officers listed in HPMS for the organizations we monitor.

Question: During the Accuracy and Accessibility Study, when testing interpreter availability, if the CMS caller remains on the line for more than the eight minutes allowed, before having an ability to ask for an interpreter, would this be considered an unsuccessful – or failed – call result?

Answer: If a CMS caller waits for a live person to answer for 10 minutes in the IVR or on hold but no live person picked up the call, the call will time out and it will be counted as *an unsuccessful call.* If a live person answers, this is a *connected call outcome*. If the CSR cannot get the interpreter on the line and have the interpreter help to answer the introductory question before the 8-minute LEP Hold timer goes off, the call is ended, and the interpreter availability measure does not have a complete result.

Question: Regarding the rule about connecting an interpreter within eight minutes, does this apply to each call or is this an average?

Answer: It applies to each call. If it takes longer than eight minutes for the CSR to bring the interpreter onto the call to answer our introductory question, the timer will expire, and the call will end. This results in an unsuccessful outcome. For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be ableto respond "yes" to the introductory question before the 8-minute timer expires.

Question: During the interpreter availability test, is there actually a Limited English Proficient (LEP) person on the line, or do you use bilingual agents?

Answer: We use bilingual interviewers. They are fluent in the language being tested.

TTY Functionality

Question: Do plans have to use teletypewriters for TTY functionality?

Answer: For the purpose of this study TTY can refer to either a machine (device) or IP software, including real time text (RTT). If using RTT, plans must ensure that it is backwards compatible with TTY.

Question: Are we able to use alternate technologies to TTY, like real-time text (RTT)?

Answer: Any alternative technology must be backwards compatible with TTY.

Question: Do you ask questions in foreign languages when testing TTY functionality?

Answer: The TTY measure is conducted in English only. For plans with service areas exclusively in Puerto Rico, please be aware that we do test TTY only in English for your plans as well.

Question: How should we decide if we want to use an in-house TTY device or software or a relay service?

Plan: This is a business decision for the plan to make, and CMS cannot offer an opinion. Plans should weigh the pros and cons of using an in-house TTY system versus the national 711relay service or their state relay number. Note that any in-house technology, such as RTT, must be backward compatible with TTY.

Question: Should we list 711 or the state relay operator's number in HPMS?

Answer: You may list either number in HPMS. When 711 is dialed, the call will route to the locality of where the call originates from. Please understand that you can dial 711 to connect to certain forms of telecommunications relay services in the United States *instead of* having to remember a ten-digit telephone number for the state relay service. Dialing 711 makes it easier for travelers to use the relay service because they do not have to remember telecommunications relay service numbers in every state.

Question: Is there anything we should do to test our in-house TTY devices or software?

Answer: CMS makes the following suggestions for testing in-house TTY devices or software:

- Regularly test your device or software to ensure that it is working properly.
- Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into the TTY system to test.)
- Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
- When testing, check for garbled language on both sides of the call.
- Whenever you make a telephone system change, retest all TTY systems.
- If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx- xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a phone line *and* a TTY line.
- Verify with your telecom provider that TTY calling is supported, in case there are any settings on the carrier side that need to be adjusted.
- If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is a packet loss, internet speed will need to beincreased.
- Ensure your technology, if not TTY, is backward compatible to TTY.

<u>Accuracy Measure</u>

Question: If the timer expired during our accuracy question and we were not able to answer it, is the result counted against the contract's performance?

Answer: No, the effect is neutral to the contract. During the Accuracy and Accessibility Study, CMS callers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR can provide an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to general Medicare accuracy questions. The percentage of accurate responses is calculated as the number of *questions answered accurately* divided by *the total number of answered questions* x 100. ***Note: If a***

CSR is unable to answer the question before the timer expires, the call ends. The effect of a timed-out call is neutral to the contract, meaning the question was not answered accurately or inaccurately and therefore is not counted in the equation since a response was not received in the allotted time.

Question: Are we permitted to answer the three accuracy questions within 21 minutes?

Answer: No. Each accuracy question has a seven-minute timer. If the first accuracy question is not answered before the seven-minute timer expires, the call ends. The second accuracy question will not be asked.

Question: Why is accuracy not included in the Star Ratings?

Answer: The accuracy measure results were previously part of the Star Ratings. In the past, the majority of plans scored high ranks and that clustered the majority of plans together with similar results, so the measure itself was deemed to be not particularly helpful in differentiating one plan from another.

Question: Is the accuracy test on the actual answer provided by the plan's CSR or on the quality of the interpreter to relay the answer in the foreign language?

Answer: Two of the goals of the Accuracy and Accessibility Study, which is performed by testing interpreter availability, TTY functionality, and accuracy of the questions asked, is to determine if interpreters are available, and to determine the accuracy of responses given to prospective members. An interpreter must be able to accurately relay the CSR's answer to the caller, so if the interpreter fails to do so, this must be attributed to the plan's performance.

Question: Please provide further clarity as to the timeliness metric utilized. For example, if a CSR begins providing the answer at six and a half minutes and finishes after the seven-minutelimit. Does this count as untimely?

Answer: If the answer is not finished before the seven-minute mark, it would be considered to have "timed out".

Question: Are the accuracy questions that were used in prior years published and available? I would like to pass them along to the Member Services staff to be used in training.

Answer: No, they are not published or available. At the conclusion of this study, you will receive the questions, the expected responses, and your actualstudy results. These results are stored in HPMS for you to download.

Question: We are a plan with both SNPs and non-SNPs. Our SNPs receive calls that ask only your introductory question and nothing more. Why do you do this?

Answer: SNPs are exempt from the accuracy measure, so we do not ask accuracy questions. The reason for this is that SNPs may have Medicaid or other benefits beyond the standard Medicare benefits offered because of state-specific contracts, for example.

Accuracy and Accessibility Study Raw Data

Question: Where do I find raw data for the Accuracy and Accessibility Study?

Answer: The raw data is available to you in HPMS under the performance metrics sections. For the Accuracy and Accessibility Study, you can find detailed results for your contract in HPMS by following the paths below:

1. For Part C results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part C Prospective Beneficiary Customer Service > [choose date of study] > [enter the contract number].

2. For Part D results, from the HPMS home page (https://hpms.cms.gov): Quality and Performance > Performance Metrics > Call Center Monitoring > Part D Prospective Beneficiary Customer Service > [choose date of study] > [enter the contract number].

Raw Data supporting the Part C and Part D performance metrics are available to you in HPMS in a link immediately below the performance metrics for the selected contract under Part C and Part D. Please access the link entitled "Raw Data for Xxxxx," with the variable being the contract ID you selected. This is available to you for a single contract as an Excel download. Also available for your convenience is a link entitled "Raw Data for All Contracts." This link will provide a download of all raw data to which you are entitled under your parent organization identification code. The multiple-contract data are available to you in a text-delimited file format. You may usethis file to import into Excel, Access, or some other database product.

You will also find a link to an Excel document entitled, "Data Dictionary for Raw Data." This is a data dictionary that explains the numerical codes used within the raw data. The data dictionary also contains all the questions asked during the Accuracy and Accessibility Study and the numerical coding that explains the answer received by our callers.

In addition to the above resources, CMS provided a link for you to Technical Notes for the Accuracy and Accessibility Study.

Question: How are completed and unsuccessful calls identified in the call level data? When reviewing the raw data, we are unclear on how a completed TTY or interpreter availability call is identified in the call level data. We had assumed that ERC=295 (Reached CSR/TTY/Interviewer - completed questions) identified the completed calls. However, one call has an ERC code = 290.7 (Partial interview - CSR could not answer question in seven minutes) so we interpreted that as an unsuccessful call. Is that correct?

Answer: When downloading your raw data from HPMS, you should also see a link to a data dictionary for each study just to the left of the raw data link. Please be aware that the Timeliness Study (current enrollees) uses one dictionary, while the Accuracy and Accessibility Study (prospective enrollees) uses a different dictionary. If you ever need these, simply download from HPMS at the same time you download the raw data.

In the raw data, look for the "ERC Code" and use the dictionary to decipher the numerical codes. Both ERC = 290.X and 295 would be counted as completed calls, because the first purpose of this study is that the contracts can provide interpreters and TTY functionality – and the second purpose

is to test accuracy. Both 290 and 295 codes represent the situation that our caller has already talked to interpreters and received the answer to the introductory question. As a result, the difference between codes 290 and 295 is just that when we ask accuracy questions, some unexpected situations can occur (such as the timer expiring before the accuracy question is answered, which is neutral to the plan). If all three accuracy questions are asked, the call will be coded as 295 (smooth completion of all parts of the call.) If something happened such as timeout or a disconnection, we will code the call as 290.X (dot X would tell us in detail what happened when asking those accuracy questions.) However, these 290 codes will not hurt the plan in regard to LEP and TTY functionality scores. In addition, if something happens when asking an accuracy question (an example would be the question is not actually answered), the question will not be counted in either the accuracy, so the effect is neutral to the plan: the CSR neither answered correctly nor incorrectly.

Because the main purpose of this study is the availability of interpreters and functionality of TTY, any situations that happened after a plan already completed the availability/functionality will not hurt the plan from those perspectives. Subsequently, code 290 is a code for a completed call with some problems that would benefit the plans to know how to improve when answering questions in the future. On the other hand, the code also tells us that at least the planalready fulfilled the minimum requirement of interpreter availability and TTY functionality.

Question: In reviewing the raw data for a prior Accuracy and Accessibly Study result, we are noticing that there is variation within the Part C rates for three of our plans, for which calls are serviced at the same call center. Because the Accuracy and Accessibility Survey is measured atthe call center level, doesn't that indicate that plans with calls serviced at the same call center would receive the same rate? Would you be able to explain the variation in the rates?

Contract ID	Plan Name	Part C Rate
HXX A	Example Plan 1	94%
HXX B	Example Plan 2	94%
HXX C	Example Plan 3	92%

Answer: Yes, this study is conducted at the call center level, so plans that do not share a call center may have different results. There are other considerations that will result in a variation of results when applied at the contract level. For example, SNPs are not asked the accuracy questions. Non-SNPs *are* asked accuracy questions. Results are rolled up to the contract level. So, if you have a contract with ONLY SNPs, the contract will not have accuracy results. If you have multiple contracts using the samecall center indicator where some contracts are SNP-only and some are a mixture of SNP and non-SNP, you will not see uniform results for the accuracy measure.

Other considerations are the counties served by the plans and those time zones they serve. CMS schedules outgoing test calls at appropriate times based upon the time zones served by those plans. To minimize burden on the call centers, we attribute the resultsof those calls to contracts within the call center indicator, but the results are only rolled up to the contract level *when appropriate to do so*, meaning one should not expect to see uniform rates simply because the same call center is used. Let's say your call center covers 3 time zones, and you have 1 contract with plans under it that serve all 3 time zones. In that case, all call results would be attributed to that one contract. If you have a separate contract that only covers the Eastern Time Zone, then the results from calls made from 8:00 am to 8:00 pm in Eastern Time ***only*** would be included in that contract's performance.

Please be aware that once assigned, call center indicators remain with the associated plan benefit packages and while phone numbers must be kept current in HPMS, the Accuracy and Accessibility study indicators will not be updated after the Call Center Indicator collection activity is completed.

General Questions

Question: Who do I contact if I have questions?

Answer: If your questions are related to our call center monitoring studies, send an email with your contract ID, date of call, time of call, and include the phone number on which the call wasreceived, if possible, to CallCenterMonitoring@cms.hhs.gov. Please **do NOT** send your questions via secure email. We never share personally identifiable information on this project.CMS monitors thousands of plans and hundreds of contracts and does not have the resources to maintain separate registrations for all these contracts.

If your questions are related specifically to your Star Rating, send your question to PartCandDStarRatings@cms.hhs.gov.

If your question is related to call center performance metrics that fed into your Star Rating, and you are not sure which team to consult, send an email to both resource mailboxes and we will work together to answer your question.

Question: Please confirm how IVR menu choices are handled when monitoring calls are made. When the menu includes an option for member services, is this the option that will be chosen forthe monitoring? In other words, they won't select options such as Behavioral Health crisis lines, provider lines or nurse lines. Is that correct?

Answer: For the Accuracy and Accessibility Study, our callers will make an IVR/menu selection for prospective members whenever that is an available option in your IVR, *and it is an appropriate choice for the type of call we are placing*. For example, if we are placinga native language call, we call your prospective phone number and listen to the options. As long as you include a choice for prospective members, sales, or for more information about the plan inyour IVR call tree, we'll make that selection. We would not make selections for behavioral health lines, nurse lines, crisis lines, or other such choices.

If the correct IVR option is not immediately obvious to our callers, no IVR selection will be made. For this reason, ensure your phone systems will default to a live person if no IVR option is selected, or no voice command is given.

Finally, when testing interpreter availability, our callers are simulating the experience of anon-English-speaking caller, so if IVR instructions are not available in the language we are testing, we do not make an IVR selection because a non-English-speaking caller could not understand what is being said and could not make that IVR selection. For this reason, ensure your phone systems will default to a live customer service representative if no IVR selection is made, or voice command given.

Question: We found a call coded as 297.12 in our raw data. This disposition code says, "Neither Call Center Contact nor Ring/No Answer." Why are you counting this call against our plan's performance if you didn't contact us?

Answer: CMS's raw data lists the disposition codes from the calls we make in our call center monitoring studies (see data dictionaries that explain those codes for each study). Code 297.12 is one of the codes we use when we are unable to connect to a plan. This code is used for situations like receiving a message of "all circuits are busy" or a fast-busy signal. Our contractorhas a system in place that requires their survey callers to make a second attempt *for any disposition where we cannot connect to the plan*, such as 297.12. The system will not allow the caller to record the information of "Neither Call Center Contact nor Ring/No Answer" unless a second attempt has been made to connect to the plan. Only one outcome is counted "against" the plan, but two attempts are made for every call in this scenario.

CMS's contractor has investigated to rule out any phone equipment failures, caller errors, or an issue on the part of its phone carrier before the results are issued to you. CMS is not able to offer an opinion about a call disposition of no plan contact other than it could have been a phone carrier's inability to transfer the call to the call center. The plan may check with their phone carrier to determine if there were any outages during the date and time in question. If a phone carrier caused the call not to transfer to the plan, the same outcome would happen to a real prospective beneficiary attempting to call the plan, so the disposition is included, and the information is reported out with the contract's performance metrics and duplicated raw data. This is longstanding practice that meets the expectations of the study's design.

Question: Our contracts under our parent organization share a phone number. Why are the results different for one or more of our contracts?

Answer: In a situation like the one above, it is best for you to send the specific details of your question to CallCenterMonitoring@cms.hhs.gov. We will research the issue with our contractor. Things to consider are: (1) the Accuracy and Accessibility Study is conducted at the *call center level.* All share results *at the contract level* but one or more contracts might have been under sanction during the Accuracy and Accessibility Study and therefore would have been excluded. (2) The plan sponsor might have changed the phone number in HPMS at some point during the study. Our contractor tracks this and can tell us when the change was made. (3) Some functions of studies do not apply to all situations. For example, contracts with *only* SNPs are excluded from the accuracy measure in theAccuracy and Accessibility Study. (4) Contracts under one parent organization may vary, especially based upon their service areas. For example, one contract may serve only the Eastern Time Zone while another contract may serve Eastern and Central Time Zones. This would mean that each could be called the same number of hours (from 8:00 am to 8:00 pm in their local service areas), but those times would be different and thus the results applicable to a certain contract may be different. (5) The compliance officer may have told us that the phone numbers route to separate and distinct call centers for the Accuracy and Accessibility Study.

Question: Our compliance officer sees a compliance action in the Compliance Activity Module in HPMS, but she never received the letter herself. Is this letter valid?

Answer: Yes. Compliance actions are sent to the compliance officer on record and stored in

HPMS, with your organization having access to all compliance actions. CMS suggests:

- Confirming a correct email address in HPMS. (The CAM auto populates letters with whatever email address is available in HPMS, so make sure HPMS is accurate.)
- Add HPMS@cms.hhs.gov to your contacts list so the emails do not go to the junkfolder; and
- Make certain the IT system he or she uses isn't blocking the email address HPMS@cms.hhs.gov.

Question: I'm having a hard time downloading the raw data from HPMS. Can you send it tome?

Answer: Please contact the HPMS help desk at 1-800-220-2028 or hpms@cms.hhs.gov. The HPMS Team at CMS has asked that we refer folks to the HPMS help desk whenever problems occur so that they can learn what is causing the problem and what they need to do to fix it. If this does not resolve the problem, please write to us at CallCenterMonitoring@cms.hhs.gov and tell us the contract ID, and the time period for that study.

Question: Our call center received a CMS test call after our center closed. We serve only the Eastern Time Zone, and we are open from 8:00 a.m. to 8:00 p.m. Your test call came in at 8:15 Why did this happen, and will the result be counted against us?

Answer: First, be sure to adjust the timing of the call in the raw data to your time zone. You'll need to adjust the time accordingly if your call center is located in another time zone. If the time zone is not a factor and the call was truly placed outside of 8:00 a.m. to 8:00 p.m. in your service area, CMS can invalidate the call and the call's outcome will NOT be counted against your organization.

Question: The upcoming Christmas and New Year's Day holiday falls on a Sunday. One of my plans will observe the holidays on the Mondays after (12/26 and 1/2). Are they permitted to use alternative technologies on these two days?

Answer: They are permitted to use alternative technologies on Thanksgiving Day and Christmas Day only, per 42 CFR §§ 422.111(h)(1)(i), 423.128(d)(1)(i). This means they will have to support their call centers on December 26 and January 2.

Note: MMPs negotiate their holiday call center coverage. MMPs holiday coverage is dictated by their state-specific marketing guidance.

Question: How long must we retain the recordings of call center calls?

Answer: Though it is not a requirement of CMS to record a phone call, if an organization chooses to record calls, then those recordings would be considered a record and would be required to comply with 42 CFR 422.504.

Question: I'd like to send you a recording of a call. How can I do that?

Answer: If you can, please convert the software to .mp3 or .wav format and put it in a compressed zip file format to email to CMS. To compress the file, highlight the file, right click with your mouse, and choose "send to a compressed file." Once compressed, please email it to CallCenterMonitoring@cms.hhs.gov along with the contract ID, the phone number on which the

call was received, the date and time of the call, and the details of your request. CMS uses VLC software for recording playback. This software can read several formats including 3GP, ASF, AVI, DVR-MS, FLV, Matroska (MKV), MIDI, QuickTime File Format, MP4, Ogg, OGM, WAV, MPEG-2 (ES, PS, TS, PVA, MP3), AIFF, Raw audio, Raw DV, MXF, VOB, RM, DVD-Video, VCD, SVCD, CD Audio, DVB.

Please remember to send this via regular email and not secure email. This project never shares personally identifiable information, so secure email for a CMS test call should not be necessary.

Question: We created a contingency plan in the unlikely event all systems or phones go down.We know ideally when it comes to the test calls and member experience, we never want this to happen, but we want to be prepared for all circumstances. Does CMS have guidance or best practices if an outage like this occurs? We can play a cloud message letting callers know they can call back and would accordingly self-report it to CMS, but what happens if a test call comesin? Would we fail it if we had a cloud message and self-reported it to CMS?

Answer: Regarding contingency plans and guidance, Part D sponsors and MAOs are required to have operational continuity plans in place. These requirements are described at 42 C.F.R §422.504(o) and 42 C.F.R §423.505(p). The plans for continuity of operations must include the operation of call center customer services. Therefore, if call center operations cease temporarilydue to an emergency situation or disaster declaration (or as stated above due to phone outages), the MAO or Part D sponsor should implement their continuity plan. MAO/sponsor continuity plans should include contingency plans to maintain operations or if unable, to restore call center operation within 72 hours.

Question: How was compliance determined for the 2025 Accuracy and Accessibility Study?

Answer: Interpreter Availability was tested to determine if the services were compliant with 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii), which require interpreters to be available for 80 percent of incoming calls requiring an interpreter within 8 minutes. TTY functionality was tested to determine if services were complaint with 42 C.F.R. §§ 422.111(h)(1)(iv) and 423.128(d)(1)(iv), which require 80 percent of incoming calls requiring TTY services to be connected to a TTY operator within 7 minutes. Accuracy was tested to determine if the services were compliant with 42 C.F.R. §§ 422.2262(a)(1)(i) and 423.2262(a)(1)(i), which requires MA organizations and Part D sponsors not to provide information that is inaccurate or misleading. For 2025, we determined the accuracy compliance threshold to be 90 percent. MA organizations and Part D sponsors with accuracy results below 90 percent are outliers and per 42 C.F.R. §§ 422.504(m)(2) and 423.505(n)(2), CMS may determine that an MA Organization or Part D sponsor is out of compliance when its performance in fulfilling requirements represents an outlier relative to the performance of other organizations.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 5, 2024

TO: All Medicare Advantage Organizations (MAOs), Prescription Drug Plan Sponsors and Medicare-Medicaid Plans (MMPs) (excluding PACE contracts, cost contracts, MSA contracts, and employer-only plans)

FROM: Vanessa S. Duran, Director
Medicare Drug Benefit and C & D Data Group

SUBJECT: 2025 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2025. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2025 call center information **no later than December 20, 2024**.

For 2025, CMS has contracted with Hendall Inc., and its subcontractor American Institutes for Research (AIR), to monitor the performance of plan sponsors' call centers with respect to the standards at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1).

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk telephone lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5 percent or less. Please note that the Timeliness Study results are not part of the Star Rating measures.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the plan, not due to CMS, divided by the total number of calls made to the telephone number associated with the contract.

2. The average hold time is defined as the average time spent on hold by the caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person.

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2)

teletypewriter (**TTY) functionality,** and (3) the **accuracy of plan information provided by customer service representatives** (CSRs) in all languages. The availability of interpreters and TTY functionality are used for star ratings measures. Languages tested in 2025 are unchanged from 2024 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2025.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language.

2. TTY functionality is defined as the ability of a hearing and/or speech impaired caller using TTY to communicate with a CSR and receive answers to questions at the plan's call center directly or via a relay operator.

3. Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.

4. Contracts or plan benefit packages (PBPs) under marketing and enrollment sanction are excluded from the study.

In the event that an organization believes that CMS may have miscalculated its call center results based on data posted in HPMS, it may bring the relevant information to CMS's attention and ask for a review of the results. **We advise organizations that they ask for this review within 2 weeks of results being posted in HPMS.** CMS may not be able to make adjustments to the Timeliness Study if issues aren't brought to its attention within 2 weeks. Although organizations may request CMS review of Interpreter Availability and TTY functionality results through the end of the Stars plan preview 2 window, we urge organizations to submit requests for review prior to the Stars plan preview periods. **CMS will not revise results without evidence which shows the call was erroneously marked as unsuccessful, nor based on challenges to the methodology, which has been applied to all subjects of the study.**

IMPORTANT ACTION: Verify 2025 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2025 Part C and/or Part D call center telephone numbers in HPMS by **December 20, 2024**. This includes current and prospective enrollee **toll-free** beneficiary call center telephone numbers**, toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis beginning in December of the year prior to the study year and updated in the monitoring contractor's automated dialing software. If any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately, pursuant to 42 C.F.R. §§ 422.504(f)(2)(vii) and 423.505(f)(2)(vii). **If an organization achieves poor results on the measures due to calls to an inaccurate telephone number, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is**

available in HPMS prior to the launch of the studies. Use the paths outlined below to verify and/or update the telephone numbers.

Verify your pharmacy technical help desk number, which is a contract-level contact and not a bid-level contact, using the following path: HPMS home page: > Contract Management > Basic Contract Management > [enter contract number]or [enter the contract name] > Contact Data > Pharmacy Technical Help Desk Contact. There are primary and secondary contacts collected in this section. The primary contact is mandatory, and the secondary contact is optional. Please note that for call center monitoring purposes, we call only the primary contact. For any additional questions on updating your contact information, please contact the HPMS Help Desk.

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: > Plan Bids > Bid Submission > CY 2025 – Manage Plans > Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

1. On the Select a Contract screen, enter a contract number into the field provided (Option 1) or select a contract number (Option 2). Click Next to advance to the Update and Save Data screen.

2. On the Update and Save Data screen, select a plan, and select a contact tab.

3. Edit the mailing address, telephone numbers, and e-mail address for applicable contracts.

4. After entering data for the first contact type, the user can complete data entry for other contact types under the same plan.

Notes:

- The above process to verify the accuracy of call center telephone numbers is separate from the Call Center Indicator activity that has already begun. You should have received communication from **CallCenterIndicators@hendall.com** in November 2024. The Call Center Indicators identify PBP phone numbers that are served by the same physical call center. This information is important as the Accuracy and Accessibility study is conducted at the call center level, with legal entities sharing results of calls placed to a shared call center, with limited exceptions. The Timeliness study is conducted at the phone number level. Results of calls placed to a shared phone number are shared by all legal entities utilizing that phone number, with limited exceptions. The Accuracy and Accessibility study indicators do not impact the Timeliness study. **Please be aware that while phone numbers must be kept current in HPMS, the Accuracy and Accessibility study indicators cannot be updated after the Call Center Indicator collection activity is completed.**

- Our regulations at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1) require the operation of a toll-free customer call center; MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.*** Contact the HPMS Help Desk

at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

- **All TTY numbers must be either three numeric characters or ten numeric characters and entered into HPMS.**

  Please make certain you have entered into HPMS the **TTY local telephone number** and the **TTY toll-free telephone number.** If your plan does not use a dedicated, in-house TTY service, you may enter 711 in both fields, or you may enter the toll-free ten-digit number for a specific state relay service. The toll-free TTY telephone number must be populated, as this is the telephone number we pull for the Accuracy & Accessibility Study.

  This information can be found in Chapter 1 of the CY2025 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2025 > View Documentation (under "Documentation" Section) > Bid Submission User Manual for Contract Year 2025)*.

VOLUNTEERS FOR CMS INTERVIEWER TRAINING SESSIONS

CMS solicits volunteers for abbreviated training periods prior to the beginning of a study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next interviewer training session. These sessions are to train the CMS interviewers on how to properly place a call and how to navigate plan IVR systems. Your participation in a training period should not be used as a replacement for your own testing to verify that your call center is compliant with regulatory requirements.

Tips for Success/Best Practices

Based on several years of study results, CMS provides the following tips to help improve results.

General:

- Review call center requirements under 42 CFR §§ 422.111 and 423.128.

- Provide basic services and information to individuals with disabilities, upon request or when otherwise learning of the enrollee's primary language or need for an accessible format.

- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio and data CDs, and in requested alternate languages) to individuals with disabilities upon request or when otherwise learning of the enrollee's primary language or need for an accessible format.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot

program what options they should select for each plan. We train them to listen for options such as "current members," "pharmacy," or an option for those "interested in learning more about enrolling" for prospective calls, for example. When you are setting up your IVR options, please keep this in mind. IVR options should be intuitive for enrollees/perspective enrollees. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. You may experience more successful call outcomes if the representative offers a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, "You need to call another number" or answering "no" to the introductory question, "Are you the right person to answer questions about…." will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make a reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plan, or at least transfer us to the correct party who can answer those questions.

Ability to Accept Calls:

- Callers to current enrollee and prospective enrollee customer service call centers need to be able to communicate with a live person when they call from 8:00 a.m. to 8:00 p.m. Messages that ask a caller to leave their telephone number, or automatic callbacks, are not appropriate and will not be counted as a successful call.

- CMS's monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Call centers should evaluate their own needs and consider increased staffing during busier times.

- If your organization intends to implement any new technology affecting telephone systems, ensure it will not interfere with the organization's ability to accept calls, including TTY communications.

- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
    - Test every telephone number supported by the call center.
    - Review and test the telephone numbers in HPMS and ensure they ring to the intended location.
    - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.
    - Test with more than one caller at the same time.
    - See TTY section below for specific TTY testing suggestions.

- **Ensure that your organization does not employ IVR logic or other functions that will block calls at certain times based solely upon the area code of the caller.** We call regions spanning from the Atlantic time zone to as far west as Guam. We will call you during the business standard hours of operation (8:00 a.m. to 8:00 p.m. in the time zone(s) the plan serves). If our caller cannot reach a live representative due to programming on your end, or we hear messages stating the office is closed during the required hours of operation, the call will be counted as unsuccessful.

- Carefully review your service areas to ensure the call center is open and provides services at least in accordance with standard business practices. This means that the current and prospective enrollee call centers are open minimally from **8:00 a.m. to 8:00 p.m. for <u>all</u> of your plans' local service areas.** Check carefully to verify your coverage for any counties that are split into two time zones or to confirm observance of daylight savings time. For example, some contracts will occasionally serve counties that are split into two time zones. Also, most of Arizona is exempt from daylight savings time. However, the Navajo Nation lands, which extend to the states of Arizona, New Mexico, and Utah, observe daylight savings time. Regardless of whether two time zones are served, or daylight savings time is or is not observed, call centers are required to be open minimally from 8:00 a.m.to 8:00 p.m. in **<u>all</u>** local service areas for all current and potential enrollees.

- **Ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.** Every year CMS encounters plans that offer limited IVR options without a clear way to select the option to speak with a current member representative or a prospective beneficiary representative, and the IVR message cycles over and over without a live representative answering the telephone. This results in unsuccessful calls due to time-outs. Test your systems. When planning the IVR choices, ask yourself, "If I am calling to get information so I can decide if I want to enroll in this plan, is there an IVR option for me on this prospective beneficiary telephone number, even if I do not speak English (or other than the primary language in the area)?"

- Ensure callers with private or masked numbers are able to connect to your plan's customer service telephone numbers.

- When we call customer service lines, we ask a question intended to determine if we have reached a person who has authority to answer questions about the Medicare plan we are calling. **If the CSR insists on first knowing the caller's name, date of birth, membership ID number, or Social Security Number, or refuses to answer the question by stating "no," the call will be counted as an unsuccessful call unless the party transfers the call to a person who can answer "yes" in a timely manner. The CSR should refrain from requesting additional identifying information until at a minimum the caller is able to confirm that they have reached the correct person.**

Interpreter Availability:

- Utilize an interpretation service to identify the beneficiary's language.

- Use interpreter services personnel who are familiar with healthcare terms and Medicare benefit concepts.

- Interpreters should:
  - Adhere to generally accepted interpreter ethics principles, including confidentiality.
  - Demonstrate proficiency in speaking and understanding at least spoken English

and the spoken language in need of interpretation.
    - Interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

- Train CSRs to connect foreign-language callers with an interpreter.

- Ensure CSRs stay on the telephone when a foreign-language interpreter joins the call.

- In order to replicate a beneficiary's actual experience, CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the IVR system if the instruction is only in the primary language. **Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.** If the IVR instruction is available in the language being tested, the test callers will make an appropriate IVR selection. For example, if the language being tested is French, *and instruction is available in French in the IVR* to select an option for French, the test caller will make that selection. (Please note that the primary language in Puerto Rico is Spanish and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)

TTY Functionality:

- Ensure that TTY services are available in languages other than English.

- CMS makes the following suggestions for testing in-house TTY devices:
    - Regularly test your service to ensure that it is working properly.
    - Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into your TTY system to test.)
    - Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
    - When testing, check for garbled language on both sides of the call.
    - Whenever you make a telephone system change, retest all TTY systems.
    - If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a telephone line *and* a TTY line.
    - Verify with your telecom provider that TTY calling is supported, in case there are any settings on the carrier side that need to be adjusted.
    - If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.

- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.

- If using an in-house TTY device, ensure CSRs always use "GA" for "Go Ahead" after they have communicated their opening remark or other response via TTY device, so the other party knows it can now safely transmit its next thought. Failure to use "GA" may confuse beneficiaries who are familiar with TTY systems and could result in a plan hanging up on a TTY caller who has not responded, because the caller is waiting for the "GA" as clearance to respond.

- When using a relay service:

- Ensure that beneficiaries using relay services can reach a CSR who has been trained on how to best communicate through a relay operator.

- Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions.

- **The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan.** If you use a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller's area code. It is the plan's responsibility to ensure that calls from any area code can be received via their state relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements of 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1). Review the 2025 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2025. Consider sharing the most recent *Medicare & You* with your translator service provider.

- CSRs should have specific PBP level benefit and formulary data easily available.

- Because the time is limited to 7 minutes for each of the general accuracy questions, a best practice for CSRs is to speak at a high level first and offer more detail if asked.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (HHS OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*). Originally published in 2000, an enhanced version of the *National CLAS Standards* was most recently updated by HHS OMH in 2013. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The essential goal of the National CLAS Standards is framed in its Principal Standard (standard 1): "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." The remaining 14 standards span three themes, including: 1) governance,

leadership, and workforce; 2) communication and language assistance; and 3) engagement, continuous improvement, and accountability. The second theme, Communication and Language Assistance, encompasses standards 5 - 8: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (standard 7); and providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (standard 8).

The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and adopt the *National CLAS Standards* and their implementation document, *The Blueprint to Advancing and Sustaining CLAS Policy and Practice*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH's free e-learning program, *The Guide to Providing Effective Communication and Language Assistance Services*. If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes (including Frequently Asked Questions) and Data Dictionaries for each study are stored in HPMS via the Download drop down when you pull your plan results from the Performance Metrics page. Results can be found through the following path: HPMS homepage > Quality and Performance > Performance Metrics > Reports > Call Center Monitoring.

If you have any questions about the 2025 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Do not use secure email when communicating with this resource. **CMS will not open a secure email message.** CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.

Clover Health

Request for Recalculation of C32 Measure Score for Contract H5141

Executive Summary

For 2024, Clover Health (contract H5141) respectfully requests removal of nine 2024 level 2 appeals that were incorrectly included in the calculations of Measure C32–Reviewing Appeals Decisions. Without these errors, Clover Health would have earned a compliance rate of 98% instead of 94% for this measure–thus materially impacting Clover Health's overall Star Rating. These appeals should be removed from C32 calculations for at least the following three reasons.

First, with respect to one appeal, the Independent Review Entity (IRE) made a clear-cut clerical reporting error (Case 1-14595402316, described below). Specifically, the IRE dismissed the case. But instead of reporting that case as dismissed, the IRE incorrectly reported it as "favorable" (*i.e.*, resolved in the patient's favor). This is a black-and-white reporting error.

Second, with respect to one appeal, the IRE ruled against Clover Health, claiming that Clover Health "had failed to supply *any* medical records at all with this appeal request" (Case 1-14385393292, described below). (Emphasis added). The IRE was flat-out wrong. Clover Health had provided the medical records for this case not once, but twice.

Third, with respect to six appeals, the IRE failed to remove six improperly submitted cases from review. (Cases 1-13664105851, 1-13814982651, 1-13976245156, 1-14005223730, 1-14173810816, and 1-14196773261, described below). The IRE's decision rests entirely on a misapplication of the 180-day timeliness standard set forth in 80.3.1 of CMS's Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. But that standard is inapplicable here—for not one, but two compelling and independently sufficient reasons.

(i) The record is unequivocal: Clover Health initiated the reopening of these cases. Clover Health identified that the original determinations were incorrect and took corrective action by covering the treatments or procedures at issue. CMS guidance at Section 80.3.1 could not be clearer: when a plan

initiates a reopening, it has up to one year to do so. Clover Health acted well within that one-year window. There is no dispute on this point. The IRE's reliance on a 180-day limit in this context is plainly wrong and directly contradicts CMS's own rules. This alone is sufficient grounds to overturn the IRE's decision.

(ii) Even if CMS were to question whether the reopenings were plan-initiated—an unlikely and unfounded position—the IRE's justification still does not hold. The 180-day limit applies only to the types of "reopenings" defined by CMS and described in Section 80.3 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance—*i.e.*, those involving the reconsideration of evidence, such as new or material information, or obvious factual errors.

That is not what happened here. Clover Health's request had nothing to do with new evidence or re-litigation of past decisions. Clover Health approved coverage. Labeling this plan-initiated action (for the benefit of the member) as a "reopening" subject to an IRE-initiated action, subject to a 180-day limit is a mischaracterization of CMS's policy and the facts.

1. **The IRE made a clear-cut reporting error–reporting the case as "favorable" after dismissing the case**

- **Measure:** C32 - Reviewing Appeals Decisions
- **Contract:** H5141
- **Data Discrepancy:** On April 17, 2025, the IRE notified the parties to the appeal that the IRE had identified this case as an invalid appeal. As a result of this finding, the IRE confirmed they had changed their decision and were dismissing the case; however, the IRE made an administrative error when documenting the decision in their records. While the IRE informed the parties that the case was dismissed, the data from the IRE incorrectly reported the decision as favorable. The text of the IRE decision has been provided below:

April 17, 2025

[redacted]

The Reopening Number is:
1-14595402316R1
For Appeal Number
1-14595402316

We have reopened your case because the Plan thought we made a mistake when we made our first decision. This letter is about our new decision in your appeal to CLOVER INSURANCE COMPANY (the Plan) for procedure code 64491 billed for May 15, 2024.

Our decision

We had previously decided that the Plan was right. **We have changed our decision. We are now dismissing your case.** After looking at all of the information in this case, we found that your complaint is not a valid appeal for medical coverage. The Plan sent this case to us in error.

We have jurisdiction to review only those cases where a plan has issued an organization reconsideration decision or dismissal, which at this time, the Plan has not yet issued. This means that we do not have jurisdiction to review your request at this time.

You may contact the Plan with any questions about requesting an organization reconsideration.

Please remember that you signed a Waiver of Liability in which you agreed not to bill the enrollee for these services. This Waiver does not, however, deny your right to seek further appeal from an Administrative Law Judge (ALJ).

cc: H5141: CLOVER INSURANCE COMPANY, c/o Marlene H.
New York CMS Regional Office

- **Case with this Data Discrepancy:**
  - 1-14595402316

As described above, the IRE made an administrative error when logging their April 17, 2025, dismissal decision and incorrectly logged the decision as favorable. This error resulted in the plan being incorrectly penalized on the C32 measure because the actual decision of the IRE was dismissal. This case should be removed from consideration in the measure C32 for this reason.

2. The IRE repeatedly and erroneously claimed that Clover Health failed to provide "any medical records." Clover Health *had* provided medical records – at least twice.

- **Measure:** C32 - Reviewing Appeals Decisions
- **Contract:** H5141
- **Data Discrepancy:** On August 12, 2024, the plan upheld the initial decision to deny the claim, and submitted this case to the IRE for a level 2 review. On October 4, 2024, the IRE notified the parties of their favorable decision, and that the decision was based on the plan supposedly "ha[ving] failed to supply *any medical records at all* with this appeal request" with the original submission to the IRE. (Emphasis added).

  The plan then confirmed that its original submission on August 12, 2024, did in fact contain 4 separate medical record documents, the EOC, and the case narrative. The plan then submitted a reopening request to the IRE on November 14, 2024. The reopening request explained that the medical records had been submitted and that a second copy of those medical records in addition to all the other documents previously submitted were being resubmitted with the reopening request. The below medical records were submitted with both the original submission and the reopening request:

  - File name: 2022 Medical Records.pdf
    - Records from St. Mary's General Hospital for the member's inpatient stay on 01/16/2022
  - File name: Medical Records 1.pdf
    - Statements from St. Mary's General Hospital regarding the member's inpatient stay on 01/16/2022
  - File name: Medical Records 2.pdf
    - Statements from St. Mary's General Hospital regarding the member's inpatient stay on 01/16/2022
    - Largely duplication of Medical Records 1.pdf
  - File name: Medical Records 3.pdf

- Statements from St. Mary's General Hospital regarding the member's inpatient stay on 01/16/2022
- Largely duplication of Medical Records 1.pdf

On December 11, 2024, the IRE notified the parties of their decision to dismiss the reopening request. The IRE stated again that they failed to receive medical records, and the IRE used this as the basis for the dismissal decision. Given that the plan supplied the medical records and other documents as part of both the original submission and the reopening submission, this decision was erroneous.

- **Cases with this Data Discrepancy:**
  - 1-14385393292

As described above, the IRE's decisions were based on its incorrect finding that the plan supposedly "had failed to supply *any* medical records at all with this appeal request." (Emphasis added). That was clearly not the case. This error results in the plan being incorrectly penalized on the C32 measure because neither the original submission nor the reopening submission received the appropriate review on the merits. This case should be removed from consideration for measure C32 based on this error.

3. The IRE incorrectly applied the 180-day deadline for requests for "reopenings" to Clover Health's requests to remove erroneously submitted cases.

- **Measure:** C32 - Reviewing Appeals Decisions
- **Contract:** H5141
- **Data Discrepancy:** The IRE's rejection of Clover Health's removal request was based solely on the claim that the request was submitted outside the 180-day time frame, outlined in Section 80.3.1 of CMS's Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. But the IRE's rationale fails~~the 180-day time limit does not apply to these cases~~ for multiple~~at least two~~ independent and alternative reasons.

First, even assuming a 180-day time frame applies, the plan satisfied this reopening period. For each of the six cases at issue, the evidence is unambiguous that Clover Health initiated a

reopening and revised the initial determination (i.e., the underlying claim denial) in well under 180 days. We summarize the initial determinations and Clover Health reopenings as follows:

- **1-13664105851** - Initial Determination denial on January 18, 2024 (Attachment O); reopening by Clover to approve coverage on January 22, 2024 (Attachment A; *see also* Attachment T).
- **1-13814982651** - Initial determination denial on February 21, 2024 (Attachment P); reopening by Clover to approve coverage on March 25, 2024 (Attachment D; *see also* Attachment U).
- **1-13976245156** - Initial determination denial on April 18, 2024 (Attachment Q); reopening by Clover to approve coverage on April 22, 2024 (Attachment F; *see also* Attachment V).
- **1-14005223730** - Initial determination denial on April 29, 2024 (Attachment R); reopening by Clover to approve coverage on May 1, 2024 (Attachment F; *see also* Attachment W).
- **1-14173810816** - Initial determination denial on June 5, 2024 (Attachment S); reopening by Clover to approve coverage on August 13, 2024 (Attachment J; *see also* Attachment X).
- **1-14196773261** - Initial determination denial on June 16, 2024 (Attachment N); reopening by Clover to approve coverage on July 7, 2024 (Attachment L; *see also* Attachment Y).

Thus, the IRE's argument fails on its face as unsupported by CMS rules and the available evidence. As a plan, Clover Health has a right to reopen initial determinations. *See generally* Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance § 80.1 (plans may revise initial determinations via re-openings, and CMS looks to the fee-for-service reopening regulations in 42 C.F.R. pt. 405 to supply additional standards); 42 C.F.R. §§ 405.980 (reopenings include changing binding "initial determinations"), 405.924 ("initial determinations" include coverage decisions). Here, Clover Health exercised that right and indisputably reopened and revised the initial determinations within weeks (or sometimes days) of each initial determination. In each case, the reopening was well within 180 days, and the IRE's finding to the contrary is arbitrary and capricious.

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Second, the IRE has also applied the wrong time-frame in determining if reopening was timely. It appears the IRE has applied a 180-day timeframe and then counted from the date of the underlying claim denial *to the date that Clover Health contacted the IRE to notify it that Clover Health had re-approved the claim on reopening*–rather than the date when Clover Health actually reopened the underlying claim by re-approving coverage. But even assuming the IRE's end date is appropriate (which it is not), the IRE still applied the wrong time-frame: As noted, the reopening ~~request~~ was *plan-initiated*, and a 365-day time frame therefore applies.

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As evidenced in the documentation submitted to the IRE, and in alignment with the CMS Guidelines for reopening in Section 80.1 ("A plan to revise the initial determination or level 1 appeal decision"), Clover Health proactively reviewed the cases, determined that they were handled incorrectly, and subsequently approved coverage for the treatment or procedure in question. Thus, any reopening was necessarily "plan-initiated," and, under CMS guidance at Section 80.3.1, plan-initiated reopenings must be requested "within one year" of the initial determination—not within 180 days. Clover complied within this one year (365 day) time frame, and the IRE misapplied CMS criteria in finding the time period for any reconsideration to have passed.

Third~~*Second*~~, and alternatively, if CMS does not consider the cases to have been resolved through a plan-initiated reopening, a 180-day limitation still would not apply. This is because the adjustment still would not meet CMS's definition of a "reopening" subject to a 180-day time limit.

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As described in CMS's guidance (at 107), the 180-day limit is applicable only to "reopenings" that involve substantive review of new or material evidence or correction of an obvious error. The cited examples include requests for the IRE to reconsider evidence or correct a prior determination based on that evidence.

Clover Health's request did not involve any such evidentiary reconsideration. Instead, it was a corrective action by the plan to retroactively approve coverage for cases that were erroneously

sent to the IRE. This distinction is critical: because if these actions did not constitute "reopenings" under CMS's definition, the 180-day limit does not apply.

Because the only basis for the IRE's rejection was a 180-day limitation–and because that limitation was not violated or does not apply for multiple ~~at least two~~ independent and alternative reasons–Clover Health respectfully requests that CMS direct the removal of these cases from the C32 calculation. *See generally Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 US 29, 43 (1983) (decisions must be upheld on the basis relied upon by the agency).

