United States Court of Appeals
for the District of Columbia Circuit

No. 25-5269

HMO LOUISIANA, INC.,

Plaintiff-Appellant,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the Department of Health & Human Services; MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare & Medicaid Services; CENTERS FOR MEDICAID AND MEDICAID SERVICES,

Defendants-Appellees.

On Appeal from the United States District Court for the District of Columbia in No. 1:24-cv-02931-CRC, Christopher Reid Cooper, U.S. District Judge

JOINT APPENDIX

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December 5, 2025

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TABLE OF CONTENTS

Page

U.S. District Court
District of Columbia (Washington, DC)
CIVIL DOCKET FOR CASE #: 1:24-cv-02931-CRC

HMO LOUISIANA, INC. v. DEPARTMENT OF HEALTH AND HUMAN SERVICES et al
Assigned to: Judge Christopher R. Cooper
Case in other court: USCA, 25-05269
Cause: 05:551 Administrative Procedure Act

Date Filed: 10/17/2024
Date Terminated: 07/09/2025
Jury Demand: None
Nature of Suit: 151 Contract: Recovery Medicare
Jurisdiction: U.S. Government Defendant

Plaintiff

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Date Filed	#	Docket Text
10/17/2024	1	COMPLAINT against All Defendants (Filing fee $ 405 receipt number ADCDC-11238231) filed by HMO LOUISIANA, INC.. (Attachments: # 1 Civil Cover Sheet, # 2 Exhibit 1, # 3 Exhibit 2, # 4 Exhibit 3, # 5 Summons for U.S. Department of Health and Human Services, # 6 Summons fpr Centers for Medicare and Medicaid Services, # 7 Summons for Chiquita Brooks-Lasure, in her official capacity as Administrator of CMS, # 8 Summons for Xavier Becerra, as Secretary of U.S. Department of Health and Human Services, # 9 Summons for the Office of the U.S. Attorney for D.C., # 10 Summons for U.S. Attorney General)(Werner, Paul) (Entered: 10/17/2024)
10/17/2024	2	LCvR 26.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by HMO LOUISIANA, INC. (Werner, Paul) (Entered: 10/17/2024)
10/17/2024	3	MOTION for Temporary Restraining Order by HMO LOUISIANA, INC.. (Attachments: # 1 Memorandum in Support, # 2 Text of Proposed Order)(Werner, Paul) (Entered: 10/17/2024)
10/17/2024		Case Assigned to Judge Christopher R. Cooper. (znmw) (Entered: 10/17/2024)
10/17/2024	4	SUMMONS (6) Issued Electronically as to All Defendants, U.S. Attorney and U.S. Attorney General (Attachments: # 1 Notice and Consent)(znmw) (Entered: 10/17/2024)

10/18/2024		MINUTE ORDER: Plaintiff's counsel is directed to Local Civ. Rule 65.1, which requires applications for temporary restraining orders to be accompanied by a certificate from counsel, or other proof satisfactory to the Court, stating (1) that actual notice of the time of making the application, and copies of all pleadings and papers filed in the action to date or to be presented to the Court at the hearing, have been furnished to the adverse party; or (2) the efforts made by the applicant to give such notice and furnish such copies. Once Defendants have been provided actual notice under the local rule, the parties are directed to meet and confer through counsel and propose a briefing schedule on Plaintiff's 3 TRO application. If agreement cannot be reached on a briefing schedule, the parties may jointly contact chambers at (202) 354-3480 to arrange a remote scheduling conference. The Court would have availability today for a conference. The Court is in trial next week, however, so its availability will be limited. So Ordered by Judge Christopher R. Cooper on 10/18/2024. (lccrc1) (Entered: 10/18/2024)
10/18/2024	5	NOTICE *of Compliance With Local Rule 65.1* by HMO LOUISIANA, INC. re 3 Motion for TRO (Werner, Paul) (Entered: 10/18/2024)
10/18/2024	6	NOTICE of Appearance by Imad Sayed Matini on behalf of HMO LOUISIANA, INC. (Matini, Imad) (Entered: 10/18/2024)
10/21/2024	7	NOTICE of Appearance by M. Jared Littman on behalf of XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (Littman, M.) (Entered: 10/21/2024)
10/28/2024	8	Joint MOTION to Stay *(Temporarily)* by HMO LOUISIANA, INC.. (Attachments: # 1 Text of Proposed Order)(Werner, Paul) (Entered: 10/28/2024)
10/30/2024		MINUTE ORDER granting 8 Motion to Stay. The case is stayed for 15 days, which shall expire on November 12, 2024. The pending Motion for Temporary Restraining Order is held in abeyance until the stay is lifted. Signed by Judge Christopher R. Cooper on 10/30/2024. (lccrc1) (Entered: 10/30/2024)
11/18/2024		MINUTE ORDER: The parties are hereby directed to file a joint status report by November 22, 2024, updating the Court on the status of their settlement discussions. Signed by Judge Christopher R. Cooper on 11/18/2024. (lccrc1) (Entered: 11/18/2024)
11/22/2024	9	Joint STATUS REPORT by HMO LOUISIANA, INC.. (Werner, Paul) (Entered: 11/22/2024)
11/26/2024		MINUTE ORDER: In light of the parties' 9 Joint Status Report, Plaintiff is hereby directed to seek leave to file an amended complaint by December 6, 2024. Signed by Judge Christopher R. Cooper on 11/26/2024. (lccrc1) (Entered: 11/26/2024)
12/06/2024	10	MOTION for Leave to File *An Amended Complaint* by HMO LOUISIANA, INC.. (Attachments: # 1 Memorandum in Support, # 2 Text of Proposed Order, # 3 Exhibit A - Redline of Proposed Amended Complaint, # 4 Exhibit B - Proposed Amended Complaint) (Werner, Paul) (Entered: 12/06/2024)
12/10/2024	11	ORDER granting 10 Motion for Leave to File Amended Complaint. See full Order for details. Signed by Judge Christopher R. Cooper on 12/10/2024. (lccrc1) (Entered: 12/10/2024)
12/10/2024	12	AMENDED COMPLAINT against XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES filed by HMO LOUISIANA, INC..(znmw) (Entered: 12/10/2024)