Reopening Guidance: Section 80 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

- **Cases with this Data Discrepancy:**
  - 1-13664105851
    - *See* Attachment O 1-13664105851 at PDF page 3 (showing initial determination date of January 18, 2024).
    - *See* Attachment A 1-13664105851 at PDF page 1 (on January 22, 2024, approving coverage); *see also* Attachment T at PDF page 1 (on January 24, 2024 approving coverage).
    - *See* Attachment B Request to ~~Reopen and~~ Remove Case Submitted in Error (explaining to IRE, "This case should have followed a different process).
    - *See* Attachment C 1-13664105851 March 20, 2025 Receipt for Removal Request (IRE acknowledging receipt of Request to ~~Reopen and~~ Remove Case Submitted in Error).
  - 1-13814982651
    - *See* Attachment P 1-13814982651 at PDF page 3 (showing initial determination date of February 21, 2024).
    - *See* Attachment D 1-13814982651 at PDF page 1 (on March 25, 2024 approving coverage); *see also* Attachment U at PDF page 1 (on March 25, 2024 approving coverage).

- *See* Attachment B Request to ~~Reopen and~~ Remove Case Submitted in Error (explaining to IRE, "This case should have followed a different process).
- *See* Attachment E 1-13814982651 March 20, 2025 Receipt for Removal Request (IRE acknowledging receipt of Request to ~~Reopen and~~ Remove Case Submitted in Error).

- 1-13976245156
  - *See* Attachment Q 1-13976245156 at PDF page 3 (showing initial determination date of April 18, 2024).
  - *See* Attachment F 1-13976245156 (on April 22, 2024 approving coverage); *see also* Attachment V at PDF page 1 (on April 22, 2024 approving coverage).
  - *See* Attachment B Request to ~~Reopen and~~ Remove Case Submitted in Error (explaining to IRE, "This case should have followed a different process).
  - *See* Attachment G 1-13976245156 November 14, 2024 Receipt for Removal Request (IRE acknowledging receipt of Request to ~~Reopen and~~ Remove Case Submitted in Error).
- 1-14005223730
  - *See* Attachment R 1-14005223730 at PDF page 3 (showing initial determination date of April 29, 2024).
  - *See* Attachment H 1-14005223730 (on May 1, 2024 approving coverage); *see also* Attachment W at PDF page 1 (on May 1, 2024 approving coverage).
  - *See* Attachment B Request to ~~Reopen and~~ Remove Case Submitted in Error (explaining to IRE, "This case should have followed a different process).
  - *See* Attachment I 1-14005223730 March 20, 2025 Receipt for Removal Request (IRE acknowledging receipt of Request to ~~Reopen and~~ Remove Case Submitted in Error).
- 1-14173810816
  - *See* Attachment S 1-14173810816 at PDF page 3 (showing initial determination date of June 5, 2024).
  - *See* Attachment J 1-14173810816 (on August 13, 2024 approving coverage); *see also* Attachment X at PDF page 1 (on August 13, 2024 approving coverage).
  - *See* Attachment B Request to ~~Reopen and~~ Remove Case Submitted in Error (explaining to IRE, "This case should have followed a different process).

- *See* Attachment K 1-14173810816 March 20, 2025 Receipt for Removal Request (IRE acknowledging receipt of Request to ~~Reopen and~~ Remove Case Submitted in Error).

- 1-14196773261
  - *See* Attachment N 1-14196773261 at PDF pages 3 (showing initial determination date of June 16, 2024).
  - *See* Attachment L 1-14196773261 (at PDF page 2 on July 7, 2024 approving coverage); *see also* Attachment Y at PDF page 1 (on July 7, 2024 approving coverage).
  - *See* Attachment B Request to ~~Reopen and~~ Remove Case Submitted in Error (explaining to IRE, "This case should have followed a different process).
  - *See* Attachment M 1-14196773261 March 20, 2025 Receipt for Removal Request (IRE acknowledging receipt of Request to ~~Reopen and~~ Remove Case Submitted in Error).

Commented [1]: "Date of plan's reconsideration denial"

Files Excluded Because They Contain Protected Health Information

Attachment A – Attachment Y

Clover Health

Request for Recalculation of C31 Measure Score for Contract H5141 - IRE Errors

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Executive Summary

Clover Health (Contract H5141) respectfully requests that CMS review and recalculate its C31 measure score—Plan Makes Timely Decisions about Appeals—due to errors in the classification of five Level 2 appeals. These errors have resulted in Clover Health receiving a compliance rate of 97% instead of 99% for C31, thereby materially impacting Clover Health's overall Star Rating.

Specifically, CMS has incorrectly categorized these five cases as untimely submissions to the Independent Review Entity (IRE). In three cases, the IRE used an incorrect date for the appeal, and in another case, the IRE counted a duplicate submission as a separate appeal. In a fifth case, a reconsideration appeal was submitted within the relevant timeframe.

We request that CMS correct the handling of these cases by either excluding them from the untimely count or eliminating any duplicative entries, and subsequently update Clover Health's C31 measure score to reflect the correction.

In each of these five instances, Clover Health's actions have been mischaracterized, resulting in an inaccurate representation of our timeliness. This misclassification contradicts the underlying appeals data and/or CMS's own guidance, and unfairly reduces our Star Rating score for this measure.

We appreciate your attention to this matter and look forward to your timely review and resolution.

Discussion

The 5 appeals fall into the following three scenarios:

- Cases 1-13931154263, 1-14156837886, and 1-14575068066: the date used by the IRE to calculate the reconsideration receipt date is inaccurate.

- Case 1-14506371416: the IRE counted a duplicate submission as a separate Level 2 appeal.
- Case 1-13926566786: the IRE applied an incorrect IRE Appeal Priority.

Below, Clover Health explains why CMS's actions under each of these scenarios must be corrected to appropriately calculate our C31 measure score.

1. **The date used by the IRE to calculate the reconsideration receipt date is inaccurate**

- **Measure:** C31: Plan Makes Timely Decisions about Appeals
- **Contract:** H5141
- **Data Discrepancy:** The date used by the IRE to calculate the reconsideration receipt date is inaccurate for three cases. The measure is intended to report timeliness of plan appeal decisions; however, by using the incorrect start date for the timeliness calculations the plan is penalized inappropriately. In each of these cases (as shown below), Clover Health submitted the corrected/valid Waiver of Liability (WOL) to the IRE. Nevertheless, the IRE used the invalid WOL, with the incorrect date.
- **Cases with this Data Discrepancy and Evidence of Data Discrepancy**
    - **1-13931154263** - The IRE incorrectly used the date 02/01/2024, as the day the plan received the provider's first attempt to submit a WOL; however, the first WOL received was invalid due to containing an erroneous signature date. *See* Attachment A, 1-13931154263 First WOL Attempt (at PDF page 6 showing an incorrect signature date of 02/01/*2023* (Emphasis added to show that the *correct* date should have been 02/01/2024)).

      After the plan confirmed with the provider via phone call on 03/28/2024 that the signature date was a provider office error, the plan requested and received a corrected/valid WOL later that same day, 03/28/2024. *See* Attachment B, 1-13931154263 corrected-valid WOL (at PDF page 5 showing a corrected signature date of 02/01/2024). Maximus, CMS' contractor, received notice "03/28/2024 - WOL Received." *See* Attachment C, 1-13931154263 Case Narrative. This is the date the IRE should have used for the calculation of plan submission timeliness per section 50.1.1, paragraph 3 of the Parts C & D Enrollee Grievances, Organization/Coverage

Determinations, and Appeals Guidance ("The plan is not required to undertake a review of the appeal until or unless the [WOL] form is obtained"). Using the correct date of 03/28/2024 with the date the plan submitted the appeal to the IRE, 04/08/2024, shows the plan submission was timely within the 60 day timeframe.

- **1-14156837886** - The IRE incorrectly used the date 02/01/2024, as the date the plan received the provider's first attempt to submit a WOL; however, the first WOL received was invalid due to containing an erroneous signature date. *See* Attachment D 1-14156837886 first WOL attempt (at PDF page 5). After the plan confirmed with the provider via phone call on 04/01/2024 that the signature date was a provider office error, the plan requested and received a corrected/valid WOL later that same day, 04/01/2024. *See* Attachment E 1-14156837886 corrected-valid WOL (At PDF page 1). Maximus, CMS's contractor, received notification, "04/01/2024 - Valid WOL received at 04:08:00 PM." *See* Attachment F 1-14156837886 Case Narrative (at PDF page 1). This is the date the IRE should use for the calculation of plan submission timeliness per section 50.1.1, paragraph 3 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance ("The plan is not required to undertake a review of the appeal until or unless the [WOL] form is obtained"). Using the correct date of 04/01/2024 with the date the plan submitted the appeal to the IRE, 05/31/2024, shows the plan submission was timely within the 60-day timeframe.
- **1-14575068066** - The IRE incorrectly used the date 08/01/2024, as the day the plan received the provider's first attempt to submit an appeal request; however, this first request lacked a WOL. *See* Attachment G 1-14575068066 first request lacking WOL (lacking a WOL). Upon receipt of the provider's incomplete appeal request the plan successfully made outreach to the provider and was able to obtain a valid WOL on 08/22/2024. *See* Attachment H 1-14575068066 valid WOL provided (at PDF page 3). Maximus, CMS's contractor, received notification, "08/22/2024 - Waiver of Liability Form received from provider Doam Kim." *See* Attachment I 1-14575068066 Case Narrative (at PDF page 1). This is the date the IRE should use for the calculation of plan submission timeliness per section 50.1.1, paragraph 3 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance ("The plan is not required to undertake a review of the appeal until or unless the

[WOL] form is obtained"). Using the correct date of 08/22/2024 with the date the plan submitted the appeal to the IRE, 10/07/2024, shows the plan submission was submitted timely within the 60 day timeframe.

Classifying these Level 2 appeals as untimely submissions is inconsistent with CMS guidance, mischaracterizes the number of untimely Level 2 submissions made by the plan, and penalizes the plan based on inaccurate information. These data for these cases should be updated to correctly reflect the timely submission of these cases.

2. The IRE counting a duplicate submission as a separate Level 2 appeal

- **Measure:** C31: Plan Makes Timely Decisions about Appeals
- **Contract:** H5141
- **Data Discrepancy:** On August 16, 2024, Clover Health received an expedited pre-service appeal. The plan upheld the original denial and submitted the appeal to the Independent Review Entity (IRE) for Level 2 review in a timely manner on August 18, 2024. The IRE assigned case ID **1-14405396635** and issued an unfavorable decision on August 21, 2024.

  On September 17, 2024, a clerical error by a plan processor resulted in the same case being inadvertently reforwarded to the IRE. This duplicate submission—assigned IRE case ID **1-14506371416**—was incorrectly treated as a separate, untimely appeal. However, the case had already been properly submitted, adjudicated, and closed. The duplicate submission served no functional purpose in the appeals process, and it should have been dismissed by the IRE.

  We acknowledge the error and have taken swift corrective action. Specifically, the plan has strengthened its internal Quality Assurance process to include an additional review of all appeal submissions prior to forwarding to the IRE. This enhancement ensures that duplicate or erroneous submissions are caught before transmission, preventing recurrence of this issue.

  Given the facts of the case and the prompt corrective measures implemented, we respectfully urge CMS to exclude this duplicate submission from the C31 measure calculations. Counting this case as a valid Level 2 appeal—especially one marked as untimely—artificially and unfairly distorts the plan's performance, and penalizes us for a one-time clerical oversight that has since been resolved. Including this error contradicts the intent of the C31 measure, which is

to assess a plan's true responsiveness to member appeals. This case should be removed from consideration in the C31 Star rating calculation.

- **Case with this Data Discrepancy:**
  - **1-14506371416**

3. The IRE claim reconsideration appeal (retrospective) submission timeframe was met

- **Measure:** C31: Plan Makes Timely Decisions about Appeals
- **Contract:** H5141
- **Data Discrepancy:**

On February 26, 2024, Clover Health received an appeal of a claim denial from a non-contracted provider. After conducting a thorough review, the plan upheld the original denial and, on April 5, 2024, appropriately submitted the case to the Independent Review Entity (IRE) for Level 2 appeal.

This appeal pertains to a retrospective claim reconsideration, for which CMS clearly establishes a 60-day timeframe for submission to the IRE, as outlined in Section 50.7.1 of the *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*. Clover Health submitted the case on Day 59—clearly within the allowable timeframe.

While a vendor error led to the incorrect designation of the IRE Appeal Priority, this clerical misstep does not alter the fundamental nature of the case. It remains a retrospective review, and the applicable standard is the 60-day submission window. Therefore, the plan's actions were fully compliant with CMS guidance, and the case should be evaluated according to the correct timeliness metric.

Clover Health respectfully requests that CMS acknowledge the timely submission under the appropriate regulatory framework and disregard the inadvertent priority classification error made during transmission.

- **Cases with this Data Discrepancy:**
  - 1-13926566786

Classifying this Level 2 appeal as an untimely submission mischaracterizes the number of untimely Level 2 submissions made by the plan. Using this case in the C31 measure calculations is inaccurate. This case priority should be updated to retrospective and the Plan Timely data column updated to Yes for an accurate result.

Files Excluded Because They Contain Protected Health Information

Attachment A – Attachment I

From:	CMS PartC&DStarRatings
To:	Cheree Pasalakis
Cc:	Cameron Pringle; Robert Davis; Will Chang; Duran, Vanessa (CMS/CM); Goldstein, Elizabeth (CMS/CM); Shelly Gupta; CMS PartC&DStarRatings
Subject:	RE: Patient Safety Measures- D10, D08, and D09
Date:	Tuesday, August 5, 2025 11:23:12 AM
Attachments:	CMS Response to Clover.pdf

Hello,

Please review the attached response from CMS Part C & D Star Ratings.

Thank you
Part C & D Star Ratings

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Friday, June 13, 2025 9:37 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; PatientSafety <PatientSafety@acumenllc.com>
Cc: Cameron Pringle <cameron.pringle@cloverhealth.com>; Robert Davis <robert.davis@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>; Goldstein, Elizabeth (CMS/CM) <Elizabeth.Goldstein@cms.hhs.gov>; Shelly Gupta <shelly.gupta@cloverhealth.com>
Subject: Patient Safety Measures- D10, D08, and D09

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Good morning,
We are requesting your review of the below and attached information. Thank you.

- **Contract Number**: H5141
- **Patient Safety Report:** May Patient Safety Report
- **Year of Service:** 2024
- **Patient Safety Measure:** D10 - Medication **Adherence** for Cholesterol (**Statins**), D08 - Medication Adherence for diabetes medications, D09 Medication Adherence for Hypertension (RAS antagonists)
- **Description of the Inquiry**:

On behalf of Clover Health, we respectfully reiterate our ongoing challenge to CMS's decision to include certain members in the latest 2024 patient safety report (published on April 1st)--within Measure D10, Medication Adherence for Cholesterol (Statins). In addition, we respectfully challenge CMS's decision to include certain members within Measure D08, Medication Adherence for Diabetes Medication and Measure D09, Medication Adherence for Hypertension (RAS antagonists).

As explained in Clover Health's April 30, 2025 letter, it is inappropriate for Measure D10 to penalize plans with members who have discontinued statins for medically

appropriate reasons. It is also inappropriate for Measures D08 and D09 to penalize plans with members who have discontinued diabetes medications or RAS antagonists for medically appropriate reasons. The doctors of these members or CMS's own guidance has determined that continuing statins, diabetes medications, or RAS antagonists would have been medically unnecessary and perhaps harmful for the members–not to mention unduly costly. Given the voluminous statutes, CMS regulations, and guidance on medical necessity, patient harm, and undue cost, Star Ratings measures cannot–and should not–require medically unnecessary and inappropriate treatments in order to achieve compliance under those measures.

In your April 30, 2025 response, CMS did not address–let alone dispute–the substantive merits of our challenge. Instead, CMS simply says "that the current methodology does not account for medication discontinuations" and "all Patient Safety measures are adapted from measures developed and endorsed by the Pharmacy Quality Alliance." CMS then directs us to the Pharmacy Quality Alliance (PQA) to address our challenges.

Respectfully, CMS's reliance on the measures is arbitrary, capricious, and otherwise not in accordance with law. And while CMS may consult and adopt measures developed by PQA, under the Medicare Act and the Administrative Procedure Act, CMS must ensure that any adopted measure design is methodologically sound and non-arbitrary. In short, CMS is legally responsible for Measures D08, D09, and D10 (and other Star Ratings measures). CMS cannot avoid that responsibility by pointing us to PQA.

Under CMS's Medicare 2025 Part C & D Star Ratings Technical Notes, federal law, and other applicable authorities, CMS must exclude the members identified in our prior letter as well as the additional members identified in this letter for at least four independent reasons.

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From:	CMS PartC&DStarRatings
To:	Cheree Pasalakis
Cc:	Jaye Johnston; Will Chang; Wendy Richey; Jamie Reynoso; Kim Williams; CMS PartC&DStarRatings; CMS PartC&DStarRatings
Bcc:	Hawkins, Kaitlin (CMS/CM); Cho, Taemi (CMS/CM); Lee-Martin, Alice (CMS/CM); Bhandari, Rajesh (CMS/CM); Al-Showk, Shafa (CMS/CM)
Subject:	RE: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010
Date:	Thursday, August 14, 2025 8:23:00 AM
Attachments:	RE Patient Safety Measures- D10 D08 and D09.msg

Good morning Cheree,

Thank you for your inquiry. Please refer to the attached prior response dated 8/5/2025 addressing Clover's concerns regarding the Part D Star Rating Medication Adherence measures methodology. CMS will not be making changes to Clover's Medication Adherence measure results.

In addition, please refer to prior Plan Request responses regarding complaints data. CMS will not be making changes to the complaint measure rates.

Thank you.
Part C and D Star Ratings Team

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Tuesday, August 12, 2025 7:15 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jaye Johnston <jaye.johnston@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Wendy Richey <wendy.richey@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>
Subject: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

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Good afternoon,
Attached is our appeal documentation for plan preview #1. Thank you in advance for your review and consideration.

Cheree Pasalakis
Manager, Compliance
615.426.5531

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This message was secured by **Zix®**.

From: Cheree Pasalakis
To: CMS PartC&DStarRatings
Cc: CMS CallCenterMonitoring; Will Chang; Maggie Meixell
Subject: Re: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010
Date: Friday, August 15, 2025 3:36:12 PM
Attachments: image001.png

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Thank you! The new files have been uploaded.

On Fri, Aug 15, 2025 at 2:03 PM CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov> wrote:

> Hello,
>
> Both files have been deleted. Please confirm once you've uploaded replacement documents.
>
> Sincerely,
>
> **Part C & D Star Ratings Team**
>
> Medicare Drug Benefit and C&D Data Group (MDBG)
>
> PartCandDStarRatings@cms.hhs.gov
>
> CENTERS FOR MEDICARE & MEDICAID SERVICES
>
> ***Confidentiality and Restricted Disclosure Notice:*** This e-mail is intended only for the use of the named addressee(s) and may contain information that is confidential, privileged or regulated under federal and/or state law, including The Privacy Act and HIPAA. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this e-mail is strictly prohibited. If you have received this e-mail in error, please notify the sender immediately by replying to the e-mail and destroy all copies of the original message. If you are the intended recipient, you are notified that you have the obligation to ensure that any

further dissemination, distribution or copying is consistent with applicable law.

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Friday, August 15, 2025 2:57 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Will Chang <william.chang@cloverhealth.com>; Maggie Meixell <maggie.meixell@cloverhealth.com>
Subject: Re: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

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Good afternoon,

It is come to our attention that the following two documents submitted with our Plan Preview #1 appeal:

- The 2025 08 09 Drug Adherence Measures - Privileged and Confidential and
- SUBMISSION ERRORS_A&G Decisions - 2026 Plan Preview Appeals

Inadvertently included material that is privileged under the attorney-client privilege and attorney-work product doctrine. Would it be possible for us to upload replacement documents that remove the privileged content via the secure portal. We respectfully ask you to confirm deletion of the other documents.

Thank you!

On Wed, Aug 13, 2025 at 4:30 PM CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov> wrote:

> Thank you!
>
> ---
>
> **From:** Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
> **Sent:** Wednesday, August 13, 2025 5:28 PM
> **To:** CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
> **Cc:** Wendy Richey <wendy.richey@cloverhealth.com>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; Jaye Johnston <jaye.johnston@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>
> **Subject:** Re: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

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Thank you! I received the invitation to the Box and I have shared our files.

On Wed, Aug 13, 2025 at 4:14 PM CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov> wrote:

> Hello,
>
> Please share these files via a box folder. You should be receiving an invitation link shortly. Kindly confirm once you've successfully uploaded the files in that folder.
>
> Sincerely,
>
> **Part C & D Star Ratings Team**
>
> Medicare Drug Benefit and C&D Data Group (MDBG)
>
> PartCandDStarRatings@cms.hhs.gov
>
> CENTERS FOR MEDICARE & MEDICAID SERVICES
>
> ***Confidentiality and Restricted Disclosure Notice*:** This e-mail is intended only for the use of the named addressee(s) and may contain information that is confidential, privileged or regulated under federal and/or state law, including The Privacy Act and HIPAA. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this e-mail is strictly prohibited. If you have received this e-mail in error, please notify the sender immediately by replying to the e-mail and destroy all copies of the original message. If you are the intended recipient, you are notified that you have the obligation to ensure that any further dissemination, distribution or copying is consistent with applicable law.

From: Wendy Richey <wendy.richey@cloverhealth.com>
Sent: Wednesday, August 13, 2025 5:08 PM
To: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; Jaye Johnston <jaye.johnston@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>
Subject: Re: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

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Please also be advised. We submitted through secure platform but if you have another means please advise.

On Wed, Aug 13, 2025 at 4:06 PM Cheree Pasalakis <cheree.pasalakis@cloverhealth.com> wrote:

> Thank you. In our original email, sent last night, our zip file also included appeal documentation for the following:
>
> - 2025 Measures D08, D09 Drug Adherence Appeals
> - TTY Admin Plan Preview Appeals
> - CTM Plan Preview Appeals
>
> All of which include PHI; we are requesting a secure means for transferring this information to you. Please advise how we can submit.
>
> Thank you!
>
> On Wed, Aug 13, 2025 at 2:29 PM CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov> wrote:
>
> > We noticed in your attachments that you provided enrollee names. As is stated in our Plan Preview memo, no PHI should be sent through email. Please delete these files from your system. If you need to provide PHI, as stated you need to request a secure means for transferring the information.
> >
> > Below we provide feedback about each of the case numbers in your email regarding the Part C appeals measures.

Case 1-13931154263- When your plan submitted the case file to Maximus, there was not sufficient information about the WOL date issue. Thank you for providing additional information and Maximus will change the appeal request date to 3/28/24. In the future, please try to make these requests earlier if your plan incorrectly entered the appeal receipt date.

Case 1-14156837886- No changes will be made. There is no evidence of an issue with the signature date in the case file sent to Maximus. The WOL has a date stamp of when the plan received this via fax that explicitly states 2/1/24 at 16:20:11. This was a valid WOL as per the documentation sent to Maximus so we see no issues to correct.

1-14575068066- It looks like your plan entered the wrong date when the case was submitted to Maximus. We are having Maximus update the date to 8/22/2024.

1-14506371416- This case was submitted nearly a month after the first one that you claim is a duplicate. This is an expedited appeal, and it is very common for a patient to request multiple appeals for the same item/service if their clinical circumstances change. It also does not look like you requested a reopening of this case. No changes are being made to this case.

1-14506371416- Your plan submitted this case as an expedited appeal and no changes can be made to change the appeal priority. For this appeal your plan notes that this is an expedited request in multiple places in the file submitted to maximus.

1-14595402316- Reopening decisions do not impact the timeliness measure. Reopenings are not related to the timeliness calculations. Reopenings only affect Reviewing Appeals Decisions measure, not the Plan Makes Timely Decisions measure.

1-14385393292- Maximus does not have medical records related to this case so no updates can be made.

For all of the cases related to re-openings, Clover did not request a reopening

within 180 days of the Maximus decision. It appears that Clover is saying on their own initiative that they reopened the cases while the appeals were being processed. Clover is not able to reopen a decision after they receive an appeal request. Please see the below citation.

42 CFR § 405.980(a)(4) – When a party has filed a valid request for an appeal of an initial determination, redetermination, reconsideration, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen an issue on a claim that is under appeal until all appeal rights for that issue are exhausted. Once the appeal rights for the issue have been exhausted, the contractor, QIC, ALJ or attorney adjudicator, or Council may reopen as set forth in this section.

We also checked the dates related to the below cases and corrections are in red.

- **1-13664105851** - Initial Determination denial on January 18, 2024 (Attachment O); reopening by Clover to approve coverage on January 22, 2024 (Attachment A; *see also* Attachment T).
    - Initial denial on December 26, 2023; Plan received appeal request on January 17, 2024; plan forwarded to Maximus on January 19, 2024
- **1-13814982651** - Initial determination denial on February 21, 2024 (Attachment P); reopening by Clover to approve coverage on March 25, 2024 (Attachment D; *see also* Attachment U).
    - Initial determination denied on January 25, 2024; plan received appeal request on February 14, 2024; plan forwarded to Maximus on March 4, 2024
- **1-13976245156** - Initial determination denial on April 18, 2024 (Attachment Q); reopening by Clover to approve coverage on April 22, 2024 (Attachment F; *see also* Attachment V).
    - Initial determination denied on April 12, 2024; plan received appeal request on April 17, 2024; plan forwarded to Maximus on April 19, 2024
- **1-14005223730** - Initial determination denial on April 29, 2024 (Attachment R); reopening by Clover to approve coverage on May 1, 2024 (Attachment F; *see also* Attachment W).
    - Initial determination denied on April 26, 2024; plan received appeal request on April 26, 2024; plan forwarded to Maximus on April 29, 2024
- **1-14173810816** - Initial determination denial on June 5, 2024 (Attachment S); reopening by Clover to approve coverage on August 13, 2024 (Attachment J; *see also* Attachment X).

- Initial determination denied on February 16, 2024; plan received appeal request on April 13, 2024; plan forwarded to Maximus on June 09, 2024

- **1-14196773261** - Initial determination denial on June 16, 2024 (Attachment N); reopening by Clover to approve coverage on July 7, 2024 (Attachment L; *see also* Attachment Y).

    - Initial determination denied on June 4, 2024; plan received appeal request on June 13, 2024; plan forwarded to Maximus on June 16, 2024

Part C and D Star Ratings Team

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Tuesday, August 12, 2025 7:15 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jaye Johnston <jaye.johnston@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Wendy Richey <wendy.richey@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>
Subject: Secure - Plan Preview #1 - Appeal Documentation for H5141 and H8010

This message was sent securely using Zix®

Good afternoon,

Attached is our appeal documentation for plan preview #1. Thank you in advance for your review and consideration.

Cheree Pasalakis

Manager, Compliance

615.426.5531

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--

Wendy Richey

Medicare Compliance Officer

Clover Health

551-225-2014

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From:	CMS PartC&DStarRatings
To:	Cheree Pasalakis; CMS CallCenterMonitoring
Cc:	Wendy Richey; Jamie Reynoso; Kim Williams; Karen Soares; Will Chang; Shelly Gupta; CMS PartC&DStarRatings
Subject:	RE: Clover Health Reply to CMS Response Regarding 2026 Star Rating Plan Preview Measure Appeals
Date:	Tuesday, August 26, 2025 4:51:55 PM
Attachments:	Clover Response August 26 2025.docx

In the attached we have addressed each of your concerns.

Sincerely,

Part C and D Star Ratings Team

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Saturday, August 16, 2025 12:56 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Wendy Richey <wendy.richey@cloverhealth.com>; Jamie Reynoso <jamie.reynoso@cloverhealth.com>; Kim Williams <kim.williams@cloverhealth.com>; Karen Soares <karen.soares@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Shelly Gupta <shelly.gupta@cloverhealth.com>
Subject: Clover Health Reply to CMS Response Regarding 2026 Star Rating Plan Preview Measure Appeals

Dear Centers for Medicare & Medicaid Services (CMS) Representative:

Clover Health (Contract Nos. H5141 and H8010) acknowledges CMS's responses to the plan preview #1 appeals submitted by Clover Health on the following measures:

(1) Plan Makes Timely Decisions about Appeals (C31);
(2) Reviewing Appeal Decisions (C32);
(3) Foreign Language Interpreter and TTY Availability (C33, D01);
(4) Medication Adherence Measures (D08, D09, D10), and
(5) Complaints About the Health Plan (C28).

We very much appreciate CMS's consideration of the issues raised in our plan preview appeals. But we continue to disagree with the agency on several issues. We have uploaded, via the Box portal, information in reply to the agency's responses to document our concerns with the agency's responses.

Titles of documents uploaded via the box: 2025
Omnibus Response, Exhibit A, Exhibit B, Exhibit C, and Exhibit D.

Thank you.

Response to Clover's Email Sent August 16, 2025

Below we summarize our feedback to your questions outlined in your email from August 16, 2025. Any measure-level updates will be made following the second plan preview.

Part C Appeals measures

1-14156837886:

Please send Maximus documentation such as Appendix E through fax or the Maxmus portal. Without documentation, Maximus cannot make any changes in their system. The documentation needs to come directly from Clover to them. Any updates from changes in this case would be made following the second plan preview.

1-14506371416:

In the future, Clover needs to be careful not to submit two separate reviews to Maximus for the same issue. If this happens in the future, Clover should request a reopening to fix the error. We will delete case 1-14506371416 following the second plan preview.

1-14595402316:

In Clover's reopening request to Maximus, Clover confirmed that they should have never sent the case to Maximus. Maximus appropriately issued a dismissal on the reopening decision, stating that it was sent to us in error. However, Maximus does see a data entry error in the Medicare Appeals System related to this case. They will correct the data entry issue and this will remove the case from the 'Reviewing Appeals Decisions' measure following the second plan preview.

1-13926566786:

Clover submitted that this case as an expedited one to Maximus. Based on what has been submitted to Maximus, we would update this case to a pre-service one. This update would occur following the second plan preview.

1-14385393292:

Maximus does not have any medical records. In its portal submission, Clover did indicate that they had provided records, but the actual documents submitted by Clover included no such records. The portal submission for the original case included a total of 50 pages (none of which were medical records), and a copy of Clover's 2024 Evidence of Coverage. That's the totality of what was submitted. For the reopening, the Plan submitted a 4-page reopening request. With its reopening request, Clover states that it included medical records in its original submission. Below is a complete listing of what Clover provided to Maximus:

1. Data entry printout from the Plan's portal submission (pages 1-3)

2. Appeal letter from the provider hospital (pages 4-7)
3. Clover Health Payment Dispute Uphold letter (pages 8-10)
4. A copy of SSA 1862 (pages 11-28)
5. A fax cover sheet from the provider hospital (page 29)
6. A cover letter from the provider hospital (pages 30-31)
7. USPS tracking document (pages 32-33)
8. Waiver of Liability (page 34)
9. Clover Claims Payment dispute form (page 35)
10. Redetermination request letter from provider hospital (pages 36-39)
11. Another copy of the Clover Health Payment Dispute Uphold Letter (pages 40-42)
12. Case Narrative (pages 43-44)
13. A letter from the provider hospital dated 5/29/24 (pages 45-46)
14. Another USPS tracking document (pages 47-48)
15. Another copy of the Waiver of Liability (page 49)
16. Another copy of the Clover Claims Payment Dispute Form (page 50)

Please let us know which pages are missing.

Reopening Issue:

Cases 1-13664105851, 1-13814982651, 1-13976245156, 1-14005223730, 1-14173810816, and 1-14196773261:

Below is information about (1) the applicability of the regulation restricting plans from reopening decisions that are on appeal and (2) the confusion related to the dates we provided in the last response.

The regulation at 42 CFR § 405.980(a)(4) is an Original Medicare regulation (which is why it does not use the term "plan") that is incorporated into the MA program through §§ 422.562(d) and 422.616. Below is an excerpt from CMS-4208-F (April 15, 2025) that discusses this longstanding policy in greater detail.

Under the regulations at § 422.576, an organization determination is binding on all parties unless it is reconsidered under the rules at §§ 422.578 through 422.596 or is reopened and revised under § 422.616. The reopening rules at § 422.616 permit an organization or

reconsidered determination made by an MA organization that is otherwise final and binding to be reopened and revised by the MA organization under the applicable rules in part 405, subpart I, at §§ 405.980 through 405.986. The reopening rules in part 405, subpart I, are implementing section 1869(b)(1)(G) of the Act, which states that the Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established in regulations. While the reopening rules in §§ 405.980 through 405.986 are applicable to the Traditional Medicare program, the regulatory provisions at 42 CFR part 405 historically have been cross-referenced in the managed care regulations and have been applied to the MA program consistent with the provisions at §§ 422.562(d) and 422.616 since the inception of the MA program (and to MA's predecessor, the Medicare+Choice program). Thus, the ability of an MA organization to reopen and revise an organization determination for the reasons set forth in regulation is well established in the MA program. For purposes of this provision, the discussion is specific to the application of the reopening rules to organization determinations made by an MA organization that involve inpatient hospital admission decisions.

CMS explains the restriction on plans reopening determinations that are on appeal in Section 80.2 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (the same manual and section Clover cites in its response).

The reopening process is separate and distinct from the appeals process. When a party has filed a valid request for a level 1 appeal, level 2 appeal, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen a case that is under appeal until all appeal rights for that case are exhausted or a subsequent request by the appellant to withdraw the appeal has been granted. For example, if a party requests a level 2 appeal and a reopening of an initial determination simultaneously, the level 2 appeal would be the only action processed. As a result, a party cannot have an appeal and a reopening occurring simultaneously with respect to the same case.

An MA plan cannot reopen and modify its reconsideration decision after the case file for the adverse decision has been forwarded to the IRE, as CMS considers this an issue still under appeal.

Regarding the dates in red from CMS's prior response, despite Clover's declaration otherwise, the dates we provided contradict information supplied in the previous response (i.e., the date of the initial determination) and we wanted to correct any inaccurate information). In addition, we provided the dates Clover received the appellants' reconsideration requests and, therefore, no longer had jurisdiction to reopen the initial determinations. We also supplied the dates Clover forwarded the case files to the IRE to further emphasize that Clover lacked jurisdiction to reopen the previous decisions.

Foreign Language Interpreter and TTY Availability Measures

An IVR is interactive with options from which to choose, and a message stating that the call center is closed does not provide the types of instructions nor options menu addressed in the memo - those that would take the caller to the appropriate customer service representative. CMS callers are necessarily bilingual for the purpose of placing test calls and are expected to end a call upon hearing a message, in any language, that the call center is closed, because we trust that what Clover represents in the message is accurate. Here, the callers ended the calls upon hearing the call center is closed message, consistent with both CMS's published guidance and testing protocol.

Medication Adherence and Complaints About the Plan (CTM) Measures

The three Part D Medication Adherence measures calculate the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of target medication. Adherence is calculated based on a proportion of days covered (PDC) at 80 percent or higher. The 80 percent threshold is based on an industry standard that is supported by a large body of studies and clinical evidence.

Also, the three Part D Medication Adherence measures are included in the Categorical Adjustment Index (CAI), which 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 included in the calculations 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. See the draft 2026 Medicare Part C & D Star Ratings Technical Notes in HPMS for information on the CAI.

CMS will implement risk adjustment for the three Medication Adherence measures based on age, gender, LIS/DE status, and disability status, as finalized in the April 2023 final rule (88 FR 22265 through 22270), beginning with the 2026 measurement year (2028 Star Ratings), and then the measures will no longer be included in the CAI. CMS will first display the updated risk adjusted Medication Adherence measures for the 2024 measurement year (2026 display page).

Please refer to prior Plan Request responses regarding complaints data. CMS will not be making changes to the complaint measure rates.

From:	CMS PartC&DStarRatings
To:	Cheree Pasalakis
Cc:	Duran, Vanessa (CMS/CM); Goldstein, Elizabeth (CMS/CM); Wendy Richey; Will Chang; Jaye Johnston; CMS PartC&DStarRatings
Subject:	RE: 2026 Plan Preview #2 Appeal Request - Clover Health: H5141 & H8010
Date:	Thursday, September 18, 2025 2:13:00 PM

Good afternoon,

Unlike Clover's prior communications to which CMS responded substantively during the plan preview period, this request is limited to issues that are outside the scope of the plan preview. The plan preview periods before each Star Ratings release are for MA and Part D organizations to preview their Star Ratings data in HPMS prior to display on the Medicare Plan Finder. During the preview periods contracts are validating their own data before the data are public, and CMS is focused on investigating and processing any necessary data corrections.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 16, 2025 2:49 PM
To: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Cc: Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>; Goldstein, Elizabeth (CMS/CM) <Elizabeth.Goldstein@cms.hhs.gov>; Wendy Richey <wendy.richey@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Jaye Johnston <jaye.johnston@cloverhealth.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: 2026 Plan Preview #2 Appeal Request - Clover Health: H5141 & H8010

Confirming receipt.

From: Cheree Pasalakis <cheree.pasalakis@cloverhealth.com>
Sent: Tuesday, September 16, 2025 2:28 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>; Goldstein, Elizabeth (CMS/CM) <Elizabeth.Goldstein@cms.hhs.gov>; Wendy Richey <wendy.richey@cloverhealth.com>; Will Chang <william.chang@cloverhealth.com>; Jaye Johnston <jaye.johnston@cloverhealth.com>
Subject: 2026 Plan Preview #2 Appeal Request - Clover Health: H5141 & H8010

Good afternoon,

Clover Health objects to CMS's inclusion of certain measures in the calculation of our 2026 Star Ratings; details are outlined in the attached appeal request. We are requesting that CMS exclude the identified measures from its 2026 Star Ratings and recalculate our 2026 Star Ratings. Thank you in advance for your review and consideration of our appeal request.

HPMS Appeal – 2026 Plan Preview 2: Removal of Star Ratings Measures

Contract No.(s): H5141 and H8010

September 16, 2025

Clover Health (Contract No.(s): H5141, H8010) ("Clover") objects to CMS's inclusion of certain measures in the calculation of Clover's 2026 Star Ratings. Inclusion of these measures in Clover's 2026 Star Ratings exceeds CMS's statutory authority and is otherwise unlawful. Clover requests that CMS exclude the measures identified below from its 2026 Star Ratings, and recalculate Clover's 2026 Star Ratings excluding these measures.

Post-2003 Data Sources Concerning Clover: Congress has limited the data on which Star Ratings may be based to the "types of data that were collected by the Secretary as of November 1, 2003." 42 U.S.C. § 1395w-22(e)(3)(B)(i); *see also id.* § 1395w-23(o)(4)(A) (Star Ratings must be "based on the data collected under section 1395w–22(e)"). CMS has limited authority to change the types of data collected in certain circumstances following submission of a report to Congress, but has not historically made any such report to Congress. *Id.* § 1395w-22(e)(3)(B)(ii). CMS has indicated its intent to calculate Clover's 2026 Star Ratings based on the following measures, which utilize data that is not the type of data collected by the Secretary as of November 1, 2003:

(1) Part C: Call Center – Foreign Language Interpreter / TTY (C33) and Part D: Call Center – Foreign Language Interpreter / TTY (D01);
(2) Reducing the Risk of Falling (C15), Improving Bladder Control (C16), and Care Coordination (C27);
(3) Medication Adherence for Diabetes Medication, Hypertension, And Cholesterol (D08, D09, and D10);
(4) Pharmacy Medication Therapy Management Program Completion Rate (D11);
(5) Pharmacy Statin Use with Diabetes (D12); and
(6) Rating of Drug Plan (D05) and Getting Needed Prescription Drugs (D06).

None of these measures are based on types of data that were collected by the Secretary as of November 1, 2003. Therefore, CMS does not have the statutory authority to use these measures to calculate Clover's 2026 Star Ratings. CMS must exclude these measures from Clover's 2026 Star Ratings.

Data Concerning Clover Not Collected Under Section 1395w-22(e): Congress has also limited the data on which Star Ratings may be based to the "data collected under section 1395w-22(e) of this title." 42 U.S.C. § 1395w-23(o)(4)(A). Section 1395w-22(e) provides that "each [Medicare Advantage] organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality." *Id.* § 1395w-22(e).

But CMS has indicated its intent to calculate Clover's 2026 Star Ratings based on the following measures, which utilize data drawn from other sources that are not collected under section 1395w-22(e):

(1) Part C: Call Center – Foreign Language Interpreter / TTY (C33) and Part D: Call Center – Foreign Language Interpreter / TTY (D01);
(2) Reducing the Risk of Falling (C15), Improving Bladder Control (C16), Care Coordination (C27), Improving and Maintaining Mental Health (C05), and Improving and Maintaining Physical Health (C04);
(3) Medication Adherence for Diabetes Medication, Hypertension, And Cholesterol (D08, D09, and D10);
(4) Pharmacy Medication Therapy Management Program Completion Rate (D11);
(5) Pharmacy Statin Use with Diabetes (D12);
(6) Rating of Drug Plan (D05) and Getting Needed Prescription Drugs (D06); and
(7) Plan Makes Timely Decisions on Appeals (C31) and Reviewing Appeals Decisions (C32).

As CMS itself acknowledges, these measures are not based on "data collected under section 1395w-22(e) of this title." *See* 83 Fed. Reg. 16440, 16531-16532 (2018) (CMS conceding this issue). Therefore, CMS does not have the statutory authority to use these measures to calculate Clover's 2026 Star Ratings. CMS must exclude these measures from Clover's 2026 Star Ratings.

Evaluations of Clover By Private Third Party Contractors: CMS has unlawfully delegated authority to rate Clover's performance to private contractors. An agency cannot outsource to private parties governmental decision-making functions, including the evaluation of the quality of Medicare Advantage plans. *See FCC v. Consumers' Rsch.*, 145 S. Ct. 2482, 2507-11 (2025) (detailing this limitation). But CMS has unlawfully delegated its functions for several measures to private contractors. These contractors purport to evaluate the quality of plans, rather than CMS doing so itself. *See UnitedHealthcare Benefits of Texas, Inc. v. CMS*, 2024 WL 4870771, at *7-9 (E.D. Tex. Nov. 22, 2024) (explaining why CMS's delegation to private contractors of call center measures violates federal law).

These measures include the following:

(1) Call Center—Foreign Language Interpreter/TTY measures (C33 and D01) and
(2) Reviewing Appeals Decisions measure (C32).

These measures are based entirely on evaluations of Clover's performance by CMS's private contractors rather than by the government itself. Therefore, CMS must exclude these measures from Clover's 2026 Star Ratings.

Measures Adopted Without Required Rulemaking: The Supreme Court has explained that CMS must engage in notice-and-comment rulemaking before it adopts any "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter." *Azar v. Allina Health Servs.*, 587 U.S. 566, 572 (2019) (quoting 42 U.S.C. § 1395hh(a)(2)); *see also Office of the United States Attorney General* (February 5, 2025) (acknowledging, "Guidance documents violate the law when they are issued without undergoing the rulemaking process established by law yet purport to have a direct effect on the rights and obligations of private parties governed by the agency or otherwise act as a substitute for rulemaking"). That, of course, includes the Star Ratings measures applied to Clover, which in turn determine CMS payments to Clover, Clover's benefits offered to beneficiaries, and Clover's eligibility to participate in the Medicare Advantage program. Yet, CMS has adopted all of the foregoing measures identified throughout this entire document without engaging in the required notice-and-comment rulemaking under § 1395hh(a)(2).

The same problem also impacts the following measures:

(1) Annual Flu Vaccine (C03),
(2) Improving and Maintaining Mental Health (C05),
(3) Improving and Maintaining Physical Health (C04),
(4) Getting Needed Care (C22),
(5) Getting Appointments and Care Quickly (C23),
(6) Customer Service (C24), and
(7) Rating of Health Care Quality (C25).

These measures were all adopted without notice-and-comment rulemaking required by 42 U.S.C. § 1395hh(a)(2). Therefore, they must be excluded from Clover's 2026 Star Ratings.

Further Measures Adopted Without Required Rulemaking: Even if CMS were to disagree with Clover's view of *Allina*, CMS has unlawfully chosen to evaluate Clover using

measures that CMS did not adopt through the required notice-and-comment rulemaking as required under CMS's own regulations. Under 42 C.F.R. § 422.164(c)(2), CMS must adopt new measures through rulemaking. For the 2026 Star Ratings, CMS has adopted the new measures Improving and Maintaining Mental Health (C05), and Improving and Maintaining Physical Health (C04). As CMS makes clear in its 2026 Star Ratings Technical Notes, these are "new measures." 2026 Technical Notes at 131 ("*Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures have a weight of 1 for the 2026 Star Ratings because they are considered new measures."); *see also id.* at 2, 162 (similar concessions). Also impacted by the same problem is Pharmacy Statin Use with Diabetes (D12), which was previously adopted by CMS as a new measure without required notice-and-comment-rulemaking prior to its adoption. Because CMS adopted these new measures without required notice-and-comment rulemaking, CMS must exclude these measures from Clover's Star Rating.

Arbitrary and Capricious Measures: Several of CMS's unauthorized measures are also arbitrary and capricious. For example, Clover has identified the numerous flaws in Medication Adherence measures (D08, D09, and D10) in its prior submissions dated May 21, 2025 and August 15, 2025, and incorporates those arguments here by reference.

Similarly, Part C: Call Center – Foreign Language Interpreter / TTY (C33) and Part D: Call Center – Foreign Language Interpreter / TTY (D01) are arbitrary and capricious, because rather than measuring plan quality, they instead measure the happenstance of the quality of communication and connectivity between a CMS-selected vendor, on the one hand, and plans, on the other. A "perfect" score is generally required to obtain five stars, and just one or a handful of calls can result in a multi-star drop, even when it is caused by minor technical issues not attributable to the plan. This gives rise to an annual process in which plans appeal to CMS, and then courts, to adjudicate individualized technical and communication issues, like phone line quality and callers' foreign language proficiency, that are entirely unrelated to plan quality. And notably, CMS has made no effort to determine which foreign languages should properly be tested, and whether there is any need for these services in selected languages, much less the over 100 languages CMS requires (or TTY services). These flaws have previously been detailed in the summary judgment filings by SCAN Health Plan (No. 1:23-cv-03910 (D.D.C.)) and UnitedHealthcare (No. 6:24-cv-00357 (E.D. Tex.)), and are incorporated here by reference.

Another such arbitrary measure is Improving Bladder Control (C16). This measure evaluates whether a patient decided to discuss incontinence with a provider. Unlike other measures, which evaluate quality of services provided by plans and providers, evaluating Clover on whether a patient volunteers information is entirely unrelated to measuring plan quality. *See* 42 U.S.C. § 1395w-22(e)(3)(B)(i).

The foregoing measures should be excluded from Clover's 2026 Star Ratings.

* * *

For the above reasons, Clover requests that CMS exclude these measures from Clover's final 2026 Star Ratings, and calculate Clover's final 2026 Star Ratings without application of the above-identified measures. Clover also reiterates and incorporates by reference all previously raised objections, and reserves all rights.

Sincerely,

William Chang

Will Chang
Vice President and Deputy General Counsel

CC: Vanessa Duran, vanessa.duran@cms.hhs.gov
Elizabeth Goldstein, elizabeth.goldstein@cms.hhs.gov

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



CENTER FOR MEDICARE

TO: All Part D Sponsors

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group
Cheri Rice, Director, Medicare Plan Payment Group

SUBJECT: Prohibition on Submitting PDEs for non-Part D prescriptions

DATE: May 11, 2012

The purpose of the memorandum is to address questions we have received on whether Part D sponsors may report prescription drug events (PDEs) based on data collected through other means than claims submitted by network pharmacies or requests for reimbursement from beneficiaries. More specifically, we have been asked if Part D sponsors can submit PDEs if they obtain, either directly or through a vendor, claims-level information from pharmacies and/or prescriber offices for prescriptions or physician samples that were dispensed to their enrollees outside of their Part D benefit. We surmise that Part D sponsors may be looking to obtain the additional drug history in order to improve care coordination, medication therapy management and point-of-sale edits that identify duplicate therapies and drug interactions that would otherwise go undetected. Reporting of these dispensing events as PDEs potentially could provide CMS with more accurate data on which to evaluate plan performance and base patient safety measures used to establish star ratings and quality bonus payment.

While we understand the good intent behind efforts to obtain such missing claims data, we have not yet been able to determine that we are authorized to accept such data or understand its impact on payment operations. We also have serious concerns about how to ensure beneficiary privacy protections and data validation. It is unclear to us how Part D sponsors could implement sufficient internal controls to meet audit standards necessary to ensure the quality of the data, especially in the case of physician samples. Until such time as we can resolve these questions and concerns, we must prohibit the reporting of any PDE data that has not been submitted directly by network pharmacies or beneficiaries, consistent with our existing guidance.

In the meantime, we encourage Part D sponsors to develop incentives for network pharmacies to submit claims under the plan unless beneficiaries have explicitly requested otherwise. Such incentives could include nominal amounts paid by the Part D sponsors--for example, CMS has accepted PDEs for one cent claims. Additionally, we urge Part D sponsors to work with the National Council for Prescription Drug Programs (NCPDP) to develop coding to permit zero

dollar claims transmission so that zero dollar promotional drugs, such as antibiotics, can be submitted under the plan.

We are open to having future discussions with industry about this practice and our data quality and beneficiary privacy concerns, but at this time CMS will not accept PDEs for claims that were not submitted for processing and/or reimbursement under the plan by either a network pharmacy or enrollee. Although CMS is not aware of any applicable PDEs having been submitted to date, Part D plans must delete any such previously reported PDEs.

If you have questions about the guidance in this memorandum, please contact Craig Miner at craig.miner@cms.hhs.gov or (410) 786-7937.

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

MEDICARE PLAN PAYMENT GROUP

TO: All Part D Plan Sponsors

FROM: Cheri Rice, Director
Medicare Plan Payment Group

SUBJECT: May 2013 Updates to the Drug Data Processing System

DATE: April 23, 2013

The Centers for Medicare & Medicaid Services (CMS) is announcing upcoming changes to the Drug Data Processing System (DDPS) that will take place in the month of May. An updated edit spreadsheet will be posted to the Customer Service and Support Center (CSSC) Operations website. Please submit questions regarding these changes to PDEJan2011@cms.hhs.gov.

Allowing $0 PDEs

Beginning on May 12, 2013, CMS will allow Prescription Drug Event (PDE) records where the sum of the cost fields (*i.e.*, Ingredient Cost Paid+ Dispensing Fee Paid + Vaccine Administration Fee + Total Amount Attributed to Sales Tax) equals zero on all PDEs regardless of date of service (DOS).

Currently, there are two situations in which sponsors may have PDEs with $0.00 in drug costs. First, certain pharmacies (e.g., Wegmans for antibiotics and Atorvastatin) are known to be marketing certain generic prescription drugs for free to their customers. In this case, if beneficiaries fill these free prescriptions using their Part D benefit the plan sponsor should submit a $0.00 PDE. For this particular scenario we expect sponsors to implement for dispensing events with a 2013 date of service. Thus, if a sponsor has already submitted zero dollar event as a $0.01 PDE to get around our previous editing, CMS expects the sponsor to submit an adjustment PDE at $0.00 in cost. We will not require adjustment of PDEs that fit this first scenario for years prior to 2013. Second, as stated in the Calendar Year 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, if a sponsor recoups the full claims payment from a pharmacy, then the PDE should reflect that recoupment and should indicate $0.00 in drug cost. This policy will impact the payment reconciliation conducted in 2013 for the 2012 coverage year. Thus, any 2012 PDEs with a full recoupment should be adjusted to $0.00 no later than the June 2013 cutoff for the reconciliation of the 2012 coverage year.

All of the edits listed below, with the exception of edit code 694, will be bypassed to allow PDEs with the sum of the cost fields = zero. Edit 694 will be modified to allow the cost fields to equal zero.

Edit 670: For PDEs with a DOS prior to 1/1/2011, if the Catastrophic Coverage Code = 'blank', GDCB must be greater than zero. For DOS 1/1/2011 and forward, if True Out-of-Pocket Accumulator < OOP Threshold, GDCB must be greater than zero. This edit applies to Covered Drugs only. The edit is bypassed if the sum of the cost fields = zero.

Edit 672: For DOS prior to 1/1/2011, if the Catastrophic Coverage Code is 'A', GDCB must be greater than zero. This edit applies to Covered Drugs only. The edit is bypassed if the sum of the cost fields = zero.

Edit 673: For DOS prior to 1/1/2011, if the Catastrophic Coverage Code is 'C', GDCA must be greater than zero. For DOS 1/1/2011 and forward, if True Out-of-Pocket Accumulator = OOP Threshold, GDCA must be greater than zero. This edit applies to Covered Drugs only. The edit is bypassed if the sum of the cost fields = zero.

Edit 694: The sum of Ingredient Cost, Dispensing Fee, and Vaccine Administration Fee must be >= zero. This requirement also applies to OTC drugs funded by administrative costs.

Edit 699: The true out of pocket cost is greater than the out of pocket threshold, the entire PDE falls within the catastrophic coverage phase and submitted GDCA is not greater than 0. This edit applies to Covered drugs with DOS on or after 1/1/2011. The edit is bypassed if the sum of the cost fields = zero.

Modify the “current” System Timestamp to Greenwich Mean Time (GMT)

CMS has been made aware of an issue where any time a PDE is processed by DDPS within 7 hours of the listed Claim Adjudication Timestamp, the DDPS Eastern Time (ET) timestamp appears to be before the submitted Greenwich Mean Time (GMT) timestamp, and the PDE will reject with edit 651. This anomaly occurs because DDPS uses an ET timestamp to compare to a GMT timestamp. Edit 651 will be modified to convert the “current” system timestamp to GMT when comparing the current system timestamp to the submitted Claim Adjudication Timestamp. Sponsors receiving edit 651 as a result of this issue can resubmit the PDEs after May 12, 2013.

Edit 651: The Claim Adjudication Began Timestamp is missing or invalid. For DOS 1/1/2011 and forward, must be a valid timestamp in the CCYY-MM-DD- HH.MM.SS.MMMMMM format. The field cannot contain a future date or < DOS. For DOS prior to 1/1/2011, the field must be zeros or spaces. This edit assumes time is formatted as Greenwich Mean Time (GMT).

Modify the Prescriber ID Edits

Beginning on May 6, 2013, The Prescriber ID and Prescriber ID Qualifier edits will be modified to reflect the regulatory changes that go into effect beginning in 2013. CMS requires PDEs to be submitted with an NPI in the Prescriber ID field as of January 1, 2013. CMS will reject PDEs with a DOS between January 1, 2013 and May 5, 2013 if submitted without a valid Type 1 (individual) or Type 2 (organization) NPI code value. CMS will reject PDEs with a DOS on or after May 6, 2013 if submitted without a valid individual Type 1 NPI code. In addition, CMS will reject PDEs with a DOS of January 1, 2012 or later if submitted with a valid NPI code value that has been deactivated for over one year. The following edits have been modified to reflect these changes.

Edit 622: Prescriber ID Qualifier is missing. This edit applies to all standard format claims, regardless of DOS, and applies to all non-standard format claims with DOS on or after 1/1/2012.

Edit 623: Prescriber ID Qualifier is invalid. Prior to DOS 1/1/2013, the Prescriber ID Qualifier must be equal to '01'-NPI, or '06'-UPIN, or '08 -State License, or '12'-DEA. On or after 1/1/2013, the Prescriber ID Qualifier must be equal to '01'. This edit applies to standard and non-standard format PDEs.

Edit 624: The Prescriber ID is missing. The field must not be blank. This edit applies to all standard format claims, regardless of DOS, and applies to all non-standard format claims with DOS on or after 1/1/2012.

Edit 832: NPI number not found on CMS NPI table; however it contains a valid check digit. This edit applies to Covered Drugs with DOS on or after 1/1/2012. This edit is discontinued beginning 5/6/2013.

Edit 833: NPI number not found on CMS NPI table. This edit applies to Covered Drugs with DOS on or after 1/1/2012. Effective 5/6/2013, the Prescriber ID must be a Type 1 (individual) NPI.

Edit 834: NPI is not active for the Date of Service. This edit applies to Covered Drugs with DOS on or after 1/1/2012. The DOS must be within one year of the NPPES deactivation date.



Medicare 2026 Part C & D Star Ratings Technical Notes

Updated – 09/25/2025

Document Change Log

Previous Version	Description of Change	Revision Date
Draft 09/04/2025	The reporting requirements for the Kidney Health Evaluation for Patients with Diabetes (C13) measure were updated to reflect CCP with Only I-SNP contracts are required to report this measure. The cut points for this measure were also updated consistent with this change.	09/25/2025

OMB Approved Data Sources

The data collected for the Part C & D Star Ratings come from a variety of different data sources approved under the following Office of Management and Budget (OMB) Paperwork Reduction Act numbers:

Data Source	OMB Number
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0938-0732
Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

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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 '2026 Medicare Part C & D Star Ratings' because they are posted prior to the 2026 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 "2026" 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.

Differences between the 2025 Star Ratings and 2026 Star Ratings

There have been several changes between the 2025 Star Ratings and the 2026 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2026 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment J.

- Changes
    a. The weight of the patient experience, complaints, and access measures was decreased from 4 to 2.
    b. Since the respecified Part C Controlling Blood Pressure measure is no longer treated as a new measure, guardrails are now applied after mean resampling.

c. Re-specified Part C Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health measures moved into the 2026 Star Ratings as new measures with a weight of 1 for the first year.
d. Part C Kidney Health Evaluation for Patients with Diabetes measure moved into the 2026 Star Ratings as a new measure with a weight of 1.
e. Removed the 60 percent rule for non-CAHPS measures such that the numeric score values for affected contracts with 60 percent or more of their enrollees in Federal Emergency Management Agency (FEMA) designated Individual Assistance areas at the time of an extreme and uncontrollable circumstance are no longer excluded from the clustering algorithm or from the reward factor calculations.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. None
- Retired measures
  a. None

Health/Drug Organization Types Included in the Star Ratings

All health and drug plan quality and performance measure data described in this document are reported at the contract/sponsor level. Table 1 lists the contract year 2026 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2026 Organization Types Reported in the 2026 Star Ratings

Organization Type	Technical Notes Abbreviation	Medicare Advantage (MA)	Can Offer SNPs	Part C Ratings	Part D Ratings
1876 Cost	1876 Cost	No	No	Yes	Yes (if drugs offered)
Demonstration (Medicare-Medicaid Plan) †	MMP	No	No	No	No
Employer/Union Only Direct Contract Local Coordinated Care Plan (CCP)	CCP	Yes	No	Yes	Yes
Employer/Union Only Direct Contract Prescription Drug Plan (PDP)	PDP	No	No	No	Yes
Employer/Union Only Direct Contract Private Fee-for-Service (PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)
HCPP 1833 Cost	HCPP	No	No	No	No
Local Coordinated Care Plan (CCP)	CCP	Yes	Yes	Yes	Yes
Medical Savings Account (MSA)	MSA	Yes	No	Yes	No
National PACE	PACE	No	No	No	No
Medicare Prescription Drug Plan (PDP)	PDP	No	No	No	Yes
Private Fee-for-Service (PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)
Regional Coordinated Care Plan (CCP)	CCP	Yes	Yes	Yes	Yes
Religious Fraternal Benefit Private Fee-for-Service (RFB PFFS)	PFFS	Yes	No	Yes	Yes (if drugs offered)

† Note: The measure scores from these organizations are displayed in HPMS only during the first plan preview. Data from these organizations are not used in calculating the Part C & D Star Ratings.

The Star Ratings Framework

The Star Ratings are based on health and drug plan quality and performance measures. Each measure is reported in two ways:

Score: A score is either a numeric value or an assigned 'missing data' message.

Star: The measure numeric value is converted to a Star Rating.

The measure Star Ratings are combined into three groups and each group is assigned 1 to 5 stars. The three groups are:

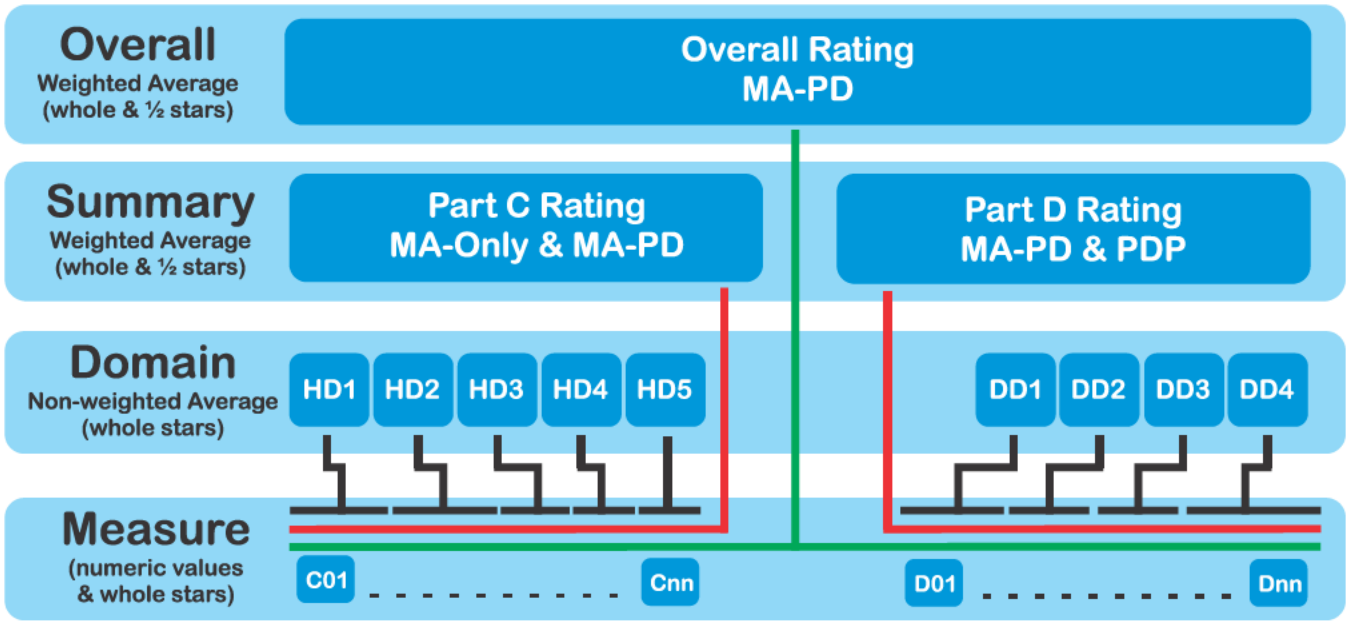
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

Summary: Part C measures are grouped to calculate a Part C Rating; Part D measures are grouped to calculate a Part D Rating. Summary ratings are calculated from the weighted average Star Ratings of the included measures.

Overall: For MA-PDs, all unique Part C and Part D measures are grouped to create an overall rating. The overall rating is calculated from the weighted average Star Ratings of the included measures.

Figure 1 shows the four levels of Star Ratings that are calculated and reported publicly.

Figure 1: The Four Levels of Star Ratings



The whole star scale used at the measure and domain levels is shown in Table 2.

Table 2: 5-Star Scale

Numeric	Graphic	Description
5	★★★★★	Excellent
4	★★★★	Above Average
3	★★★	Average
2	★★	Below Average
1	★	Poor

To allow for more variation across contracts, CMS assigns half stars to the summary and overall ratings. As different organization types offer different benefits, CMS classifies contracts into three contract types. The highest level Star Rating differs among the contract types because the set of required measures differs by contract type. Table 3 clarifies how CMS classifies contracts for purposes of the Star Ratings and indicates the highest rating available for each organization type.

Table 3: Relation of 2026 Organization Types to Contract Types and Highest Rating in the 2026 Star Ratings

Organization Type	1876 Cost (no drugs) †	1876 Cost (offers drugs) †	CCP	MSA	PDP	PFFS (no drugs)	PFFS (offers drugs)
Rated As	MA-Only	MA-PD	MA-PD	MA-Only	PDP	MA-Only	MA-PD
Highest Rating	Part C rating	Overall Rating	Overall Rating	Part C Rating	Part D Rating	Part C Rating	Overall Rating

† Note: While 1876 contracts are not MA contracts, for the purposes of determining the highest rating they are considered to be rated as either "MA-only" or "MA-PD" depending on whether they offer drugs.

Sources of the Star Ratings Measure Data

The 2026 Star Ratings include a maximum of 9 domains comprised of a maximum of 45 measures.

- MA-Only contracts are measured on 5 domains with a maximum of 33 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 45 measures, 43 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.

Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type

Part	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	11 of 22	13 of 26	15 of 29	9 of 17	13 of 25	N/A	13 of 26
D	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.

For a detailed description of all Part C and Part D measures, see the section entitled "Framework and Definitions for the Domain and Measure Details."

Contract Enrollment Data

The enrollment data used in the Part C and Part D "Complaints about the Health/Drug Plan" measures are pulled from HPMS. These data may also be accessed on the Monthly Enrollment by Contract page on CMS.gov. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2024 through December 2024) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the two Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. (The "Care for Older Adults – Functional Status Assessment" measure is currently on the display page). When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor (see following section), there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2024 through December 2024), and the average enrollment in the plan across those months is used in calculating the combined rate.

Handling of Biased, Erroneous, and/or Not Reportable (NR) Data

The data used for CMS's Star Ratings must be accurate and reliable. CMS has identified issues with some contracts' data and has taken steps to protect the integrity of the data. For any measure scores CMS identifies to be based on inaccurate or biased data, CMS's policy is to reduce a contract's measure rating to 1 star and set the measure score to "CMS identified issues with this plan's data."

Inaccurate or biased data result from the mishandling of data, inappropriate processing, or implementation of incorrect practices. Examples include, but are not limited to: a contract's failure to adhere to HEDIS, Health Outcomes Survey (HOS), or CAHPS reporting requirements; a contract's failure to adhere to Medicare Plan Finder data requirements; a contract's errors in processing organization determinations and appeals; compliance actions taken against the contract due to errors in operational areas that impact the data reported or processed for specific measures; or a contract's failure to pass validation of the data reported for specific measures.
For HEDIS data, CMS uses the audit designation information assigned by the HEDIS auditor. An audit designation of 'NR' (Not reported) is assigned when the contract chooses not to report the measure. An audit designation of 'BR' (Biased rate) is assigned when the individual measure score is materially biased (e.g., the auditor informs the contract the data cannot be reported to the National Committee for Quality Assurance (NCQA) or to CMS). When either a 'BR' or 'NR' designation is assigned to a HEDIS measure audit designation, the contract receives 1 star for the measure and the measure score is set to "CMS identified issues with this plan's data." In addition, CMS reduces contracts' HEDIS measure ratings to 1 star if the patient-level data files are not successfully submitted and validated by the submission deadline. Also, if the HEDIS summary-level data value varies substantially from the value in the patient-level data, the measure is reduced to a rating of 1 star. If an approved CAHPS or HOS vendor does not submit a contract's CAHPS or HOS data by

the data submission deadline, the contract automatically receives a rating of 1 star for the CAHPS or HOS measures and the measure scores are set to "CMS identified issues with this plan's data."

Data Handling of Measures for Contracts Affected by a Major Disaster

CMS has a policy for making adjustments in the Star Ratings to take into account major disasters. That policy was described in the 2026 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.) This is also codified in regulation at §422.166(i) and §423.186(i).

This section describes how the policy is implemented for measures from each of the different data sources in the 2026 Star Ratings. The methodology used by CMS to identify the major disaster geographic areas, determine which contracts were affected, and how much of their geographic service area and percent of enrollment resided in an affected area can be found in Attachment P.

The disaster policy specifies a threshold of "25% or more" of the contract's membership at the time of the disaster resided in a FEMA-designated Individual Assistance area. CMS calculated the percentage of enrollment affected for every contract being rated and applied the following rules to the data from those contracts that meet or exceed the threshold.

- CAHPS adjustments:
  - All contracts were required to administer the 2025 CAHPS survey unless the contract requested and CMS approved an exemption based on having greater than 25% of beneficiaries in Individual Assistance areas at the time of the 2025 Los Angeles County wildfires. If a contract received an exemption, CAHPS measure scores and ratings from the 2025 Star Ratings were used.
  - All affected contracts with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster receive the higher of the 2025 or the 2026 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure). The CAHPS data used in the 2026 Star Ratings are adjusted for 2024 disasters and 2025 Los Angeles County wildfires.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated individual Assistance areas that were affected by disasters that began in 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2023 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected). For example, if a doubly-affected contract reverted back to the 2024 Star Rating on a given measure in the 2025 Star Ratings, the 2024 Star Rating is *not* used in determining the 2026 Star Rating. Rather the 2026 Star Rating is compared to what the 2025 Star Rating would have been absent any disaster adjustments.
- HOS adjustments:
  - The HOS data used in the 2026 Star Ratings are adjusted for 2023 disasters (see Attachment P of the 2025 Star Ratings Technical Notes for the identification of contracts affected by 2023 disasters).
  - All affected contracts (i.e., contracts affected by 2023 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2025 or the 2026 Star Rating (and corresponding measure score) for each HOS and HEDIS-HOS measure.

- In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2023 were also affected by disasters in 2022. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2022 disaster for each HOS and HEDIS-HOS measure (we use the corresponding measure score for the Star Ratings year selected).

- HEDIS adjustments:
  - All contracts were required to report HEDIS measurement year 2024 unless the contract requested and CMS approved an exemption. Contracts were able to work with NCQA to adjust samples if necessary.
  - Contracts with 25% or more affected members received the higher of the 2025 or 2026 Star Rating (and corresponding measure scores) for each HEDIS measure.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2023 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- Part C and D Call Center:
  - For all contracts, no adjustments were made.
- New measures:
  - Contracts with 25% or more affected members have a hold harmless provision applied which compares the result of a contract's overall rating "with" and "without" including all of the applicable new measure(s) and/or respecified measure(s). If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating. For the 2026 Star Ratings, two new measures are HOS measures and one is a HEDIS measure. As noted above, HOS measures are adjusted for disasters occurring in 2023 whereas HEDIS measures are adjusted for disasters occurring in 2024. Therefore, the hold harmless provision is conditionally applied for a given contract according to the new measures' available data. Contracts with data for both the new HEDIS measure and at least one of the new HOS measures are eligible for the new measure hold harmless provision if the percentage of beneficiaries affected by a disaster is at least 25 percent in either 2023 or 2024. Contracts with only available data for the new HEDIS measure are eligible for the new measure hold harmless provision if the percentage of beneficiaries affected by a disaster is at least 25 percent in 2024. Contracts with only data for one or both of the new HOS measures are eligible for the new measure hold harmless provision if the percentage of beneficiaries affected by a disaster is at least 25 percent in 2023.
  - A similar hold harmless provision is applied for the Part C and D summary ratings, when applicable. If a contract has 25% or more affected members, the Part C and D summary ratings are calculated "with" and "without" including all of the applicable new measure(s) and/or respecified measure(s), and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary ratings. For the 2026 Star Ratings, all new measures are Part C measures with differing disaster year adjustments, and a similar conditional hold harmless provision as described above for the overall rating is applied based on new measures' available data.

- All other measures:
    - Contracts with 25% or more affected members receive the higher of the 2025 or 2026 measure stars (and corresponding measure scores).
    - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2023 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- All adjustments:
    - For all adjustments, if the Star Rating is the same in both years, the Star Rating and the measure score from the most recent year are used.
- Improvement measures:
    - For affected contracts that reverted back to the data underlying the previous year's Star Rating for a particular measure for either 2025 or 2026 Star Ratings, that measure is excluded from both the count of measures (used to determine whether the contract has at least half of the measures needed to calculate the relevant improvement measure) and the improvement measures' calculation. Affected contracts do not have the option of reverting to the prior year's improvement rating.
- Affected contracts with missing data:
    - If an affected contract has missing data in either the current or previous year (e.g., because of a data integrity issue, it is too new, or it is too small), the final measure rating comes from the current year. Missing data includes data where there is a data integrity issue.

Methodology for Assigning Stars to the Part C and Part D Measures

CMS assigns stars for each numeric measure score by applying one of two methods: clustering, or relative distribution and significance testing. Each method is described below. Attachment K explains the clustering and relative distribution and significance testing (used for CAHPS measures) methods in greater detail.

A. Clustering

This method is applied to the majority of the Star Ratings measures, ranging from operational and process-based measures, to HEDIS and other clinical care measures. Using this method, the Star Rating for each measure is determined by applying a clustering algorithm to the measure's numeric value scores from all contracts. Conceptually, the clustering algorithm identifies the "gaps" among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). The scores in the same Star Rating level are as similar as possible; the scores in different Star Rating levels are as different as possible. Star Rating levels 1 through 5 are assigned with 1 being the worst and 5 being the best.

Technically, the variance in measure scores is separated into within-cluster and between-cluster sum of squares components. The clusters reflect the groupings of numeric value scores that minimize the variance of scores within the clusters. The Star Ratings levels are assigned to the clusters that minimize the within-cluster sum of squares. The cut points for star assignments are derived from the range of measure scores per cluster, and the star levels associated with each cluster are determined by ordering the means of the clusters.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling within the hierarchical clustering algorithm.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are randomly separated into 10 equal-sized groups. The hierarchal clustering algorithm is then applied 10 times, each time leaving one of the 10 groups out of the clustered data. The method results in 10 sets of measure-specific cut points. The mean for each 1 through 5 star level cut point is taken across the 10 sets for each measure to produce the final cut points. For the improvement measures, mean resampling is done separately for contracts with negative improvement scores and for contracts with improvement scores greater than or equal to zero.

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.

Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type

Part	Domain Name (Identifier)	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	Staying Healthy: Screenings, Tests and Vaccines (HD1)	4 of 6	4 of 6	4 of 6	2 of 2	4 of 6	N/A	4 of 6
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 9	7 of 12	8 of 15	6 of 11	7 of 12	N/A	7 of 12
C	Member Experience with Health Plan (HD3)	4 of 6	4 of 6	4 of 6	N/A	4 of 6	N/A	4 of 6
C	Member Complaints and Changes in the Health Plan's Performance (HD4)	2 of 3	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3
C	Health Plan Customer Service (HD5)	2 of 2	2 of 3	2 of 3	2 of 3	2 of 2	N/A	2 of 3
D	Drug Plan Customer Service (DD1)	N/A*	1 of 1	1 of 1	1 of 1	N/A	1 of 1	1 of 1*
D	Member Complaints and Changes in the Drug Plan's Performance (DD2)	2 of 3*	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3*
D	Member Experience with the Drug Plan (DD3)	2 of 2*	2 of 2	2 of 2	N/A	N/A	2 of 2	2 of 2*
D	Drug Safety and Accuracy of Drug Pricing (DD4)	4 of 6*	4 of 6	4 of 6	4 of 6	N/A	4 of 6	4 of 6*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts that offer drug benefits and which do not submit data for the MPF measure must have a rating in 3 out of 5 Drug Safety and Accuracy of Drug Pricing (DD4) measures to receive a rating in that domain.

Summary and Overall Ratings: Weighting of Measures

The summary and overall ratings are calculated as weighted averages of the measure stars. For the 2026 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by outcome and intermediate outcome measures, then by patient experience/complaints and access measures, and finally process measures. New measures included in the Star Ratings are given a weight of 1 for their first year of inclusion in the ratings; in subsequent years the weight associated with the measure weighting category is used. The weights assigned to each measure and their weighting category are shown in Attachment G.

In calculating the summary and overall ratings, a measure given a weight of 3 counts three times as much as a measure given a weight of 1. For any given contract, any measure without a rating is not included in the calculation. The first step in the calculation is to multiply each measure's weight by the measure's rating and sum these results. The second step is to divide this sum by the sum of the weights of the contract's rated measures. For the summary and overall ratings, half stars are assigned to allow for more variation across contracts.

Methodology for Calculating Part C and Part D Summary Ratings

The Part C and Part D summary ratings are calculated by taking a weighted average of the measure stars for Parts C and D, respectively. To receive a Part C and/or Part D summary rating, a contract must meet the minimum number of rated measures. The Parts C and D improvement measures are not included in the count of the minimum number of rated measures. The minimum number of rated measures required is determined as follows:

- 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	13 of 25	15 of 29	16 of 32	9 of 18	14 of 28	N/A	15 of 29
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 9 measures 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 45 measures (33 in Part C, 12 in Part D) in the 2026 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 41 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	17 of 33*	19 of 38	21 of 41	13 of 25	N/A	N/A	19 of 38*

* 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 16 out of 32 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 2026 Star Ratings are calculated for the 2026 contract year using data primarily from measurement year 2024. If a contract offered a SNP PBP in measurement year 2024, but is no longer offering a SNP PBP for the 2026 contract year, the 2026 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 (C30) 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 (C30 & D04) for MA-PD contracts.
   a. C30 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 (C30) 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 less than 30th percentile),
  - medium (greater than or equal to 30th to less than 70th percentile) and
  - high (greater than or equal to 70th percentile)
- Develop the reward factor as follows:
  - r-Factor = 0.4 (for contract w/ low variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.3 (for contract w/ medium variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.2 (for contract w/ low variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.1 (for contract w/ medium variance & relatively high mean (mean greater than or equal to 65th & less than 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 2026 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	65th	3.695652	3.740741	3.385522	3.649351
With	With	85th	4.000000	4.000000	3.913300	3.932432
With	Without	65th	3.708333	3.740741	3.385522	3.656716
With	Without	85th	4.019608	4.000000	3.913300	3.943662
Without	With	65th	3.717391	3.769231	3.318182	3.686567
Without	With	85th	4.020408	4.136364	4.117647	3.953125
Without	Without	65th	3.736842	3.769231	3.318182	3.700000
Without	Without	85th	4.023810	4.136364	4.117647	3.966667

Table 9: Variance Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	30th	0.918435	0.754209	0.869005	0.914850
With	With	70th	1.285170	1.268986	1.747939	1.263462
With	Without	30th	0.909844	0.754209	0.869005	0.905154
With	Without	70th	1.281071	1.268986	1.747939	1.272639
Without	With	30th	0.914326	0.736111	0.749180	0.908919
Without	With	70th	1.328432	1.318182	1.814773	1.269610
Without	Without	30th	0.908942	0.736111	0.749180	0.915156
Without	Without	70th	1.310167	1.318182	1.814773	1.289063

Categorical Adjustment Index (CAI)

The Categorical Adjustment Index (CAI) is an analytical adjustment 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 2025 Star Ratings. To calculate the CAI, case-mix adjustment is applied to clinical Star Rating measure scores (see below) 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 2025 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 2025 measures used in the 2026 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 6.092755
2	6.092755 to less than 9.274484
3	9.274484 to less than 13.191153
4	13.191153 to less than 18.339007
5	18.339007 to less than 26.699929
6	26.699929 to less than 38.938694
7	38.938694 to less than 55.108425
8	55.108425 to less than 78.990228
9	78.990228 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 14.248145
2	14.248145 to less than 20.849011
3	20.849011 to less than 29.981129
4	29.981129 to less than 43.027888
5	43.027888 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	D1	-0.063262
2	L2-L3 L1-L3 L1-L2	D1 D2 D3	-0.040422
3	L4-L5 L4	D1 D2	-0.017803
4	L6-L8 L5-L6 L3-L5 L1-L3	D1 D2 D3 D4-D5	0.003256
5	L9-L10 L7-L10 L6-L8 L4-L6	D1 D2 D3 D4-D5	0.018790
6	L7	D4	0.045683
7	L8 L7-L8	D4 D5	0.058145
8	L9-L10 L9	D3-D4 D5	0.101257
9	L10	D5	0.145515

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 5.954454
2	5.954454 to less than 9.130047
3	9.130047 to less than 12.937535
4	12.937535 to less than 18.051788
5	18.051788 to less than 26.285153
6	26.285153 to less than 38.318544
7	38.318544 to less than 54.171489
8	54.171489 to less than 78.912575
9	78.912575 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 14.052399
2	14.052399 to less than 20.586681
3	20.586681 to less than 29.918328
4	29.918328 to less than 42.948173
5	42.948173 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	-0.058259
2	L2-L3 L1-L2	D1 D2	-0.036927
3	L4 L3-L4 L1-L3	D1 D2 D3	-0.013699
4	L5-L8 L5-L7 L4-L7 L1-L5	D1 D2 D3 D4-D5	0.004022
5	L6-L7	D4-D5	0.032302
6	L9-L10 L8	D1-D3 D2-D5	0.059788
7	L9-L10 L9	D4 D5	0.080451
8	L10	D5	0.102370

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 6.444755
2	6.444755 to less than 10.035143
3	10.035143 to less than 14.606291
4	14.606291 to less than 20.303651
5	20.303651 to less than 30.231295
6	30.231295 to less than 42.953664
7	42.953664 to less than 61.465546
8	61.465546 to less than 95.305544
9	95.305544 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 14.421553
2	14.421553 to less than 21.736420
3	21.736420 to less than 31.819192
4	31.819192 to less than 45.115107
5	45.115107 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	D1	-0.033144
2	L2-L8 L1-L4 L1	D1 D2 D3	-0.014987
3	L5-L8 L2-L8 L1-L3	D2 D3 D4-D5	-0.002688
4	L4-L8 L4-L7	D4 D5	0.046282
5	L9-L10 L8-L9	D1-D4 D5	0.072332
6	L10	D5	0.128476

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 1.351684
2	1.351684 to less than 2.907975
3	2.907975 to less than 4.682845
4	4.682845 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 6.315789
2	6.315789 to less than 8.540366
3	8.540366 to less than 12.638758
4	12.638758 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	-0.227881
2	L3-L4 L1-L2	D1-D3 D3-D4	-0.082454
3	L3-L4	D4	0.025549

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

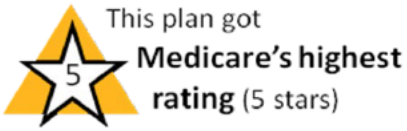
Raw Summary / Overall Score	Final Summary / Overall Rating
Greater than or equal to 0.000000 and less than 0.250000	0
Greater than or equal to 0.250000 and less than 0.750000	0.5
Greater than or equal to 0.750000 and less than 1.250000	1.0
Greater than or equal to 1.250000 and less than 1.750000	1.5
Greater than or equal to 1.750000 and less than 2.250000	2.0
Greater than or equal to 2.250000 and less than 2.750000	2.5
Greater than or equal to 2.750000 and less than 3.250000	3.0
Greater than or equal to 3.250000 and less than 3.750000	3.5
Greater than or equal to 3.750000 and less than 4.250000	4.0
Greater than or equal to 4.250000 and less than 4.750000	4.5
Greater than or equal to 4.750000 and less than or equal to 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 2024, 2025, and 2026 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	2024 C	2025 C	2026 C	2024 D	2025 D	2026 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 2024 was at least 500 but less than 1,000 will be included in the Star Ratings in 2026 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 and dividing by 16. This assumes that all contracts have the same correlation between pairs of measures.

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 2026 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
- 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 and Data Validation (Part C & D): PartsCDPlanReportingandDV@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 50-74 who had a mammogram.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 558
Metric:	The percentage of women MA enrollees 52 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 who died any time during the measurement period. • 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 the criteria for bilateral mastectomy: – Bilateral mastectomy. – Unilateral mastectomy with a bilateral modifier (same procedure). – Unilateral mastectomy found in clinical data with a bilateral qualifier value (same procedure). – 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). –Unilateral mastectomy found in clinical data with a right-side qualifier value (same procedure). – Unilateral mastectomy found in clinical data with a left-side qualifier value procedure (same procedure). – Absence of the left breast. – Absence of the right breast. – Left unilateral mastectomy. – Right unilateral mastectomy.

Title	Description
	• Medicare members 66 years of age and older by the end of the measurement period 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. • Members 66 years of age and older by the end of the measurement period with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: – **Frailty.** At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims. – **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period: • Advanced illness on at least two different dates of service. Do not include laboratory claims. • Dispensed dementia medication. • Members receiving palliative care any time during the measurement period. • Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.
Meaningful Measure Area:	Wellness and Prevention

Title	Description

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
Less than 58 %	Greater than or equal to 58 % to less than 71 %	Greater than or equal to 71 % to less than 76 %	Greater than or equal to 76 % to less than 84 %	Greater than or equal to 84 %

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 colorectal cancer.

HEDIS Label: Colorectal Cancer Screening (COL)

Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 578

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:

• Members who use hospice services or elect to use a hospice benefit any time during the measurement period.

• Members who died any time during the measurement period.

• Members who had colorectal cancer any time during the member's history through December 31 of the measurement year. Do not include laboratory claims.

• Members who had a total colectomy any time during the member's history through December 31 of the measurement period.

• Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
– Living long-term in an institution any time during the measurement period.

• Members 66 years of age and older by the end of the measurement period with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:

Title	Description
	– **Frailty.** At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims. – **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period: • Advanced illness on at least two different dates of service. Do not include laboratory claims. • Dispensed dementia medication. • Members receiving palliative care any time during the measurement period. • Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. 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 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
	Less than 48 %	Greater than or equal to 48 % to less than 60 %	Greater than or equal to 60 % to less than 70 %	Greater than or equal to 70 % to less than 78 %	Greater than or equal to 78 %

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, 2024?
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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles Wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
Meaningful Measure Area:	Wellness and Prevention

Title	Description
CMIT #:	00259-01-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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 57	Greater than or equal to 57 to less than 61	Greater than or equal to 61 to less than 68	Greater than or equal to 68 to less than 73	Greater than or equal to 73

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 - Improving or Maintaining Physical Health

Title	Description
Label for Stars:	Improving or Maintaining Physical Health
Label for Data:	Improving or Maintaining Physical Health
Description:	Percent of plan members whose physical health was the same or better than expected after two years.
Metric:	The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose physical health status was the same or better than expected (numerator).
Primary Data Source:	HOS
Data Source Description:	2022-2024 Cohort 25 Performance Measurement Results (2022 Baseline data collection, 2024 Follow-up data collection) 2-year PCS change – Questions: 1, 2a-b, 3a-b & 5
Data Source Category:	Survey of Enrollees
Exclusions	Contracts with less than 100 responses are suppressed.
Data Time Frame:	07/17/2024 – 11/01/2024
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes

Title	Description
Weighting Category:	Outcome Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Patient's Reported Functional Outcomes
CMIT #:	Not Applicable.
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
Less than 66 %	Greater than or equal to 66 % to less than 70 %	Greater than or equal to 70 % to less than 72 %	Greater than or equal to 72 % to less than 75 %	Greater than or equal to 75 %

Measure: C05 - Improving or Maintaining Mental Health

Title	Description
Label for Stars:	Improving or Maintaining Mental Health
Label for Data:	Improving or Maintaining Mental Health
Description:	Percent of plan members whose mental health was the same or better than expected after two years.
Metric:	The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose mental health status was the same or better than expected (numerator).
Primary Data Source:	HOS
Data Source Description:	2022-2024 Cohort 25 Performance Measurement Results (2022 Baseline data collection, 2024 Follow-up data collection) 2-year MCS change – Questions: 4a-b, 6a-c, & 7.
Data Source Category:	Survey of Enrollees
Exclusions:	Contracts with less than 100 responses are suppressed.
Data Time Frame:	07/17/2024 – 11/01/2024
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included

Title	Description
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Outcome Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Prevention, Treatment, and Management of Mental Health
CMIT #:	Not Applicable.
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
Less than 81 %	Greater than or equal to 81 % to less than 83 %	Greater than or equal to 83 % to less than 85 %	Greater than or equal to 85 % to less than 88 %	Greater than or equal to 88 %

Measure: C06 - 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 2023 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 25 Follow-up Data collection (2024) and Cohort 27 Baseline data collection (2024). 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.

Title	Description

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: 07/17/2024 – 11/01/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2023 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
Less than 41 %	Greater than or equal to 41 % to less than 47 %	Greater than or equal to 47 % to less than 53 %	Greater than or equal to 53 % to less than 59 %	Greater than or equal to 59 %

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C07 - 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:	The data for this measure were reported by contracts to CMS per the 2024 Part C Reporting Requirements (data pulled June 2025). Validation of these data was performed retrospectively during the 2025 data validation cycle (deadline June 15, 2025 and data validation results pulled July 2025).
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, 2025) 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:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 42 %	Greater than or equal to 42 % to less than 60 %	Greater than or equal to 60 % to less than 73 %	Greater than or equal to 73 % to less than 88 %	Greater than or equal to 88 %

Measure: C08 - 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 medications, OTC medications, herbal or supplemental remedies) 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 2024 Technical Specifications Volume 2, page 101
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 2024 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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
General Notes:	The formula used to calculate this measure can be found in Attachment E.

Title	Description
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 58 %	Greater than or equal to 58 % to less than 85 %	Greater than or equal to 85 % to less than 93 %	Greater than or equal to 93 % to less than 98 %	Greater than or equal to 98 %

Measure: C09 - 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 live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Pain Screening
Measure Reference:	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 101

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 2024 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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 65 %	Greater than or equal to 65 % to less than 86 %	Greater than or equal to 86 % to less than 95 %	Greater than or equal to 95 % to less than 99 %	Greater than or equal to 99 %

Measure: C10 - 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 2024 Technical Specifications Volume 2, page 208
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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 32 %	Greater than or equal to 32 % to less than 41 %	Greater than or equal to 41 % to less than 53 %	Greater than or equal to 53 % to less than 68 %	Greater than or equal to 68 %

Measure: C11 - 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 2024 Technical Specifications Volume 2, page 179
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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 60 %	Greater than or equal to 60 % to less than 72 %	Greater than or equal to 72 % to less than 80 %	Greater than or equal to 80 % to less than 86 %	Greater than or equal to 86 %

Measure: C12 - 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:	Glycemic Status Assessment for Patients With Diabetes (GSD) – HbA1c poor control (greater than 9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 162
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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 54 %	Greater than or equal to 54 % to less than 77 %	Greater than or equal to 77 % to less than 87 %	Greater than or equal to 87 % to less than 91 %	Greater than or equal to 91 %

Measure: C13 - Kidney Health Evaluation for Patients with Diabetes

Title	Description
Label for Stars:	Kidney Health Evaluation for Patients with Diabetes
Label for Data:	Kidney Health Evaluation for Patients with Diabetes
Description:	Percent of plan members with diabetes who received a kidney health evaluation during the year.
HEDIS Label:	Kidney Health Evaluation for Patients with Diabetes (KED)
Measure Reference:	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 189
Metric:	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Required exclusions for 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 with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of 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. Exclude members who meet any of the following criteria: • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66-80 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): 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. Visit type need not be the same for the two visits. o At least one acute inpatient encounter with an advanced illness diagnosis.