12/19/2024	13	Joint MOTION for Briefing Schedule by DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES. (Littman, M.) (Entered: 12/19/2024)
12/20/2024		MINUTE ORDER granting 13 Motion for Briefing Schedule. Defendants shall file the certified index of the Administrative Record and serve Administrative Record on Plaintiff by January 10, 2025. Plaintiff shall file its Motion for Summary Judgment by February 14, 2025. Defendants shall file their Cross-Motion for Summary Judgment and Opposition to Plaintiff's Motion for Summary Judgment by March 14, 2025. Plaintiff shall file its Opposition to Defendants' Cross-Motion and Reply in Support of Plaintiff's Summary Judgment Motion by April 11, 2025. Defendants shall file their Reply in Support of Their Cross-Motion for Summary Judgment by April 25, 2025. The parties shall file their Joint Appendix by May 2, 2025. Signed by Judge Christopher R. Cooper on 12/20/2024. (lccrc1) (Entered: 12/20/2024)
01/10/2025	14	NOTICE *of certified list of contents of administrative record* by DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES (Attachments: # 1 Exhibit Certification and Index of Administrative Record)(Littman, M.) (Entered: 01/10/2025)
01/17/2025	15	NOTICE of Appearance by Tifenn Virginie Drouaud on behalf of HMO LOUISIANA, INC. (Drouaud, Tifenn) (Entered: 01/17/2025)
02/14/2025	16	NOTICE of Appearance by Hannah J. Wigger on behalf of HMO LOUISIANA, INC. (Wigger, Hannah) (Entered: 02/14/2025)
02/14/2025	17	MOTION for Summary Judgment by HMO LOUISIANA, INC.. (Attachments: # 1 Memorandum in Support, # 2 Declaration of B. Vicidomina, # 3 Text of Proposed Order) (Werner, Paul) (Entered: 02/14/2025)
02/14/2025		RESOLVED.....NOTICE of Provisional/Government Not Certified Status re 17 MOTION for Summary Judgment by HMO LOUISIANA, INC.. (Attachments: # 1 Memorandum in Support, # 2 Declaration of B. Vicidomina, # 3 Text of Proposed Order)(Werner, Paul). Your attorney renewal/government certification has not been received. As a result, your membership with the U.S. District & Bankruptcy Courts for the District of Columbia is not in good standing, and you are not permitted to file. Pursuant to Local Civil Rule 83.9, you must immediately correct your membership status by following the appropriate instructions on this page of our website: https://www.dcd.uscourts.gov/attorney-renewal. Please be advised that the presiding judge in this case has been notified that you are currently not in good standing to file in this court. Renewal Due by 2/21/2025. (zhcn) Modified on 2/18/2025 (zhcn). (Entered: 02/18/2025)
03/10/2025	18	Consent MOTION to Modify *the Briefing Schedule* by DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES. (Littman, M.) (Entered: 03/10/2025)
03/12/2025		MINUTE ORDER granting 18 Motion to Modify Deadlines. Defendants' Cross-Motion for Summary Judgment and Opposition is due on or before March 21, 2025; Plaintiff's Opposition and Reply is due on or before April 18, 2025; Defendants' Reply is due on or before May 2, 2025; and the Joint Appendix is due on or before May 9, 2025. Signed by Judge Christopher R. Cooper on 3/12/2025. (lccrc1) (Entered: 03/12/2025)

03/21/2025	19	Memorandum in opposition to re 17 Motion for Summary Judgment filed by DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES. (Attachments: # 1 Exhibit Goldstein Declaration)(Littman, M.) (Entered: 03/21/2025)
03/21/2025	20	Cross MOTION for Summary Judgment by DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES. (Attachments: # 1 Exhibit Goldstein Declaration) (Littman, M.) (Entered: 03/21/2025)
04/18/2025	21	RESPONSE re 20 Cross MOTION for Summary Judgment , *and Reply in Support of Plaintiff's Motion for Summary Judgment* filed by HMO LOUISIANA, INC.. (Werner, Paul) Modified on 4/21/2025 to correct docket link/ docket text (zjm). (Entered: 04/18/2025)
04/18/2025	22	REPLY to opposition to motion re 17 Motion for Summary Judgment filed by HMO LOUISIANA, INC.. (See Docket Entry 21 to view document) (zjm) (Entered: 04/21/2025)
05/02/2025	23	REPLY to opposition to motion re 20 Motion for Summary Judgment filed by XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES. (Littman, M.) (Entered: 05/02/2025)
05/06/2025	24	NOTICE *of Filing of Joint Appendix* by HMO LOUISIANA, INC. (Attachments: # 1 Joint Appendix)(Werner, Paul) (Entered: 05/06/2025)
06/04/2025		MINUTE ORDER Setting Hearing on Motion. The parties shall appear for a hearing on the cross-motions for summary judgment on June 26, 2025, at 2:00 p.m. in Courtroom 27A (In Person) before Judge Christopher R. Cooper. Signed by Judge Christopher R. Cooper on 6/4/2025. (lccrc1) (Entered: 06/04/2025)
06/04/2025		Set/Reset Hearings: Motion Hearing set for 6/26/2025 at 2:00 PM in Courtroom 27A (in person) before Judge Christopher R. Cooper. (lsj) (Entered: 06/04/2025)
06/11/2025	25	Consent MOTION to Continue *Hearing* by HMO LOUISIANA, INC.. (Attachments: # 1 Text of Proposed Order)(Werner, Paul) (Entered: 06/11/2025)
06/12/2025		MINUTE ORDER granting 25 Motion to Continue. The hearing scheduled for June 26, 2025 at 2 P.M. is continued until July 2, 2025 at 10 A.M. in Courtroom 27A (In Person). Signed by Judge Christopher R. Cooper on 6/12/2025. (lccrc1) (Entered: 06/12/2025)
06/12/2025		Set/Reset Hearings: Motion Hearing reset for 7/2/2025 at 10:00 AM in Courtroom 27A (in person) before Judge Christopher R. Cooper. (lsj) (Entered: 06/12/2025)
06/12/2025		MINUTE ORDER: Motion Hearing set for July 2, 2025 at 10:00 A.M. is hereby continued until July 2, 2025 at 03:00 PM before Judge Christopher R. Cooper. Signed by Judge Christopher R. Cooper on 6/12/2025. (lccrc1) (Entered: 06/12/2025)
06/13/2025	26	NOTICE OF SUBSTITUTION OF COUNSEL by John Bardo on behalf of XAVIER BECERRA, CHIQUITA BROOKS-LASURE, CENTERS FOR MEDICAID & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES Substituting for attorney M. Jared Littman (Bardo, John) (Entered: 06/13/2025)
06/16/2025	27	NOTICE of Appearance by Kenneth Ryan Whitley on behalf of All Defendants (Whitley, Kenneth) (Entered: 06/16/2025)
07/02/2025		Minute Entry for proceedings held before Judge Christopher R. Cooper: Motion Hearing held on 7/2/2025 re 20 Cross MOTION for Summary Judgment filed by CHIQUITA

		BROOKS-LASURE, XAVIER BECERRA, DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICAID & MEDICAID SERVICES. Oral arguments heard; motion taken under advisement. (Court Reporter Lisa Moreira) (znbn) (Entered: 07/02/2025)
07/09/2025	28	ORDER denying Plaintiff's 17 Motion for Summary Judgment and granting Defendant's 20 Cross-Motion for Summary Judgment. Plaintiff's 3 Motion for TRO is further denied as moot. See full Order and accompanying Memorandum Opinion for details. Signed by Judge Christopher R. Cooper on 7/9/2025. (lccrc1) (Entered: 07/09/2025)
07/09/2025	29	MEMORANDUM OPINION re 28 Order denying Plaintiff's Motion for Summary Judgment and granting Defendant's Cross-Motion for Summary Judgment. See full Memorandum Opinion for details. Signed by Judge Christopher R. Cooper on 7/9/2025. (lccrc1) (Entered: 07/09/2025)
07/21/2025	30	NOTICE OF APPEAL TO DC CIRCUIT COURT as to 28 Order on Motion for TRO,, Order on Motion for Summary Judgment,,, by HMO LOUISIANA, INC.. Filing fee $ 605, receipt number ADCDC-11832249. Fee Status: Fee Paid. Parties have been notified. (Werner, Paul) (Entered: 07/21/2025)
07/21/2025	31	Transmission of the Notice of Appeal, Order Appealed (Memorandum Opinion), and Docket Sheet to US Court of Appeals. The Court of Appeals fee was paid re 30 Notice of Appeal to DC Circuit Court,. (mg) (Entered: 07/22/2025)
07/23/2025		USCA Case Number 25-5269 for 30 Notice of Appeal to DC Circuit Court, filed by HMO LOUISIANA, INC.. (mg) (Entered: 07/23/2025)
08/22/2025	32	TRANSCRIPT OF MOTION HEARING before Judge Christopher R. Cooper held on July 2, 2025; Page Numbers: 1-42. Date of Issuance:August 22, 2025. Court Reporter/Transcriber Lisa A. Moreira, RDR, CRR, Telephone number (202) 354-3187, Transcripts may be ordered by submitting the Transcript Order Form For the first 90 days after this filing date, the transcript may be viewed at the courthouse at a public terminal or purchased from the court reporter referenced above. After 90 days, the transcript may be accessed via PACER. Other transcript formats, (multi-page, condensed, CD or ASCII) may be purchased from the court reporter. **NOTICE RE REDACTION OF TRANSCRIPTS:** The parties have twenty-one days to file with the court and the court reporter any request to redact personal identifiers from this transcript. If no such requests are filed, the transcript will be made available to the public via PACER without redaction after 90 days. The policy, which includes the five personal identifiers specifically covered, is located on our website at www.dcd.uscourts.gov. Redaction Request due 9/12/2025. Redacted Transcript Deadline set for 9/22/2025. Release of Transcript Restriction set for 11/20/2025.(Moreira, Lisa) (Entered: 08/22/2025)

PACER Service Center			
Transaction Receipt			
12/01/2025 11:02:42			
PACER Login:	tifdrouaud	**Client Code:**	99YS-399303
Description:	Docket Report	**Search Criteria:**	1:24-cv-02931-CRC
Billable Pages:	7	**Cost:**	0.70

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 24-2931

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiff HMO Louisiana, Inc. ("HMOLA"), submits the following Amended Complaint for declaratory and injunctive relief against Defendants Department of Health and Human Services ("HHS"), the Centers for Medicare & Medicaid Services ("CMS"), Xavier Becerra, in his official capacity as Secretary of HHS, and Chiquita Brooks-LaSure, in her official capacity as Administrator of CMS (collectively, "Defendants" or "CMS"), and alleges as follows:

INTRODUCTION

1. This is yet another case in which CMS miscalculated a Medicare Advantage Plan's Star Ratings, causing serious and irreparable harms to the plan and its members that will persist if left uncorrected.