Title	Description

- At least on acute inpatient discharge with an advanced illness diagnosis on the discharge claim.
- A dispensed 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 measurement year.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 34 %	Greater than or equal to 34 % to less than 51 %	Greater than or equal to 51 % to less than 62 %	Greater than or equal to 62 % to less than 74 %	Greater than or equal to 74 %

Measure: C14 - 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 Measurement Year 2024 Technical Specifications Volume 2, page 132
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 (less than 140/90 mm Hg) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	(Required) Exclude members who meet any of the following criteria: • Members in hospice or using hospice services any time during the measurement period. • Members who die any time during the measurement period. • Members receiving palliative care any time during the measurement period. • Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims. • Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims. • Members with a diagnosis of pregnancy any time during the measurement year. Do not include laboratory claims • Members 66 years of age and older by the end of the measurement period 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. • 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: – **Frailty.** At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims. – **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period: • Advanced illness on at least two different dates of service. Do not include laboratory claims.

Title	Description
	• Dispensed 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 measurement year. Do not include laboratory claims. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 67 %	Greater than or equal to 67 % to less than 75 %	Greater than or equal to 75 % to less than 80 %	Greater than or equal to 80 % to less than 86 %	Greater than or equal to 86 %

Measure: C15 - 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 2023 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 25 Follow-up Data collection (2024) and Cohort 27 Baseline data collection (2024). 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:	07/17/2024 – 11/01/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2023 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
Less than 51 %	Greater than or equal to 51 % to less than 57 %	Greater than or equal to 57 % to less than 62 %	Greater than or equal to 62 % to less than 71 %	Greater than or equal to 71 %

Measure: C16 - 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 2023 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 25 Follow-up Data collection (2024) and Cohort 27 Baseline data collection (2024).

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:	07/17/2024 – 11/01/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00378-01-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
	Less than 41 %	Greater than or equal to 41 % to less than 45 %	Greater than or equal to 45 % to less than 49 %	Greater than or equal to 49 % to less than 53 %	Greater than or equal to 53 %

Measure: C17 - 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 2024 Technical Specifications Volume 2, page 294
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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 40 %	Greater than or equal to 40 % to less than 60 %	Greater than or equal to 60 % to less than 74 %	Greater than or equal to 74 % to less than 87 %	Greater than or equal to 87 %

Measure: C18 - 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 2024 Technical Specifications Volume 2, page 448
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate.

Title	Description
	See Attachment F: Calculating Measure C18: 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 2024 enrollment report and having measure score reliability less than 0.7 are excluded. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was less than 500 as of the July 2024 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:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Greater than 12 %	Greater than 10 % to less than or equal to 12 %	Greater than 9 % to less than or equal to 10 %	Greater than 7 % to less than or equal to 9 %	Less than or equal to 7 %

Measure: C19 - 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 2024 Technical Specifications Volume 2, page 148
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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.
Meaningful Measure Area:	Chronic Conditions

Title	Description

CMIT #: 00700-01-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	No	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 81 %	Greater than or equal to 81 % to less than 85 %	Greater than or equal to 85 % to less than 88 %	Greater than or equal to 88 % to less than 91 %	Greater than or equal to 91 %

Measure: C20 - 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 2024 Technical Specifications Volume 2, page 294

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:

Title	Description

- Members in hospice or using hospice services any time during the measurement year.
- Members who died any time during the measurement year.

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

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 44 %	Greater than or equal to 44 % to less than 56 %	Greater than or equal to 56 % to less than 69 %	Greater than or equal to 69 % to less than 79 %	Greater than or equal to 79 %

Measure: C21 - 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 2024 Technical Specifications Volume 2, page 304
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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 50 %	Greater than or equal to 50 % to less than 59 %	Greater than or equal to 59 % to less than 67 %	Greater than or equal to 67 % to less than 78 %	Greater than or equal to 78 %

Domain: 3 - Member Experience with Health Plan

Measure: C22 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

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
less than 78	Greater than or equal to 78 to less than 80	Greater than or equal to 80 to less than 82	Greater than or equal to 82 to less than 84	Greater than or equal to 84

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 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025

Title	Description
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
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
less than 80	Greater than or equal to 80 to less than 82	Greater than or equal to 82 to less than 84	Greater than or equal to 84 to less than 86	Greater than or equal to 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: C24 - 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.

Title	Description
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 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
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
less than 88	Greater than or equal to 88 to less than 89	Greater than or equal to 89 to less than 91	Greater than or equal to 91 to less than 92	Greater than or equal to 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: C25 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Title	Description
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00642-01-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
less than 84	Greater than or equal to 84 to less than 86	Greater than or equal to 86 to less than 87	Greater than or equal to 87 to less than 88	Greater than or equal to 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: C26 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included

Title	Description
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
	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
less than 84	Greater than or equal to 84 to less than 85	Greater than or equal to 85 to less than 87	Greater than or equal to 87 to less than 89	Greater than or equal to 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: C27 - 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?

Title	Description
	• 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? • 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
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
less than 85	Greater than or equal to 85 to less than 86	Greater than or equal to 86 to less than 88	Greater than or equal to 88 to less than 89	Greater than or equal to 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.

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

Measure: C28 - 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 2024 complaints made by the May 30, 2025 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 January 6, 2025, 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:	01/01/2024 – 12/31/2024
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Greater than 1.34	Greater than 0.71 to less than or equal to 1.34	Greater than 0.32 to less than or equal to 0.71	Greater than 0.11 to less than or equal to 0.32	Less than or equal to 0.11

Measure: C29 - 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, 2024–December 31, 2024 (numerator) divided by all members enrolled in the contract at any time during 2024 (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. • Members that enrolled into an Applicable Integrated Plan where the contract the member disenrolled from is not an Applicable Integrated Plan. D-SNPs in Florida are not included in this exclusion.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2024 and 12/31/2024 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:	01/01/2024 – 12/31/2024
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Greater than 39 %	Greater than 28 % to less than or equal to 39 %	Greater than 17 % to less than or equal to 28 %	Greater than 8 % to less than or equal to 17 %	Less than or equal to 8 %

Measure: C30 - 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 2025 and 2026 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2025 and 2026 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.

Title	Description
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 #:	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
Less than -0.121368	Greater than or equal to -0.121368 to less than 0	Greater than or equal to 0 to less than 0.202884	Greater than or equal to 0.202884 to less than 0.391253	Greater than or equal to 0.391253

Domain: 5 - Health Plan Customer Service

Measure: C31 - 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: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 74 %	Greater than or equal to 74 % to less than 90 %	Greater than or equal to 90 % to less than 99 %	Greater than or equal to 99 % to less than 100 %	Greater than or equal to 100 %

Measure: C32 - 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.

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:

Title	Description
	([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, 2025, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2025 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:	01/01/2024 – 12/31/2024
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00652-01-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
	Less than 83 %	Greater than or equal to 83 % to less than 96 %	Greater than or equal to 96 % to less than 98 %	Greater than or equal to 98 % to less than 100 %	Greater than or equal to 100 %

Measure: C33 - 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:	02/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No

Title	Description
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	No adjustment for 2023 or 2024 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
Less than 51 %	Greater than or equal to 51 % to less than 74 %	Greater than or equal to 74 % to less than 97 %	Greater than or equal to 97 % to less than 100 %	Greater than or equal to 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:	02/2025 – 05/2025
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: 2

Major Disaster: No adjustment for 2023 or 2024 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	Less than 45 %	Greater than or equal to 45 % to less than 79 %	Greater than or equal to 79 % to less than 95 %	Greater than or equal to 95 % to less than 100 %	Greater than or equal to 100 %
PDP	Less than 75 %	Greater than or equal to 75 % to less than 90 %	Greater than or equal to 90 % to less than 98 %	Greater than or equal to 98 % to less than 100 %	Greater than or equal to 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 2024 complaints made by the May 30, 2025 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 January 6, 2025, 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:	01/01/2024 – 12/31/2024
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Greater than 1.34	Greater than 0.71 to less than or equal to 1.34	Greater than 0.32 to less than or equal to 0.71	Greater than 0.11 to less than or equal to 0.32	Less than or equal to 0.11
PDP	Greater than 0.31	Greater than 0.19 to less than or equal to 0.31	Greater than 0.1 to less than or equal to 0.19	Greater than 0.03 to less than or equal to 0.1	Less than or equal to 0.03

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, 2024–December 31, 2024 (numerator) divided by all members enrolled in the contract at any time during 2024 (denominator).
Primary Data Source:	MBDSS

Title	Description
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
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. • Members that enrolled into an Applicable Integrated Plan where the contract the member disenrolled from is not an Applicable Integrated Plan. D-SNPs in Florida are not included in this exclusion.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2024 and 12/31/2024 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:	01/01/2024 – 12/31/2024
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Greater than 39 %	Greater than 28 % to less than or equal to 39 %	Greater than 17 % to less than or equal to 28 %	Greater than 8 % to less than or equal to 17 %	Less than or equal to 8 %
PDP	Greater than 17 %	Greater than 11 % to less than or equal to 17 %	Greater than 5 % to less than or equal to 11 %	Greater than 3 % to less than or equal to 5 %	Less than or equal to 3 %

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 2025 and 2026 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings

Title	Description
Data Source Description:	2025 and 2026 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 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	Less than -0.233766	Greater than or equal to -0.233766 to less than 0	Greater than or equal to 0 to less than 0.320439	Greater than or equal to 0.320439 to less than 0.579545	Greater than or equal to 0.579545
PDP	Less than -0.183824	Greater than or equal to -0.183824 to less than 0	Greater than or equal to 0 to less than 0.330927	Greater than or equal to 0.330927 to less than 0.672727	Greater than or equal to 0.672727

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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Title	Description
Meaningful Measure Area:	Person-Centered Care
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	less than 85	Greater than or equal to 85 to less than 86	Greater than or equal to 86 to less than 88	Greater than or equal to 88 to less than 89	Greater than or equal to 89
PDP	less than 82	Greater than or equal to 82 to less than 83	Greater than or equal to 83 to less than 86	Greater than or equal to 86 to less than 88	Greater than or equal to 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: 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

Title	Description
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
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:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
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	less than 87	Greater than or equal to 87 to less than 88	Greater than or equal to 88 to less than 90	Greater than or equal to 90 to less than 91	Greater than or equal to 91
PDP	less than 88	Greater than or equal to 88 to less than 89	Greater than or equal to 89 to less than 90	Greater than or equal to 90 to less than 91	Greater than or equal to 91

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—that is, the reported price is higher than the actual price—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 PDE data and MPF Pricing Files. Reference data sources include HPMS approved formulary extracts, Formulary Reference File, RxNorm, FDA NSDE data, and data from First DataBank and Medi-span. The PDE data for this measure are from the data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-September 30, 2024. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the MPF measure calculations. If the PDE edit is informational, and therefore does not result in the PDE being rejected, then the PDE is used in the MPF measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2024 PDE submission deadline are used to

Title	Description
	calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	A contract with less than 30 PDE claims over the measurement period will not have the measure calculated. 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 • The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.
General Notes:	Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2024 – 09/30/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Less than 92	Greater than or equal to 92 to less than 93	Greater than or equal to 93 to less than 94	Greater than or equal to 94 to less than 99	Greater than or equal to 99
PDP	Less than 92	Greater than or equal to 92 to less than 93	Greater than or equal to 93 to less than 94	Greater than or equal to 94 to less than 99	Greater than or equal to 99

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description

Label for Stars: Taking Diabetes Medication

Label for Data: Taking Diabetes Medication

Description: The percentage 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 taking the medication.

One of the most important ways people with diabetes can manage their health is by taking their medication. 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 *dipeptidyl peptidase 4 (DPP-4) inhibitor,* a glucose-dependent insulinotropic *polypeptide/glucagon-like peptide 1 (GIP/GLP-1) receptor agonist*, a *meglitinide drug,* or a *sodium glucose cotransporter 2* (*SGLT2) inhibitor*.)

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DPP-4 inhibitors, GIP/GLP-1 receptor agonists, meglitinides, and SGLT2 inhibitors. The proportion of days covered (PDC) is the percentage of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for a target medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period.

This percentage is calculated as the number of continuously enrolled Medicare Part D beneficiaries, 18 years and older, with a PDC of 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two fills of diabetes medication(s) on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator).

Title	Description
	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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 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 Common Working File (CWF), and the Encounter Data Systems (EDS). The data cutoff 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 and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • 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 exclusion 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 continuously enrolled beneficiaries (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period unless otherwise specified: • In hospice • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin in the treatment period
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.

Title	Description

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 treatment period.

Data Time Frame: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Less than 83 %	Greater than or equal to 83 % to less than 86 %	Greater than or equal to 86 % to less than 89 %	Greater than or equal to 89 % to less than 92 %	Greater than or equal to 92 %
PDP	Less than 85 %	Greater than or equal to 85 % to less than 87 %	Greater than or equal to 87 % to less than 89 %	Greater than or equal to 89 % to less than 92 %	Greater than or equal to 92 %

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

Title	Description
Label for Stars:	Taking Blood Pressure Medication
Label for Data:	Taking Blood Pressure Medication
Description:	The percentage 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 taking the medication. One of the most important ways people with high blood pressure can manage their health is by their taking medication. 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 percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: ACEI, ARB, or direct renin inhibitor medications. The proportion of days covered (PDC) is the percentage of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for the target medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period. This percentage is calculated as the number of continuously enrolled beneficiaries, 18 years and older, with a PDC of 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two RAS antagonist medication fills on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator). 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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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

Title	Description
	single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2024 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 RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the CME, the CWF, and the EDS. The data cutoff 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 and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • 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 exclusion 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 continuously enrolled beneficiaries (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period unless otherwise specified: • In hospice • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan during the treatment period
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. 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 treatment period.
Data Time Frame:	01/01/2024 – 12/31/2024
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Less than 84 %	Greater than or equal to 84 % to less than 88 %	Greater than or equal to 88 % to less than 91 %	Greater than or equal to 91 % to less than 93 %	Greater than or equal to 93 %
PDP	Less than 88 %	Greater than or equal to 88 % to less than 90 %	Greater than or equal to 90 % to less than 91 %	Greater than or equal to 91 % to less than 93 %	Greater than or equal to 93 %

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Stars:	Taking Cholesterol Medication
Label for Data:	Taking Cholesterol Medication
Description:	The percentage 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 taking the medication. One of the most important ways people with high cholesterol can manage their health is by taking their medication. The plan, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for statin cholesterol medications. The proportion of days covered (PDC) is the percentage of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for a statin medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the

Title	Description
	measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period. This percentage is calculated as the number of continuously enrolled beneficiaries, 18 years and older, with a PDC of 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two statin cholesterol medication fills on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator). 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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. 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 2024 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. Additional data sources include the CME, 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 and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • 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 exclusion 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 continuously enrolled beneficiaries (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period:

Title	Description

- 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.

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 treatment period.

Data Time Frame: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Less than 84 %	Greater than or equal to 84 % to less than 88 %	Greater than or equal to 88 % to less than 90 %	Greater than or equal to 90 % to less than 93 %	Greater than or equal to 93 %
PDP	Less than 87 %	Greater than or equal to 87 % to less than 89 %	Greater than or equal to 89 % to less than 90 %	Greater than or equal to 90 % to less than 92 %	Greater than or equal to 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.
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.

Title	Description
	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 2024 Part D Reporting Requirements (data pulled June 2025). Validation of these data was performed retrospectively during the 2025 data validation cycle (deadline June 15, 2025 and data validation results pulled July 2025). Additionally, the Common Medicare Environment (CME) is used to identify beneficiaries in hospice (data pulled June 2025).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2025) 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.

Title	Description
	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:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Less than 62 %	Greater than or equal to 62 % to less than 82 %	Greater than or equal to 82 % to less than 91 %	Greater than or equal to 91 % to less than 96 %	Greater than or equal to 96 %
PDP	Less than 27 %	Greater than or equal to 27 % to less than 51 %	Greater than or equal to 51 % to less than 70 %	Greater than or equal to 70 % to less than 83 %	Greater than or equal to 83 %

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 percentage 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 index prescription start date (IPSD) is the earliest date of service for a diabetes medication during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month. Beneficiaries are only included in the measure calculation if the IPSD occurs at least 90 days before the end of the measurement period. The percentage is calculated as the number of continuously enrolled beneficiaries, 40-75 years old, who received a statin medication fill during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 40-75 years old, with at least two diabetes medication fills on unique dates of service during the measurement period and an IPSD that occurs at least 90 days prior to the end of the measurement period (denominator). 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.
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 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024 – December 31, 2024. 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 2024 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 CWF, and the EDS. The data cutoff date for all the additional data sources listed below such as the CME, CWF, and EDS is

Title	Description
	determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer continuously enrolled beneficiaries (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.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00702-01-C-PARTD

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	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 81 %	Greater than or equal to 81 % to less than 85 %	Greater than or equal to 85 % to less than 89 %	Greater than or equal to 89 % to less than 93 %	Greater than or equal to 93 %
PDP	Less than 82 %	Greater than or equal to 82 % to less than 83 %	Greater than or equal to 83 % to less than 84 %	Greater than or equal to 84 % to less than 86 %	Greater than or equal to 86 %

Attachment A: CAHPS and HOS Case-Mix Adjustment

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 0.0587, indicating that respondents in that age range tend to score their plans 0.0587 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 0.0834 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 (C22) CAHPS Measure Composite Items

Predictor	Get appointment with specialist	Easy to get care
Age: 64 or under	0.0553	-0.0093
Age: 65 – 69	0.0148	-0.0206
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0042	0.0130
Age: 80 – 84	0.0173	0.0069
Age: 85 and older	0.0220	-0.0217
Education: Less than an 8th grade education	0.0105	-0.0030
Education: Some high school	0.0035	-0.0106
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.0532	-0.0593
Education: College graduate	-0.0824	-0.0731
Education: More than a bachelor's degree	-0.1388	-0.0994
General health rating: excellent	0.0992	0.0707
General health rating: very good	0.0522	0.0516
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0523	-0.0404
General health rating: poor	-0.0921	-0.1499
Mental health rating: excellent	0.1935	0.1776
Mental health rating: very good	0.1088	0.1000
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0580	-0.0327
Mental health rating: poor	-0.1554	-0.1819
Proxy helped	-0.0169	-0.0204
Proxy answered	0.0657	0.0714
Medicaid dual eligible	0.0187	0.0248
Low-income subsidy (LIS)	-0.0255	0.0218
Asian survey language	-0.2197	-0.1702

Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C23) CAHPS Measure Composite Items

Predictor	Getting needed care as soon as wanted	Getting routine care as soon as wanted
Age: 64 or under	-0.0353	0.0789
Age: 65 – 69	0.0000*	0.0069
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0424	0.0321
Age: 80 – 84	0.0501	0.0289
Age: 85 and older	0.0484	0.0423
Education: Less than an 8th grade education	0.0213	0.0077
Education: Some high school	-0.0458	0.0090
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.0328	-0.0209
Education: College graduate	-0.0203	-0.0608
Education: More than a bachelor's degree	-0.0578	-0.0799
General health rating: excellent	0.0769	0.0368
General health rating: very good	0.0272	0.0231
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0483	-0.0473
General health rating: poor	-0.1042	-0.1019
Mental health rating: excellent	0.1265	0.1558
Mental health rating: very good	0.0775	0.0842
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0258	-0.0275
Mental health rating: poor	-0.1424	-0.1504
Proxy helped	-0.0078	0.0023
Proxy answered	0.0900	0.0482
Medicaid dual eligible	0.0162	-0.0066
Low-income subsidy (LIS)	0.0187	-0.0575
Asian survey language	-0.2559	-0.3890

*Coefficient value is not exactly equal to 0 but has been rounded to the same level of precision as other values in the table (4 decimal places).

Table A-3: Coefficients of Part C Customer Service (C24) CAHPS Measure Composite Items

Predictor	Paperwork easy	Plan customer service gives information	Plan customer service courtesy and respect
Age: 64 or under	0.0127	-0.0033	-0.0251
Age: 65 – 69	0.0095	-0.0131	-0.0003
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0005	0.0023	0.0038
Age: 80 – 84	-0.0187	-0.0118	-0.0052
Age: 85 and older	-0.0018	-0.0025	0.0027
Education: Less than an 8th grade education	-0.0333	-0.0104	-0.0145
Education: Some high school	-0.0091	-0.0327	-0.0255
Education: High school graduate	0.0000	0.0000	0.0000
Education: Some college	-0.0155	-0.0798	-0.0038
Education: College graduate	-0.0185	-0.1291	-0.0289
Education: More than a bachelor's degree	-0.0268	-0.1617	-0.0469
General health rating: excellent	0.0196	0.0640	-0.0201
General health rating: very good	0.0110	0.0174	-0.0230
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0309	-0.0238	0.0035
General health rating: poor	-0.0471	-0.0541	-0.0009
Mental health rating: excellent	0.0593	0.2098	0.1334
Mental health rating: very good	0.0242	0.0958	0.0626
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0280	-0.0281	0.0025
Mental health rating: poor	-0.0702	-0.0595	-0.0394
Proxy helped	-0.0776	-0.0364	-0.0280
Proxy answered	-0.0377	-0.0034	0.0036
Medicaid dual eligible	-0.0386	0.0691	0.0196
Low-income subsidy (LIS)	0.0016	0.0682	0.0241
Asian survey language	-0.0782	-0.0731	-0.1389

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	C25: Rating of Health Care Quality	C26: Rating of Health Plan
Age: 64 or under	-0.1032	-0.1580
Age: 65 – 69	-0.0801	-0.1132
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0193	0.0587
Age: 80 – 84	-0.0412	0.0944
Age: 85 and older	-0.0859	0.0963
Education: Less than an 8th grade education	0.0757	0.1584
Education: Some high school	0.0011	0.0880
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.1540	-0.2041
Education: College graduate	-0.1877	-0.3112
More than a bachelor's degree	-0.2290	-0.4332
General health rating: excellent	0.2996	0.2638
General health rating: very good	0.1828	0.1117
General health rating: good	0.0000	0.0000
General health rating: fair	-0.2072	-0.1343
General health rating: poor	-0.5387	-0.2751
Mental health rating: excellent	0.4685	0.3981
Mental health rating: very good	0.2364	0.2183
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1913	-0.1087
Mental health rating: poor	-0.6445	-0.4070
Proxy helped	-0.0760	-0.0834
Proxy answered	0.0604	-0.0305
Medicaid dual eligible	0.0480	0.2888
Low-income subsidy (LIS)	0.0946	0.1077
Asian survey language	0.1792	-0.0634

Table A-5: Coefficients of Part C Care Coordination (C27) CAHPS Measure Composite Items

Predictor	MD/office help to manage care	MD informed about specialist care	MD follows up about test results and gives results as soon as needed	Talk with MD about medicines	MD has medical records about care
Age: 64 or under	-0.0060	-0.0006	0.0368	0.0601	-0.0206
Age: 65 – 69	0.0007	0.0097	0.0084	0.0194	-0.0063
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0147	0.0173	0.0088	-0.0347	0.0078
Age: 80 – 84	-0.0189	-0.0177	0.0007	-0.1064	-0.0086
Age: 85 and older	-0.0617	-0.0354	-0.0329	-0.1945	-0.0172
Education: Less than an 8th grade education	-0.0026	0.0565	-0.0190	0.0460	-0.0412
Education: Some high school	-0.0118	0.0426	-0.0278	-0.0096	-0.0073
Education: High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Education: Some college	-0.0118	-0.0308	-0.0305	-0.0170	-0.0074
Education: College graduate	-0.0270	-0.1055	-0.0269	-0.0431	-0.0112
Education: More than a bachelor's degree	-0.0144	-0.1091	-0.0291	-0.0862	-0.0182
General health rating: excellent	0.0394	-0.0051	0.0835	0.0701	0.0204
General health rating: very good	0.0160	0.0050	0.0390	0.0454	0.0118
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0440	-0.0220	-0.0420	-0.0499	-0.0212
General health rating: poor	-0.0413	-0.0131	-0.0768	-0.0467	-0.0288
Mental health rating: excellent	0.0405	0.1835	0.1342	0.1571	0.0792
Mental health rating: very good	0.0204	0.1034	0.0655	0.0829	0.0458
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0628	-0.0816	-0.0576	-0.0557	-0.0340
Mental health rating: poor	-0.0819	-0.1318	-0.1352	-0.1671	-0.0694
Proxy helped	0.0150	0.0054	-0.0001	0.1036	-0.0095
Proxy answered	0.0609	0.0163	0.0515	0.1231	0.0289
Medicaid dual eligible	0.0008	0.0762	-0.0305	-0.0050	-0.0262
Low-income subsidy (LIS)	-0.0263	0.0829	-0.0098	-0.0289	-0.0059
Asian survey language	-0.0003	0.0179	0.0283	-0.1419	-0.0562

Table A-6: Coefficients of Part D CAHPS Stand-alone Measures

Predictor	MA-PD D05: Rating of Drug Plan	PDP D05: Rating of Drug Plan
Age: 64 or under	-0.2293	0.1212
Age: 65 – 69	-0.1267	-0.1495
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.1239	0.2770
Age: 80 – 84	0.1774	0.3368
Age: 85 and older	0.1841	0.4200
Education: Less than an 8th grade education	0.0427	-0.4582
Education: Some high school	0.0676	-0.1973
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.2061	-0.3762
Education: College graduate	-0.3163	-0.1688
Education: More than a bachelor's degree	-0.4047	-0.3632
General health rating: excellent	0.2444	0.2813
General health rating: very good	0.1309	0.1928
General health rating: good	0.0000	0.0000
General health rating: fair	-0.1548	-0.2680
General health rating: poor	-0.3410	-0.4054
Mental health rating: excellent	0.3163	0.0942
Mental health rating: very good	0.1850	0.0652
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0448	-0.1058
Mental health rating: poor	-0.3079	-0.9739
Proxy helped	-0.1482	0.0627
Proxy answered	-0.0450	0.4117
Medicaid dual eligible	0.5175	0.6521
Low-income subsidy (LIS)	0.3586	0.4538
Asian survey language	-0.2289	0.0000

Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items

Predictor	MA-PD: Get needed prescription drugs	MA-PD: Get prescription drugs from mail or pharmacy	PDP: Get needed prescription drugs	PDP: Get prescription drugs from mail or pharmacy
Age: 64 or under	-0.0756	-0.0426	0.0628	0.0323
Age: 65 – 69	-0.0275	-0.0203	0.0458	0.0029
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	0.0216	0.0195	0.0415	0.0175
Age: 80 – 84	0.0237	0.0081	0.0605	0.0538
Age: 85 and older	0.0157	0.0189	0.0349	-0.0014
Education: Less than an 8th grade education	-0.0536	-0.0498	-0.2152	-0.1192
Education: Some high school	-0.0095	-0.0002	-0.0627	-0.0968
Education: High school graduate	0.0000	0.0000	0.0000	0.0000
Education: Some college	-0.0458	-0.0337	-0.0803	-0.0751
Education: College graduate	-0.0405	-0.0499	-0.0902	-0.0546
Education: More than a bachelor's degree	-0.0702	-0.0836	-0.1130	-0.0956
General health rating: excellent	0.0523	0.0895	0.0971	0.0292
General health rating: very good	0.0475	0.0316	0.0819	0.0820
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0482	-0.0471	-0.1058	-0.1382
General health rating: poor	-0.0826	-0.0775	-0.1323	-0.0798
Mental health rating: excellent	0.0967	0.1149	0.0658	0.0829
Mental health rating: very good	0.0575	0.0758	0.0933	0.0569
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0361	-0.0300	-0.0903	-0.1071
Mental health rating: poor	-0.1208	-0.0749	-0.1247	-0.0361
Proxy helped	-0.0260	-0.0240	-0.0099	0.0566
Proxy answered	0.0198	-0.0176	0.1678	-0.0429
Medicaid dual eligible	0.0798	0.0449	0.0497	0.0344
Low-income subsidy (LIS)	0.0699	0.0351	0.1368	0.1006
Asian survey language	-0.0246	0.0243	0.0000	0.0000

HOS 2022-2024 Cohort 25 Case-Mix Adjustment

The longitudinal outcomes for the Medicare HOS 2022-2024 Cohort 25 Performance Measurement analysis are based on risk-adjusted mortality rates, changes in physical health as measured by the physical component summary (PCS) score, and changes in mental health as measured by the mental component summary (MCS) score for the participating Medicare Advantage Organizations (MAOs). For reporting purposes, death and PCS outcomes are combined into one overall measure of change in physical health. Thus, there are two primary outcomes: (1) Alive and PCS Better + Same (vs. PCS Worse or Death) and (2) MCS Better + Same (vs. MCS Worse). For the Medicare Part C Star Ratings, the primary outcomes are reported as the percentage of respondents within an MAO who are "Improving or Maintaining Physical Health" and the percentage within an MAO who are "Improving or Maintaining Mental Health" over the two-year period, after adjustment for case-mix.

The analysis of death outcomes for the HOS performance measurement includes beneficiaries who are 65 years or older at baseline, completed the HOS at baseline with a calculable PCS or MCS score, and whose MAO participated in the HOS at follow up. Beneficiaries are included in the analysis of PCS and MCS change scores if they are 65 years or older at baseline, alive at follow up, enrolled in their original MAO when the follow up sample was drawn, and completed the HOS with calculable PCS and MCS scores at baseline and follow up. HOS outcomes are analyzed by calculating the national averages, and the differences between actual and expected contract-level results for death, PCS, and MCS over two years. The expected results are adjusted for the case-mix of beneficiaries within an MAO to control for pre-existing baseline differences across MAOs with respect to covariates, such as baseline measures of sociodemographic characteristics, chronic medical conditions, and functional health status. The PCS results are combined with the percentage remaining alive in the MAO. An adjusted contract-level percentage for each of the two primary outcomes (PCS and MCS change scores) is calculated by combining the national average and the MAO difference score, using a logit transformation.

Table A-8 includes one multivariate logistic regression model for each of three outcomes (i.e., death, PCS, and MCS) that are used to case-mix adjust HOS outcomes, and to calculate expected outcomes for each beneficiary. Beginning in 2022 for the 2024 Star Ratings, CMS updated the case-mix specifications for the expected outcomes of the HOS performance measures from a multi-model approach requiring non-missing values for all covariates in each model to a single model for each outcome that uses the Contract-Mean Imputation (CMI) method for covariates with missing data. Under the CMI approach, a missing case-mix adjuster (covariate) for a beneficiary is replaced with the mean value for that adjuster for other beneficiaries in the same contract who have responses contributing to the longitudinal PCS and MCS measures: Improving or Maintaining Physical Health and Improving or Maintaining Mental Health. Since the change to the case-mix specifications was substantive, the two measures remained on display through the 2025 Star Ratings and are now returning for the 2026 Star Ratings.

The coefficients in the table report the log-odds for beneficiaries with a given characteristic having the expected outcome compared to beneficiaries in the reference category for that characteristic, controlling for all other model characteristics. In Table A-8, the coefficient for "Female" in the PCS Better + Same Model is -0.605538, indicating a lower probability of PCS Better + Same for female compared to male respondents (the reference category), who otherwise have the same demographic and health characteristics. However, the coefficient for age and sex interaction in the PCS Better + Same Model is 0.008386, indicating a very small positive difference in the expected outcome between females and males of the same age.

More information about the calculation of HOS outcomes at the beneficiary and MAO contract levels is available on the HOS website at www.HOSonline.org.

Table A-8: HOS Model Covariates at Baseline (Death, PCS Better + Same, and MCS Better + Same models)

Death Model Covariates	Death Model	PCS Model	MCS Model
Sociodemographic Variables			
Constant	-5.851021	2.232077	2.150314
Age (linear)	0.049369	-0.015024	-0.006411
Age 75+	0.042227	-0.027605	-0.035074
Age 85+	0.015949	0.030890	0.013175
Age and sex interaction	0.000296	0.008386	0.003247
Female	-0.539998	-0.605538	-0.275339
Hispanic only	-0.583694	0.003988	-0.235942
Asian only	-0.860608	-0.083129	-0.174167
Native Hawaiian or Pacific Islander only	-0.054307	0.115009	-0.100125
Black only	-0.323382	0.016556	-0.152964
American Indian or Alaskan Native only	-0.160022	-0.107038	-0.320198
Multiracial	-0.130566	0.020639	-0.110609
Married	-0.206517	0.013132	-0.054578
Receive Medicaid	0.126520	-0.094744	-0.329650
Eligible for SSI	0.004176	-0.143549	-0.369289
Homeowner	-0.105033	0.060250	0.181851
High school graduate or greater	-0.001094	0.122368	0.182702
Baseline Functional Status			
One-item measure of General Health compared to others	0.215457		
Physical Functioning/Activities of Daily Living Scale	-0.019277		
General Health item	0.237715		
Physical Functioning item (limitations in moderate activities)	-0.019810		
Physical Functioning item (limitations climbing several flights of stairs)	0.049275		
Role-Physical item (accomplished less than would like)	0.028639		
Role-Physical item (limited in the kind of work or other activities)	0.056056		
Role-Emotional item (accomplished less than would like)	0.037802		
Role-Emotional item (did not do work or other activities as carefully)	-0.004613		
Bodily Pain item (pain interfered with normal work)	-0.159989		
Mental Health item (felt calm and peaceful)	-0.043500		
Vitality item (had a lot of energy)	0.038276		
Mental Health item (felt downhearted and blue)	0.000888		
Social Functioning item (health interfered with social activities)	-0.068082		
Chronic Medical Conditions			
Hypertension	-0.077153		
Angina/coronary artery disease	-0.068116		
Congestive heart failure	0.466143		
Myocardial infarction	0.088617		
Other heart conditions	-0.022755		
Stroke	0.168361		
Pulmonary disease	0.199861		
Gastrointestinal disorders	-0.246909		
Diabetes	0.033180		
Depression	-0.146026		

Death Model Covariates	Death Model	PCS Model	MCS Model
Any cancer other than skin cancer	0.383996		
Colon cancer treatment	0.216094		
Breast cancer treatment	-0.077125		
Prostate cancer treatment	-0.234924		
Lung cancer treatment	0.959773		

Attachment B: Calculating Measure Data for the Surviving Contract of a Consolidation

First Year Following a Consolidation

In the first year following a consolidation, the measure values for the surviving contract of a consolidation are calculated as the enrollment-weighted mean of all contracts in the consolidation. The month(s) of enrollment used to calculate the enrollment weighted means varies by the type of measure. Table B-1 below lists the enrollment used for each type of measure and the rule followed to determine the month(s) of enrollment. Table B-2 provides an example calculation.

Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation

Type of Measure	Rule for Which Month of Enrollment is Used	Month(s) of Enrollment Used for 2026 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2025
Call Center	Average enrollment during the study period	Feb 2025 – May 2025
HOS	Enrollment at the time survey sample is pulled	February 2022
HEDIS-HOS	Enrollment at the time survey sample is pulled	February 2024
HEDIS	Enrollment in July of the measurement period	July 2024
All Other Measures	Enrollment in July of the measurement period	July 2024

Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation

Contract ID	Surviving or Consumed Contract	Value for Breast Cancer Screening (BCS) Measure	July 2024 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

$$\text{Value for BCS for HAAAA} = \frac{75.13*43{,}326+50.91*20{,}933}{43{,}326+20{,}933} = 67.240097$$

Second Year Following a Consolidation

In the second year following a consolidation, the measure values for the surviving contract of a consolidation are as reported for CAHPS, call center, HOS, and HEDIS measures. For all other measures, with the exception of measures using Part C and D reporting requirements data, the measure values for the surviving contract of a consolidation are calculated as the enrollment weighted mean of all contracts in the consolidation. (CMS does not require consumed contracts to complete Part C and D reporting requirements and data validation, and CMS does not require data from consumed contracts.)

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of contract numeric and star values for each measure reported in the 2026 Star Ratings. The averages are calculated after the disaster adjustment has been applied.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	74%	3.2
C02	Colorectal Cancer Screening	71%	3.8
C03	Annual Flu Vaccine	66%	3.2
C04	Improving or Maintaining Physical Health	71%	3.2
C05	Improving or Maintaining Mental Health	84%	3.2
C06	Monitoring Physical Activity	50%	3.1
C07	Special Needs Plan (SNP) Care Management	76%	3.5
C08	Care for Older Adults – Medication Review	94%	4.2
C09	Care for Older Adults – Pain Assessment	94%	3.9
C10	Osteoporosis Management in Women who had a Fracture	45%	2.8
C11	Diabetes Care – Eye Exam	77%	3.4
C12	Diabetes Care – Blood Sugar Controlled	84%	3.6
C13	Kidney Health Evaluation for Patients with Diabetes	61%	3.5
C14	Controlling Blood Pressure	79%	3.4
C15	Reducing the Risk of Falling	58%	2.7
C16	Improving Bladder Control	45%	2.7
C17	Medication Reconciliation Post-Discharge	77%	3.8
C18	Plan All-Cause Readmissions	10%	2.9
C19	Statin Therapy for Patients with Cardiovascular Disease	87%	3.3
C20	Transitions of Care	63%	3.1
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	61%	2.8
C22	Getting Needed Care	81	3.4
C23	Getting Appointments and Care Quickly	84	3.5
C24	Customer Service	90	3.5
C25	Rating of Health Care Quality	87	3.4
C26	Rating of Health Plan	87	3.4
C27	Care Coordination	87	3.5
C28	Complaints about the Health Plan	0.24	4.1
C29	Members Choosing to Leave the Plan	16%	3.7
C30	Health Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.5
C31	Plan Makes Timely Decisions about Appeals	98%	4.1
C32	Reviewing Appeals Decisions	97%	3.7
C33	Call Center – Foreign Language Interpreter and TTY Availability	97%	4.2

Table C-2: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD Numeric Average	MA-PD Star Average	PDP Numeric Average	PDP Star Average
D01	Call Center – Foreign Language Interpreter and TTY Availability	98%	4.4	98%	4.2
D02	Complaints about the Drug Plan	0.24	4.1	0.04	4.5
D03	Members Choosing to Leave the Plan	16%	3.7	7%	3.5
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.4	Medicare only shows a Star Rating for this measure	3.2
D05	Rating of Drug Plan	87	3.3	85	3.5
D06	Getting Needed Prescription Drugs	90	3.5	90	3.6
D07	MPF Price Accuracy	98	4.6	98	4.7
D08	Medication Adherence for Diabetes Medications	87%	3.1	87%	2.7
D09	Medication Adherence for Hypertension (RAS antagonists)	89%	3.3	89%	2.6
D10	Medication Adherence for Cholesterol (Statins)	89%	3.2	88%	2.7
D11	MTM Program Completion Rate for CMR	91%	3.7	62%	3.4
D12	Statin Use in Persons with Diabetes (SUPD)	88%	3.3	84%	3.3

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	01/01/2024 – 12/31/2024
C02	Colorectal Cancer Screening	HEDIS	01/01/2024 – 12/31/2024
C03	Annual Flu Vaccine	CAHPS	03/2025 – 05/2025
C04	Improving or Maintaining Physical Health	HOS	07/19/2024 – 11/01/2024
C05	Improving or Maintaining Mental Health	HOS	07/19/2024 – 11/01/2024
C06	Monitoring Physical Activity	HEDIS-HOS	07/17/2024 – 11/01/2024
C07	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2024 – 12/31/2024
C08	Care for Older Adults – Medication Review	HEDIS	01/01/2024 – 12/31/2024
C09	Care for Older Adults – Pain Assessment	HEDIS	01/01/2024 – 12/31/2024
C10	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2024 – 12/31/2024
C11	Diabetes Care – Eye Exam	HEDIS	01/01/2024 – 12/31/2024
C12	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2024 – 12/31/2024
C13	Kidney Health Evaluation for Patients with Diabetes	HEDIS	01/01/2024 – 12/31/2024
C14	Controlling Blood Pressure	HEDIS	01/01/2024 – 12/31/2024
C15	Reducing the Risk of Falling	HEDIS-HOS	07/17/2024 – 11/01/2024
C16	Improving Bladder Control	HEDIS-HOS	07/17/2024 – 11/01/2024
C17	Medication Reconciliation Post-Discharge	HEDIS	01/01/2024 – 12/31/2024
C18	Plan All-Cause Readmission	HEDIS	01/01/2024 – 12/31/2024
C19	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2024 – 12/31/2024
C20	Transitions of Care	HEDIS	01/01/2024 – 12/31/2024
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2024 – 12/31/2024
C22	Getting Needed Care	CAHPS	03/2025 – 05/2025
C23	Getting Appointments and Care Quickly	CAHPS	03/2025 – 05/2025
C24	Customer Service	CAHPS	03/2025 – 05/2025
C25	Rating of Health Care Quality	CAHPS	03/2025 – 05/2025
C26	Rating of Health Plan	CAHPS	03/2025 – 05/2025
C27	Care Coordination	CAHPS	03/2025 – 05/2025
C28	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2024 – 12/31/2024
C29	Members Choosing to Leave the Plan	MBDSS	01/01/2024 – 12/31/2024
C30	Health Plan Quality Improvement	Star Ratings	Not Applicable
C31	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2024 – 12/31/2024
C32	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2024 – 12/31/2024
C33	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2025 – 05/2025

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2025– 05/2025
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2024 – 12/31/2024
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2024 – 12/31/2024
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2025 – 05/2025
D06	Getting Needed Prescription Drugs	CAHPS	03/2025 – 05/2025
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2024 – 09/30/2024
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2024 – 12/31/2024
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024

1. Medicare Part C Reporting Requirements Measure (C07: SNP Care Management)

Step 1: Start with all contracts that offer at least one SNP plan that was active at any point during contract year 2024.

Step 2: Exclude contracts that did not 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) greater than or equal to 30] during contract year 2024.

Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2025), or that were not required to participate in data validation. This exclusion aligns with the statement found under subsection Exclusions from Part C Reporting of Section B. General Information of the contract year 2024 Medicare Part C Plan Reporting Requirements Technical Specifications: "**Note:** If a contract terminates before July 1 in the following year after the contract year (CY) reporting period, the contract is not required to report any data for the respective two years – the CY reporting period, and the following year… If a PBP (Plan) under a contract terminates at any time in the CY reporting period and the contract remains active through July 1 of the following year, the contract must still report data for all PBPs, including the terminated PBP."
This excludes:

- Contracts that terminate on or before 07/01/2025 according to the Contract Info extract.

Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the SNP Care Management section and contracts that scored 95% or higher on data validation for the SNP Care Management section but that were not compliant with data validation standards/sub-standards for at least one of the following SNP 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)
- Number of annual reassessments performed on enrollees eligible for reassessment (Element F)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2024 SNP Care Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2024 SNP Care Reporting Requirements data but that failed at least one of the four data elements (elements A, B, C, and F) are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have a SNP Care Assessment rate denominator [Number of New Enrollees due for an Initial HRA (Element A) + Number of enrollees

eligible for an annual reassessment HRA (Element B)] of fewer than 30 are listed as "No data available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contract using the formula:

[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)]

2. NCQA HEDIS Measures - (C08 – C09: Care for Older Adults)

The example NCQA measure combining methodology specifications below are written for two Plan Benefit Package (PBP) submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

Rates are produced for any contract offering a SNP in the ratings year which provided SNP HEDIS data in the measurement year.

Definitions

Let N_1 = The Total Number of Members Eligible for the HEDIS measure in the first PBP ("fixed" and auditable)

Let N_2 = The Total Number of Members Eligible for the HEDIS measure in the second PBP ("fixed" and auditable)

Let P_1 = The estimated rate (mean) for the HEDIS measure in the first PBP (auditable)

Let P_2 = The estimated rate (mean) for the same HEDIS measure in the second PBP (auditable)

Setup Calculations

Based on the above definitions, there are two additional calculations:

Let W_1 = The weight assigned to the first PBP results (estimated, auditable). This is estimated from the formula $W_1 = N_1 / (N_1 + N_2)$

Let W_2 = The weight assigned to the second PBP results (estimated, auditable). This is estimated from the formula $W_2 = N_2 / (N_1 + N_2)$

Pooled Analysis

The pooled result from the two rates (means) is calculated as: $P_{pooled} = W_1 * P_1 + W_2 * P_2$

NOTES:
Weights are based on the eligible member population. While it may be more accurate to remove all excluded members before weighting, NCQA and CMS have chosen not to do this (to simplify the method) for two reasons: 1) the number of exclusions relative to the size of the population should be small, and 2) exclusion rates (as a percentage of the eligible population) should be similar for each PBP and negligibly affect the weights.