2. HMOLA is one of the nation's largest Medicare Advantage health plans ("MA Plans"), currently serving approximately 30,000 members in Louisiana.

3. In 2024, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated two of its contracts, H6453 and H5576, with HMOLA's H6453 contract surviving.

4. MA Plans, like HMOLA, receive annual Star Ratings from CMS for their contracts based on "health and drug plan quality and performance measures" that are used by Medicare beneficiaries to shop for plans.

5. HMOLA's contract H6453 did not offer a Special Needs Plan ("SNP"), which is one of the measures CMS evaluates in developing Star Ratings.

6. Thus, according to its own regulations, CMS should have excluded consideration of Measure C05 in developing HMOLA's Star Ratings so they were not artificially impacted by a measure pertaining to a non-existent offering.

7. But CMS did just the opposite. It considered Measure C05, which caused HMOLA's 2025 Part C Star Ratings to precipitously plunge, from 4 to 3.5 Stars, and caused its overall 2025 Star Ratings also to drop from 4 to 3.5 Stars.

8. CMS publicly disclosed HMOLA's unlawfully calculated Star Ratings on its website, which has resulted in irreparable harm to HMOLA's reputation, goodwill, and competitive position, as well as impaired its ability to attract beneficiaries.

9. When HMOLA confronted the agency about its failure to exclude the C05 measure, CMS refused to recognize it regulations and guidance required it to treat C05 as a "no score."

10. CMS's refusal to apply the plain text of its regulations is an arbitrary and capricious agency action in violation of the APA.

11. Accordingly, HMOLA brings this action to obtain relief for the unlawful actions CMS has engaged in to calculate HMOLA's 2025 Star Ratings, which have caused immediate and irreparable harms to its reputation, market and competitive position, and more importantly,

undermined HMOLA's effort to keep approximately 30,000 Medicare beneficiaries healthy and independent.

PARTIES

12. HMOLA is a Louisiana business corporation, with its principal place of business in Baton Rouge, Louisiana, and is a wholly-owned subsidiary of BCBSLA, which is a non-profit, mutual insurance company.

13. Defendant HHS is the department of the federal government ultimately responsible for the federal Medicare and Medicaid programs.

14. HHS has delegated its authority to administer the Medicare and Medicaid programs to Centers for Medicare and Medicaid Services. *See* 66 Fed. Reg. 35437.

15. Defendant CMS is a federal agency within HHS with the primary oversight responsibility for the Medicare program and the federal portion of the Medicaid program. It was created by the Reorganization Act of March 9, 1977. *See* 66 Fed. Reg. 35437.

16. Defendant Xavier Becerra is named in his official capacity as the Secretary of HHS. *See* 42 C.F.R. § 405.1136(d)(1).

17. Defendant Chiquita Brooks-LaSure is named in her official capacity as Administrator of the Centers for Medicare and Medicaid Services. The Administrator is responsible for the administration of the Medicare program, including the Star Ratings. *Id.*

JURISDICTION & VENUE

18. This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 because this action arises under the APA, 5 U.S.C. §§ 701 *et seq.*, and 42 U.S.C. §§ 1395 *et seq.*

19. Venue is proper in this Court under 28 U.S.C. § 1391(e) because this is an action against officers and agencies of the United States and a substantial part of the events giving rise to HMOLA's claims occurred in this District.

20. The Complaint is timely under 28 U.S.C. § 2401(a).

REGULATORY AND FACTUAL BACKGROUND

The Medicare Program And Star Ratings

21. The Medicare program, authorized under Title XVIII of the Social Security Act ("SSA"), is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42 U.S.C. §§ 1395 *et seq.*

22. The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

23. Individuals enrolled in Medicare may elect to receive their benefits under Part C of the Medicare program, commonly referred to as the "Medicare Advantage" program, as an alternative to original Medicare.

24. Under Part C, CMS contracts with private insurance payors, commonly known as Medicare Advantage Plans ("MA Plans"), to provide and arrange for Medicare-covered benefits for Medicare beneficiaries who enroll in their benefit plan. *See* 42 C.F.R. § 422.4.

25. Besides arranging and paying the Medicare-covered benefits of Medicare beneficiaries, MA Plans typically provide supplemental benefits as well as lower co-payments and other cost sharing, which further reduce the cost of covered services for beneficiaries.

26. The Medicare Advantage program is intended to shift the financial risk of providing health care to beneficiaries from the federal government to the privately run MA Plans in exchange for a per-member, per-month payment.

27. MA Plans that are better at keeping their members healthy, by effectively managing their care and providing important related services, receive higher Star Ratings, and overall, perform better in the marketplace. *See generally* 42 C.F.R. § 422.160.

28. By providing additional benefits beyond those covered by Medicare, MA Plans compete with original Medicare and with one another to convince beneficiaries to select their plan.

29. In an effort to encourage MA Plans to offer high quality plans and to assist Medicare beneficiaries in selecting a plan, CMS studies and surveys MA Plans for quality, compliance, and other metrics to develop numerical ratings for each MA Plan ("Star Ratings").

30. The Star Ratings are based on a five-star scale, with 1 star being the lowest rating and 5 stars being the highest. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

31. The Star Ratings are designed to be "a true reflection of the plan's quality" and must be based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

32. Star Ratings information is widely available to Medicare beneficiaries to consider when choosing to enroll in an MA Plan. These measures are particularly important, as they allow beneficiaries to compare health plans based on quality.

33. CMS prominently displays Star Ratings on available MA Plans in its online and print resources as required under the SSA. *See* 42 U.S.C. § 1395w–21.

34. Indeed, through the online Medicare Plan Finder tool, CMS displays MA Plans in highest to lowest Star Ratings order to prospective members, with the express purpose of guiding beneficiaries to higher-rated plans first.

35. The Star Ratings also impact the amount of funds CMS will pay to each MA Plan.

36. Under Section 1853(o) of the SSA, CMS allocates quality bonuses to MA Plans based on their Star Ratings and awards additional funds to MA Plans rated at or above 4 stars. *See* 42 U.S.C. § 1395w–23.

37. MA Plans use these bonuses, which are often in the tens, if not hundreds of millions, of dollars, to provide additional benefits and services to further improve care to their members.

38. Conversely, MA Plans that consistently receive Star Ratings below 3 stars may be terminated from the Medicare Advantage program altogether. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

39. Thus, the Star Ratings have tremendous value to MA Plans and are strong incentives for these plans to provide quality care and comprehensive benefits to their members, allow them to compete in the marketplace, receive higher compensation, and even remain eligible to continue to participate in the Medicare Advantage program.

Calculation Of Star Ratings

40. To calculate Star Ratings, CMS must use clear and unambiguous calculations established in its regulations. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

41. Star Ratings for MA Plans are based on a calculation of numerous performance measures designed to assess member satisfaction and receipt of care, including but not limited to preventative health services, management of long-term conditions, member experiences with the health plan, member complaints, and customer service.[1]

[1] *See* Medicare 2025 Part C & D Star Ratings Technical Notes at 30–105, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf (hereinafter "2025 Technical Notes").

42. MA Plans (including HMOLA) use Star Ratings to target areas of improvement and investment to ensure they are maximizing their services for beneficiaries, and in turn, earn higher Star Ratings.

43. Any changes to the Star Ratings calculations can have serious, and sometimes catastrophic, impacts on MA Plans.

44. When Star Ratings fall because of changes in criteria and calculation methodology, MA Plans may be disqualified from receiving quality bonus payments and can even be removed from the Medicare Advantage program altogether, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries.

45. Given their significance, in developing and applying each MA Plan's Star Ratings, CMS must treat each MA Plan "fairly and equally," judging them only on matters that are "under the control of the health or drug plan," in a system that will "minimize unintended consequences" adopted through a "process of developing [a ratings methodology that] is transparent and allows for multi- stakeholder input." 83 Fed. Reg. 16440, 16521.

46. To meet those obligations, CMS calculates Star Ratings based on a rigid methodology set forth in its own regulations that focuses on "health and drug plan quality and performance measures." 42 C.F.R. §§ 422.164 & 422.166; 2025 Technical Notes at 3–5 & 30–105.

47. CMS also issues annual "Technical Notes" that provide further explanation and direction on its Star Ratings methodology, generally, and how to calculate the relevant "measures" that are "used for a particular Star Rating," specifically. 42 C.F.R. § 422.164(a); *see* 2025 Technical Notes at 3 & 30–105.

48. CMS issues its Technical Notes to "provide quality and performance information" to MA beneficiaries to "assist them in choosing their health and drug services" and "describes the methodology for creating the Part C & D Star Ratings" for each plan. 2025 Technical Notes, at 1.

49. CMS's regulations further specifically incorporate and include its Technical Notes. 42 C.F.R. § 422.164(a).

50. To ensure equal and transparent treatment of all plans, CMS cannot adopt or use a metric different from that articulated in its regulations and Technical Notes. *Id.*; *see e.g.*, *UnitedHealthcare Benefits of Texas, Inc. v. Centers for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, ECF No. 28, at 8–9 (E.D. Tex. Nov. 22, 2024) (remanding an agency action that was "contrary to the agency's" Call Center Technical Notes).

51. Among other measures used to develop Star Ratings, CMS assesses each plan's offering of Special Needs Plan Care Management ("SNP"), which is identified by CMS as C05. *See* 2025 Technical Notes at 37–38.

52. SNPs are designed for specific types of beneficiaries, such as those with chronic disease and conditions and who live in an institution, such as a nursing home. *Id.*

53. For CMS to consider a plan's C05 measure as part of its Star Ratings, the plan "must have 30 or more enrollees." 2025 Technical Notes at 38.

54. But if a Plan does not offer an SNP, or has an SNP with fewer than 30 enrollees, CMS will treat Measure C05 for that plan as a "no score." *Id.* at 119.

55. Accordingly, to ensure the absence of a score does not skew the ratings, CMS will not issue a rating for Measure C05 and "exclude" consideration of that measure in developing the plan's overall Star Ratings. *Id.*

CMS's Regulations For Consolidated Contracts

56. For MA Plans, they may consolidate contracts, meaning "combines multiple contracts into a single contract for the start of the subsequent contract year." 42 C.F.R. § 422.162(a).

57. HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated contracts belonging to HMOLA (contract H6453) and another subsidiary (contract H5576), with HMOLA's H6453 contract surviving.

58. Generally, when contracts are consolidated, CMS develops the Star Ratings for the surviving contract for the two years after consolidation using an enrollment-weighted average of the measures of the consumed contract and surviving contract. *See* 42 CFR § 422.162(b)(3)(ii); 2025 Technical Notes, Attachment B, at 114.

59. But when either the surviving or consumed contract has a measure that receives a "no score," then the measure is properly treated as a "no score" for both contracts. *Id.*

60. Otherwise, the Star Ratings for a plan facing consolidation would be incorrectly weighted because it would have only one – as opposed to two – measure for averaging.