If one or more of the submissions has a status of NA, those submissions are dropped and not included in the weighted rate (mean) calculations. If one or more of the submissions has an audit designation of BR or NR

(which has been determined to be biased or is not reported by choice of the contract), the rate is set to zero as detailed in the section titled "Handling of Biased, Erroneous and/or Not Reportable (NR) Data" and the average enrollment for the year is used for the eligible population in the PBP. An example is shown in table E-1.

Table E-1: Example Calculation Using Effectiveness of Care Rate

Numeric Example Using an Effectiveness of Care Rate	
# of Total Members Eligible for the HEDIS measure in PBP 1, N_1 =	1500
# of Total Members Eligible for the HEDIS measure in PBP 2, N_2 =	2500
HEDIS Result for PBP 1, Enter as a Proportion between 0 and 1, P_1 =	0.75
HEDIS Result for PBP 2, Enter as a Proportion between 0 and 1, P_2 =	0.5
Setup Calculations - Initialize Some Intermediate Results	
The weight for PBP 1 product estimated by $W_1 = N_1 / (N_1 + N_2)$	0.375
The weight for PBP 2 product estimated by $W_2 = N_2 / (N_1 + N_2)$	0.625
Pooled Results	
$P_{pooled} = W_1 * P_1 + W_2 * P_2$	0.59375

Attachment F: Calculating Measure C18: Plan All-Cause Readmissions

All data are available in the CMS Measurement Year 2024 HEDIS® Public Use File (PUF).[1] and can be looked up by IndicatorKey (row) and Variable name (column).

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

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

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

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

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

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

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

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) OE larger than or equal to 0.2 and less than or equal to 5.0.
For each contract, calculate the Final Rate and convert to percentages:

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

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

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

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

NatAvgObs = 0.135181

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

Final Rate Contract 1 = 0.992355 × 0.135181 x 100 = 13.41
Final Rate reported for Contract 1 = 13%

The actual calculated National Observed Rate used in the 2026 Star Ratings was 0.107940666493859.

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

Attachment G: Weights Assigned to Individual Performance Measures

Table G-1: Part C Measure Weights

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
C01	Breast Cancer Screening	Process Measure	1
C02	Colorectal Cancer Screening	Process Measure	1
C03	Annual Flu Vaccine	Process Measure	1
C04	Improving or Maintaining Physical Health	Intermediate Outcome Measure	1*
C05	Improving or Maintaining Mental Health	Intermediate Outcome Measure	1*
C06	Monitoring Physical Activity	Process Measure	1
C07	Special Needs Plan (SNP) Care Management	Process Measure	1
C08	Care for Older Adults – Medication Review	Process Measure	1
C09	Care for Older Adults – Pain Assessment	Process Measure	1
C10	Osteoporosis Management in Women who had a Fracture	Process Measure	1
C11	Diabetes Care – Eye Exam	Process Measure	1
C12	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C13	Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
C14	Controlling Blood Pressure	Intermediate Outcome Measure	3
C15	Reducing the Risk of Falling	Process Measure	1
C16	Improving Bladder Control	Process Measure	1
C17	Medication Reconciliation Post-Discharge	Process Measure	1
C18	Plan All-Cause Readmissions	Outcome Measure	3
C19	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C20	Transitions of Care	Process Measure	1
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
C22	Getting Needed Care	Patients' Experience and Complaints Measure	2
C23	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
C24	Customer Service	Patients' Experience and Complaints Measure	2
C25	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
C26	Rating of Health Plan	Patients' Experience and Complaints Measure	2
C27	Care Coordination	Patients' Experience and Complaints Measure	2
C28	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
C29	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
C30	Health Plan Quality Improvement	Improvement Measure	5
C31	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
C32	Reviewing Appeals Decisions	Measures Capturing Access	2
C33	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

*Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures have a weight of 1 for the 2026 Star Ratings because they are considered new measures. For the 2027 Star Ratings, the weight will return to 3.

Table G-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary and MA-PD Overall
D01	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
D02	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2
D03	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
D04	Drug Plan Quality Improvement	Improvement Measure	5
D05	Rating of Drug Plan	Patients' Experience and Complaints Measure	2
D06	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2
D07	MPF Price Accuracy	Process Measure	1
D08*	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
D09*	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
D10*	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
D11	MTM Program Completion Rate for CMR	Process Measure	1
D12	Statin Use in Persons with Diabetes (SUPD)	Process Measure	1

*For contracts whose service area only covers Puerto Rico, the weight for each adherence measure is set to zero (0) when calculating the summary and overall rating.

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) Star Rating for contract *j* is estimated as:

$$\bar{x}_j = \frac{\sum_{i=1}^{n_j} w_{ij} x_{ij}}{\sum_{i=1}^{n_j} w_{ij}}$$

where n_j is the number of performance measures for which contract *j* is eligible; w_{ij} is the weight assigned to performance measure *i* for contract *j*; and x_{ij} is the measure star for performance measure *i* for contract *j*. The variance of the Star Ratings for each contract j, s_j^2, must also be computed in order to estimate the reward factor (r-Factor):

$$s_j^2 = \frac{n_j}{(n_j - 1)(\sum_{i=1}^{n_j} w_{ij})} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j \right)^2 \right]$$

Thus, the $\bar{x}_j$'s are the new summary (or overall) Star Ratings for the contracts. The variance estimate, s_j^2, simply replaces the non-weighted variance estimate that was previously used for the r-Factor calculation. For all contracts *j*, $w_{ij} = w_i$ (i.e., the performance measure weights are the same for all contracts when estimating a given Star Rating (Part C or Part D summary or MA-PD overall ratings).

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 2025 and 2026.

For measures where a higher score is better:

$$\text{Improvement Change Score} = \text{Score in 2026} - \text{Score in 2025}$$

For measures where a lower score is better:

$$\text{Improvement Change Score} = \text{Score in 2025} - \text{Score in 2026}$$

An eligible measure was defined as a measure for which a contract was scored in both the 2025 and 2026 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 2025 and 2026 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 2

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.

$$\text{Improvement Measure Score} = \frac{\text{Net_Imp_Process} + 3 * \text{Net_Imp_Outcome} + 2 * \text{Net_Imp_PtExp}}{\text{Elig_Process} + 3 * \text{Elig_Outcome} + 2 * \text{Elig_PtExp}}$$

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 2026 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2025 standard error for contract i on measure C01

Y_{i2} Represents the 2026 rate for contract i on measure C01

Y_{i1} Represents the 2025 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 (2026 and 2025). 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

Improvement change score standard error for measure C03 for contract A = sqrt ($2.805^2 + 3.000^2 - 2 * 0.901 * 2.805 * 3.000$) = 1.305

Standard Error Formulas (SEF) for Specific Measures

The following formulas are used for calculating the contract-specific standard errors for specific measures in the 2026 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. **SEF for Measures: C01, C02, C06, C07, C10 – C12, C14 – C17, C19, C21, C29, C31 – C33, D01, D03, D08 – D12**

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2025, 2026

$Denominator_y$ is as defined in the Measure Details section for each measure.

2. **SEF for Measures: C08, C09**

These measures are rolled up from the plan level to the contract level following the formula outlined in Attachment E: NCQA HEDIS Measures. The standard error at the contract level is calculated as shown below. The specifications are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

The plan level standard error is calculated as:

$$SE_{yj} = \sqrt{\frac{Score_{yj} * (100 - Score_{yj})}{Denominator_{yj}}}$$

for y = 2025, 2026 and j = Plan 1, Plan 2

The contract level standard error is then calculated as:

Let W_{y1} = The weight assigned to the first PBP results (estimated, auditable) for year y, where y = 2025, 2026. This result is estimated by the formula $W_{y1} = N_{y1} / (N_{y1} + N_{y2})$

Let W_{y2} = The weight assigned to the second PBP results (estimated, auditable) for year y, where y = 2025, 2026. This result is estimated by the formula

$$W_{y2} = N_{y2} / (N_{y1} + N_{y2})$$

$$SE_{yi} = \sqrt{(W_{y1})^2 * (SE_{y1})^2 + (W_{y2})^2 * (SE_{y2})^2}$$

for y = Contract Year 2025, Contract Year 2026 and i = Contract i

3. **SEF for Measure C18**

$$SE_y = 100 * \text{National Observed Rate}_y * \sqrt{\frac{\text{Oberved Count}_y}{\text{Expected Count}_y^2}}$$

for y = 2025, 2026

National Observed Rate, Observed Count, and Expected Count as defined in Attachment F.

4. **SEF for Measure C20**

Let T_{1y}, T_{2y}, T_{3y}, and T_{4y} be the four Transitions of Care component measures.

Let Z_y be the Transitions of Care measure, which is calculated as an average of the four component measures.

$$\mathrm{Var}(Z_y) = \frac{1}{16} * [\mathrm{Var}(T_{1y}) + \mathrm{Var}(T_{2y}) + \mathrm{Var}(T_{3y}) + \mathrm{Var}(T_{4y}) + 2\mathrm{Cov}(T_{1y}, T_{2y}) + 2\mathrm{Cov}(T_{1y}, T_{3y}) + 2\mathrm{Cov}(T_{1y}, T_{4y}) + 2\mathrm{Cov}(T_{2y}, T_{3y}) + 2\mathrm{Cov}(T_{2y}, T_{4y}) + 2\mathrm{Cov}(T_{3y}, T_{4y})]$$

$$SE_y = \sqrt{\mathrm{Var}(Z_y)}$$

for y = 2025, 2026

In the above formula, $Var(T_{1y}) = (100 * \frac{n_{1y}}{d_{1y}}) * \frac{(100-(100*\frac{n_{1y}}{d_{1y}})}{d_{1y}}$ where n_{1y} is the numerator for T_{1y} and d_{1y} the denominator, and so on for each of the four component measures.

$Cov(T_{1y}, T_{2y}) = Corr(T_{1y}, T_{2y}) * \sqrt{Var(T_{1y})} * \sqrt{Var(T_{2y})}$ and so on for each pair of component measures. We estimate the correlations between pairs of component measures by calculating the sample correlation across all contract scores. These correlations are shown in the table below.

Measures		2025 Correlation	2026 Correlation
Patient Engagement After Inpatient Discharge	Receipt of Discharge Information	0.556274	0.535619
Patient Engagement After Inpatient Discharge	Notification of Inpatient Admission	0.526902	0.489659
Patient Engagement After Inpatient Discharge	Medication Reconciliation Post-Discharge	0.544586	0.499420
Receipt of Discharge Information	Notification of Inpatient Admission	0.762500	0.771564
Receipt of Discharge Information	Medication Reconciliation Post-Discharge	0.408025	0.460944
Notification of Inpatient Admission	Medication Reconciliation Post-Discharge	0.540088	0.596070

5. SEF for Measures: C03, C22 – C27, and D05, D06

The CAHPS measure standard errors for 2025 and 2026 were provided to CMS by the CAHPS contractor following the formulas documented in the CAHPS Macro Manual. The actual values used for each contract are included on the Measure Detail CAHPS page in the HPMS preview area.

6. SEF for Measures: C28, D02

$$SE_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{\text{NumDays}}$$

NumDays: 2025 = 365, 2026 = 366

7. SEF for Measure D07

The standard error of the MPF Composite Price Accuracy Score for each contract is calculated by using binomial approximations for each of the component scores (Price Accuracy Score and Claim Percentage Score, as described in Attachment M). Since the MPF Composite Price Accuracy Score is equal to (0.5 x Price Accuracy Score) + (0.5 x Claim Percentage Score), the composite measure's variance (and standard error) is a function of the variance of the Price Accuracy Score, the variance of the Claim Percentage Score, and the covariance between them. We assume that the product of the total PDE cost and the Price Accuracy Score (on a 0-1 scale) follows a binomial distribution, and likewise that the product of the number of PDE claims and the

Claims Percentage Score (on a 0-1 scale) also follows a binomial distribution. With these assumptions in place, the standard error of the MPF Composite Accuracy Score is calculated as follows:

1. The contract's component scores, on their original 0-100 scale, have variances calculable using formulas based on the binomial variance assumptions described above, separately for each year y = 2025, 2026.

    a. For the Price Accuracy Score, the variance in year y is represented by

$$Var\left(Price\ Acc.Score_y\right) = \frac{\left(Price\ Acc.Score_y \times \left(100 - Price\ Acc.Score_y\right)\right)}{Total\ PDE\ Cost_y}$$

    b. For the Claim Percentage Score, the variance in year y is represented by

$$Var\left(Claims\ Pct.Score_y\right) = \frac{\left(Claims\ Pct.Score_y \times \left(100 - Claims\ Pct.Score_y\right)\right)}{Number\ of\ PDE\ Claims_y}$$

2. The contract-specific covariance between the component scores, shown as $Cov\left(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y\right)$ in step 3 below, is calculated as the product of:
    a. the contract-specific standard errors of the two component scores, which are the square roots of the two variance estimates shown above in step 1, and
    b. the correlation between the two component scores estimated based on all contracts. The correlations for the two measurement years are show below.

2025 Correlation	2026 Correlation
0.599486	0.653381

3. The standard error of the MPF Composite Price Accuracy Score is calculated from the components calculated in steps 1 and 2 as shown below:

$$SE_y = \sqrt{\frac{Var\left(Price\ Acc.\ Score_y\right)}{4} + \frac{Var\left(Claim\ Pct.\ Score_y\right)}{4} + \frac{Cov\left(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y\right)}{2}}$$

for y = 2025, 2026

Star Ratings Measures Used in the Improvement Measures

Table I-1: Part C Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.945918
C02	Colorectal Cancer Screening	Included	0.888326
C03	Annual Flu Vaccine	Included	0.902341
C04	Improving or Maintaining Physical Health	Not Included	-
C05	Improving or Maintaining Mental Health	Not Included	-
C06	Monitoring Physical Activity	Included	0.845725
C07	Special Needs Plan (SNP) Care Management	Included	0.868694
C08	Care for Older Adults – Medication Review	Included	0.854992
C09	Care for Older Adults – Pain Assessment	Included	0.928640
C10	Osteoporosis Management in Women who had a Fracture	Included	0.833787
C11	Diabetes Care – Eye Exam	Included	0.843728
C12	Diabetes Care – Blood Sugar Controlled	Included	0.791850
C13	Kidney Health Evaluation for Patients with Diabetes	Not Included	-
C14	Controlling Blood Pressure	Included	0.835804
C15	Reducing the Risk of Falling	Included	0.841469
C16	Improving Bladder Control	Included	0.432892
C17	Medication Reconciliation Post-Discharge	Included	0.872774
C18	Plan All-Cause Readmissions	Included	0.523042
C19	Statin Therapy for Patients with Cardiovascular Disease	Included	0.729464
C20	Transitions of Care	Included	0.887062
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Included	0.463245
C22	Getting Needed Care	Included	0.787381
C23	Getting Appointments and Care Quickly	Included	0.729360
C24	Customer Service	Included	0.740178
C25	Rating of Health Care Quality	Included	0.711479
C26	Rating of Health Plan	Included	0.784188
C27	Care Coordination	Included	0.747242
C28	Complaints about the Health Plan	Included	0.713325
C29	Members Choosing to Leave the Plan	Included	0.790100

Measure ID	Measure Name	Measure Usage	Correlation
C30	Health Plan Quality Improvement	Not Included	-
C31	Plan Makes Timely Decisions about Appeals	Included	0.433903
C32	Reviewing Appeals Decisions	Included	0.490732
C33	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.453086

Table I-2: Part D Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
D01	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.518133
D02	Complaints about the Drug Plan	Included	0.723507
D03	Members Choosing to Leave the Plan	Included	0.791540
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.784401
D06	Getting Needed Prescription Drugs	Included	0.681827
D07	MPF Price Accuracy	Included	0.832817
D08	Medication Adherence for Diabetes Medications	Included	0.605524
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.757009
D10	Medication Adherence for Cholesterol (Statins)	Included	0.754567
D11	MTM Program Completion Rate for CMR	Included	0.779423
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.835138

Attachment J: Star Ratings Measure History

The tables below cross-reference the measures code in each of the yearly Star Ratings releases. Measure codes that begin with DM are display measures which are posted on CMS.gov on this page: http://go.cms.gov/partcanddstarratings.

Table J-1: Part C Measure History

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Access to Primary Care Doctor Visits	HEDIS				DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11
C	Adult BMI Assessment	HEDIS						C07	C07	C07	C07	C07	C07	C08	C10	C10	C12
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS									DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05
C	Asthma Medication Ratio	HEDIS									DMC18	DMC27					
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01
C	Call Answer Timeliness	HEDIS											DMC02	DMC02	DMC02	DMC02	DMC02
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC12		DMC15	DMC15	
C	Call Center – CSR Understandability	Call Center Monitoring															
C	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	C33	C30	C30	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36
C	Call Center – Information Accuracy	Call Center Monitoring													DMC10	DMC10	DMC10
C	Cardiac Rehabilitation – Achievement	HEDIS	DMC25	DMC25	DMC25	DMC29											
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC26	DMC26	DMC30											
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC27	DMC27	DMC31											
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DMC28	DMC28	DCM32											
C	Cardiovascular Care – Cholesterol Screening	HEDIS												C02	C03	C03	C03
C	Care Coordination	CAHPS	C27	C24	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29	

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Care for Older Adults – Functional Status Assessment	HEDIS	DMC21	DMC21	DMC21	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12	C14
C	Care for Older Adults – Medication Review	HEDIS	C08	C06	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13
C	Care for Older Adults – Pain Assessment	HEDIS	C09	C07	C07	C07	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13	C15
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29	DMC29	DMC29												
C	Complaints about the Health Plan	CTM	C28/D02	C25/D02	C25/D02	C23/D02	C23/D02	C27/ D04	C28/ D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06
C	Computer use by provider helpful	CAHPS										DMC20	DMC21	DMC20			
C	Computer use made talking to provider easier	CAHPS										DMC21	DMC22	DMC21			
C	Computer used during office visits	CAHPS										DMC19	DMC20	DMC19			
C	Continuous Beta Blocker Treatment	HEDIS	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC04	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C14	C11	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21
C	Customer Service	CAHPS	C24	C21	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C12	C10	C10	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19
C	Diabetes Care – Cholesterol Controlled	HEDIS												C17	C18	C18	C20
C	Diabetes Care – Cholesterol Screening	HEDIS												C03	C04	C04	C04
C	Diabetes Care – Eye Exam	HEDIS	C11	C09	C09	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17
C	Diabetes Care – Kidney Disease Monitoring	HEDIS				C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18
C	Doctors who Communicate Well	CAHPS	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19		
C	Enrollment Timeliness	MARx									DME01	DME01	DME01	DME01	DME01	C37 / D05	D05
C	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	C21	C18	C18	DMC15	DMC17	DMC17	DMC18								

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)	HEDIS		DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01
C	Getting Appointments and Care Quickly	CAHPS	C23	C20	C20	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27
C	Getting Needed Care	CAHPS	C22	C19	C19	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26
C	Glaucoma Testing	HEDIS													C05	C05	C05
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11	
C	Health Plan Quality Improvement	Star Ratings	C30	C27	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33	
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC15	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24					
C	Improving Bladder Control	HEDIS-HOS	C16	C13	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23
C	Improving or Maintaining Mental Health	HOS	C05	DMC23	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09
C	Improving or Maintaining Physical Health	HOS	C04	DMC24	DMC24	DMC28	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08
C	Initiation and Engagement of Substance Use Disorder (SUD) Treatment Average	HEDIS	DMC14	DMC14	DMC14												
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18		
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	C13	DMC22	DMC22	DMC26											
C	Medication Management for People With Asthma	HEDIS										DMC26					
C	Medication Reconciliation Post-Discharge	HEDIS	C17	C14	C14	C15	C15	C19	C19	C20	C20	DMC23					
C	Members Choosing to Leave the Plan	MBDSS	C29/D03	C26/D03	C26/D03	C24/D03	C24/D03	C28/ D05	C29/ D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08
C	Monitoring Physical Activity	HEDIS-HOS	C06	C04	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C10	C08	C08	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16
C	Osteoporosis Testing	HEDIS-HOS					DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17		

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16		
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC20	DMC20	DMC24											
C	Plan All-Cause Readmissions	HEDIS	C18	C15	C15	DMC21	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23	C25
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE) / Maximus	C31	C28	C28	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07
C	Rating of Health Care Quality	CAHPS	C25	C22	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29
C	Rating of Health Plan	CAHPS	C26	C23	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30
C	Reducing the Risk of Falling	HEDIS-HOS	C15	C12	C12	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24
C	Reminders for appointments	CAHPS										DMC16	DMC17	DMC16			
C	Reminders for immunizations	CAHPS										DMC17	DMC18	DMC17			
C	Reminders for screening tests	CAHPS										DMC18	DMC19	DMC18			
C	Reviewing Appeals Decisions	Independent Review Entity (IRE) / Maximus	C32	C29	C29	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35
C	Rheumatoid Arthritis Management	HEDIS					C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C07	C05	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14	
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C19	C16	C16	C16	C16	C20	C21	C22	DMC17	DMC25					
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS		DMC04	DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07
C	Transitions of Care – Average	HEDIS	C20	C17	C17	DMC20	DMC22	DMC22	DMC23								
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC16	DMC16	DMC18	DMC18	DMC19								
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC17	DMC17	DMC19	DMC19	DMC20								
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC18	DMC18	DMC20	DMC20	DMC21								

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC19	DMC19	DMC19	DMC19	DMC21	DMC21	DMC22								

Table J-2: Part D Measure History

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)															DMD03	
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data																
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	DMD08	DMD08	DMD08	DMD08	DMD08	DMD12	DMD14	DMD16	DMD18							
D	Appeals Auto–Forward	Independent Review Entity (IRE) / Maximus						D02	D02	D02	D02	D02	D02	D01	D02	D03	D03	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus						D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD02	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	
D	Call Center – Calls Disconnected – Pharmacist	Call Center Monitoring																
D	Call Center – Calls Disconnected When Customer Calls Drug Plan	Call Center Monitoring	DMD01	DMD01	DMD01	DMD01	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	
D	Call Center – CSR Understandability	Call Center Monitoring																
D	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	D01	D01	D01	D01	D01	D01	D01	D01	D01	D01	D01		D01	D02	D02	
D	Call Center – Information Accuracy	Call Center Monitoring													DMD05	DMD05	DMD06	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD04	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	
D	Complaint Resolution	Complaints Tracking Module (CTM)																
D	Complaints – Enrollment	Complaints Tracking Module (CTM)																

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	Complaints – Other	Complaints Tracking Module (CTM)																
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C28/ D02	C25/ D02	C25/ D02	C23/ D02	C23/ D02	C27 / D04	C28 / D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06	
D	Diabetes Medication Dosing	Prescription Drug Event (PDE) Data							DMD06	DMD06	DMD06	DMD06	DMD06	DMD04	DMD07	DMD07	DMD08	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data												D10	D12	D15	D14	
D	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	Acumen / OIT (LIS Match Rates)						DMD06	DMD07	DMD07	DMD07	DMD07	DMD07	DMD05	DMD08	DMD08	DMD09	
D	Drug Plan Quality Improvement	Star Ratings	D04	D04	D04	D04	D04	D06	D06	D06	D07	D07	D07	D05	D07	D09		
D	Drug-Drug Interactions	Prescription Drug Event (PDE) Data						DMD05	DMD05	DMD05	DMD05	DMD05	DMD05	DMD03	DMD06	DMD06	DMD07	
D	Enrollment Timeliness	MARx									DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	
D	Formulary Administration Analysis	Part D Sponsor								DMD15	DMD17							
D	Getting Information From Drug Plan	CAHPS										DMD10	DMD10	DMD09	DMD14	D10	D09	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D06	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	
D	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		
D	High Risk Medication	Prescription Drug Event (PDE) Data							DMD14	DMD14	DMD16	D11	D11	D09	D11	D14	D13	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15	DMD15	DMD15	DMD15												
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	D10	D10	D10	D10	D10	D12	D12	D12	D13	D14	D14	D13	D15	D18	D17	
D	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) Data	D08	D08	D08	D08	D08	D10	D10	D10	D11	D12	D12	D11	D13	D16	D15	
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D09	D09	D09	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16	

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	Members Choosing to Leave the Plan	MBDSS	C29/ D03	C26/ D03	C26/ D03	C24/ D03	C24/ D03	C28 / D05	C29 / D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	
D	MPF – Composite	PDE Data, MPF Pricing Files															D12	B
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD03	DMD03	DMD03	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10		A
D	MPF – Updates	PDE Data, MPF Pricing Files													DMD09	DMD09	DMD10	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	D07	D07	D07	D07	D09	D09	D09	D10	D10	D10	D08	D10	D13		A
D	MTM Program Completion Rate for CMR	Prescription Drug Event (PDE) Data	D11	D11	D11	D11	D11	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12		
D	Persistence to Basal Insulin (PST-INS)	Prescription Drug Event (PDE) Data	DMD16	DMD16	DMD16													
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	DMD05	DMD05	DMD05	DMD05	DMD05	DMD09	DMD10	DMD10	DMD10	DMD12	DMD12	DMD10	DMD16			
D	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Prescription Drug Event (PDE) Data	DMD13	DMD13	DMD13	DMD13	DMD13	DMD20										
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	DMD14	DMD14	DMD14	DMD14	DMD14	DMD21										
D	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	Fu Associates										DMD09	DMD09	DMD08	DMD13	DMD13		
D	Rating of Drug Plan	CAHPS	D05	D05	D05	D05	D05	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13				
D	Reminders to take medications	CAHPS	DMD07	DMD07	DMD07	DMD07	DMD07	DMD11	DMD12	DMD13	DMD14	DMD16	DMD16	DMD14				
D	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Data	D12	D12	D12	D12	D12	D14	D14	D14	DMD15	DMD17						
D	Timely Effectuation of Appeals	Independent Review Entity (IRE) / Maximus						DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	Timely Receipt of Case Files for Appeals	Independent Review Entity (IRE) / Maximus						DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis								DMD11								D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis									DMD12	DMD14	DMD14	DMD12				C
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis									DMD11	DMD13	DMD13	DMD11				C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data						DMD15										
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data	DMD11	DMD11	DMD11	DMD11	DMD11	DMD18										
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	DMD12	DMD12	DMD12	DMD12	DMD12	DMD19										

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012

B: Composite measure - combined MPF - Accuracy and MPF Stability

C: Part of composite measure Transition Monitoring - Composite starting in 2019

D: Composite Measure – "Transition monitoring - failure rate for drugs within classes of clinical concern" and "Transition monitoring - failure rate for all other drugs"

Table J-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014		2013	2012
E	Beneficiary Access and Performance Problems	Administrative Data		DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey		DME04	DME04	DME04	DME04	DME04	DME04	DME04	DME04	DME05	DME05	DME05	DME05			
E	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)	Disenrollment Reasons Survey		DME06	DME06	DME06	DME06	DME06	DME06	DME06	DME06	DME07	DME07	DME07	DME07			
E	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)	Disenrollment Reasons Survey		DME02	DME02	DME02	DME02	DME02	DME02	DME02	DME02	DME03	DME03	DME03	DME03			
E	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)	Disenrollment Reasons Survey		DME03	DME03	DME03	DME03	DME03	DME03	DME03	DME03	DME04	DME04	DME04	DME04			
E	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	Disenrollment Reasons Survey		DME05	DME05	DME05	DME05	DME05	DME05	DME05	DME05	DME06	DME06	DME06	DME06			
E	Enrollment Timeliness	MARx										DME01	DME01	DME01	DME01	DME01	C37 / D05	D05
E	Grievance Rate	Part C & D Plan Reporting		DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11	

Attachment K: Individual Measure Star Assignment Process

This attachment provides detailed information about the clustering and the relative distribution and significance testing (CAHPS) methodologies used to assign stars to individual measures.

The analyses described in this section were run on Linux SAS/STAT v15.1 (Linux LIN 64 Red Hat Enterprise Linux release 9.6) and validated on SAS 9.4 (TS1M7) with SAS/STAT Version 15.2 installed on Version 10.0.26100 of Windows 11, 64-bit.

Clustering Methodology Introduction

To separate a distribution of scores into distinct groups or categories, a set of values must be identified to separate one group from another group. The set of values that break the distribution of the scores into non-overlapping groups is the set of cut points.

For each individual measure, CMS determines the measure cut points using the information provided from the hierarchical clustering algorithm in SAS, described in "Clustering Methodology Detail" below. Conceptually, the clustering algorithm identifies the natural gaps that exist within the distribution of the scores and creates groups (clusters) that are then used to identify the cut points that result in the creation of a pre-specified number of categories.

For Star Ratings, the algorithm is run with the goal of determining the four cut points (labeled in the Figure J-1 below as A, B, C, and D) that are used to create the five non-overlapping groups that correspond to each of the Star Ratings (labeled in the diagram below as G1, G2, G3, G4, and G5). For Part D measures, CMS determines MA-PD and PDP cut points separately. Data identified to be biased, erroneous, or excluded by disaster rules are removed from the algorithm. The scores are grouped such that scores within the same Star Rating category are as similar as possible, and scores in different categories are as different as possible.

Figure K-1: Diagram showing gaps in data where cut points are assigned.



As mentioned, the cut points are used to create five non-overlapping groups. The value of the lower bound for each group is included in the category, while the value of the upper bound is not included in the category. CMS does not require the same number of observations (contracts) within each group. The groups are identified such that within a group the measure scores must be similar to each other and between groups, the measure scores in one group are not similar to measure scores in another group. The groups are then used for the conversion of the measure scores to one of five Star Ratings categories. For most measures, a higher score is better, and thus, the group with the highest range of measure scores is converted to a rating of five stars. An example of a measure for which higher is better is *Medication Adherence for Diabetes Medications*. For some measures a lower score is better, and thus, the group with the lowest range of measure scores is converted to a rating of five stars. An example of a measure for which a lower score is better is *Members Choosing to Leave the Plan*.

Example 1 – Clustering Methodology for a Higher is Better measure

Consider the information provided for the cut points for *Medication Adherence for Diabetes Medications* in Table K-1 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately (e.g., different cut points are calculated for MA-PD and PDPs). If the MA-PD cut points identified using the clustering algorithm are 80%, 85%, 87%, and 91%; for PDPs, the cut points are 84%, 86%, 88%, and 90%. (The set of values corresponds to the cut points in figure J-2 below as A, B, C, and D and the categories

for each of the five Star Ratings are indicated above each group.) Since a measure score can only assume a value between 0% and 100% (including 0% and 100%), the one-star and five-star categories contain only a single value in the table below as the upper or lower bound.

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 80%	Greater than or equal to 80% to less than 85%	Greater than or equal to 85% to less than 87%	Greater than or equal to 87% to less than 91%	Greater than or equal to 91%
PDP	Less than 84%	Greater than or equal to 84% to less than 86%	Greater than or equal to 86% to less than 88%	Greater than or equal to 88% to less than 90%	Greater than or equal to 90%

Figure K-2: Diagram showing star assignment based cut points.



Since higher is better for *Medication Adherence for Diabetes Medications*, a rating of one star is assigned to all MA-PD measure scores below 80% in this example. For each of the other Star Rating categories, the value of the lower bound is included in the rating category, while the upper bound value is not included. Focusing solely on the cut points for MA-PDs, a rating of two stars is assigned to each measure score that is at least 80% (the first cut point) to less than 85% (the second cut point) in this example. Since measure scores are reported as percentages with no decimal places, any measure score of 80% to 84% would be assigned two stars, while a measure score of 85% would be assigned a rating of three stars. Measure scores that are at least 85% to less than 87% would be assigned a rating of three stars. For a conversion to four stars, a measure score of at least 87% to less than 91% would be needed. A rating of five stars would be assigned to any measure score of 91% or more. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Example 2 – Clustering Methodology for a Lower is Better measure

Consider the information provided for the cut points for *Members Choosing to Leave the Plan* in Table K-2 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately. In the example, the MA-PD cut points for *Members Choosing to Leave the Plan* determined using the clustering algorithm are 44%, 29%, 16%, and 9%; for PDPs, the cut points are 20%, 13%, 19%, and 6%. (These correspond to the cut points in figure K-3 as A, B, C, and D).

Since lower is better for this measure, the five-star category will have the lowest measure score range, while the one-star category will have scores that are highest in value. For each of the other Star Rating categories, the value of the lower bound is not included in the rating category, while the upper bound value is included. (The inclusivity and exclusivity of the upper and lower bounds is opposite for a measure score where lower is better as compared to higher is better.) For MA-PDs, a rating of five stars would be assigned to measure scores of 9% or less. Measure scores that are greater than 9% up to a maximum value of 16% (including a measure score of 16%) would be assigned a rating of four stars. A rating of three stars would be assigned to measure scores greater than 16% up to a maximum value of 29%. A rating of two stars would be assigned to a measure score that is greater than 29% up to and including 44%. A rating of one star would be assigned to any measure score greater than 44%. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Greater than 44%	Greater than 29% to less than or equal to 44%	Greater than 16% to less than or equal to 29%	Greater than 9% to less than or equal to 16%	less than or equal to 9%
PDP	Greater than 20%	Greater than 13% to less than or equal to 20%	Greater than 9% to less than or equal to 13%	Greater than 6% to less than or equal to 9%	less than or equal to 6%

Figure K-3: Diagram showing star assignment based on cut points.



Clustering Methodology Detail

This section details the steps of the clustering method performed in SAS to allow the conversion of the measure scores to measure-level stars.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion for the Part C and Part D Improvement Measures is performed separately for contracts receiving negative scores and those receiving scores of zero or higher prior to threshold estimation, consistent with how clustering is performed for these measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling to the hierarchical clustering algorithm. The 1st and 3rd quartiles can be obtained by using the MEANS procedure in SAS. The Tukey outer fence outlier cutoffs can then be calculated as:

- Lower outlier cutoff: first quartile – 3.0*(third quartile – first quartile)
- Upper outlier cutoff: third quartile + 3.0*(third quartile – first quartile).

Measures with data displays of percentages with no decimal places ranging from 0 to 100 will have the lower and upper outlier cutoffs capped at those values, respectively. Any other measures with range restrictions, such as have a lower bound of zero, will have the respective outlier cutoff capped at the restricted value.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are separated into 10 equal-sized groups, using a random assignment process to assign each contract's measure score to a group. The random assignment of contracts into 10 groups can be produced using the SURVEYSELECT procedure in SAS as follows:

```
proc surveyselect data=inclusterdat groups=10 seed=8675309 out=inclusterdat_random;
run;
```

In the above code, the input dataset, *inclusterdat,* is the list of contracts without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. The *group=10* option identifies that 10 random groupings of the data should be created. The *seed=8675309* option specifies the seed value that controls the starting point of the random sequence of numbers and allows for future replication of the randomization process. The output dataset, *inclusterdat_random,* is identical to the input dataset with the addition of a new column, named *groupid,* that has the group assignments (from 1 through 10) for each contract.

The hierarchal clustering algorithm (steps 1 through 4 below) is then applied 10 times, each time leaving out one of the 10 groups. For each measure and leave-one-out contract set, the clustering method does the following:

- Produces the individual measure distance matrix.
- Groups the measure scores into an initial set of clusters.
- Selects the set of clusters.

1. Produce the individual measure distance matrix.

For each pair of contracts j and k (j is greater than or equal to k) among the n contracts with measure score data, compute the Euclidian distance of their measure scores (e.g., the absolute value of the difference between the two measure scores). Enter this distance in row j and column k of a distance matrix with n rows and n columns. This matrix can be produced using the DISTANCE procedure in SAS as follows:

```
proc distance data= inclusterdat_leave1out out=distancedat method=Euclid;
        var interval(measure_score);
        id contract_id;
run;
```

In the above code, the input data set, *inclusterdat_leave1out,* is the list of contracts (excluding the group left out) without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. Each record has a unique contract identifier, *contract_id*. The option *method=Euclid* specifies that distances between contract measure scores should be based on Euclidean distance. The input data contain a variable called *measure_score* that is formatted to the display criteria outlined in the Technical Notes. In the *var* call, the parentheses around *measure_score* indicate that *measure_score* is considered to be an interval or numeric variable. The distances computed by this code are stored to an output data set called *distancedat.*

2. Create a tree of cluster assignments.

The distance matrix calculated in Step 1 is the input to the clustering procedure. The stored distance algorithm is implemented to compute cluster assignments. The following process is implemented by using the CLUSTER procedure in SAS:

- The input measure score distances are squared.
- The clusters are initialized by assigning each contract to its own cluster.
- In order to determine which pair of clusters to merge, Ward's minimum variance method is used to separate the variance of the measure scores into within-cluster and between-cluster sum of squares components.
- From the existing clusters, two clusters are selected for merging to minimize the within-cluster sum of squares over all possible sets of clusters that might result from a merge.
- Steps 3 and 4 are repeated to reduce the number of clusters by one until a single cluster containing all contracts results.

The result is a data set that contains a tree-like structure of cluster assignments, from which any number of clusters between 1 and the number of contract measure scores could be computed. The SAS code for implementing these steps is:

```
proc cluster data=distancedat method=ward outtree=treedat noprint;
```

```
        id contract_id;
run;
```

The *distancedat* data set containing the Euclidian distances was created in Step 1. The option *method=ward* indicates that Ward's minimum variance method should be used to group clusters. The output data set is denoted with the *outtree* option and is called *treedat*.

3. Select the final set of clusters from the tree of cluster assignments.

The process outlined in Step 2 will produce a tree of cluster assignments, from which the final number of clusters is selected using the TREE procedure in SAS as follows:

```
proc tree data=treedat ncl=NSTARS horizontal out=outclusterdat noprint;
        id contract_id;
run;
```

The input data set, treedat, is created in Step 2 above. The syntax, ncl=NSTARS, denotes the desired final number of clusters (or star levels). For most measures, NSTARS= 5. In cases where multiple clusters have the same score value range those clusters are combined, leading to fewer than 5 clusters. Since the improvement measures have a constraint that contracts with improvement scores of zero or greater are to be assigned at least 3 stars for improvement, the clustering is conducted separately for contract measure scores that are greater than or equal to zero versus those that are less than zero. Specifically, Steps 1-3 are first applied to contracts with improvement scores that are greater than or equal to zero, in which case NSTARS equals three. The resulting improvement measure stars can take on values of 3, 4, or 5. For those contracts with improvement scores less than zero, Steps 1-3 are applied with NSTARS=2 and these contracts will either receive 1 or 2 stars.

4. Final Thresholds

The cluster assignments produced by the above approach have cluster labels that are unordered. The final step after applying the above steps to all contract measure scores is to order the cluster labels so that the 5-star category reflects the cluster with the best performance and the 1-star category reflects the cluster with the worst performance. With the exception of the improvement measures which are assigned lower thresholds of zero for the 3-star category, the measure thresholds are defined by examining the range of measure scores within each of the final clusters. The lower limit of each cluster becomes the cut point for the star categories for higher is better measures.

Determining Stars from Scores and Thresholds

The mean-resampling approach results in 10 sets of measure-specific cut points, one for each of the 10 implementations of the hierarchical clustering algorithm. For higher-is-better measures, the minimum score observed in each star category defines the effective cut points for the star categories. For lower-is-better measures, the maximum score observed in each star category defines the effective cut points for the star categories. These cut points are calculated after the application of Tukey outlier deletion. The final set of estimated thresholds are then calculated as the mean cut point for each threshold per measure from the 10 different cut point values. Tables K-3 and K-4 show the mean resampling final estimated thresholds for the 2026 Star Ratings. Tables K-5 and K-6 show the upper and lower Tukey outlier cutoffs.

Table K-3: 2026 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	Less than 63 %	Greater than or equal to 63 % to less than 71 %	Greater than or equal to 71 % to less than 76 %	Greater than or equal to 76 % to less than 84 %	Greater than or equal to 84 %
C02	Less than 41 %	Greater than or equal to 41 % to less than 60 %	Greater than or equal to 60 % to less than 70 %	Greater than or equal to 70 % to less than 77 %	Greater than or equal to 77 %
C04	Less than 66 %	Greater than or equal to 66 % to less than 70 %	Greater than or equal to 70 % to less than 72 %	Greater than or equal to 72 % to less than 75 %	Greater than or equal to 75 %
C05	Less than 81 %	Greater than or equal to 81 % to less than 83 %	Greater than or equal to 83 % to less than 85 %	Greater than or equal to 85 % to less than 88 %	Greater than or equal to 88 %
C06	Less than 41 %	Greater than or equal to 41 % to less than 47 %	Greater than or equal to 47 % to less than 53 %	Greater than or equal to 53 % to less than 59 %	Greater than or equal to 59 %
C07	Less than 42 %	Greater than or equal to 42 % to less than 60 %	Greater than or equal to 60 % to less than 73 %	Greater than or equal to 73 % to less than 88 %	Greater than or equal to 88 %
C08	Less than 81 %	Greater than or equal to 81 % to less than 86 %	Greater than or equal to 86 % to less than 93 %	Greater than or equal to 93 % to less than 98 %	Greater than or equal to 98 %
C09	Less than 83 %	Greater than or equal to 83 % to less than 90 %	Greater than or equal to 90 % to less than 95 %	Greater than or equal to 95 % to less than 99 %	Greater than or equal to 99 %
C10	Less than 32 %	Greater than or equal to 32 % to less than 41 %	Greater than or equal to 41 % to less than 53 %	Greater than or equal to 53 % to less than 68 %	Greater than or equal to 68 %
C11	Less than 60 %	Greater than or equal to 60 % to less than 72 %	Greater than or equal to 72 % to less than 80 %	Greater than or equal to 80 % to less than 86 %	Greater than or equal to 86 %
C12	Less than 74 %	Greater than or equal to 74 % to less than 83 %	Greater than or equal to 83 % to less than 87 %	Greater than or equal to 87 % to less than 91 %	Greater than or equal to 91 %
C13	Less than 34 %	Greater than or equal to 34 % to less than 51 %	Greater than or equal to 51 % to less than 62 %	Greater than or equal to 62 % to less than 74 %	Greater than or equal to 74 %
C14	Less than 67 %	Greater than or equal to 67 % to less than 75 %	Greater than or equal to 75 % to less than 80 %	Greater than or equal to 80 % to less than 86 %	Greater than or equal to 86 %
C15	Less than 51 %	Greater than or equal to 51 % to less than 57 %	Greater than or equal to 57 % to less than 62 %	Greater than or equal to 62 % to less than 71 %	Greater than or equal to 71 %
C16	Less than 41 %	Greater than or equal to 41 % to less than 45 %	Greater than or equal to 45 % to less than 49 %	Greater than or equal to 49 % to less than 53 %	Greater than or equal to 53 %
C17	Less than 40 %	Greater than or equal to 40 % to less than 60 %	Greater than or equal to 60 % to less than 74 %	Greater than or equal to 74 % to less than 87 %	Greater than or equal to 87 %
C18	Greater than 12 %	Greater than 10 % to less than or equal to 12 %	Greater than 9 % to less than or equal to 10 %	Greater than 7 % to less than or equal to 9 %	Less than or equal to 7 %
C19	Less than 81 %	Greater than or equal to 81 % to less than 85 %	Greater than or equal to 85 % to less than 88 %	Greater than or equal to 88 % to less than 91 %	Greater than or equal to 91 %
C20	Less than 44 %	Greater than or equal to 44 % to less than 56 %	Greater than or equal to 56 % to less than 69 %	Greater than or equal to 69 % to less than 79 %	Greater than or equal to 79 %
C21	Less than 50 %	Greater than or equal to 50 % to less than 59 %	Greater than or equal to 59 % to less than 67 %	Greater than or equal to 67 % to less than 78 %	Greater than or equal to 78 %
C28	Greater than 0.68	Greater than 0.46 to less than or equal to 0.68	Greater than 0.26 to less than or equal to 0.46	Greater than 0.11 to less than or equal to 0.26	Less than or equal to 0.11
C29	Greater than 39 %	Greater than 28 % to less than or equal to 39 %	Greater than 17 % to less than or equal to 28 %	Greater than 8 % to less than or equal to 17 %	Less than or equal to 8 %
C30	Less than -0.121368	Greater than or equal to -0.121368 to less than 0	Greater than or equal to 0 to less than 0.202884	Greater than or equal to 0.202884 to less than 0.391253	Greater than or equal to 0.391253

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C31	Less than 96 %	Greater than or equal to 96 % to less than 98 %	Greater than or equal to 98 % to less than 99 %	Greater than or equal to 99 % to less than 100 %	Greater than or equal to 100 %
C32	Less than 92 %	Greater than or equal to 92 % to less than 96 %	Greater than or equal to 96 % to less than 98 %	Greater than or equal to 98 % to less than 100 %	Greater than or equal to 100 %
C33	Less than 86 %	Greater than or equal to 86 % to less than 94 %	Greater than or equal to 94 % to less than 97 %	Greater than or equal to 97 % to less than 100 %	Greater than or equal to 100 %

Notes: These are not the final thresholds for the 2026 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2026 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	Less than 90 %	Greater than or equal to 90 % to less than 94 %	Greater than or equal to 94 % to less than 97 %	Greater than or equal to 97 % to less than 100 %	Greater than or equal to 100 %
D01	PDP	Less than 95 %	Greater than or equal to 95 % to less than 97 %	Greater than or equal to 97 % to less than 98 %	Greater than or equal to 98 % to less than 100 %	Greater than or equal to 100 %
D02	MA-PD	Greater than 0.68	Greater than 0.46 to less than or equal to 0.68	Greater than 0.26 to less than or equal to 0.46	Greater than 0.11 to less than or equal to 0.26	Less than or equal to 0.11
D02	PDP	Greater than 0.06	Greater than 0.04 to less than or equal to 0.06	Greater than 0.02 to less than or equal to 0.04	Greater than 0.01 to less than or equal to 0.02	Less than or equal to 0.01
D03	MA-PD	Greater than 39 %	Greater than 28 % to less than or equal to 39 %	Greater than 17 % to less than or equal to 28 %	Greater than 8 % to less than or equal to 17 %	Less than or equal to 8 %
D03	PDP	Greater than 12 %	Greater than 8 % to less than or equal to 12 %	Greater than 5 % to less than or equal to 8 %	Greater than 3 % to less than or equal to 5 %	Less than or equal to 3 %
D04	MA-PD	Less than -0.233766	Greater than or equal to -0.233766 to less than 0	Greater than or equal to 0 to less than 0.320439	Greater than or equal to 0.320439 to less than 0.579545	Greater than or equal to 0.579545
D04	PDP	Less than -0.183824	Greater than or equal to -0.183824 to less than 0	Greater than or equal to 0 to less than 0.330927	Greater than or equal to 0.330927 to less than 0.672727	Greater than or equal to 0.672727
D07	MA-PD	Less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 99	Greater than or equal to 99
D07	PDP	Less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 99	Greater than or equal to 99
D08	MA-PD	Less than 83 %	Greater than or equal to 83 % to less than 86 %	Greater than or equal to 86 % to less than 89 %	Greater than or equal to 89 % to less than 92 %	Greater than or equal to 92 %
D08	PDP	Less than 85 %	Greater than or equal to 85 % to less than 87 %	Greater than or equal to 87 % to less than 89 %	Greater than or equal to 89 % to less than 92 %	Greater than or equal to 92 %
D09	MA-PD	Less than 84 %	Greater than or equal to 84 % to less than 88 %	Greater than or equal to 88 % to less than 91 %	Greater than or equal to 91 % to less than 93 %	Greater than or equal to 93 %
D09	PDP	Less than 88 %	Greater than or equal to 88 % to less than 90 %	Greater than or equal to 90 % to less than 91 %	Greater than or equal to 91 % to less than 93 %	Greater than or equal to 93 %
D10	MA-PD	Less than 84 %	Greater than or equal to 84 % to less than 88 %	Greater than or equal to 88 % to less than 90 %	Greater than or equal to 90 % to less than 93 %	Greater than or equal to 93 %
D10	PDP	Less than 87 %	Greater than or equal to 87 % to less than 89 %	Greater than or equal to 89 % to less than 90 %	Greater than or equal to 90 % to less than 92 %	Greater than or equal to 92 %
D11	MA-PD	Less than 81 %	Greater than or equal to 81 % to less than 87 %	Greater than or equal to 87 % to less than 91 %	Greater than or equal to 91 % to less than 96 %	Greater than or equal to 96 %

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D11	PDP	Less than 27 %	Greater than or equal to 27 % to less than 51 %	Greater than or equal to 51 % to less than 70 %	Greater than or equal to 70 % to less than 83 %	Greater than or equal to 83 %
D12	MA-PD	Less than 81 %	Greater than or equal to 81 % to less than 85 %	Greater than or equal to 85 % to less than 89 %	Greater than or equal to 89 % to less than 93 %	Greater than or equal to 93 %
D12	PDP	Less than 82 %	Greater than or equal to 82 % to less than 83 %	Greater than or equal to 83 % to less than 84 %	Greater than or equal to 84 % to less than 86 %	Greater than or equal to 86 %

Notes: These are not the final thresholds for the 2026 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2026 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	36	100
C02	26	100
C04	57	85
C05	70	98
C06	20.5	80
C07	0	100
C08	68	100
C09	71	100
C10	0	100
C11	36	100
C12	58	100
C13	9	100
C14	51	100
C15	20.5	94
C16	24	66
C17	1	100
C18	3	17
C19	73	100
C20	0	100
C21	21	98
C28	0	1.04
C29	0	82
C30 (improve)	0	1
C30 (decline)	-0.628528	0
C31	92	100
C32	84	100
C33	80	100

Notes: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For C30 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the C30 (improved) group.

Table K-6: 2026 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Type	Lower Cutoff	Upper Cutoff
D01	MA-PD	88	100
D02	MA-PD	0	1.04
D03	MA-PD	0	82
D04 (improve)	MA-PD	0	1
D04 (decline)	MA-PD	-0.844155	0
D07	MA-PD	99	99
D08	MA-PD	73	100
D09	MA-PD	79	100
D10	MA-PD	75	100
D11	MA-PD	71	100
D12	MA-PD	70	100
D01	PDP	88	100
D02	PDP	0	0.19
D03	PDP	0	28
D04 (improve)	PDP	0	1
D04 (decline)	PDP	-1	0
D07	PDP	99	99
D08	PDP	76	97
D09	PDP	82	96
D10	PDP	81	95
D11	PDP	0	100
D12	PDP	80	87

Note: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For D04 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the D04 (improved) group.

Guardrails are then applied to all non-CAHPS measures, with a few exceptions. Guardrails are not applied to the Part C and Part D improvement measures. Additionally, guardrails are not applied to new measures that have been in the Part C and D Star Rating program for 3 years or less. Measures returning to the Star Ratings after a substantive measure specification change are treated as new measures. Cut points for these new measures and improvement measures are based on the hierarchal clustering methodology with mean resampling. When applying guardrails, the difference between the current year and prior year's cut point is calculated for each of the 1 to 5 star levels. A cap value is then calculated and compared to the observed threshold difference.

- For measures having a 0 to 100 scale, an absolute percentage cap of 5 percentage point is applied.
  - If the absolute difference between the current and prior year's cut point is less than or equal to 5 percentage points, the current year's cut point is used as the final cut point value.
  - If the absolute difference between the current and prior year's cut point is greater than 5 percentage points, a 5 percentage point cap is applied. That is, 5 percentage points are added

to or subtracted from the prior year's cut point value (depending on the direction of movement for the cut point value in the current year) to obtain the final cut point value for the current year.

- For measures not having a 0 to 100 scale, a restricted range cap of 5 percent of the prior year's score range is applied. Specifically, the restricted range cap is equal to the prior year's (maximum score value – minimum score value excluding outer fence outliers) * 0.05.
    - If the absolute difference between the current and prior year's is less than or equal to the calculated restricted range cap value, the current year's cut point is used as the final cut point value.
    - If the absolute difference between the current and prior year's is greater than the calculated restricted range cap value, then the restricted range cap is applied. That is, the calculated restricted range cap value is added to or subtracted from the prior year's cut point value (depending on the direction of the movement of the cut point value in the current year) to obtain the final cut point value for the current year.

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 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. All contracts' mean scores used in star assignments are case-mix adjusted and weighted to represent eligible enrollees by Part D status.

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-7 and K-8 contain the rules applied to determine the final CAHPS measure star value.

Table K-7: 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.

Table K-8: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
Less than 15th percentile by greater than 1 SE	1	1	1	2	2	2	2
Less than 15th percentile by less than or equal to 1 SE		2	1	2	2	2	2
Greater than or equal to 15th to less than 30th percentile	2	2	2	3	2	3	2
Greater than or equal to 30th to less than 60th percentile	3	2	2	3	3	4	4
Greater than or equal to 60th to less than 80th percentile	4	3	4	3	4	4	4
Greater than or equal to 80th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
Greater than or equal to 80th percentile by greater than 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (less than 0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability greater than or equal to 0.60 but less than 0.75 and also in the lowest 12% of contracts ordered by reliability. The SE is considered when the measure score is below the 15th percentile (in base group 1), significantly below average, and has low reliability: in this case, 1 star is assigned if and only if the measure score is at least 1 SE below the unrounded base group 1/2 cut point. Similarly, the SE is considered when the measure score is at or above the 80th percentile (in base group 5), significantly above average, and has low reliability: in this case, 5 stars are assigned if and only if the measure score is at least 1 SE above the unrounded base group 4/5 cut point.
For example, a contract in base group 4 that was not significantly different from average and had low reliability would receive 3 final stars.

As noted above, low reliability scores for CAHPS measures are defined as those with at least 11 respondents and reliability greater than or equal to 0.60 but less than 0.75 and also in the lowest 12% of contracts ordered by reliability. Table K-9 contains the 12% reliability cutoffs.

Table K-9: CAHPS Measure 12% Reliability Cutoffs

Measure	12% reliability cutoff
Annual Flu Vaccine	0.845946*
Getting Needed Care	0.725813
Getting Appointments and Care Quickly	0.589771**
Customer Service	0.624092
Rating of Health Care Quality	0.666920
Rating of Health Plan	0.810887*
Care Coordination	0.582772**
Rating of Drug Plan (MA-PD)	0.719340
Getting Needed Prescription Drugs (MA-PD)	0.575119**
Rating of Drug Plan (PDP)	0.926741*
Getting Needed Prescription Drugs (PDP)	0.803801*

Note: Reliabilities must be greater than or equal to 0.60 but less than 0.75 and also in the lowest 12% of contracts ordered by reliability to be designated as low reliability.
*These cutoffs are higher than 0.75, thus these cutoffs did not affect low reliability designations.
**These cutoffs are lower than 0.6, thus low reliability designations are not assigned for these measures.

Attachment L: Medication Adherence Measure Calculations

NOTE: The examples below provide a snapshot of how to calculate PDC adjustments for overlapping fill and for inpatients and skilled nursing facility stays. These examples are not intended to represent the calculation of the measures for the entire treatment period. Reminder, the treatment period should be at least 91 days.

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the treatment period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Calculating the PDC Adjustment for IP Stays and SNF Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

In this example, a beneficiary fills benazepril and captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the Captopril prescription after the days' supply for the Benazepril medication ended.

Table L-1: No Adjustment

	January		February		March		April
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Benazepril	15	16	15	13			
Captopril					15	16	30

PDC Calculation
Covered Days: 120
Treatment Period: 120
PDC: 120/120 = 100%

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same target generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted generic ingredient. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing hydrochlorothiazide. However, hydrochlorothiazide is not a RAS antagonist or targeted generic ingredient, so this overlap is not shifted.

Table L-2: Before Overlap Adjustment

	January		February		March		April
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Lisinopril	15	16					
Lisinopril & HCTZ		16	15				
Benazepril & HCTZ			15	13			

PDC Calculation
Covered Days: 59
Measurement Period: 120
PDC: 59/120 = 49%

Table L-3: After Overlap Adjustment

	January		February		March		April
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Lisinopril	15	16					
Lisinopril & HCTZ			15	13	3		
Benazepril & HCTZ			15	13			

PDC Calculation
Covered Days: 62
Measurement Period: 120
PDC: 62/120 = 52%

Example 3: Overlapping Fills of the Same and Different Target Drugs
In this example, a beneficiary is refilling both lisinopril and captopril. When a single and combination product both containing lisinopril overlap, there is an adjustment to the PDC. When lisinopril overlaps with captopril, we do not make any adjustment to the days covered.

Table L-4: Before Overlap Adjustment

	January		February		March		April	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 92
Measurement Period: 120
PDC: 92/120: 77%

Table L-5: After Overlap Adjustment

	January		February		March		April	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105/120: 88%

PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples

In response to Part D sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Star Ratings (using 2011 PDE data) to adjust for beneficiary stays in inpatient (IP) facilities, and with the 2015 Star Ratings (using 2013 PDE data) to also adjust for hospice enrollments and beneficiary stays in skilled nursing facilities (SNF). These adjustments account for periods that the Part D sponsor would not be responsible for providing prescription fills for targeted medications or more accurately reflect drugs covered under the hospice benefit or waived through the beneficiary's hospice election; thus, their medication fills during an IP or SNF stay or during hospice enrollment would not be included in the PDE claims used to calculate the Patient Safety adherence measures.

The PDC modification for IP stays, hospice enrollments, and SNF stays reflects this situation. Please note that while this modification will enhance the adherence measure calculation, extensive testing indicates that most Part D contracts will experience a negligible impact on their adherence rates. On average, the 2011 adherence rates increased 0.4 to 0.6 percentage points due to the inpatient stay adjustment, and the adjustment may impact the rates positively or negatively.

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. Hospice information and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs.

SNF claims from the CWF have been used to adjust the SNF PDC adjustments for PDPs. Starting in the 2019 measurement year, when available for MA-PDs in the CWF, adjust the SNF PDC adjustments. Additionally, starting in 2020 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries.

Note: Hospice enrollment is no longer a PDC adjustment but rather an exclusion starting with the 2020 Star Ratings (2018 YOS).

Calculating the PDC Adjustment for IP Stays and SNF Stays

The PDC modification for IP stays and SNF stays is based on two assumptions: 1) a beneficiary receives their medications through the facility during the IP or SNF stay, and 2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay or SNF stay, that supply can be used once he/she returns home. The modification is applied using the steps below:

- Identify start and end dates of relevant types of stays for beneficiaries included in adherence measures. The discharge date is included in the PDC adjustment.
  - Use IP claims from the CWF to identify IP stays, and when available for MA-PDs.
  - Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount with Medicare utilization days to identify Medicare Part A covered SNF stays. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 and/or a no payment reason code.
  - Use IP and SNF stay encounter data when available for MA-PD beneficiaries. Additionally, if IP and SNF stay claims for MA-PD enrolled beneficiaries are reported in the CWF, the CWF will remain as an additional data source.
- Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion of days covered calculation.
- Shift days' supply from Part D prescription fills that overlap with the stay or subsequent fills for the same drug class to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

If SNF and/or IP stays span a beneficiary's entire treatment period within the measurement period, the beneficiary is excluded from the denominator.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC.

NOTE: The examples below provide a snapshot of how to calculate the PDC adjustments for IP and SNF stays. These examples are not intended to represent the calculation of the measures for the entire treatment period. Reminder, the treatment period should be at least 91 days.

Example 1: Gap in Coverage after IP Stay

In this example, the treatment period is 15 days and the beneficiary meets eligibility criteria for the measure by receiving at least two fills on different dates of service. This beneficiary had drug coverage on days 1-8 and 12-15 and an IP stay on days 5 and 6, as illustrated in Table L-6.

Table L-6: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1	X1				X2	X2	X2	X2
Inpatient Stay					+	+									

PDC Calculation:
Covered Days: 12
Treatment Period: 15

PDC: 12/15 = 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the treatment period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received his/her medication through the hospital on days 5 and 6, then he/she accumulated two extra days' supply during the IP stay. The two extra days' supply is used to cover the gaps in Part D drug coverage in days 9 and 10. This is illustrated in Table L-7.

Table L-7: After Adjustment

Day	1	2	3	4	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	+	+		X2	X2	X2	X2
Inpatient Stay													

PDC Calculation:
Covered Days: 12
Treatment Period: 13
PDC: 12/13 = 92%

Example 2: Gap in Coverage before IP Stay

In this example, the treatment period is 15 days and the beneficiary meets eligibility criteria for the measure by receiving at least two fills on different dates of service. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and 13, as illustrated in Table L-8.

Table L-8: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2	X2	X2
Inpatient Stay												+	+		

PDC Calculation:
Covered Days: 11
Treatment Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the treatment period. While there are two days' supply from the IP stay on days 12 and 13, there are no days without drug coverage after the IP stay. Thus, the extra days' supply is not shifted. This is illustrated in Table L-9.

Table L-9: After Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2
Inpatient Stay													

PDC Calculation:
Covered Days: 9
Treatment Period: 13
PDC: 9/13 = 69%

Example 3: Gap in Coverage Before and After IP Stay

In this example, the treatment period is 15 days and the beneficiary meets eligibility criteria for the measure by receiving at least two fills on different dates of service. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, and an IP stay on days 6-9, as illustrated in Table L-10.

Table L-10: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			X2	X2	X2	X2			X3	X3	X3	X3
Inpatient Stay						+	+	+	+						

PDC Calculation:
Covered Days: 11
Treatment Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 6-9 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay, based on the assumption that the beneficiary received his/her medication through the hospital on days 6-9. In this case, only days 10 and 11 do not have drug coverage and are after the IP stay, so two days' supply are shifted to days 10 and 11. This is illustrated in Table L-11.

Table L-11: After Adjustment

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			+	+	X2	X2	X3	X3
Inpatient Stay											

PDC Calculation:
Covered Days: 9
Treatment Period: 11
PDC: 9/11 = 82%

Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class

In this example, the treatment period is 15 days and the beneficiary meets eligibility criteria for the measure by receiving at least two fills on different dates of service. This beneficiary had drug coverage from days 1-4, and 7-11 for the same drug class, and an IP stay on days 2-4, as illustrated in Table L-12.

Table L-12: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1			X2	X2	X2	X2	X2				
Inpatient Stay		+	+	+											

PDC Calculation:
Covered Days: 9
Treatment Period: 15
PDC: 9/15 = 60%

With the adjustment for the IP stay, days 2-4 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days' supply of the subsequent fill are

shifted. In this example, the days' supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes one day supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12. This is illustrated in Table L-13.

Table L-13: After Adjustment

Day	1	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	+	+	+	X2	X2	X2	X2	X2			
Inpatient Stay												

PDC Calculation:
Covered Days: 9
Treatment Period: 12
PDC: 9/12 = 75%

Attachment M: Methodology for MPF Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (MPF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the MPF price to the PDE price and determining the magnitude and frequency of differences found when the PDE price exceeds the MPF price. This document summarizes the methods currently used to construct each contract's MPF Composite Price Accuracy Score.

Contract Selection

The MPF Accuracy measure relies in part on the submission of pricing data to MPF. Therefore, only contracts with at least one plan meeting all of the following criteria are included in the analysis:

Not a PACE plan
Not a demonstration plan
Not an employer plan
Part D plan
Plan not terminated during the contract year

Only contracts with at least 30 eligible claims throughout the year are included in the accuracy measure. This ensures that the sample size of PDEs is large enough to produce a reliable accuracy score.

MPF Composite Price Accuracy Score

To calculate the MPF Composite Price Accuracy Score, the point-of-sale total cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the total cost resulting from using the unit price[1] reported on Plan Finder multiplied by the quantity listed on the PDE, plus the MPF dispensing fee.

This comparison includes only PDEs for which an MPF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. 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. NCPDP numbers are mapped to their corresponding NPI numbers.

1. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.[2]

2. The reference NDC must be on the plan's formulary. Drugs omitted from the plan's formulary are not included in the measure calculation, regardless of whether the drug is on the excluded drug supplemental file.

3. Because the retail unit cost reported on MPF is intended to apply to a 1, 2, or 3-month supply of a drugs, only claims with a Days Supply of 28-34, 60-62, or 90-93 are included. If a plan's bid indicates a 1, 2, or

[1] MPF unit costs are reported by plan, drug, days of supply, and pharmacy. The plan, drug, days of supply and pharmacy from the PDE are used to assign the corresponding MPF unit cost posted on medicare.gov on the date of the PDE.

[2] MPF prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use Medi-Span and then First Data Bank (FDB) if Medi-Span data is unavailable to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to MPF reference NDCs.

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. For example, a plan that submits a 3 month retail supply of 100 days in their bid will have claims with a days supply of 90-100 included in their accuracy measure calculation.

4. PDEs for dates of service during which the plan was suppressed from Plan Finder or where the relevant pharmacy or drug was not reported in Plan Finder are not included since no Plan Finder cost can be assigned.[3]
5. PDEs for compound drugs or non-covered drugs are not included.
6. The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

The MPF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the MPF. The contract's MPF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and MPF total cost,[4] and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to MPF prices.

Once MPF unit ingredient costs are assigned, the MPF ingredient cost is calculated by multiplying the unit costs reported on MPF by the quantity listed on the PDE. The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the MPF TC is the sum of the MPF ingredient cost and the MPF dispensing fee that corresponds to the same pharmacy, plan, and days of supply as that observed in the PDE[5]. Each claim is then given a score based on the difference between the PDE TC and the MPF TC. If the PDE TC is lower than or equal to the MPF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when point of sale costs are lower than or equal to the advertised costs. However, if the PDE TC is higher than the MPF TC, then the claim receives a score equal to the difference between the PDE TC and the MPF TC.[6, 7] The contract level MPF Price Accuracy Index is the sum of the claim level scores and PDE TC across all PDEs that meet the inclusion criteria, divided by the PDE TC for those same claims. The MPF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the MPF TC. Note that the best possible MPF Price Accuracy Index is 1, and the best possible MPF Claim Percentage Index is 0. This occurs when the MPF TC is never lower than the PDE TC. The formulas below illustrate the calculation of the contract level MPF Price Accuracy Index and MPF Claim Percentage Index:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iMPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

[4] MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is $10.237, then it is rounded to $10.24. MPF unit costs are not rounded.

[5] When assigning the MPF dispensing fee, CMS identifies brand or generic status of a drug using reference data sources (FDA NSDE and RxNorm). If a drug's status is inconsistent, CMS will assign the higher of the brand or generic dispensing fee.

[6] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded MPF cost by at least two cents ($0.02) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded MPF cost is $10.23, the 2-cent difference would be counted towards plan's accuracy score. However, if the rounded MPF cost is higher than $10.23, the difference would not count towards the plan's accuracy score.

[7] The MPF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the MPF price is lower than the floor price, the PDE price is compared against the floor price.

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i, and
TC_{iMPF} is the ingredient cost plus dispensing fee calculated from MPF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{\text{iPDE>MPF}}}{\sum_i \text{Claims}_{\text{iTotal}}}$$

where

$\text{Claims}_{\text{iPDE>MPF}}$ is the total number of claims where the PDE price is greater than the rounded MPF price

$\text{Claims}_{\text{iTotal}}$ is the total number of claims

We use the following formulas to convert the Claim Percentage Index and Price Accuracy Index into the MPF Composite Price Accuracy score:

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$
$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$
$$\text{MPF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

The MPF Composite Price Accuracy Score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table M-1 shows an example of the MPF Composite Price Accuracy Score calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 eligible claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the MPF data that had been submitted by the contract and posted on MPF on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength, and dosage form. Using the reference NDC, the following MPF data are obtained: brand/generic dispensing fee (from the pharmacy cost file) and unit cost (from the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The MPF cost is computed as the quantity dispensed from PDE multiplied by the MPF unit cost plus the MPF brand/generic dispensing fee (brand or generic status is assigned based on the NDC), and then rounded to the nearest cent.
The last column shows the amount by which the PDE cost is higher than the rounded MPF cost. When PDE cost is less than or equal to the rounded MPF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table M-1: Example of Price Accuracy Index Calculation

NDC	Pharmacy Number	PDE Data DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PDE Days of Supply	MPF Data Biweekly Posting Period	MPF Data Unit Cost	MPF Data Dispensing Fee Brand	MPF Data Dispensing Fee Generic	Assigned Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost MPF	Calculated Value Amount that PDE is higher than MPF
A	111	01/08/2024	3.82	2	60	60	01/06/24 - 01/19/24	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2024	0.98	2	30	60	01/20/24 - 02/02/24	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2024	10.48	1.5	24	28	02/03/24 - 02/16/24	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2024	47	1.5	90	30	02/17/24 - 03/01/24	0.48	1.5	2.25	G	48.50	45.45	3.05
											Totals	69.28		5.78
											Price Accuracy Index			1.08343
											Claim Percentage Index			0.5
											MPF Composite Price Accuracy Score			71

PDE = Prescription Drug Event
MPF = Medicare Plan Finder

Attachment N: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2024. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.

Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2024.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2025), or that were not required to participate in data validation.

- Contracts that terminate on or before 07/01/2025 according to the Contract Info extract.

Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section and contracts that scored 95% or higher on data validation for the MTM Program section but that were not compliant with data validation standards/sub-standards for at least one of the following MTM 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)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

File DV failure: Contracts that failed to submit the CY 2024 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2024 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2024 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have fewer than 31 beneficiaries enrolled are listed as "Not enough data available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contracts using the following formula:

Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period / Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period, met the specified targeting criteria per CMS during the reporting period, weren't in hospice at any point during the reporting period, and who were enrolled in the MTM program for at least 60 days during the reporting period. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are 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.

Attachment O: Methodology for the Puerto Rico Model

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. The categorization of contracts into final adjustment categories for the Categorical Adjustment Index (CAI) relies on both the use of a contract's percentages of beneficiaries with Low Income Subsidy/Dual Eligible (LIS/DE) and disabled beneficiaries. 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.

The contract-level modified LIS/DE percentages for Puerto Rico contracts for the 2026 Star Ratings are developed using the following sources of information:

- The 2023 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2023 ACS 5-year estimates for the percentage of people living below 150% of the FPL; for Puerto Rico and for the 10 poorest US states (which may include the District of Columbia).
- The Medicare enrollment data file for those enrolled during 2024 provided for beneficiaries who were alive at least through December 2024, the percentage of each contract's beneficiaries who were DE, and for non-Puerto Rico contracts, the percentage who were LIS/DE. Beneficiary DE status was determined using the monthly beneficiary dual status codes. For non-Puerto Rico contracts, beneficiaries who were LIS were determined using the monthly beneficiary LIS status codes, and beneficiaries were classified LIS/DE by combining the beneficiaries identified as DE and beneficiaries identified as LIS.

The following steps are employed to determine the modified percentages of LIS/DE for MA contracts solely serving the population of beneficiaries in Puerto Rico. All references to contracts in Puerto Rico are limited to the contracts solely serving the population of beneficiaries in Puerto Rico.

- The 10 states with the highest proportion of people living below the FPL are identified, based on 2023 1-year data from ACS (U.S. Census Bureau, U.S. Department of Commerce. "Population 65 Years and Over in the United States." *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S0103*, https://data.census.gov/table/ACSST1Y2023.S0103?q=S0103&g=010XX00US$0400000&y=2023&d=ACS+1-Year+Estimates+Subject+Tables. Accessed on 6 Jun 2025.) The states identified are *Alabama, Arkansas, District of Columbia, Kentucky, Louisiana, Mississippi, New Mexico, New York, Oklahoma, and West Virginia.*
- Data are aggregated from Medicare Advantage contracts that had at least 90% of their beneficiaries enrolled with mailing addresses within the 10 highest poverty states identified in step (1).
  For the 2026 Star Ratings adjustment, the data used for the model development included a total of 134 Medicare Advantage contracts with at least 90% of their beneficiaries with mailing addresses in one of the ten poorest states listed above.
- A linear regression model is developed using the known LIS/DE percentage and the corresponding DE percentage from the MA contracts in the 10 highest poverty states with at least 90% of their beneficiaries with mailing addresses in one of the ten states.
- The model for Puerto Rico is developed using the model in step (3) as its base.

The estimated slope from the linear fit in the previous step (3) is retained to approximate the expected relationship between the hypothetical percentage of beneficiaries with LIS/DE status for each contract in Puerto Rico and its DE percentage. Note that the percentage of Puerto Rican beneficiaries eligible for LIS is hypothetical, since LIS status is not available to beneficiaries in Puerto Rico. However, as Puerto Rico contracts are expected to have a larger percentage of low-income beneficiaries, the intercept term is adjusted to be more suitable for use with Puerto Rico contracts as follows:

The intercept term for the Puerto Rico model is estimated by assuming that the Puerto Rico model will pass through the point (x, y) where x is the observed average DE percentage in the Puerto Rico contracts, and y is the expected hypothetical average percentage of LIS/DE in Puerto Rico. The expected hypothetical average percentage of LIS/DE in Puerto Rico (the y value) is not observable but is estimated by multiplying the observed average percentage of LIS/DE in the 10 highest poverty states identified in step (1) by the ratio based on the 2023 5-year ACS estimates of the percentage living below 150% of the FPL in Puerto Rico compared to the corresponding percentage in the 10 poorest US states.

- To obtain each Puerto Rico contract's modified LIS/DE percentage, a contract's observed DE percentage is used in the Puerto Rico model developed in the previous step (4).

  A contract's observed DE percentage is multiplied by the slope estimate, and then, the newly derived intercept term is added to the product. The estimated modified LIS/DE percentage is capped at 100%. Any estimated LIS/DE percentage that exceeds 100% is categorized in the final adjustment category for LIS/DE with an upper bound of 100%.

  Note that the District of Columbia is included with the 50 US states when determining the 10 poorest in 2023. All estimated modified LIS/DE values for Puerto Rico are rounded to six decimal places when expressed as a percentage. (This rounding rule aligns with the limits for the adjustment categories for LIS/DE for the CAI.)

Model

The generic model developed to estimate a contract's LIS/DE percentage using its DE percentage is as follows:

$$\widehat{\text{LIS/DE}} = (\text{ Slope} \times \text{contract's DE percentage }) + (\text{ intercept })$$

Using the data from the 10 highest poverty states, the estimated slope was calculated to be 0.953992.

$$\widehat{\text{LIS/DE}} = (0.953992 \times \text{contract's DE percentage }) + (\text{ intercept })$$

Next, the intercept for the Puerto Rico model was determined using the point (x, y) where x is the observed average DE percentage in Puerto Rico contracts (28.804884%) and y is an estimated expected average hypothetical percentage of LIS/DE in Puerto Rico.

To calculate the estimated expected average percentage of LIS/DE in Puerto Rico, the observed average percentage of LIS/DE in the 10 poorest US states identified in step (1) is multiplied by the ratio of the percentage of Puerto Rico residents living below 150% of the FPL to the analogous percentage in the 10 poorest US states.

Description	Value
Percent of PR residents below 150% of FPL	58.400000%
Percent of residents in the 10 poorest US states below 150% of FPL	24.328679%
Observed average LIS/DE percentage in the 10 poorest US states	47.923411%
Observed average DE percentage in Puerto Rico contracts	28.804884%

The product thus becomes $\left(47.923411 \times \frac{58.400000}{24.328679}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.953992 \times \text{contract's DE percentage}) + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)\right)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 5%, the value of 5.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.953992 \times \text{contract's DE percentage}) + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)\right)$$

The hypothetical contract's DE percentage of 5.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.953992 \times 5.000000) + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)\right)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 5.000000% is 92.328521%.

The final adjustment category for the CAI adjustment is identified using the LIS/DE percentage 92.328521%.

Attachment P: Identification of Contracts Affected by Disasters

Natural disasters such as hurricanes and wildfires can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide them with important medical care and prescription drug coverage. These disasters may negatively affect the underlying operational and clinical systems that CMS relies on for accurate performance measurement in the Star Ratings program.

The 2026 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html) describes CMS's policy for making adjustments in the Star Ratings to take into account the effects of extreme and uncontrollable circumstances which occurred during the performance period. This is also codified in regulation at §422.166(i) and §423.186(i).

Operational Steps to Calculating Enrollment Impacted in Affected Contracts.

- Identify the areas which experienced both extreme and uncontrollable circumstances as defined in Section 1135 (g) of the Act and also are within a county or statistically equivalent entity, U.S. territory or tribal government designated in a major disaster declaration under the Stafford Act.
  - Areas where the Health and Human Services (HHS) Secretary exercised their authority under Section 1135 of the Act can be found at the Public Health Emergency website at https://www.phe.gov/emergency/news/healthactions/section1135/Pages/default.aspx
  - Major disaster areas are identified by the Federal Emergency Management Agency (FEMA) website at: https://www.fema.gov/disasters.

  Table P-1 lists the Section 1135 waivers issued by the HHS Secretary along with associated FEMA major disaster information that falls within the performance period for the 2026 Star Ratings.

Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
7/12/2024	Hurricane Beryl	Hurricane	Texas	**7/5/2024**
8/6/2024	Hurricane Debby	Hurricane	Florida	**8/1/2024**
8/7/2024	Hurricane Debby	Hurricane	Georgia	**8/4/2024**
9/12/2024	Hurricane Francine	Hurricane	Louisiana	9/9/2024
9/26/2024	Hurricane Helene	Hurricane	Florida	9/23/2024
9/27/2024	Hurricane Helene	Hurricane	Georgia	9/24/2024
9/28/2024	Hurricane Helene	Hurricane	North Carolina	9/25/2024
9/30/2024	Hurricane Helene	Hurricane	Tennessee	9/26/2024
9/30/2024	Hurricane Helene	Hurricane	South Carolina	9/25/2024
10/8/2024	Hurricane Milton	Hurricane	Florida	10/5/2024
1/10/2025*	Wildfires	Wildfires and Straight-line Winds	California	1/7/2025

*Applies to CAHPS measures only. For all contracts affected by the 2025 Los Angeles County wildfires (i.e., at least 25 percent of their enrollees resided in Los Angeles County at the time of the disaster), the CAHPS

measure-level better-of policy codified at §§ 422.166(i)(2)(iv) and 423.186(i)(2)(iv) will be implemented for the 2026 and 2027 Star Ratings.

- Identify the counties or statistically equivalent entities which were declared as Individual Assistance areas by each of the FEMA major disaster declarations that meet the criteria set out in Step 1 below.

  Table P-2 lists all of the relevant FEMA major disaster declarations along with the state and associated Individual Assistance counties.

Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4798-TX	Texas	Austin, Bowie, Brazoria, Chambers, Fort Bend, Galveston, Harris, Jackson, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Nacogdoches, Orange, Polk, San Jacinto, Shelby, Trinity, Walker, Waller, Wharton
DR-4806-FL	Florida	Alachua, Baker, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hillsborough, Jefferson, Lafayette, Levy, Madison, Manatee, Pinellas, Sarasota, Suwannee, Taylor
DR-4821-GA	Georgia	Bryan, Bulloch, Chatham, Effingham, Evans, Liberty, Long, Screven
DR-4817-LA	Louisiana	Ascension, Assumption, Jefferson, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne
DR-4828-FL	Florida	Alachua, Baker, Bradford, Charlotte, Citrus, Collier, Columbia, DeSoto, Dixie, Duval, Franklin, Gilchrist, Gulf, Hamilton, Hernando, Hillsborough, Jefferson, Lafayette, Lee, Leon, Levy, Madison, Manatee, Pasco, Pinellas, Putnam, Sarasota, Suwannee, Taylor, Union, Wakulla
DR-4830-GA	Georgia	Appling, Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Bryan, Bulloch, Burke, Butts, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Colquitt, Columbia, Cook, Dodge, Echols, Effingham, Elbert, Emanuel, Evans, Fulton, Glascock, Glynn, Hancock, Irwin, Jeff Davis, Jefferson, Jenkins, Johnson, Lanier, Laurens, Liberty, Lincoln, Long, Lowndes, McDuffie, McIntosh, Montgomery, Newton, Pierce, Rabun, Richmond, Screven, Stephens, Taliaferro, Tattnall, Telfair, Thomas, Tift, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler, Wilkes
DR-4827-NC	North Carolina	Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Eastern Band of Cherokee Indians of North Carolina, Forsyth, Gaston, Graham, Haywood, Henderson, Iredell, Jackson, Lee, Lincoln, Macon, Madison, McDowell, Mecklenburg, Mitchell, Nash, Polk, Rowan, Rutherford, Stanly, Surry, Swain, Transylvania, Union, Watauga, Wilkes, Yadkin, Yancey
DR-4832-TN	Tennessee	Carter, Cocke, Greene, Hamblen, Hawkins, Johnson, Unicoi, Washington
DR-4829-SC	South Carolina	Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Catawba Indian Reservation, Cherokee, Chester, Edgefield, Fairfield, Greenville, Greenwood, Hampton, Jasper, Kershaw, Laurens, Lexington, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union, York
DR-4834-FL	Florida	Brevard, Charlotte, Citrus, Clay, Collier, DeSoto, Duval, Flagler, Glades, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miccosukee Indian Reservation, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia
DR-4856-CA*	California	Los Angeles

*Applies to CAHPS measures only. For all contracts affected by the 2025 Los Angeles County wildfires (i.e., at least 25 percent of their enrollees resided in Los Angeles County at the time of the disaster), the CAHPS measure-level better-of policy codified at §§ 422.166(i)(2)(iv) and 423.186(i)(2)(iv) will be implemented for the 2026 and 2027 Star Ratings.

- Identify the service area at the state/county level for each contract in operation during the performance period. The service area of some organization types rated in the Star Ratings are not defined at the state/county level, so their service area must be transformed to include all states and counties covered by their service area.

  Table P-3 lists how the service area for each organization type rated in the Star Ratings is defined and what transformation, if any, is needed to create a common state/county level file for all contracts.

Table P-3: Organization type service areas and necessary transformations

Star Rating Organization Types	How Service Area is defined	How Service Area is transformed
1876 Cost, E-CCP, E-PDP, E-PFFS, Local CCP, MSA, PFFS, R-PFFS & R-CCP	State/County	Not necessary, service area is defined at the state/county level
Regional CCP	MA Region	A record is created for each state/county within the MA region
PDP	PDP Region	A record is created for each state/county within the PDP region

- Compare the Individual Assistance states and counties from Step 2 below to the service area from all contracts created in Step 3 below with the state and counties. Create a list of all contracts which have any county that matches in both lists.
- Create a second list of all contracts that do not share any service area with the Individual Assistance counties, so that information on the status of all contracts is accounted for during the performance period.
- Identify the timeframe for each disaster and the associated enrollment files. Each of the disasters occurred during a specific period of time. Since the enrollment in a contract is constantly changing, CMS used the enrollment the contract was paid for in a month that as closely matched the disaster period in the specific state/county as possible for all further processing, following the months in the table below.

  Table P-4 shows each of the disasters where relief was granted along with the disaster start date, and the enrollment file month that was used for that specific disaster. The enrollment file choice was based on the enrollment file cut-off date the file was created.

Table P-4: Major Disasters with associated enrollment months

FEMA Declaration	State	Start Date	Enroll File	Enroll Cut Off
DR-4798-TX	Texas	7/5/2024	August 2024	July 5, 2024
DR-4806-FL	Florida	8/1/2024	September 2024	August 9, 2024
DR-4821-GA	Georgia	8/4/2024	September 2024	August 9, 2024
DR-4817-LA	Louisiana	9/9/2024	October 2024	September 6, 2024
DR-4828-FL	Florida	9/23/2024	November 2024	October 4, 2024
DR-4830-GA	Georgia	9/24/2024	November 2024	October 4, 2024
DR-4827-NC	North Carolina	9/25/2024	November 2024	October 4, 2024
DR-4832-TN	Tennessee	9/26/2024	November 2024	October 4, 2024
DR-4829-SC	South Carolina	9/25/2024	November 2024	October 4, 2024
DR-4834-FL	Florida	10/5/2024	November 2024	October 4, 2024
DR-4856-CA	California	1/7/2025	February 2025	January 3, 2024

- Calculate disaster impacted enrollment for contracts experiencing multiple disasters. Because the contracts serve areas of different sizes and can sometimes serve large, diverse areas, it is common for a contract to be affected by more than one of the disasters. To account for this, CMS averaged the county/state level enrollments from each of corresponding enrollment periods in which the contract was affected.

  Table P-5 shows an example where all possible enrollment periods are accounted for and how the enrollment for a contract in a state/county which matched the contract's service area state/county was calculated. Enrollment in out of service area state/counties was not included.

Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters

Formula ID	Enrolled 202X_10	Enrolled 202X_11	Enrolled 202X_12	Enrollment Used
B	True	True	True	(202X_10 + 202X_11 + 202X_12) / 3
C	True	True		(202X_10 + 202X_11) / 2
F	True		True	(202X_10 + 202X_12) / 2
H	True			202X_10
J		True	True	(202X_11 + 202X_12) / 2
L		True		202X_11
N			True	202X_12
P				0 (zero)

- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in the entire service area for the contract to be used in further processing.
- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in all of the Individual Assistance counties that correspond to the contract service area.
- Using the final list of affected contracts from Step 4 below, calculate the percentage of the contract's total service area enrollment that was affected by the Individual Assistance area enrollment. Create flags for the greater than or equal to 25% threshold for processing of the ratings data for those contracts.

Example:

Steps 1 and 2 use the disasters and counties that have already been defined in Tables P-1 & P-2. For Steps 3 through 10, we use an example contract, HAAAA, which offers services to some counties from both California and Texas.

Step 3, Table P-6 below contains the full list of counties that make up the service area for contract HAAAA.

Step 4, the Individual Assistance County column is included in Table P-6. Rows marked TRUE are matches from Individual Assistance counties in the disasters for year 202X and the service areas of HAAAA. The rows marked FALSE were not Individual Assistance counties for any of the disasters in HAAAA.

Step 5, since the example contract HAAAA has service areas that coincide with disaster counties, it is not included in the list of contracts not affected.

Step 6, there are two separate enrollment periods associated with the disasters that match example contract HAAAA's service area. Those enrollment periods are 202X/09 & 202X/11. Columns for all enrollment periods are included in Table P-6, but only the valid enrollment periods contain the necessary data.

Step 7, the average enrollment is calculated for the included enrollment periods. The result of each average enrollment calculation for each county in the example contract's service area is shown in the final column of Table P-6.

Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
06003	Alpine	CA	No	FALSE	8	-	8	8
06009	Calaveras	CA	No	FALSE	849	-	850	850
06011	Colusa	CA	No	FALSE	168	-	166	167
06015	Del Norte	CA	No	FALSE	369	-	360	364
06023	Humboldt	CA	No	FALSE	702	-	710	706
06045	Mendocino	CA	No	TRUE	428	-	429	428
06049	Modoc	CA	No	FALSE	157	-	158	158
06063	Plumas	CA	No	FALSE	182	-	181	182
06093	Siskiyou	CA	No	FALSE	798	-	800	799
06105	Trinity	CA	No	FALSE	150	-	150	150
48043	Brewster	TX	Yes	FALSE	16	-	15	16
48047	Brooks	TX	Yes	FALSE	28	-	27	28
48049	Brown	TX	Yes	FALSE	64	-	65	64
48057	Calhoun	TX	Yes	TRUE	28	-	28	28
48093	Comanche	TX	Yes	FALSE	33	-	32	32
48103	Crane	TX	Yes	FALSE	8	-	8	8
48109	Culberson	TX	Yes	FALSE	3	-	3	3
48123	DeWitt	TX	Yes	TRUE	26	-	26	26
48131	Duval	TX	Yes	FALSE	30	-	28	29
48133	Eastland	TX	Yes	FALSE	64	-	62	63
48143	Erath	TX	Yes	FALSE	61	-	59	60
48163	Frio	TX	Yes	FALSE	43	-	42	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	17
48175	Goliad	TX	Yes	TRUE	18	-	18	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	41
48237	Jack	TX	Yes	FALSE	35	-	34	34
48239	Jackson	TX	Yes	TRUE	30	-	30	30
48255	Karnes	TX	Yes	TRUE	19	-	19	19
48265	Kerr	TX	Yes	FALSE	85	-	86	86
48283	La Salle	TX	Yes	FALSE	25	-	25	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	24
48301	Loving	TX	Yes	FALSE	0	-	0	0
48311	McMullen	TX	Yes	FALSE	4	-	4	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	142
48323	Maverick	TX	Yes	FALSE	160	-	156	158
48371	Pecos	TX	Yes	FALSE	20	-	21	20
48377	Presidio	TX	Yes	FALSE	50	-	49	50

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48389	Reeves	TX	Yes	FALSE	8	-	8	8
48391	Refugio	TX	Yes	TRUE	21	-	21	21
48443	Terrell	TX	Yes	FALSE	9	-	9	9
48463	Uvalde	TX	Yes	FALSE	13	-	10	12
48469	Victoria	TX	Yes	TRUE	158	-	154	156
48475	Ward	TX	Yes	FALSE	15	-	15	15
48495	Winkler	TX	Yes	FALSE	20	-	20	20

Step 8, sum the average enrollment from all rows from Table P-6. The total comes out to 5,120 for contract HAAAA.

Step 9, sum the average enrollment from all the rows from Table P-6 where the Individual Assistance counties is TRUE for contract HAAAA. The Individual Assistance total comes out to 909.

Step 10, calculate the final percentage for contract HAAAA. (909 / 5,120) * 100 = 17.753906 = 18%. The flag for greater than or equal to 25% is set to false since the example contract did not meet those thresholds.

Attachment Q: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages in each level of the Star Ratings.