61. Moreover, by considering the measure for both contracts instead of excluding them, CMS would issue a Star Rating for services not actually offered by one of the two contracts.

62. Thus, the result of such a flawed approach would be a Star Ratings for the consolidating plan that does not "fairly" capture its true quality of services and care for beneficiaries for the year. 83 Fed. Reg. 16440, 16521. Such flawed Star Ratings would of course mislead Medicare beneficiaries about the plan's true quality.

CMS Adopted An Unlawful Interpretation Of Its Regulations And Guidance

63. Based on its high-quality care and services, HMOLA has historically received top-tier Star Ratings that are critical to its operations and ability to serve its members.

64. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024.

65. On January 1, 2024, BCBSLA, the parent corporation of HMOLA, consolidated contracts H5576 and H6453.

66. Following that contract consolidation, HMOLA's contract H6453 survived.

67. In 2023 – the measuring period for 2025 Star Ratings – HMOLA's H5576 contract offered an SNP for 2023 and received a 3 Star Rating for Measure C05.

68. But for the same 2023 period, HMOLA's surviving contract, H6453, did not offer an SNP.

69. Thus, under CMS's own regulation, CMS should have treated Measure C05 as a "no score," thereby excluding it from consideration in the development of HMOLA's Star Ratings. 2025 Technical Notes, at 38.

70. In September 2024, CMS notified HMOLA of its plan preview for their 2025 Star Ratings.

71. HMOLA's 2025 Star Ratings dropped precipitously to 3.5 Stars – instead of its expected 4.0 Stars.

72. HMOLA contacted CMS for an explanation of the sudden and surprising drop in its Star Ratings. *See* Exhibit ("Ex.") 1, CMS Correspondence on Nov. 15, 2024.

73. In its response, the agency explained it considered data from both H5576 and H6453 in the calculation of Measure C05, even though contract H6453 did not offer an SNP for the 2023 period.

74. CMS requires that C05 be treated as a "no score" for HMOLA given it did not provide an SNP under contract H6453 during the measuring period. *See* 42 C.F.R. § 422.162; 2025 Technical Notes at 37–38.

75. Nevertheless, CMS calculated HMOLA's C05 measure by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings for C05, resulting in lower overall Star Ratings for HMOLA. *See* Ex. 1.

76. HMOLA's 2025 Star Ratings significantly dropped as a result of CMS's unlawful actions.

77. Had CMS reasonably and properly applied its regulations and guidance, and excluded Measure C05 given HMOLA did not offer an SNP for the measuring year, HMOLA's Part C Star Ratings would have been 4 Stars, rather than 3.5 Stars.

78. 2025 Star Ratings for HMOLA's surviving contract is meant to provide beneficiaries with "a true reflection of the plan's quality," and in doing so, help them make informed decisions about which plan to choose. 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

79. But CMS's arbitrary and unlawful calculation of HMOLA's 2025 Star Ratings does just the opposite. It misleads beneficiaries about the plan's true quality and prevents them from making informed decisions about which plan to choose.

80. By issuing 2025 Star Ratings that relied on ratings for programs HMOLA did not *even offer* during the measuring period, the agency issued Star Ratings that do not represent a "true reflection" of HMOLA's services and care. 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

81. It also frustrates the very purpose of CMS's consolidation regulations, which is meant to ensure the Star Ratings of the surviving contract are properly measured post-consolidation to reflect the surviving plan's true quality. 42 C.F.R. § 422.162(f)(3).

82. When confronted about its flawed and unlawful approach, CMS mistakenly insisted that its regulations directed the combination of the data from the consumed and surviving contracts – regardless of the measure. *See* Ex. 1; 42 C.F.R. § 422.162(b)(2).

83. Despite HMOLA's informal efforts to have CMS correct its Star Ratings, the agency has refused to reconsider its flawed and unlawful approach.

Defendants' Unlawful Conduct
Has Caused HMOLA To Suffer Irreparable Harms

84. CMS's unlawful conduct has caused and continues to cause HMOLA to suffer severe and irreparable harms.

85. Defendants have improperly refused to calculate C05 using solely the surviving contract's "no score."

86. As a result, Defendants have issued a fundamentally flawed Part C Star Ratings for HMOLA of 3.5 Stars.

87. The impact of that significant drop in HMOLA's Star Ratings is serious and substantial.

88. The reduced Star Ratings have undermined HMOLA's competitive position, reputation, and goodwill, and impacted its ability to compete against other plans, including those that may have benefited from Defendants' flawed and unlawful methodology.

89. Additionally, as a result of CMS's flawed rating methodology and reliance on improper data, beneficiaries may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans.

90. And by reducing HMOLA's 2025 Star Ratings, CMS has rendered HMOLA ineligible for quality bonus payments in 2026, thereby impacting its operations and ability to provide enhanced benefits and lower premiums to beneficiaries.

91. HMOLA now turns to this Court to redress these grave harms by requiring Defendants to comply with federal law, vacating the flawed 2025 Star Ratings assigned to HMOLA, and enjoining them from disclosing and relying on that unlawful rating in connection with any other agency decision.

COUNT I
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)
(Consideration of H5576 Data For Measure C05)

92. HMOLA realleges the allegations set forth in Paragraphs 1 through 91 of this Complaint as if fully set forth herein.

93. CMS's consideration of H5576's C05 data to calculate HMOLA's Part C 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.162(b)(3)(ii).

94. HMOLA is adversely affected and aggrieved by CMS's calculation of the C05 Measure for HMOLA's newly-consolidated contract – without an SNP – with the C05 Measure from its consumed contract.

95. The consideration of C05 data from H5576 to calculate HMOLA's 2025 Star Ratings is arbitrary, capricious, and otherwise not in accordance with the law in violation of 5 U.S.C. § 706(2)(A).

96. Defendants failed to engage in a reasoned decision-making; to consider important aspects of the problem they believed they faced; to consider the impact that the incomplete data would have on HMOLA's Star Ratings; to provide an adequate explanation for their decision to consider incomplete data to determine HMOLA's Star Ratings; and considered the consumed contract data even though contrary evidence demonstrated it should never have been considered as is.

97. HMOLA has suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

98. HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT II
Declaratory Judgment

99. HMOLA realleges and incorporates Paragraphs 1 through 91 as if fully set forth herein.

100. CMS's calculation of the 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2).

101. HMOLA is adversely affected and aggrieved by the calculation of its Star Ratings.

102. An actual controversy has arisen and exists between HMOLA and Defendants regarding Defendants' calculation of HMOLA's 2025 Star Ratings using the consumed contract data.

103. HMOLA requests a declaration from this Court under 28 U.S.C. § 2201 that Defendants' calculation is arbitrary and capricious.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff HMOLA prays that this Court vacate HMOLA's 2025 Star Ratings and remand this matter to the agency for further consideration. Additionally, HMOLA requests the Court to:

1. Adopt an expedited schedule to resolve the merits of this Complaint;

2. Declare that:

- Defendants' consideration of the consumed contract's data to calculate Measure C05 and HMOLA's 2025 Star Ratings is arbitrary, capricious, and contrary to law in violation of 5 U.S.C. § 706(2)(A); and

- Defendants must recalculate HMOLA's 2025 Star Ratings in compliance with CMS's regulations, specifically only using H6453's "no score" for Measure C05.

3. Enjoin Defendants from disclosing and relying on that HMOLA's unlawful 2025 rating in connection with any other agency decision.

4. Require remedial action by Defendants to:

   - Issue a public statement of its error and the correction of HMOLA's 2025 Star Ratings, to be posted both on the CMS website and in one or more newspapers of general circulation in each community or county located in the service area of HMOLA's consolidated contract H6453;

   - Take all actions necessary to ensure that HMOLA is not competitively disadvantaged as a result of CMS's corrective actions to cure its unlawful star ratings calculations, including but not limited to recalculating HMOLA's 2025 Star Ratings; and

5. Award HMOLA its reasonable attorney's fees and costs, as permitted by law; and

6. Grant such other further relief as this Court deems just and proper.

Dated: December 6, 2024

By: _____

Paul Werner
Imad Matini
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Washington, D.C. 20006
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Counsel for Plaintiff

Exhibit 1

From: CMS PartC&DStarRatings
To: Miller, Wesley
Cc: Saporito, Mary; Faulk, Sheldon; Patalano, Lou; CMS PartC&DStarRatings
Subject: RE: Plan Preview #2 H6453
Date: Friday, November 15, 2024 12:35:17 PM

Good afternoon,

This is in further response to the notice of calculation errors HMO Louisiana, Inc. ("HMOLA") provided CMS on September 12, 2024, concerning the 2025 Star Ratings for its contract H6453.
In that notice, HMOLA claimed that those Star Ratings contained certain calculation errors arising out of "[t]he consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract)," effective January 1, 2024. HMOLA claimed that "to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations" of two performance measures, the SNP Care Management (C05) and the MTM Program Completion Rate (D11) measures. HMOLA claimed that "due to a technical issue with HPMS," it "was unable to submit relevant measurement information data" for each measure, which would have resulted in an increase on the C05 measure from No Star Rating to 96% (5 Stars) and an increase on the D11 measure from 92% (4 Stars) to 95% (5 Stars). HMOLA requested that "CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576."

At Louisiana Blue's request and after further consideration, CMS agreed to accept H5576's 2023 SNP and MTM data, along with the accompanying Data Validation findings, for calculation of the SNP rate and MTM CMR rate for H6453. CMS received H5576's SNP and MTM data on 10/24/24 and the data validation findings on 10/30/24. The contract's SNP and MTM data passed data validation, and CMS calculated the resulting SNP rate and MTM CMR rate for H6453 per §§ 422.162(b)(3)(iv)(B)(*1*) and 423.182(b)(3)(ii)(B)(*1*).

Below are the updated 2025 Star Ratings for the H6453 contract based on the validated data submitted by HMOLA:

SNP Care Management (C05) Measure. For the data publicly released on Medicare Plan Finder on October 10, 2024, H6453 did not receive a score for the SNP Care Management (C05) measure and did not receive a measure-level Star Rating for C05. After we accepted the data for C05 for the consumed contract (H5576), the score for C05 for H6453 (the surviving contract) was updated to 70% and a 3 star measure rating for H6453. The updated data for SNP Care Management (C05) results in a decrease in the Part C improvement measure rating from 4 to 3 stars since there was a significant decline in the measure score from the prior year, decreasing from 76% to 70%.

MTM Program Completion Rate (D11) Measure. For the data publicly released on Medicare Plan Finder on October 10, 2024, H6453 received a score for the MTM Program Completion

Rate (D11) measure of 92% and 4 stars. After we accepted the data for D11 for the consumed contract (H5576), the score for D11 was updated to 95% and increased to a 5 star measure rating for H6453.

After we accepted the data from H5576, as requested by Louisiana Blue, and updated the scores and measure-level stars for H6453, the overall rating is 3.603658 which rounds to 3.5 stars. The Part C Summary Rating decreases from 4 stars to 3.5 stars with the addition of the SNP Care Management measure and the decrease in the Part C improvement measure star. The Part D Summary Rating increases from 3.5 stars to 4 stars with the increase to the MTM measure star.