Measure level messages

Table Q-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table Q-1: Measure level missing data messages

Message	Measure Level
Coming Soon	Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live
Medicare shows only a Star Rating for this topic	Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report
Not Applicable	Used in the numeric data for the improvement measures in Plan Preview 1. In the HPMS Measure Star Page when a measure does not apply for a contract. When a Disenrollment Reasons Survey measure does not apply to the contract type.
Benefit not offered by plan	The contract was required to report this HEDIS measure but doesn't offer the benefit to members
Plan too new to be measured	The contract is too new to have submitted measure data
No data available	There were no data for the contract included in the source data for the measure
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules
Plan not required to report measure	The contract was not required to report the measure

Assignment rules for Part C measure messages

Part C uses a set of rules for assigning the missing data message that varies by the data source. The rules for each data source are defined below.

Appeals (IRE) measures (C31 & C32):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Is there a valid numeric measure rate?
  - Yes: Display the numeric measure rate
  - No: Is the contract effective date greater than 01/01/2024?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C22, C23, C24, C25, C26, & C27):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date greater than 07/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (C33):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost, MSA, or Employer/Union Only Direct Contract PDP?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date greater than 01/01/2025?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C28):

Is the contract effective date greater than 01/01/2024?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment less than 800 in 2024?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

HEDIS measures except PCR and TRC (C01, C02, C10 – C14, C17, C19, C21):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment less than 500 in July 2024?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR 18 and older (C18)

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment less than 500 in July 2024?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the combined denominator for the 18-64 and 65+ measures less than 150?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS TRC average (C20):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment less than 500 in July 2024?
  - Yes: Display message: Plan too small to be measured
  - No: Is the audit designation for all four TRC measures R?
    - No: Is the audit designation for any of the four TRC measures BD, BR, or NR?
      - Yes: Display message: CMS identified issues with this plan's data
      - No: Is the audit designation for any of the four TRC measures NB?
        - Yes: Display message: Benefit not offered by plan
        - No: The audit designation for one of the four TRC measures is NQ.
          Display message: Plan not required to report measure
    - Yes: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status for any component of the TRC average measure NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS SNP measures (C08 & C09):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2026?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Is there a valid HEDIS measure numeric rate?
      - Yes: What is the status?
        - NA: Display message: Not enough data available
        - R: Display the HEDIS measure numeric rate
      - No: Display message: No data available

HEDIS-HOS measures (C06, C15, & C16):

Is there a valid HEDIS-HOS numeric rate?
- Yes: Display the HEDIS-HOS numeric rate
- No: Is the contract effective date greater than 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Is the February 2024 contract enrollment less than 500?
    - Yes: Display message: Plan too small to be measured
    - No: Is there a HEDIS-HOS rate code?
      - Yes: Assign message according to value below:
        - NA: Display message: Not enough data available
        - NB: Display message: Benefit not offered by plan
      - No: Display message: No data available

HOS measures (C04 & C05):

Is there a valid numeric HOS measure rate?
- Yes: Display the numeric HOS rate
- No: Did the contract include only I-SNPs in 2022 or have fewer than 500 non-I-SNP enrollees in February 2022?
  - Yes: Display message: Plan not required to report measure
  - No: Was the HOS measure rate NA or is the denominator less than 100?
    - Yes: Display message: Not enough data available
    - No: Is the contract effective date greater than 01/01/2021?
      - Yes: Display message: Plan too new to be measured
      - No: Is the February 2022 contract enrollment less than 500?
        - Yes: Display message: Plan too small to be measured
        - No: Display message: No data available

Members Choosing to Leave the Plan (C29):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Plan Reporting SNP measure (C07):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2026?
- Yes: Display message: Plan not required to report measure
- No: Is there a valid Plan Reporting numeric rate?
  - Yes: Display the Plan Reporting numeric rate
  - No: Were there Data Issues Found?
    - Yes: Display message: CMS identified issues with this plan's data
    - No: Is the contract effective date greater than 01/01/2024?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C30):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part D measure messages

CAHPS measures (D05, D06):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date greater than 07/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (D01):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date greater than 01/01/2025?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (D02):

Is the contract effective date greater than 01/01/2024?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment less than 800 in 2024?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

Improvement (Star Ratings) measure (D04):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Members Choosing to Leave the Plan (D03):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

MPF Price Accuracy measure (D07):

Is the contract effective date greater than 9/30/2024?
- Yes: Display message: Plan too new to be measured
- No: Does contract have at least 30 claims over the measurement period for the price accuracy index?
  - Yes: Display the numeric price accuracy rate
  - No: Is the organization type 1876 Cost or Employer plan and does not offer Drugs?
    - Yes: Display message: Plan not required to report measure
    - No: Display message: Not enough data available

Patient Safety measures – Adherence (D08 - D10) & SUPD (D12):

Does the contract offer Part D?

Yes: Is the contract effective date greater than 12/31/2024?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiaries continuously enrolled (measure denominator)?
  - Yes: Display message: Not enough data available
  - No: Display numeric measure percentage

No: Plan not required to report measure

Patient Safety measure – MTM CMR (D11)

Is the contract effective date greater than 12/31/2024?
- Yes: Display message: Plan too new to be measured
- No: Is Part D offered?
  - Yes: Is there a numeric rate?
    - Yes: Display numeric measure percentage
    - No: Is there a Reason(s) for Display Message?
      - Yes: Display appropriate message per Table Q-2
  - No: Display message: Plan not required to report measure

Table Q-2: MTM CMR Reason(s) for Display Message conversion

Reason(s) for Display Message	Star Ratings Message
Contract failed to submit file and pass system validation by the reporting deadline	CMS identified issues with this plan's data
Contract did not pass element-level DV for at least one element	CMS identified issues with this plan's data
Contract had missing score on MTM section DV	CMS identified issues with this plan's data
Contract scored less than 95% on MTM section DV	CMS identified issues with this plan's data
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
Contract had all plans terminate by validation deadline	Not required to report
Contract had no MTM enrollees to report	Not required to report
Contract has 0 Part D enrollees	Not required to report
Contract not required to submit MTM program	Not required to report

Domain, Summary, and Overall level messages

Table Q-3 contains all of the possible messages that could be assigned to missing data at the domain, summary, and overall levels.

Table Q-3: Domain, Summary, and Overall level missing data messages

Message	Domain Level	Summary & Overall Level
Coming Soon	Used for all domain ratings in MPF between Oct 1 and when the actual Star Rating data go live	Used for all summary and overall ratings in MPF between Oct 1 and when the actual Star Rating data go live
Not enough data available	The contract did not have enough rated measures to calculate the domain rating	The contract did not have enough rated measures to calculate the summary or overall rating
Plan too new to be measured	The contract is too new to have submitted measure data for a domain rating to be calculated	The contract is too new to have submitted data to be rated in the summary or overall levels

Assignment rules for Part C & Part D domain rating level messages

Part C & D domain message assignment rules:

Is there a numeric domain star?
- Yes: Display the numeric domain star
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part C & Part D summary rating level messages

Part C & D summary rating message assignment rules:

Is there a numeric summary rating star?
- Yes: Display the numeric summary rating star
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for overall rating level messages

Overall rating message assignment rules:

Is there a numeric overall rating star?
- Yes: Display the numeric overall rating star
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2026 Star Ratings posted to the CMS downloadable Master Table and HPMS includes data collected from the Disenrollment Reasons Survey (DRS). The DRS data was not used at any point in the calculation of the Star Ratings. The data are provided for information only at this time and are shown in HPMS with the Star Ratings data and on the display page at http://go.cms.gov/partcanddstarratings.

Because there are instances where a contract does not have data to display, a set of rules was developed to assign messages where data was missing so the data area would not be left blank.
Table Q-4 contains all of the possible messages that could be assigned to missing data in the disenrollment reason data displayed in HPMS.

Table Q-4: Disenrollment Reason missing data messages

Message	Meaning
Not Applicable	Used when the DRS measure does not apply to the contract type
Not Available	Used when there is no numeric data available or data reliability indicated the value should be suppressed
Plan too new to be measured	The contract is too new for data to be collected for the measure

Disenrollment Reasons message assignment rules:

Is the contract effective date greater than 1/1/2024?
- Yes: Display message: Plan too new to be measured
- No: Is there numeric data for the contract in this DRS measure?
  - Yes: Did the data reliability check indicate the data should be suppressed?
    - Yes: Display message: Not Available
    - No: Display the numeric DRS rate
  - No: Does the DRS measure apply to the organization type
    - Yes: Display message: Not Available
    - No: Display message: Not Applicable

AEP	The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan or re-enroll into their existing Medicare Part C or D Plan or change into another Medicare plan is known as the Annual Election Period (AEP). The chosen Medicare Part C or D plan coverage begins on January 1st.
C-SNP	Chronic Condition Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2.
CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
CCP	A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS's requirements.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Cost Plan	A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan in accordance with a cost reimbursement contract under §1876(h) of the Act. In the Star Ratings, CMS classifies a Cost Plan not offering Part D as MA-Only and a Cost Plan offering Part D as MA-PD.
D-SNP	Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Disability Status	Based on the original reason for entitlement for Medicare (Disability insurance benefits or both Disability insurance benefits and End-Stage Renal Disease).
Dual eligibles	Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
Euclidean distance	The absolute value of the difference between two points, x-y.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
I-SNP	Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to institutionalized special needs individuals defined in 42 CFR 422.2.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-Only	An MA organization that does not offer Medicare prescription drug coverage.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
MSA	Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder).
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.

Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
PFFS	Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers who are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality (“signal”) rather than random variation (“noise”). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
SNP	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. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. 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).
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how likely differences observed are due to chance when plans are actually the same. CMS uses statistical tests (e.g., t-test) to determine if a contract’s measure value is statistically significantly greater or less than the national average for that measure, or whether conversely the observed differences from the national average could have arisen by chance.
Sum of Squares	Method used to measure variation or deviation from the mean.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.

Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

Attachment S: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS (https://hpms.cms.gov) to understand the various pages and fields shown in the HPMS Star Ratings module. This module employs standard HPMS user access rights so that users can only see contracts associated with their user id.

HPMS Star Ratings Module

The HPMS Star Ratings module contains the Part C & Part D data and stars for all contracts that were rated in the ratings year along with much of the detailed data that went into the various calculations. To access the Star Ratings module you must be logged into HPMS. If you do not have access to HPMS, information on how to obtain access can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Overview.html

Once you are logged into HPMS, from the home page, select *Performance Metrics* from the *Quality and Performance* menu; the Performance Metrics page will be displayed. If you do not see *Performance Metrics*, your user id does not have the correct access permissions; please contact CMSHPMS_Access@cms.hhs.gov From the Performance Metrics page, select *Reports* and then *Star Ratings and Display Measures* from the left side menu. The *Star Ratings and Display Measures* home page will be displayed.

On the *Star Ratings and Display Measures* home page, select *Star Ratings* as the Report Type and select a reporting period. The remainder of this attachment describes the HPMS pages available for the 2026 Star Ratings.

1. Measure Data page

The Measure Data page displays the numeric data for all Part C and Part D measures. This page is available during the first plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measures which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain name. The row immediately below the measure information contains the data time frame of the measure. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-1 below shows a sample of the left hand most columns shown in HPMS.

Table S-1: Measure Data page sample

Medicare Star Ratings Report Card Master Table						
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
				01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024	03/2025 - 06/2025
HAAAA	Market A	Contract A	PO A	Plan too new to be measured	Plan too new to be measured	Not enough data available
HBBBB	Market B	Contract B	PO B	Not enough data available	73%	81%
HCCCC	Market C	Contract C	PO C	63%	71%	80%

2. Measure Detail – CTM Summary page

The Measure Detail – CTM Summary page contains the underlying data used for the Part C and Part D Complaints (C28/D02) measures. This page is available during the first plan preview. Table S-2 below explains each of the columns displayed on this page.

Table S-2: Measure Detail – CTM Summary page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Number of Complaints	Number of non-excluded complaints for the contract
Complaint Average Enrollment	The average enrollment used in the final calculation
Complaints Less Than 800 Enrolled	Yes / No, Yes equals average enrollment less than 800, No equals average enrollment greater than or equal to 800

3. Measure Detail – Part C Appeals page

The Measure Detail – Part C Appeals page contains the case-level data of the non-excluded cases used in producing the Part C Appeals measures Plan Makes Timely Decisions about Appeals (C31) and Reviewing Appeals Decisions (C32). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2026 Star Ratings. This page is available during the first plan preview. Table S-3 below explains each of the columns displayed on this page.

Table S-3: Measure Detail – Part C Appeals page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Appeal Number	The case ID assigned to the appeal request
Appeal Priority	The priority of the appeal (Std Pre-Service, Exp Pre-Service, Pre-Service B Drug, or Retro)
Status	The status of the appeal (Closed, Decided, Pending, Promoted, Remanded, Reopened, Requested)
Date Appeal Filed	The Date the Plan Reconsideration was requested, as reported by the Part C Plan
Corrected Appeal Date	The Date Appeal Filed, as determined by the IRE/QIC
Date File Received (QIC)	The Date the IRE/QIC received the Appeal from the Part C Plan
Level 1 Extension	Indicates if the contract took an extension during their processing of the reconsideration, as reported by the contract
Adjusted Plan Interval	The number of days between the Date Appeal Filed (or Corrected Appeal Date, if applicable) and the Date File Received (QIC) adjusted based on the Appeal Priority (Std Pre-Service, Exp Pre-Service, or Retro) and adjusted to account for 5 mailing days
Appeal Decision	Decision associated with the appeal: Dismiss Appeal, Dismissed – Plan Approved Coverage, Favorable (Overturn MCO Denial), Partially Favorable (Partly Overturn MCO Denial), Unfavorable (Uphold MCO Denial), Withdraw Appeal, Remand to Plan.
Late Indicator	Indicates if the appeal case was considered late or not (0=Not Late, 1=Late)

4. Measure Detail – SNP CM page

The Measure Detail – SNP CM page contains the underlying data used in calculating the Part C SNP Care Management measure (C07). The formulas used to calculate the SNP CM measure are detailed in Attachment E. This page is available during the first plan preview. Table S-4 below explains each of the columns displayed on this page.

Table S-4: Measure Detail – SNP CM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Number of new enrollees	Number of new SNP enrollees eligible for an initial assessment (Data Element A)
Number of enrollees eligible for an annual HRA	Number of SNP enrollees eligible for an annual reassessment (Data Element B)
Number of initial HRAs performed on new enrollees	Number of initial assessments performed on new SNP enrollees (Data Element C)
Number of annual reassessments performed	Number of annual reassessments performed on eligible SNP enrollees (Data Element F)
Total Number of SNP Enrollees Eligible	Final measure numerator (Data Elements A + B)
Total Number of Assessments Performed	Final measure denominator (Data Elements C + F)
Percent of Eligible SNP Enrollees Receiving an Assessment	Final measure score
Data Validation Score	The data validation score for the contract
Reason for Exclusion	Reason (if any) contract submitted data was not used to generate a score

5. Measure Detail – HEDIS page

The Measure Detail – HEDIS page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adults measures, the Transitions of Care measure and the Plan All-Cause readmissions measure. The formulas used to calculate the SNP measures are detailed in Attachment E. The formula used to calculate the PCR measure is detailed in Attachment F. This page is available during the first plan preview. Table S-5 below explains each of the columns displayed on this page and Table S-6 explains the HEDIS audit designations.

Table S-5: Measure Detail – HEDIS page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
PBP ID	The Plan Benefit Package number associated with the data
Measure ID	The Star Ratings measure ID that corresponds to the data in the given row
Measure Name	The measure name that corresponds to the data in the given row
Rate	The measure rate
Eligible Population	The measure eligible population
Observed Count	The measure observed count (only applicable for PCR)
Expected Count	The expected count (only applicable for PCR)
Denominator	The measure denominator
Audit Designation	The audit designation (the audit codes are defined in the next table)
Status	The status (the status codes are defined in the next table)
Average Plan Enrollment	The average enrollment in the PBP during 2024 (see section Contract Enrollment Data)

Table S-6: HEDIS 2024 Audit Designations and 2026 Star Ratings

Audit Designation	Status	NCQA Description	Resultant Star Rating
R	R	Reportable	Assigned 1 to 5 stars depending on reported value
BR	R or NA	Biased Rate	1 star, numeric data set to "CMS identified issues with this plan's data"
R	NA	Small Denominator	"Not enough data available"
NB	R or NA	No Benefit	"Benefit not offered by plan"
NR	R or NA	Not Reported	1 star, numeric data set to "CMS identified issues with this plan's data"
NQ	R or NA	Not Required	"Plan not required to report measure" (applies only to 1876 Cost in the PCRb measure)
UN		Un-Audited	Not possible in Star Ratings measures which only use audited data

6. Measure Detail – CTM page

The Measure Detail – CTM page contains the case level data of the non-excluded cases used in producing the Part C & Part D Complaints measure (C28/D02). This page is available during the first plan preview. Table S-7 below explains each of the columns displayed on this page.

Table S-7: Measure Detail – CTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Complaint ID	The case number associated with the complaint in the HPMS CTM module
Complaint Category	The complaint category code
Category	The complaint category description of CMS or plan lead
Subcategory	The complaint subcategory description associated with this case
Subcategory — Other	The complaint additional subcategory description associated with this case
Contract Assignment / Reassignment Date	The date that complaints are assigned or re-assigned to contracts

7. Measure Detail – Disenrollment

The Measure Detail – Disenrollment page contains data that are used in calculating the Part C & Part D disenrollment measure (C29/D03). The page shows the denominator, unadjusted numerator and original rate received from the MBDSS annual report. It also contains the adjusted numerator and final rate after all members meeting the measure exclusion criteria described in the measure description have been removed. This page is available during the first plan preview. Table S-8 below explains each of the columns displayed on this page.

Table S-8: Measure Detail – Disenrollment page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Number Enrolled	The number of all members in the contract from MBDSS annual report
Number Disenrolled	The number disenrolled with a disenrollment reason code of 11, 13, 14 or 99, from the MBDSS annual report
Original Rate	The disenrollment rate as calculated by the annual MBDSS report
Adjusted Disenrolled	The adjusted numerator when all members who meet the measure exclusion criteria are removed
Adjusted Rate	The final adjusted disenrollment rate used in the Star Ratings
Greater than 1000 Enrolled	Flag indicates contract non-employer group enrollment greater than 1,000 members during the year or contracts that did not have any disenrollments meeting the inclusion criteria (True equals Yes, False equals No)

8. Measure Detail – DR (Disenrollment Reasons)

The Measure Detail – Disenrollment Reasons page contains the data from the Disenrollment Reasons Survey (DRS). The Disenrollment Reasons data are not used at any point in the calculations of the Star Ratings but are provided in HPMS for information only at this time. The data come from surveys sent to enrollees who disenrolled between 1/1/2024 and 12/31/2024. Scores are suppressed if they are measured with very low reliability (less than 0.60) and not statistically different from the national mean. This page is available during the first plan preview. Table S-9 below explains each of the columns displayed on this page.

Table S-9: Measure Detail – Disenrollment Reasons page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
DR PGPPPNC	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)
DR PCDH	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)
DR FRD	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)
DR PPDBC	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)
DR PGIHP	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)

9. Measure Detail – MTM page

The Measure Detail – MTM page contains each contract's underlying denominator and numerator after measure specifications have been applied to the plan-reported validated data to calculate the Part D MTM Program Completion Rate for CMR (D11). The formulas used to calculate the MTM measure are detailed in Attachment N. This page is available during the first plan preview. Table S-10 below explains each of the columns displayed on this page.

Table S-10: Measure Detail – MTM page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Total Part D Enrollees	The number of Part D enrollees in the contract (average monthly HPMS enrollment)
Total MTM Enrollees, All	The number of Part D enrollees enrolled in the contract's MTM program (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.
Total MTM Enrollees, Targeted	The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.
Total MTM Enrollees, Targeted, Adjusted	The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D plan-reported data) after measure specifications applied as detailed in Attachment N. (Measure Denominator)
Total MTM Enrollees, Targeted, Adjusted, Who Received a CMR	The number of beneficiaries from the denominator who received a CMR. (Measure Numerator)
MTM Program Completion Rate for CMR	The percent of MTM program enrollees who received a CMR. (Measure Numerator)/(Measure Denominator)
MTM Section Data Validation Score	Contract's score in data validation (DV) for their MTM Program Reporting Requirements data
Reason(s) for Display Message	Reason(s) for display message assignment (if applicable)

10. Measure Detail – CAHPS page

The Measure Detail – CAHPS page contains the underlying data used in calculating the Part C & D CAHPS measures: Annual Flu Vaccine (C03), Getting Needed Care (C22), Getting Appointments and Care Quickly (C23), Customer Service (C24), Rating of Health Care Quality (C25), Rating of Health Plan (C26), Care Coordination (C27), Rating of Drug Plan (D05), and Getting Needed Prescription Drugs (D06). This page is available during the first plan preview. Table S-11 below explains each of the columns displayed on this page.

Table S-11: Measure Detail – CAHPS page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
CAHPS Measure	The CAHPS measure identifier followed by the Star Ratings measure id in parenthesis
Reliability	The contract-level reliability of the measure data
Statistical Significance	The statistical significance of the measure data (Below Average, No Difference, Above Average)
Use N	The number of usable surveys with responses to the item, or at least one item of a composite
Mean Score on Original Scale	The mean score on the original survey response scale
Variance of Mean on Original Scale	The sampling variance of contract mean ("Mean score") on the original scale
Standard Error on Original Scale	The standard error of the contract mean ("Mean score") on the original scale; square root of "variance"
Scaled Mean	The contract mean score rescaled to a 0-100 scale
Scaled SE	The standard error of the 0-100 scaled mean
Base Group	Categories determined by the percentile cutoffs from the distribution of mean scores
Star Rating	Determined by the percentile cutoffs, statistical significance of the difference of the contract mean from the overall mean, the statistical reliability of the estimate, and standard error of the mean score

11. Calculation Detail – MD

The Calculation Detail – MD page contains the summary of service area and enrollment data used to calculate the percentages for use in the Major Disaster rules for the individual measures. This page is available during the first plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Calculation Detail – MD page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Disaster Flag 2024	Indicates if the contract was affected by a 2024 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2024	The total number of counties in the contract's 2024 service area (SA)
Num Cnty IA 2024	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2024 disaster
IA Enrolled 2024	The number of members residing in the contract SA designated FEMA IA counties in a 2024 disaster
Total Enrolled 2024	The total number of members residing in the contract's 2024 SA
IA % 2024	The percent of members living in IA areas in a 2024disaster (IA Enrolled) divided by (Total Enrolled)
IA % Rounded 2024	The percent of members living in IA areas in a 2024 disaster rounded to an integer
Greater than or equal to 25% 2024	Flag that indicates if the contract has met the 25% threshold for 2024 disasters (Yes: greater than or equal to 25 %, No: less than 25%)
IA% 2025 LA Wildfires	The percent of members living in IA areas for the 2025 Los Angeles County wildfires.
IA% Rounded 2025 LA Wildfires	The percent of members living in IA areas for the 2025 Los Angeles County wildfires rounded to an integer.
Greater than or equal to 25% LA Wildfires	Flag that indicates if the contract has met the 25% threshold for 2025 Los Angeles County wildfires (Yes: greater than or equal to 25 %, No: less than 25%)
CAHPS Exemption for 2025 LA Wildfires	Flag that indicates if the contract met the 25% threshold for the 2025 Los Angeles County wildfires, and requested and received an exemption for the CAHPS survey (Yes: received an exemption, No: did not qualify for an exemption)
Disaster Flag 2023	Indicates if the contract was affected by a 2023 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2023	The total number of counties in the contract's 2023 service area (SA)
Num Cnty IA 2023	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2023 disaster
IA Enrolled 2023	The number of members residing in the contract SA designated FEMA IA counties in a 2023 disaster
Total Enrolled 2023	The total number of members residing in the contract's 2023 SA
IA % 2022	The percent of members living in IA areas in a 2023 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2023	The percent of members living in IA areas in a 2023 disaster rounded to an integer
Greater than or equal to 25% 2023	Flag that indicates if the contract has met the 25% threshold for 2022 disasters (Yes: greater than or equal to 25 %, No: less than 25%)

12. Calculation Detail – CAI

The Calculation Detail – CAI page contains the enrollment data used to calculate the percentages for use in the Categorical Adjustment Index (CAI) to determine the Final Adjustment Categories for each of the summary and overall rating calculations. This page is available during the first plan preview. Table S-13 below explains the columns displayed on this page.

Table S-13: Measure Detail – CAI page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Puerto Rico Only	Does the contract's non-employer service area only cover Puerto Rico? Yes or No
Contract Type	The contract plan type used to compute the ratings
Part D Offered	Is Part D offered by the contract? Yes or No
Enrolled	The total number enrolled in the contract used to determine the % LIS/DE and % Disabled
Num LIS/DE	The number of LIS/DE enrolled in the contract
Num Disabled	The number of Disabled enrolled in the contract
% LIS/DE	The percent of LIS/DE in the contract
% Disabled	The percent Disabled in the contract
Part C LIS/DE Initial Group	The Part C LIS/DE initial group this contract is in
Part C Disabled Quintile	The Part C Disabled Quintile group this contract is in
Part C FAC	The Part C Final adjustment category this contract is in
Part C CAI Value	The CAI value that will be combined with the final Part C summary score prior to rounding to half stars
Part D MA-PD LIS/DE Initial Group	The Part D MA-PD LIS/DE initial group this contract is in
Part D MA-PD Disabled Quintile	The Part D MA-PD Disabled Quintile group this contract is in
Part D MA-PD FAC	The Part D MA-PD Final adjustment category this contract is in
Part D MA-PD CAI Value	The CAI value that will be combined with the final Part D MA-PD summary score prior to rounding to half stars
Part D PDP LIS/DE Quartile	The Part D PDP LIS/DE Quartile group this contract is in
Part D PDP Disabled Quartile	The Part D PDP Disabled Quartile group this contract is in
Part D PDP FAC	The Part D PDP Final adjustment category this contract is in
Part D PDP CAI Value	The CAI value that will be combined with the final Part D PDP summary score prior to rounding to half stars
Overall LIS/DE Initial Group	The overall LIS/DE initial group this contract is in
Overall Disabled Quintile	The overall disabled Quintile group this contract is in
Overall FAC	The overall final adjustment category this contract is in
Overall CAI Value	The CAI value that will be combined with the final overall score prior to rounding to half stars

13. Measure Detail – HEDIS LE page

The Measure Detail – HEDIS LE page contains the data used to calculate the reliability of the HEDIS measures (C01, C02, C10 – C14, C17 – C21) data for contracts with greater than or equal to 500 and less than 1,000 members enrolled in July of the measurement year (July 01, 2024). This page is available during the second plan preview. Table S-14 below explains each of the columns displayed on this page.

Table S-14: Measure Detail – HEDIS LE page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The parent organization of the contract
Measure ID	The Star Ratings measure that the other data on this row is associated with
Rate	The submitted HEDIS rate
Score	The rounded value used for the measure in the Star Ratings
Enrollment	The contract enrollment for July 2024
Reliability	The computed reliability for the contract measure
Usable	The computed reliability greater than or equal to 0.7 and rate is used equals True, reliability less than 0.7 and rate was not used equals False

14. Measure Detail – C MD Results

The Part C Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-15 below explains the columns displayed on this page.

Table S-15: Measure Detail – C MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2026 Star Ratings Part C measure ID
2025 Value	The numeric measure value for the contract from the 2025 Star Ratings
2025 Star	The measure star for the contract from the 2025 Star Ratings
2026 Value	The numeric measure value for the contract from the 2026 Star Ratings
2026 Star	The measure star for the contract from the 2026 Star Ratings
Final Value	The measure value to be used in the 2026 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2026 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

15. Measure Detail – D MD Results

The Part D Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-16 below explains the columns displayed on this page.

Table S-16: Measure Detail – D MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2026 Star Ratings Part D measure ID
2025 Value	The numeric measure value for the contract from the 2025 Star Ratings
2025 Star	The measure star for the contract from the 2025 Star Ratings
2026 Value	The numeric measure value for the contract from the 2026 Star Ratings
2026 Star	The measure star for the contract from the 2026 Star Ratings
Final Value	The measure value to be used in the 2026 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2026 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

16. Measure Detail – C Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part C measures. There is one column for each Part C measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part C measure columns which contains the final numeric Part C improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part C measure calculations are shown in Table S-17 below.

Table S-17: Part C Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new
Held Harmless	The contract had 5 stars in this measure last year and this year
Low reliability and low enrollment	The low-enrollment contract measure score did not have sufficiently high reliability

17. Measure Detail – D Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part D measures. There is one column for each Part D measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part D measure columns which contains the final numeric Part D improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part D measure calculations are shown in Table S-18 below.

Table S-18: Part D Measure Improvement Results

Improvement Measure Result	Description
No significant change	There was no significant change in the values between the two years
Significant improvement	There was a significant improvement from last year to this year
Significant decline	There was a significant decline from last year to this year
Not included in calculation	There was only one year of data available so the calculation could not be completed
Not Applicable	The measure is not an improvement measure
Not Eligible	The contract did not have data in more than half of the improvement measures or was too new
Held Harmless	The contract had 5 stars in this measure last year and this year

18. Measure Stars page

The Measure Stars page displays the Star Rating for each Part C and Part D measure. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure stars which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-19 below shows a sample of the left hand most columns shown in HPMS.

Table S-19: Measure Stars page sample

Medicare Star Ratings Report Card Master Table						
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
				01/01/2024 - 12/31/2024	01/01/2024 - 12/31/2024	03/2025 - 06/2025
HAAAA	Market A	Contract A	PO A	Plan too new to be measured	Plan too new to be measured	Not enough data available
HBBBB	Market B	Contract B	PO B	Not enough data available	4	5
HCCCC	Market C	Contract C	PO C	3	4	5

19. Domain Stars page

The Domain Stars page displays the Star Rating for each Part C and Part D domain. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part C and Part D domains. The domain columns are identified by the domain id and domain name. All subsequent rows contain the stars associated with an individual contract. Table S-20 below shows a sample of the left hand most columns shown in HPMS.

Table S-20: Domain Star page sample

Medicare Star Ratings Report Card Master Table						
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines	HD2: Managing Chronic (Long Term) Conditions	HD3: Member Experience with Health Plan
HAAAA	Market A	Contract A	PO A	4	3	4
HBBBB	Market B	Contract B	PO B	3	3	3
HCCCC	Market C	Contract C	PO C	3	3	4

20. Part C Summary Rating page

The Part C Summary Rating page displays the Part C rating and data associated with calculating the final Part C summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-21 below explains each of the columns contained on this page.

Table S-21: Part C Summary Rating page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP? (Yes/No)
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 rounded to an integer
Major Disaster Percentage 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type.
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part C Summary FAC	Part C summary final adjustment category for the contract
CAI Value	The Part C summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final Part C summary rating come from the calculation using the improvement measure? (Yes/No)
New Measure Usage	Did the final Part C summary rating come from the calculation using the new measures? (Yes/No)
2026 Part C Summary Rating	The final rounded 2026 Part C Summary Rating

21. Part D Summary Rating page

The Part D Summary Rating page displays the Part D rating and data associated with calculating the final Part D summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-22 below explains each of the columns contained on this page.

Table S-22: Part D Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 rounded to an integer
Major Disaster Percentage 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part D Summary FAC	Part D summary final adjustment category for the contract
CAI Value	The Part D summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final Part D summary rating come from the calculation using the improvement measure? (Yes/No)
2026 Part D Summary Rating	The final rounded 2026 Part D Summary Rating

22. Overall Rating page

The Overall Rating page displays the overall rating for MA-PD contracts and data associated with calculating the final overall rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-23 below explains each of the columns contained on this page.

Table S-23: Overall Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
SNP Plans	Does the contract offer a SNP? (Yes/No)
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 rounded to an integer
Major Disaster Percentage 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
2026 Part C Summary Rating	The 2026 Part C Summary Rating
2026 Part D Summary Rating	The 2026 Part D Summary Rating
Calculated Summary Mean	Contains the weighted mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Overall FAC	Overall final adjustment category for the contract
CAI Value	The Overall CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final overall rating come from the calculation using the improvement measures? (Yes/No)
New Measure Usage	Did the final overall rating come from the calculation using the new measures? (Yes/No)
2026 Overall Rating	The final 2026 Overall Rating

23. Low Performing Contract List

The Low Performing Contract List page displays the contracts that received a Low Performing Icon and the data used to calculate the assignment. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a Low Performing Icon. Table S-24 below explains each of the columns contained on this page.

Table S-24: Low Performing Contract List

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Rated As	The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"
2024 C Summary	The 2024 Part C Summary Rating earned by the contract
2024 D Summary	The 2024 Part D Summary Rating earned by the contract
2025 C Summary	The 2025 Part C Summary Rating earned by the contract
2025 D Summary	The 2025 Part D Summary Rating earned by the contract
2026 C Summary	The 2026 Part C Summary Rating earned by the contract
2026 D Summary	The 2026 Part D Summary Rating earned by the contract
Reason for LPI	The combination of ratings that met the Low Performing Icon rules. Valid values are "Part C," "Part D," "Part C and D," & "Part C or D." See the section titled "Methodology for Calculating the Low Performing Icon" for details.

24. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table S-25 below explains each of the columns contained on this page.

Table S-25: High Performing Contract List

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Rated As	The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"
Highest Rating	The highest level of rating that can be achieved for this organization, valid values are "Part C Summary," "Part D Summary," "Overall Rating"
Rating	The star value attained in the highest rating for the organization type

25. Technical Notes link

The Technical Notes link provides the user with a copy of the 2026 Star Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur to the technical notes if errors are identified outside of the plan preview periods and after MPF data release.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2026 Star Ratings Technical Notes. Right clicking on the Technical Notes link will pop up a context menu which contains Save Target As…; clicking on this will allow the user to download and save a copy of the PDF document.

26. Medication NDC List

The Medication NDC List link provides the user a means to download a copy of the medication lists used for the Medication Adherence measures (D08 – D10) & SUPD (D12). This downloadable file is in Zip format and contains two Excel files.

27. Part C and Part D Example Measure Data

The Part C and Part D Example Measure Data link provides the user with a means to download a copy of the data for sample measures for the full set of contracts used to calculate the cut points. The data are de-identified such that individual contract's data cannot be determined. The data include the measure value, a flag for contracts that had data issues where applicable, a flag for HEDIS low enrollment contracts where applicable, and a flag identifying MAPD or PDP contracts where applicable. The cut points were calculated using Linux SAS/STAT v15.1 (Linux LIN 64 Red Hat Enterprise Linux release 9.6) and validated on SAS 9.4 (TS1M7) with SAS/STAT Version 15.2 installed on Version 10.0.26100 of Windows 11, 64-bit.

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Patient Safety Analysis

Medication Adherence Measures

Star Ratings Specifications
PDP/MA-PD Contracts
Report User Guide
Year of Service 2024

Web Portal

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Technical Support

If you need help accessing the ADH Patient Safety Report or have questions about its content, please contact the Acumen, LLC help desk at:

Email	Phone
PatientSafety@AcumenLLC.com	(650) 558-8006

If you have questions or concerns about CMS policies regarding Part D performance and quality measures, please contact CMS' Medicare Drug Benefit and C & D Data Group at:

Email

PartCandDStarRatings@cms.hhs.gov

1 Introduction

The Medication Adherence (ADH) measures analyze the percentage of Medicare Part D beneficiaries, 18 years or older, who adhere to medication regimens in targeted drug classes. The Centers for Medicare & Medicaid Services (CMS) provides Part D sponsors (i.e., contracts) with monthly reports containing information related to the ADH measures, calculated with Medicare Part D Prescription Drug Event (PDE) data. The rates in the ADH Patient Safety (PS) Report allow Prescription Drug Plans (PDP) or Medicare Advantage Prescription Drug Plans (MA-PD) to compare their performance to the overall Medicare Part D and contract-type rates and monitor their progress in improving ADH rates over time. MA-PD Plans are additionally able to compare their performance to non-Medicare-Medicaid Plans (MMP) in the ADH PS Reports.

The ADH PS Reports contain three separate ADH measures for three clinical conditions. The three clinical conditions and targeted drug classes are as follows:

- Medication Adherence for Diabetes Medications (Biguanides (BG), Sulfonylureas (SFU), Thiazolidinediones (TZD), Dipeptidyl Peptidase-4 (DPP-4) inhibitors, Glucose-dependent Insulinotropic Polypeptide and Glucagon-Like Peptide-1 (GIP/GLP-1) receptor agonists, Meglitinides (MEG), and Sodium-Glucose Cotransporter 2 (SGLT2) inhibitors).
- Medication Adherence for Hypertension (renin-angiotensin system (RAS) antagonists, defined as angiotensin converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs), or direct renin inhibitors. Also known as ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor combination products).
- Medication Adherence for Cholesterol (Statins).

This user guide is provided to assist contracts with understanding their ADH PS Reports. Section 2 presents an overview of the three Star Ratings ADH measure specifications, a history of any measure updates, and additional specifications that are unique to the Star Ratings ADH measures. Section 3 describes the structure of the Star Ratings ADH report package and its contents. The exclusion diagnoses and drug classes, developed by the Pharmacy Quality Alliance (PQA), that are used for the ADH measures are available in the Value Sets found under Help Documents on the PS Analysis Web Portal. Appendices A and B provide examples of how the Proportion of Days Covered (PDC) is adjusted for overlapping fills and facility stays, respectively. Additional information about the PS Reports, including general measure specifications and reporting features, is available in the PS General User Guide, located under Help Documents on the PS Analysis Web Portal.

Please note that the data included in the PS Reports and the PS Web Portal including any downloadable files, may contain confidential, privileged, and/or proprietary information and is reserved for the use of authorized users. CMS does not authorize the public use of the PS data, graphs, or any other information available on PS Reports and the PS Web Portal.

2 Measure Overview

The ADH rates are adapted from the PQA Proportion of Days Covered (PDC) measures. The PDC is the percentage of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category. The PQA partnered with the National Committee for Quality Assurance (NCQA), who performed the concept validation and testing on behalf of the PQA and assisted in the PDC measure's technical specification development. The measure is also endorsed by the National Quality Forum (NQF).

The ADH measures analyze the percentage of beneficiaries who were adherent to the targeted drug class(es) for the specified clinical conditions during the measurement period.

Higher rates represent better performance. For any methodological questions regarding the measures, please consult PQA's Web Page or contact them at https://www.pqaalliance.org/tech-assist-form.

The following sections summarize the specifications for the ADH rates and any changes to the measure specifications over time.

2.1 Measure Specifications

2.1.1 Key Terms

Year of Service (YOS):	The calendar year (January 1 through December 31) of the date on which a prescription was filled.
Measurement Year:	The calendar year (January 1 through December 31) when the measure is assessed. The measurement year corresponds to the YOS.
Measurement Period:	The measurement period represents the span of time analyzed by a given PS Report and is limited to a single measurement year. The measurement period starts on January 1 of the measurement year and expands with each monthly report, until it spans the full measurement year. Any claim's days' supply that extends beyond the last day of the measurement period or that extend into the beginning of the measurement period from a prescription claim in the previous year are not included in either measurement period. Additional information about the measurement period is available in the PS General User Guide.

Index Prescription Start Date (IPSD):

The IPSD is the earliest date of service (DOS) for a target medication during the measurement year.

Treatment Period:

The beneficiary's treatment period begins on the IPSD and ends on the last day of enrollment during the measurement year, death, or the end of the measurement year, whichever comes first. The treatment period should be at least 91 days.

A beneficiary may qualify for the ADH denominator in more than one Part D contract within the same measurement year because the treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. Please see example table below.

Table 1: IPSD and Treatment Period Example

Month	1	2	3	4	5	6	7	8	9	10	11	12
Contract	A	A	A	A	A	A	B	B	B	B	B	B
Observed PDE Claims of Target Medications	1/15		3/15		5/15			8/15		10/15		12/15
Claims Considered IPSD	IPSD Contract A							IPSD Contract B				
ADH Treatment Period	Treatment Period Contract A							Treatment Period Contract B				

2.1.2 Measure Definitions

Star Ratings Medication Adherence for Diabetes Medications Measure (ADH-Diabetes):

The percentage of continuously enrolled (CE) Medicare Part D beneficiaries[1], 18 years or older, who were adherent across the following classes of diabetes medications: BG, SFU, TZD, DPP-4 inhibitors, GIP/GLP-1 receptor agonists, MEG, and SGLT2 inhibitors.

Star Ratings Medication Adherence for Hypertension (RAS Antagonists) Measure (ADH-RAS):

The percentage of CE Medicare Part D beneficiaries, 18 years or older, who were adherent to RAS antagonists including, ACE inhibitors, ARBs, or Direct Renin Inhibitors.

Star Ratings Medication Adherence for Cholesterol (Statins) Measure (ADH-Statins):

The percentage of CE Medicare Part D beneficiaries, 18 years or older, who were adherent to statins.

Eligible Population: Medicare Part D beneficiaries that meet the following criteria are eligible to be included in the ADH measures:

- **Age:** Beneficiaries must be 18 years or older as of January 1st of the measurement year.[2]
- **Continuous Enrollment (CE):** Continuously enrolled (CE) in a Medicare Part D contract during the treatment period. No enrollment gaps during the treatment period are allowed.[3]

[1] Please reference Section 3.3 *Continuous Enrollment* of the Patient Safety General User Guide for more information on the CE methodology.

[2] Please reference Section 3.6 *Age Criteria* of the Patient Safety General User Guide for more information on age criteria methodology.

[3] Part D Enrollment is reported monthly in the Common Medicare Environment (CME), therefore, the one-day enrollment gap allowed during the treatment period described in the PQA Measure Manual does not apply to the Medicare population given that the shortest enrollment gap observed in the CME is one month.

Denominator:	Number of CE beneficiaries from the eligible population, 18 years or older, with at least two prescription claims on different DOS for medications in the targeted drug class(es) during the treatment period. The treatment period must last at least 91 days. The prescription claims can be for the same or different targeted medications.
Numerator:	Number of CE beneficiaries in the denominator with a PDC of 80% or higher for the targeted drug class(es).

2.1.3 Measure Exclusions

Medicare Part D beneficiaries from the eligible population are excluded from the Star Ratings ADH measures' denominator if they meet any of the following criteria:

Hospice:	Beneficiaries who have elected to receive hospice care with at least one day of hospice coverage during the measurement period. Hospice coverage is determined based on the hospice coverage start and end dates from the CME.
Inpatient (IP) and Skilled Nursing Facilities (SNF) stays:	Beneficiaries in IP or SNF stays for the entire treatment period within the measurement period are excluded from the denominator.
End-Stage Renal Disease (ESRD):	Beneficiaries diagnosed with ESRD at any time during the measurement period. ESRD diagnosis is determined according to the following criteria: 1) Beneficiaries with at least one day of ESRD dialysis day during the measurement period according to the ESRD dialysis start and end dates from the CME, or 2) Beneficiaries with ESRD in the primary diagnosis or any other diagnosis fields and DOS that overlap at least one day with the measurement period from Common Working File (CWF) and the Encounter Data System (EDS) including the Chart Review Records (CRRs) (See Section 2.1.5 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes.

Star Ratings ADH-Diabetes Additional Exclusion:

Insulin: Beneficiaries who have one or more prescriptions for insulin with a DOS in the treatment period are excluded from the denominator. Therefore, if the DOS of an insulin prescription is outside the treatment period, then such claims are not considered when determining exclusions. Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible NDC codes.

In the example provided below in Table 2a, the insulin prescription claim is outside the treatment period, and therefore, if the beneficiary is eligible and meets the ADH-Diabetes measure criteria, this beneficiary is included in contract A's ADH-Diabetes measure denominator.

Table 2a: Example of Beneficiary Not Excluded from the ADH-Diabetes Measure

Month	1	2	3	4	5	6	7	8	9	10	11	12
ADH-Diabetes Treatment Period							A	A	A	A	A	A
Insulin Prescription Claim		2/15										

Star Ratings ADH-RAS Additional Exclusion:

Sacubitril/Valsartan: Beneficiaries that received one or more prescription claims for sacubitril/valsartan with a DOS in the treatment period are excluded from the denominator. Therefore, if the DOS of a sacubitril/valsartan prescription is outside the treatment period, then such claims are not considered when determining exclusions. Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible NDC codes.

In the example provided below in Table 2b, the sacubitril/valsartan prescription claim for the ADH-RAS measure is outside the treatment period, and therefore, if the beneficiary is eligible and meets the ADH-RAS measure criteria, this beneficiary is included in contract A's ADH-RAS measure denominator.

Table 2b: Example of Beneficiary Not Excluded from the ADH-RAS Measure

Month	1	2	3	4	5	6	7	8	9	10	11	12
ADH-RAS Treatment Period							A	A	A	A	A	A
Sacubitril/Valsartan Prescription Claim		2/15										

2.1.4 PDC Calculation

1. Determine the beneficiary's treatment period in days, starting with the IPSD to the end of the measurement year (or end of the current measurement period), death, or the last day of enrollment, whichever occurs first.

2. Within each treatment period, use the prescriptions' DOS and days' supply to count the number of days the patient was "covered" by at least one drug within the targeted drug class(es). Days' supply that extends beyond the last day of the measurement year (or end of the current measurement period) or that extend into the beginning of the measurement period from a fill in the previous year is not included in the count of days "covered".

3. Adjust for overlapping drug fills (See Section 2.3.2) and IP and/or SNF stays (See Section 2.3.3), if applicable.

4. Calculate the PDC by dividing the number of covered days found in Step 2 (or Step 3 if applicable) by the number of days in the treatment period days found in Step 1. The PDC rate is then rounded to the hundredth of a percent.[4]

[4] Any intermediate steps/calculations (at the beneficiary level) are rounded to the 8th decimal place. The PDC ADH rate calculations are rounded to the 2nd decimal place, per PQA's methodology.

2.1.5 Data Sources

The following table provides details on the data sources utilized for Star Ratings ADH (Diabetes, RAS and Statins) measures:

Table 3: Star Ratings ADH Measure Data Sources

Data Source	Acronym	Information Provided
Prescription Drug Event Data	PDE	Prescription drug claims covered by Medicare Part D
Common Medicare Environment	CME	Beneficiary enrollment information: • Enrollment Dates • Date of Birth • Sex • Low-Income Subsidy (LIS) Status • Dual Status • Hospice Coverage Dates • ESRD Dialysis Dates
Common Working File	CWF	Medicare Fee-for-Service (FFS) claims used to identify diagnoses based on ICD-10-CM codes, and IP/SNF stays.
Encounter Data System	EDS	Medicare Advantage (MA) claims used to identify diagnoses based on ICD-10-CM-codes, and IP/SNF stays **NOTE**: CRRs submitted to the EDS are also used to identify diagnoses based on ICD-10-CM codes[5], and IP/SNF stays
Pharmacy Quality Alliance	PQA	National Drug Codes (NDCs) and ICD-10 Value sets

2.2 Measure Update History

All updates described below apply to subsequent years, unless otherwise noted.

[5] For more information regarding CRRs please refer to the Guidance for Chart Review Record (CRR) Submissions

YOS 2024:

CE: The ADH measure methodology for Diabetes, RAS, and Statins were updated from member-years (MY) to CE to fully align with PQA specifications, starting with the measurement year 2024. During prior years, the MY methodology was used to account for a beneficiary's partial contribution to the measure calculation when the beneficiary was not enrolled for the entire measurement year. Starting with measurement year 2024, the new methodology aligns with the PQA's CE methodology for the ADH measures. No enrollment gaps during treatment period are allowed for the ADH measures since Medicare enrollment is reported monthly in the CME.

Age: Age requirement is assessed at the beginning of the measurement year; as such, beneficiaries that do not meet the age requirement on January 1 of the measurement year are excluded from the calculations.

Enrollment Information: Starting with measurement year 2024, enrollment information, ESRD dialysis dates, and hospice coverage are sourced from the CME.

Star Ratings and Display page Measures: Starting with measurement year 2024, two sets of the ADH measures will be included in the PS Reports. One set will follow the Star Ratings specifications described in this guide, and the other set will follow the Display page specifications (please refer to the Display page ADH Measures Specifications User Guide for detailed information on the Display page measure specifications). The Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies released on March 31, 2023 and the April 2023 final rule provide an overview of the Star Ratings and Display page specifications for the ADH measures. The table below summarizes the main methodological updates for measurement year 2024 and differences between the two sets of specifications:

Table 4: Methodological Difference between Star Ratings and Display page ADH Measures

	Star Ratings	**Display Page**
CE	Yes	Yes
IP/SNF PDC Adjustment	Yes	No
Risk Adjustment (RA)	No	Yes

YOS 2022:	Removal of the Risk Adjustment Processing System (RAPS) RxHCC codes from all PS measures to align with PQA's updated 2022 measure specifications. Number of Enrolled Beneficiaries is added to the Measure Summary Table Workbook.
YOS 2020:	The beneficiary HICN is no longer reported or captured in the denominator or exclusion tables. CMS added an MA-PD (non-MMP) breakout to the ADH PS Reports and the *Rate Summary* and *Performance Graph* ADH pages on the PS Web Portal. Addition of EDS for the identification of diagnoses and IP/SNF stays for MA-PD beneficiaries.
YOS 2019:	CMS added a stratified measure rates tab in the ADH contract-level workbook with breakouts by sex, LIS status, dual eligibility, disability status, and age group. CMS will no longer produce contract-level metrics by drug class, beneficiary-level reports, or prescriber-level reports for the YOS 2019 reports. Information from the beneficiary-level reports will be added to the denominator comma separated value (CSV). CMS added the total number of SNF and IP adjustment days to the denominator CSV for both MA-PDs and PDPs found in the CWF. CMS added beneficiary-level exclusions files for measures that are used in the Star Ratings.
YOS 2018:	In April 2019, CMS added beneficiary-level exclusions file for measures that are used in the Star Ratings. In April 2019, CMS added the total number of SNF and IP adjustment days to the denominator CSV for both MA-PDs and PDPs found in the CWF. The PQA added an exclusion to the denominator of the ADH-Diabetes, ADH-RAS, and ADH-Statins measures and revised the criteria for PDC adjustments. Beneficiaries with hospice enrollment are excluded from the denominator, and the PDC is no longer adjusted for hospice stays. The discharge or thru date is now included as an adjustment day for IP/SNF stays.

	The PQA added an exclusion to the denominator of the ADH-Statins rate. Beneficiaries with ESRD are excluded from the PDC calculation.
YOS 2017:	Data sources expanded for identifying all Part D enrollees with ESRD for exclusion from the diabetes and hypertension measures to include ICD-10-CM codes found in both Part A & B claims and RAPS RxHCC along with the EDB ESRD indicator. This methodology applies to all Part D enrollees and contracts. As of April 2018, the discharge date is included in the PDC adjustment for YOS 2017 reports onwards.
YOS 2015:	The PQA added an exclusion to the denominator of the ADH-RAS measure. Beneficiaries with at least one fill of sacubitril/valsartan are excluded from the PDC calculation.
YOS 2014:	CMS modified the PDC measure to use the beneficiary death date from the CME, when present, as the end date of a beneficiary's measurement period. Previously, the PDC measure used the CME beneficiary disenrollment date, which is always reported as the last day of the month. The PQA added the new drug class, SGLT2 inhibitors, to the numerator and denominator of the ADH-Diabetes measure. The PQA added an exclusion to the denominator of the ADH-Diabetes and ADH-RAS rates. Beneficiaries with ESRD are excluded from the PDC calculation. The PQA updated the shifting logic for overlapping fills. The overlap adjustment uses the generic ingredient when single product drugs overlap. Overlap adjustment also occurs when there is an overlap of a targeted single drug product to a combination product containing the targeted drug, or when there is an overlap of combination products containing the targeted drug.
YOS 2013:	CMS modified the PDC measure to adjust for hospice stays since medications may be discontinued during Medicare Part A SNF stays, the Part D sponsor would not be responsible for providing prescription fills for relevant medications. The adjustment is only applied during enrollment in a PDP Part D plan.
YOS 2011:	CMS modified the PDC measure to adjust for beneficiary stays in IP facilities during which the Part D plan was not responsible for prescription drug coverage.

2.3 Additional Specifications

Sections 2.3.1-2.3.3 outline the additional specifications that are used when calculating the three Star Ratings ADH measures. Each section includes descriptions of the specifications and examples of how they affect the ADH measure calculations. Further details can be found in Appendix A and Appendix B.

2.3.1 91 Day Restriction

Beneficiaries are only included in the measure calculation if the start of their treatment period occurs at least 91 days before the end of the treatment period within the measurement period.

The 91 days restriction criteria is waived for all beneficiaries in a contract when the measurement period is less than 92 days.

For example, in the monthly reports using 2024 YOS data, the 91 days restriction criteria is waived for the first set of ADH Reports released in April 2024, as the measurement period spans January 1, 2024 to March 31, 2024. The requirement is effective for the 2024 reports released in May 2024, after the measurement period spanned at least 92 days.

For contracts with an effective date after January 1st of the measurement year, the 91 days restriction is waived until the contract has been active at least 92 days. Using YOS 2024 reports as an example, if a contract has an effective date of April 1, 2024, the 91 days restriction takes effect starting with the 2024 reports released in August 2024 with a measurement period from January 1, 2024 to July 31, 2024.

2.3.2 PDC Adjustment for Overlapping Fills

The PDC calculation is adjusted to account for overlapping fills. A drug/medication is defined at the generic ingredient level in the overlapping fills adjustment. Thus, a beneficiary who changes dosage or switches to a medication with the same generic ingredient would still be considered to be taking the same medication. The adjustment is applied using the Value_Set_Item column from the PQA Value Sets (See Data Sources in Section 2.1.5 for more information regarding the PQA Value Sets). All products that share the same Value_Set_Item are considered the same medication.

An adjustment may result when there is an overlap in days' supply from prescription fills for:

- Multiple targeted single drug products with the same generic ingredient.
- A targeted single drug product and a combination product containing the same generic ingredient as the targeted single drug product.
- Multiple combination products containing the same generic ingredient of a targeted drug product.

See Appendix A for examples of PDC calculations with overlapping fills.

2.3.3 PDC Adjustment for Inpatient and Skilled Nursing Facility Stays

The PDC calculation for the Star Ratings ADH measures is adjusted for IP and Medicare Part A SNF stays. This adjustment is based on two assumptions:

1) a beneficiary receives their medications through the facility during the IP or SNF stay, and
2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay or SNF stay, that supply can be used once the beneficiary returns home.

The adjustment is applied using the following steps:

1. Identify start and end dates of relevant types of stays for beneficiaries eligible for the Star Ratings ADH measures. The start date is the admission date, and the end date is the discharge date.[6] If either the admission or discharge date is within the measurement period, the days within that stay that also overlap with the measurement period are considered for the adjustment. When applicable, the discharge date is also included in the PDC adjustment.
    a) Use IP claims from the CWF to identify IP stays, and when available for MA-PDs.
    b) Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount and positive Medicare utilization days to identify Medicare Part A covered SNF stays. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 (non-covered charges) and/or a no payment reason code.
    c) Use IP and SNF claims from the EDS when available for MA-PD beneficiaries. Additionally, if IP and SNF claims for MA-PD enrolled beneficiaries are reported in the CWF, the CWF will remain as an additional data source.
2. Remove days of relevant stays occurring within the treatment period being assessed for adherence from both the numerator and denominator of the PDC calculation.[7]
3. Shift days' supply from Part D prescription fills that overlap with the stay or subsequent fills for the same drug class to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant

[6] The "thru date" is used as the end of the stay for stays that have missing discharge dates. If both dates are missing, the stay is assumed to have extended through the end of the measurement period.

[7] The PDC calculation is calculated separately for each ADH measure and a single beneficiary may have treatment periods assessed for each of the ADH measures that begin on different dates during the measurement period.

medication from a different source during the stay and will save the Part D prescription fills for use after the stay is complete.

CMS's testing found that adjusting for these stays had a negligible impact on contracts' ADH rates. See Appendix B for example PDC adjustments.

3 Report Structure

Sections 3.1 and 3.2 outline the two levels of reports included in the ADH report package. Each section contains a description of the reports and a table of key elements that are found in the corresponding reports.

3.1 Contract-Level Reports

Report Description: The Contract-Level Report consists of your contract's measure rates, your contract-type's overall measure rates (i.e., PDP or MA-PD), and the Medicare Part D overall measure rates. MA-PD contracts have an additional MA-PD (non-MMP) overall measure rate available for comparison.

If your contract had zero beneficiaries meeting the denominator eligibility criteria during the measurement period, your report will only contain the overall Medicare Part D and contract-type measure rates.

The Star Ratings ADH-Diabetes, ADH-RAS, and ADH-Statins measure specifications[8] are presented in one report.

Worksheets: The Contract-Level Report contains the following worksheets:

1. Specifications
2. Measure Summary
3. Measure Stratified Rates
4. Performance Graphs

3.1.1 Measure Summary Worksheet

Worksheet Description: The Measure Summary worksheet presents the overall, contract-type, contract-level enrollment, and ADH measure rates, broken out by LIS status.

Key Elements: The following tables provide details on the key elements within the Star Ratings ADH measures summary worksheet:

[8] The Star Ratings ADH measures specifications are presented in a separate report from the Display page measure specification report.

Table 5: Star Ratings Measure Summary Key Elements for ADH-Diabetes, ADH-RAS, and ADH-Statins

Column	Element	Definition
C	Number of Part D Enrolled Beneficiaries in the Measurement Period	Number of Part D enrolled beneficiaries 18 years or older during the measurement period.
D, G, J	ADH Denominator	Number of CE beneficiaries from the eligible population, 18 years or older, with at least two prescription claims on different DOS for medications in the targeted drug class(es) during the treatment period. The treatment period must last at least 91 days. The prescription claims can be for the same or different targeted medications.
E, H, K	ADH Numerator	Number of CE beneficiaries in the denominator with a PDC of 80% or higher for the targeted drug class(es).
F, I, L	ADH Rate	(Columns E, H, K) **Divided By** (Columns D, G, J)

3.1.2 Measure Stratified Rates Worksheet

Worksheet Description: This stratification worksheet presents the overall, contract-type, and contract-level enrollment and ADH measure rates, broken out by sex, LIS status, dual eligibility, disability status, and age groups.

Key Elements: The following table provides details on the key elements within the ADH measures' stratified rates worksheet:

Table 6: Measure Stratification Key Elements

Column	Element	Definition
C	Number of Part D Enrolled Beneficiaries in the Measurement Period	Number of Part D enrolled beneficiaries 18 years or older during the measurement period.
D-E	Adherence Rate, By Sex	Adherence rate for ADH-Diabetes, ADH-RAS, and ADH-Statins by sex.

Column	Element	Definition
F-G	Adherence Rate, By LIS Status	Adherence rate for ADH-Diabetes, ADH-RAS, and ADH-Statins by LIS status.
H-I	Adherence Rate, By Dual Eligibility	Adherence rate for ADH-Diabetes, ADH-RAS, and ADH-Statins by dual eligibility status.
J-K	Adherence Rate, By Disability Status	Adherence rate for ADH-Diabetes, ADH-RAS, and ADH-Statins by disability status.
L-Q	Adherence Rate, By Age Group	Adherence rate for ADH-Diabetes, ADH-RAS, and ADH-Statins by age group (18-54, 55-64, 65-69, 70-74, 75-79, and 80+)

3.1.3 Performance Graphs Worksheet

Worksheet Description: Each contract-level PS Report contains a "Performance Graph" worksheet that depicts your rate and your contract-type's measure rates over time. Performance graphs are consistent in structure across all PS measures. Please see the PS General User Guide for further details regarding performance graphs.

3.2 Beneficiary-Level Reports

Report Description: The beneficiary-level reporting for the ADH measures consists of a Denominator CSV file containing all beneficiaries eligible for the denominator and numerator of the Star Ratings ADH measures and an Exclusion CSV file containing beneficiaries that are excluded from each Star Ratings ADH measures.

3.2.1 Denominator CSV

File Description: This file provides a complete list of all CE beneficiaries included in the denominator and numerator of each Star Ratings ADH measure, including both non-adherent and adherent beneficiaries.

Key Elements: The following table provides details on the key elements within the Star Ratings ADH measures Denominator CSV file:

Table 7: Star Ratings Measures Denominator CSV Key Elements

Column	Element	Definition
A	Beneficiary MBI	The Medicare Beneficiary Identifier
B	Beneficiary Plan ID Number	The beneficiary's cardholder ID, as reported on the PDE.

Column	Element	Definition
C	Date of Birth	The beneficiary's date of birth, which can facilitate beneficiary identification.
D	Sex	The beneficiary's sex can facilitate beneficiary identification.
E	LIS Status	"Y" indicates the beneficiary had a LIS status during the measurement period and "N" indicates the beneficiary was not LIS.
F	Enrollment Start Date	The beneficiary's Part D enrollment start date during the measurement period
G	Enrollment End Date	The beneficiary's Part D enrollment end date during the measurement period.
H	Dual Eligibility	Beneficiaries with dual eligibility during the measurement period receive "Y" for Dual Eligibility, and beneficiaries who never had Dual Eligibility status during the measurement period receive "N" for Dual Eligibility.
I	Disability	Beneficiaries with a disability during the measurement period receive "Y" for Disability, and beneficiaries who never had Disability status during the measurement period receive "N" for Disability.
J, S, AB	Days in IP	The total number of days of relevant IP stays during the treatment period used to adjust the beneficiary's PDC rate.
K, T, AC	Days in SNF	The total number of days of relevant SNF stays during the treatment period used to adjust the beneficiary's PDC rate.
L-M, U-V, AD-AE	Adjusted PDC Denominator and Numerator	Denominator: Total treatment period days between the beneficiary's IPSD for the targeted drug class(es) and the end of the measurement period, death, or last day of enrollment. IP and SNF adjustments are applied. Numerator: Total treatment period days in the measurement period for which the beneficiary was covered by at least one drug within the targeted drug class(es), adjusted for overlapping fills and IP and SNF stays, if applicable.
N, W, AF	PDC Rate	(Number of covered days for the given clinical condition, adjusted for IP and SNF stays) **Divided By** (Number of days in the beneficiary's treatment period, adjusted for IP and SNF stays)

Column	Element	Definition
O-P, X-Y, AG-AH	Unadjusted PDC Denominator and Numerator	Denominator: Total treatment period days between the beneficiary's IPSD for the targeted drug class(es) and the end of the measurement period, death, or last day of enrollment. IP and SNF adjustments are not applied. Numerator: Total treatment period days in the measurement period for which the beneficiary was covered by at least one drug with the targeted drug class(es). IP and SNF adjustments are not applied.
Q, Z, AI	Unadjusted PDC Rate	(Number of covered days for the given clinical condition, not adjusted for IP and SNF stays) **Divided By** (Number of days in the beneficiary's treatment period, not adjusted for IP and SNF stays)
R, AA, AJ	Numerator Flag	Beneficiary adherence indicator. "1" indicates the beneficiary's PDC is equal to or greater than adherence threshold (adherent) and is included in the numerator. "0" indicates beneficiary's PDC is less than adherence threshold (non-adherent). Missing value indicates beneficiary was not included in the adherence rate.

3.2.2 Exclusion Report

File Description: The Exclusion CSV file provides a complete list of all CE beneficiaries excluded from the denominator for the ADH measures, and exclusion criteria indicators for each beneficiary. The Exclusion Report is limited to the ADH measures included in the Star Ratings (i.e., this file is not generated for Display page measures).

Key Elements: The following table provides details on the key elements within the ADH measures' Exclusion CSV file:

Table 8: Exclusion CSV Key Elements

Column	Element	Definition
A	Beneficiary MBI	The Medicare Beneficiary Identifier
B	Beneficiary Plan ID Number	The beneficiary's cardholder ID, as reported on the PDE.
C	Date of Birth	The beneficiary's date of birth, which can facilitate beneficiary identification.
D	Sex	The beneficiary's sex can facilitate beneficiary identification.

Column	Element	Definition
E	LIS Status	"Y" indicates the beneficiary had a LIS status during the measurement period and "N" indicates the beneficiary was not LIS.
F	Enrollment Start Date	The beneficiary's Part D enrollment start date during the measurement period.
G	Enrollment End Date	The beneficiary's Part D enrollment end date during the measurement period.
H	Exclusion Flag for ESRD	"1" indicates the beneficiary met the ESRD exclusion criteria in the measurement period, "0" indicates the beneficiary did not meet the ESRD exclusion criteria.
I	Exclusion Flag for Hospice	"1" indicates the beneficiary met the hospice exclusion criteria in the measurement period, "0" indicates the beneficiary did not meet the hospice exclusion criteria.
J-L	Exclusion Flag for IP/SNF	"1" Indicated the beneficiary had IP/SNF stays that cover the entire treatment period during the measurement period, thus excluding the period from the measure. "0" indicates the beneficiary did not meet this criterion. There is one column each for the ADH-Diabetes, ADH-RAS, and ADH-Statins measures.
M	Exclusion Flag for Insulin	"1" indicates the beneficiary met the insulin exclusion criteria in the treatment period, "0" indicates the beneficiary did not meet the insulin exclusion criteria. This exclusion only applies to ADH-Diabetes.
N	Exclusion Flag for Sacubitril/Valsartan	"1" indicates the beneficiary met the sacubitril/valsartan exclusion criteria in the treatment period, "0" indicates the beneficiary did not meet the sacubitril/valsartan exclusion criteria. This exclusion only applies to ADH-RAS.

4 Appendix A: PDC Adjustment for Overlapping Fills Examples

NOTE: The examples below provide a snapshot of how to calculate the PDC adjustments for overlapping fills. These examples are not intended to represent the calculation of the measures for the entire treatment period. Reminder, the treatment period should be at least 91 days.

A.1 Non-Overlapping Fills of 2 Different Drugs

In this example, a beneficiary fills benazepril and captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the captopril prescription after the days' supply for the benazepril medication ended.

Covered Days (No Adjustment):

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Benazepril	15	16	15	13			
Captopril					15	16	30

PDC Calculation:

Covered Days: 120

Treatment Period: 120

PDC: 120/120 = 100%

A.2 Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted single drug product. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing hydrochlorothiazide. However, hydrochlorothiazide is not a RAS antagonist, so this overlap is not shifted.

Before Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Lisinopril	15	16					
Lisinopril & HCTZ		16	15				
Benazepril & HCTZ			15	13			

PDC Calculation:

Covered Days: 59

Treatment Period: 120

PDC: 59/120 = 49%

After Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Lisinopril	15	16					
Lisinopril & HCTZ			15	13	3		
Benazepril & HCTZ			15	13			

PDC Calculation:

Covered Days: 62

Treatment Period: 120

PDC: 62/120 = 52%

A.3 Overlapping Fills of the Same and Different Drugs

In this example, a beneficiary is refilling both lisinopril and captopril. When a single and combination product both containing lisinopril overlap, there is an adjustment to the PDC. When lisinopril overlaps with captopril, we do not make any adjustment to the days covered.

Before Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ		16	15					
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation:

Covered Days: 92

Treatment Period: 120

PDC: 92/120 = 77%

After Overlap Adjustment:

Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation:

Covered Days: 105

Treatment Period: 120

PDC: 105/120 = 88%

5 Appendix B: PDC Adjustment for Inpatient and Skilled Nursing Facility Stays Examples for the Star Ratings Measures

The following examples use IP stays to provide illustrations of the PDC adjustment for IP and SNF stays for the Start Ratings ADH measures. Please note that the "thru date" is used as the end of the stay for stays that have missing discharge dates. If both dates are missing, the stay is assumed to have extended through the end of the measurement period. Additionally, a beneficiary with a stay that covers their entire treatment period during the measurement period will be excluded from the denominator.

NOTE: The examples below provide a snapshot of how to calculate the PDC adjustments for IP and SNF stays. These examples are not intended to represent the calculation of the measures for the entire treatment period. Reminder, the treatment period should be at least 91 days.

B.1 Gap in Coverage after IP Stay

In this example, the treatment period is 15 days and the beneficiary qualifies for being eligible in the measure by receiving at least 2 fills. This beneficiary had drug coverage on days 1-8 and 12-15 and an IP stay on days 5 and 6.

Before Adjustment:

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1	X1				X2	X2	X2	X2
Inpatient Stay					+	+									

PDC Calculation:

Covered Days: 12

Treatment Period: 15

PDC: 12/15 = 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the treatment period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received their medication through the hospital on days 5 and 6, then the beneficiary accumulated two extra days' supply during the IP stay. The two extra days' supply is used to cover the gaps in Part D drug coverage in days 9 and 10.

After Adjustment:

Day	1	2	3	4	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	+	+		X2	X2	X2	X2
Inpatient Stay													

PDC Calculation:

Covered Days: 12

Treatment Period: 13

PDC: 12/13 = 92%

B.2 Gap in Coverage before IP Stay

In this example, the treatment period is 15 days and the beneficiary qualifies for being eligible in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-7 and 12-15, and an IP stay on days 12 and 13.

Before Adjustment:

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2	X2	X2
Inpatient Stay												+	+		

PDC Calculation:

Covered Days: 11

Treatment Period: 15

PDC: 11/15 = 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the treatment period. While there are two days' supply from the IP stay on days 12 and 13, there are no days without drug coverage after the IP stay. Thus, the extra days' supply are not shifted.

After Adjustment:

Day	1	2	3	4	5	6	7	8	9	10	11	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1					X2	X2
Inpatient Stay													

PDC Calculation:

Covered Days: 9

Treatment Period: 13

PDC: 9/13 = 69%

B.3 Gap in Coverage before and after IP Stay

In this example, the treatment period is 15 days and the beneficiary qualifies for being eligible in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-3, 6-9, and 12-15, and an IP stay on days 6-9.

Before Adjustment:

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			X2	X2	X2	X2			X3	X3	X3	X3
Inpatient Stay						+	+	+	+						

PDC Calculation:

Covered Days: 11

Treatment Period: 15

PDC: 11/15 = 73%

With the adjustment for the IP stay, days 6-9 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay, based on the assumption that the beneficiary received their medication through the hospital on days 6-9. In this case, only days 10 and 11 do not have drug coverage and are after the IP stay, so two days' supply are shifted to days 10 and 11. This is illustrated below:

After Adjustment:

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			+	+	X2	X2	X3	X3
Inpatient Stay											

PDC Calculation:

Covered Days: 9

Treatment Period: 11

PDC: 9/11 = 82%

B.4 Gap in Coverage after IP Stay and Overlap with Subsequent Fill of the Same Drug Class

In this example, the treatment period is 15 days and the beneficiary qualifies for being eligible in the measure by receiving at least 2 fills. This beneficiary had drug coverage from days 1-4, and 7-11 for the same drug class, and an IP stay on days 2-4.

Before Adjustment:

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1			X2	X2	X2	X2	X2				
Inpatient Stay		+	+	+											

PDC Calculation:

Covered Days: 9

Treatment Period: 15

PDC: 9/15 = 60%

With the adjustment for the IP stay, days 2-4 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days supply of the subsequent fill are shifted. In this example, the days supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes 1 days supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12.

After Adjustment:

Day	1	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	+	+	+	X2	X2	X2	X2	X2			
Inpatient Stay												

PDC Calculation:

Covered Days: 9

Treatment Period: 12

PDC: 9/12 = 75%



Patient Safety Analysis

Statin Use in Persons with Diabetes Measure
PDP/MA-PD Contracts
Report User Guide
Year of Service 2024

Web Portal

https://PartD.ProgramInfo.US/PatientSafety

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Technical Support

If you need help accessing the SUPD Patient Safety Report or have questions about its content, please contact the Acumen, LLC help desk at:

Email	Phone
PatientSafety@AcumenLLC.com	(650) 558-8006

If you have questions or concerns about CMS policies regarding Part D performance and quality measures, please contact CMS' Medicare Drug Benefit and C & D Data Group at:

Email

PartCandDStarRatings@cms.hhs.gov

1 Introduction

The Statin Use in Persons with Diabetes (SUPD) measure analyzes the percentage of Medicare Part D beneficiaries, ages 40 to 75 years, who were dispensed medications for diabetes and received a statin medication. The Centers for Medicare & Medicaid Services (CMS) provide Part D sponsors (i.e., contracts) monthly reports with information related to the SUPD measure, calculated using Medicare Part D Prescription Drug Event (PDE) data. The rates in the SUPD Patient Safety (PS) Reports allow Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PD) to compare their performance to overall Medicare Part D and contract-type rates and monitor their progress in improving SUPD measure rates over time. MA-PD plans are additionally able to compare their performance to non-Medicare-Medicaid Plans (MMP) in the SUPD PS Report.

This user guide is provided to assist contracts with understanding their SUPD PS Reports. Section 2 presents an overview of the SUPD measure specifications and a history of any measure updates. Section 3 describes the structure of the SUPD report package and its contents. The diagnosis codes and drug classes, developed by the Pharmacy Quality Alliance (PQA), that are used for the SUPD measure are available in the PQA Value Sets file found under Help Documents on the PS Analysis Web Portal. Additional information about the PS Reports, including general measure specifications and reporting features, is available in the PS General User Guide, located under Help Documents on the PS Analysis Web Portal.

Please note that the data included in the PS Reports and the PS Web Portal including any downloadable files, may contain confidential, privileged, and/or proprietary information and is reserved for the use of authorized users. CMS does not authorize the public use of the PS data, graphs, or any other information available on PS Reports and the PS Web Portal.

2 Measure Overview

The SUPD rate is adapted from the Statins Use in Persons with Diabetes measure that was developed and endorsed by the PQA. It is based on American College of Cardiology/American Heart Association (ACC/AHA) guidelines that recommend moderate to high intensity statin therapy for primary prevention in persons ages 40 to 75 years with diabetes.

The SUPD measure analyzes the percentage of beneficiaries, ages 40 to 75 years, who were dispensed medications for diabetes and received a statin medication.

Higher rates represent better performance. For any methodological questions regarding the measure, please consult PQA's Web Page or contact them at https://www.pqaalliance.org/tech-assist-form.

The following sections summarize the specifications for the SUPD rate and any changes to the measure specifications over time.

2.1 Measure Specifications

2.1.1 Key Terms

Year of Service (YOS):	The calendar year (January 1 through December 31) of the date on which a prescription was filled.
Measurement Year:	The calendar year (January 1 through December 31) when the measure is assessed. The measurement year corresponds to the YOS.
Measurement Period:	The measurement period represents the span of time analyzed by a given PS Report and is limited to a single measurement year. The measurement period starts on January 1 of the measurement year and expands with each monthly report, until it spans the full measurement year. Any claim's days' supply that extends beyond the last day of the measurement period or that extend into the beginning of the measurement period from a prescription claim in the previous year are not included in either measurement period. Additional information about the measurement period is available in the PS General User Guide.
Index Prescription Start Date (IPSD):	The earliest date of service (DOS) for a diabetes medication during the measurement year.

2.1.2 Measure Definitions

Measure Definition:	The percentage of continuously enrolled (CE) Medicare Part D beneficiaries [1], ages 40 to 75 years, who were dispensed medications for diabetes and received a statin medication during the measurement period.
Eligible Population:	Medicare Part D beneficiaries that meet the following criteria are eligible to be included in the SUPD measure: - **Age:** Beneficiaries must be 40 to 75 years as of January 1st of the measurement year.[2] - **Continuous Enrollment (CE):** Continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month.
Denominator:	Number of CE beneficiaries from the eligible population, ages 40 to 75 years, with at least two prescription claims on different dates of service (DOS) for any diabetes medication during the measurement period and an IPSD that occurs at least 90 days prior to end of the measurement period.
Numerator:	Number of CE beneficiaries in the denominator who received at least one prescription claim for a statin medication with a DOS during the measurement period.

2.1.3 Measure Exclusions

Medicare Part D beneficiaries from the eligible population are excluded from the SUPD denominator if they meet any of the following criteria:

Hospice:	Beneficiaries who have elected to receive hospice care with at least one day of hospice coverage during the measurement period. Hospice coverage is determined based on the hospice

[1] Please reference Section 3.3 *Continuous Enrollment* of the Patient Safety General User Guide for more information on the CE methodology.
[2] Please reference Section 3.6 *Age Criteria* of the Patient Safety General User Guide for more information on age criteria methodology.

coverage start and end dates from the Common Medicare Environment (CME).

End-Stage Renal Disease (ESRD):

Beneficiaries diagnosed with ESRD at any time during the measurement period.

ESRD diagnosis is determined according to the following criteria:
1) Beneficiaries with at least one day of ESRD dialysis day during the measurement period according to the ESRD dialysis start and end dates from the CME,
or
2) Beneficiaries with ESRD in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one day with the measurement period from the Common Working File (CWF) or the Encounter Data System (EDS) including Chart Review Records (CRRs) (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes.

Rhabdomyolysis and Myopathy:

Beneficiaries diagnosed with rhabdomyolysis or myopathy at any time during the measurement period.

Rhabdomyolysis and myopathy diagnoses are determined according to the following criteria:
1) Beneficiaries with rhabdomyolysis or myopathy in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one day with the measurement period from the CWF or the EDS including CRRs (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes.

Pregnancy, Lactation and Fertility:

Beneficiaries with pregnancy or lactation at any time during the measurement period or at least one prescription claim for a medication indicated for fertility during the measurement period.

Pregnancy, lactation and fertility are determined according to the following criteria:
1) Beneficiaries with pregnancy in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one

	day with the measurement period from the CWF or the EDS including CRRs (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes, or, 2) Beneficiaries with lactation in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one day with the measurement period from the CWF or the EDS including CRRs (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes, or, 3) Beneficiaries with at least one prescription claim for a medication indicated for fertility with a DOS in the measurement period. Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible NDC drug codes.
Cirrhosis:	Beneficiaries diagnosed with cirrhosis at any time during the measurement period. Cirrhosis diagnosis is determined according to the following criteria: 1) Beneficiaries with cirrhosis in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one day with the measurement period from the CWF or the EDS including CRRs (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes.
Pre-Diabetes:	Beneficiaries diagnosed with pre-diabetes at any time during the measurement period. Pre-diabetes diagnosis is determined according to the following criteria: 1) Beneficiaries with pre-diabetes in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one day with the measurement period from the CWF or the EDS including CRRs (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes.

Polycystic Ovary Syndrome (PCOS):

Beneficiaries diagnosed with PCOS at any time during the measurement period.

PCOS diagnosis is determined according to the following criteria: 1) Beneficiaries with PCOS in the primary diagnosis or any other diagnosis fields and service dates that overlap at least one day with the measurement period from the CWF or the EDS including CRRs (See Section 2.1.4 Data Sources for more information on the CRRs). Please refer to PQA Value Sets file posted on the Help Documents page of the PS Analysis Web Portal for a list of eligible ICD-10 diagnosis codes.

2.1.4 Data Sources

The following table provides details on the data sources utilized for SUPD measure:

Table 1: SUPD Measure Data Sources

Data Source	Acronym	Information Provided
Prescription Drug Event	PDE	Prescription drug claims covered by Medicare Part D
Common Medicare Environment	CME	Beneficiary enrollment information: • Enrollment Dates • Date of birth • Sex • Low Income Subsidy (LIS) status • Hospice coverage dates • ESRD dialysis dates
Common Working File	CWF	Medicare Fee-for-Service (FFS) claims used to identify diagnoses based on ICD-10-CM codes
Encounter Data System	EDS	Medicare Advantage (MA) claims used to identify diagnoses based on ICD-10-CM codes. **NOTE**: CRRs submitted to the EDS are also used to identify diagnoses based on ICD-10-CM codes[3].
Pharmacy Quality Alliance	PQA	National Drug Codes (NDCs) and ICD-10 Value sets

[3] For more information regarding CRRs please refer to the Guidance for Chart Review Record (CRR) Submissions

2.1.5 Additional Specification: 90 Day Restriction

Beneficiaries are only included in the measure calculation if the IPSD occurs at least 90 days before the end of the measurement period.

The 90 days restriction criteria is waived for all beneficiaries in a contract when the measurement period is less than 91 days.

For example, in the monthly reports using 2024 PDE data, the 90 days restriction criteria is waived for the first set of SUPD Reports released in April 2024, as the measurement period spans January 1, 2024 to March 31, 2024. The requirement is effective for the 2024 reports released in May 2024, after the measurement period spanned at least 91 days.

For contracts with an effective date after January 1st of the measurement year, the 90 days restriction criteria is waived until the contract has been active at least 91 days. Using YOS 2024 reports as an example, if a contract has an effective date of April 1, 2024, the 90 days restriction takes effect starting with the 2024 reports released in August 2024 with a measurement period from January 1, 2024 to July 31, 2024.

2.2 Measure Update History

All updates described below apply to subsequent years unless otherwise noted.

YOS 2024:	*CE*: The SUPD measure methodology was updated from member-years (MY) to CE to fully align with PQA specifications, starting with measurement year 2024. During prior years, the MY methodology was used to account for a beneficiary's partial contribution to the measure calculation when the beneficiary was not enrolled in a Part D contract for the entire measurement year. Starting with measurement year 2024, the new methodology aligns with the PQA's CE methodology during the measurement year and thus, beneficiaries who have more than one-month gap in enrollment are excluded from the calculations. *Age*: The age requirement is assessed at the beginning of the measurement year; as such, beneficiaries that do not meet the age requirement on January 1 of the measurement year are excluded from the calculations. *Enrollment Information*: Starting with measurement year 2024, enrollment information, ESRD dialysis dates, and hospice coverage are sourced from the CME.

YOS 2022:	Refined and narrowed the liver disease exclusion includes beneficiaries with a diagnosis of cirrhosis during the measurement year since liver disease without cirrhosis is not contraindicated. Therefore, liver disease is no longer an exclusion. Dapagliflozin and empagliflozin single ingredient medications were removed from the PQA Value Sets for this measure. The sodium-glucose cotransporter 2 (SGLT2) inhibitors class were recently approved for use in reducing the risk of cardiovascular death and hospitalization for heart failure in adults with reduced ejected fraction (New York Heart Association class II-IV). This update will also be reflective with the 2022 measurement year reports. Removal of the Risk Adjustment Processing System (RAPS) RxHCC codes from all PS measures to align with PQA's updated 2022 measure specifications.
YOS 2021:	The term "IPSD" was added to the measure specifications section, and a minimum of 90 days within the enrollment episode is also required for the enrollment episode to be considered in the measure rate. Starting with YOS 2021 reports, beneficiary exclusion diagnoses for the SUPD measure were expanded to include: 1) Rhabdomyolysis and Myopathy, 2) Pregnancy, Lactation and Fertility, 3) Liver disease, 4) Pre-Diabetes, and 5) PCOS.
YOS 2020:	The beneficiary HICN is no longer reported or captured in the denominator or exclusion tables. CMS added the MA-PD (non-MMP) breakout to the SUPD PS Reports and the Rate Summary and Performance Graph SUPD pages on the PS Web Portal. Addition of EDS for the identification of diagnoses.
YOS 2019:	PQA modified the SUPD measure to require that the two diabetes medication fills have different DOS. CMS removed the contract-level metrics by drug class, beneficiary-level report, and prescriber-level report for YOS 2019. Information from the beneficiary-level report was added to the denominator file. CMS began reporting additional beneficiary-level exclusions files for measures that are used in the Star Ratings.
YOS 2018:	Starting April 2019, CMS began reporting additional beneficiary-level exclusions files for measures that are used in the Star Ratings for YOS 2018.

YOS 2017:	Data sources for identifying all Part D enrollees with ESRD for exclusion from the SUPD measure expanded to include ICD-10-CM codes found in both Part A & B claims and RAPS RxHCC along with the EDB ESRD indicator. In June 2018, the "Optimal Treatment Indicator" column label in the denominator file was changed to "Numerator Flag" to reflect its use as an indicator for whether a beneficiary met the SUPD numerator criteria or not.
YOS 2015:	In April 2016, CMS began reporting additional contract-level metrics by drug class, and introduced beneficiary-level and prescriber-level reports for both YOS 2015 and YOS 2016 reports.

3 Report Structure

Sections 3.1 and 3.2 outline the two levels of reports included in the SUPD report package. Each section contains a description of the reports and a table of key elements that are found in the corresponding reports.

3.1 Contract-Level Report

Report Description: The Contract-Level report consists of your contract's measure rates, your contract-type's overall measure rates (i.e., PDP or MA-PD) and the Medicare Part D overall measure rates. MA-PD contracts have an additional MA-PD (non-MMP) overall measure rate available for comparison.

If your contract had zero beneficiaries meeting the denominator eligibility criteria during the measurement period, your report will only contain the overall Medicare Part D and contract-type measure rates.

Worksheets: The Contract-Level Report contains the following worksheets:

1. Specifications
2. Measure Summary
3. Performance Graph

3.1.1 Measure Summary Worksheet

Worksheet Description: The Measure Summary worksheet presents the overall, contract-type, contract-level enrollment, and SUPD measure rates, broken out by LIS status.

Key Elements: The following table provides details on the key elements within the SUPD measure summary worksheet:

Table 2: Measure Summary Key Elements

Column	Element	Definition
C	Number of Part D Enrolled Beneficiaries in the Measurement Period	Number of Part D enrolled beneficiaries ages 40 to 75 years during the measurement period.
D	SUPD Denominator	Number of CE beneficiaries from the eligible population, ages 40 to 75 years, with at least two prescription claims on different DOS for any diabetes medication during the measurement period and an IPSD that occurs at least 90 days prior to end of the measurement period.

Column	Element	Definition
E	SUPD Numerator	Number of CE beneficiaries in the denominator who received at least one prescription claim for a statin medication with a DOS during the measurement period.
F	SUPD Rate	(Column E) **Divided By** (Column D)

3.1.2 Performance Graph Worksheet

Worksheet Description: Each contract-level PS Report contains a "Performance Graph" worksheet that depicts your rate and your contract-type's measure rates over time. Performance graphs are consistent in structure across all PS measures. Please see the PS General User Guide for further details regarding performance graphs.

3.2 Beneficiary-Level Reports

Report Description: The beneficiary-level reporting for the SUPD measure consists of Denominator comma separated value (CSV) file containing all beneficiaries of the SUPD measure and an Exclusion CSV file containing beneficiaries that are excluded from the SUPD measure.

3.2.1 Denominator CSV

File Description: This file provides a complete list of all CE beneficiaries included in the SUPD measure.

Key Elements: The following table provides details on the key elements within the SUPD measure Denominator CSV file:

Table 3: Denominator CSV Key Elements

Column	Element	Definition
A	Beneficiary MBI	The Medicare Beneficiary Identifier
B	Beneficiary Plan ID Number	The beneficiary's cardholder ID, as reported on the PDE.
C	Date of Birth	The beneficiary's date of birth, which can facilitate beneficiary identification.

Column	Element	Definition
D	Sex	The beneficiary's sex can facilitate beneficiary identification.
E	LIS Status	"Y" indicates the beneficiary had a LIS status during the measurement period and "N" indicates the beneficiary was not LIS.
F	Enrollment Start Date	The beneficiary's Part D enrollment start date during the measurement period.
G	Enrollment End Date	The beneficiary's Part D enrollment end date during the measurement period.
H	Gap Month Flag	"Y" indicates the beneficiary is CE and has an allowable one-month gap in enrollment. "N" indicates the beneficiary is CE and has no gaps in enrollment.
I	Gap Month	The calendar month of the enrollment gap
J	SUPD Numerator Flag	"1" indicates the beneficiary met the SUPD numerator criteria, "0" indicates the beneficiary did not meet the numerator criteria.

3.2.2 Exclusion Report

File Description: The Exclusion CSV file provides a complete list of all CE beneficiaries excluded from the denominator for the SUPD measure, and exclusion criteria indicators for each beneficiary.

Key Elements: The following table provides details on the key elements within the SUPD measure's Exclusion CSV file:

Table 4: Exclusion CSV Key Elements

Column	Element	Definition
A	Beneficiary MBI	The Medicare Beneficiary Identifier
B	Beneficiary Plan ID Number	The beneficiary's cardholder ID, as reported on the PDE.
C	Date of Birth	The beneficiary's date of birth, which can facilitate beneficiary identification.
D	Sex	The beneficiary's sex can facilitate beneficiary identification.
E	LIS Status	"Y" indicates the beneficiary had a LIS status during the measurement period and "N" indicates the beneficiary was not LIS.
F	Enrollment Start Date	The beneficiary's Part D enrollment start date during the measurement period.
G	Enrollment End Date	The beneficiary's Part D enrollment end date during the measurement period.
H	Exclusion Flag for ESRD	"1" indicates the beneficiary met the ESRD exclusion criteria, "0" indicates the beneficiary did not meet the ESRD exclusion criteria.

Column	Element	Definition
I	Exclusion Flag for Hospice	"1" indicates the beneficiary met the hospice exclusion criteria, "0" indicates the beneficiary did not meet the hospice exclusion criteria.
J	Exclusion Flag for Rhabdomyolysis and Myopathy	"1" indicates the beneficiary met the Rhabdomyolysis and Myopathy exclusion criteria, "0" indicates the beneficiary did not meet the Rhabdomyolysis and Myopathy exclusion criteria.
K	Exclusion Flag for Pregnancy, Lactation and Fertility	"1" indicates the beneficiary met the Pregnancy, Lactation and Fertility exclusion criteria, "0" indicates the beneficiary did not meet the Pregnancy, Lactation and Fertility exclusion criteria.
L	Exclusion Flag for Cirrhosis	"1" indicates the beneficiary met the Cirrhosis exclusion criteria, "0" indicates the beneficiary did not meet the Cirrhosis exclusion criteria.
M	Exclusion Flag for Pre-Diabetes	"1" indicates the beneficiary met the Pre-Diabetes exclusion criteria, "0" indicates the beneficiary did not meet the Pre-Diabetes exclusion criteria.
N	Exclusion Flag for PCOS	"1" indicates the beneficiary met the PCOS exclusion criteria, "0" indicates the beneficiary did not meet the PCOS exclusion criteria.