CMS plans to proceed with updating the measure scores and stars in HPMS and Medicare Plan Finder soon. If you have questions or wish to discuss, please let us know.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, September 12, 2024 7:41 PM
To: Miller, Wesley <Wesley.Miller@lablue.com>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 H6453

Confirming receipt.

From: Miller, Wesley <Wesley.Miller@lablue.com>
Sent: Thursday, September 12, 2024 7:14 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>
Subject: Plan Preview #2 H6453
Importance: High

Good Afternoon,

Thank you for allowing Plans the opportunity to provide feedback on the Star Rating calculation prior to finalization.

Pursuant to the CMS Memorandum dated September 5, 2024 (“Second Plan Preview of 2025 Part C and D Star Ratings Data”), HMO Louisiana, Inc. (“HMOLA”) is providing notice of three (3) calculation errors identified in the Second Plan Preview STAR Ratings for its contract

H6453. These calculation errors impact HMOLA's contract H6453, which is the surviving contract following a consolidation in 2024, and result from the failure to account for data from the consumed contract (H5576). These errors include:

1) HMOLA was unable to submit relevant measurement information data relating to D11: "MTM Program Completion Rate for CMR," which data would have resulted in an increase of this measure from 92% (4 Stars) to 95% (5 Stars).

2) HMOLA was unable to submit relevant measurement information data relating to C05: "Special Needs Plan (SNP) Care Management," which data would have resulted in an increase of this measure from No Star Rating to 96% (5 Stars).

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

While we provided you with the additional information in the accompanying Appendix (including the data for measurements D11 and C05) that evidence the calculation errors, we believe the summary below provides all of the information necessary for CMS to understand the errors we have identified and correct them prior to finalization of CY 2025 STAR Ratings data.

History of Contract H6453

Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") is the parent company to HMOLA. Prior to 2024, BCBSLA and/or its subsidiaries offered products under the following H-Contracts:

- Vantage Health Plan, Inc. offered a MA HMO-POS product under **H5576** contract
- HMOLA offered a MA HMO product under **H6453** contract
- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under

H7163 contract

- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

Errors # 1 and 2: Failure to Consider Relevant Data for Measures D11 and C05

When contracts are consolidated, the STAR Rating for the surviving contract for the first year after consolidation is determined through the enrollment-weighted average of the measures of both the consumed contract and the surviving contract for all measures except improvement measures. Both the regulation addressing STAR Ratings following contract consolidations as well as current technical instructions for STAR Ratings contain this requirement that data from both contracts be included for the first two years following a contract consolidation. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Appendix B, p. 115 (Draft) (Sept. 4, 2024) ("Technical Notes"). Thus, to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations. However, only data from HH6453 was considered in the calculation of D11 and C05.

Despite its relevance to the STAR Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for contract H5576 due to a technical issue with HPMS. Specifically, HMOLA was unable was able to submit measurement information relating to measurements D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care," both of which are process measures. HMOLA was only able to submit information for these measures for contract H6453. As such, CMS used only partial information for these measures and, in doing so, failed to adhere to its own regulations. Again, had the relevant data been submitted relating to contract H5576, HMOLA's score for D11 would be 95%/5 Stars (as opposed to the calculated 92%/4 Stars), and HMOLA's score for C05 would be 96%/5 Stars (as opposed to the calculated No Star Rating). Both the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the STAR Rating for the surviving contract. Accordingly, HMOLA requests that CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576.

Error # 3: Incorrect Calculation of CAI

The consolidation of contracts H5576 and H6453 also led to an incorrect calculation of the CAI for HMOLA contract H6453. The regulation governing application of the CAI states that, for the first two years following a consolidation, CMS determines the CAI using enrollment data from both the surviving and consumed contracts in the consolidation. 42 CFR § 422.166(f)(2)(i)(B)(1). This requirement was added to the regulation in April 2024, and the text of the regulation indicates that it became effective immediately. This is in contrast to the language addressing the calculation of the HEI reward following contract consolidation, which the regulation specifies will go into effect beginning with the 2027 STAR Ratings year. 42 CFR § 422.166(f)(2).[1] In the case of the CAI, there is nothing in the text of the regulation that suggests that the methodology for applying the CAI following a contract consolidation should not go into effect immediately. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

To comply with the requirements in Section 422.166(f)(2), CMS must include in its CAI calculation the enrollment data from the consumed contract regarding beneficiaries who are dually eligible, receive the low-income subsidy, or have disability status. Using enrollment data from both the surviving and the consolidated contracts to determine the CAI adjustment factor is consistent with how CMS assesses plan performance in other contexts following a contract consolidation. As noted above, the regulations require CMS to combine measure-level data between contracts in the first two years following a consolidation. The purpose of this approach is to obtain a complete representation of plan performance when calculating STAR Ratings. Calculating a weighted average of performance data across contracts appropriately represents consolidated performance.

Prior to the April 2024 amendments, Section 422.166 did not address how to calculate the CAI adjustment factor after a contract consolidation. The Technical Notes are also silent on this issue. In the absence of a specific exception made for the calculation of the CAI adjustment factor, the default rule of weighing data from both the consumed and surviving contracts (as reflected in Section 422.162) should have applied to the current calculation of HMOLA's CAI, in compliance with the specific requirement in Section 422.166(f)(2). Accordingly, HMOLA requests that CMS recalculate the CAI factor for contract H6453 using enrollment data for contract H6453 and contract H5576.[2]

Please contact us if you believe any further information is necessary or if you are unable to validate these errors. We are happy to answer any questions you may have related to any of these issues. Otherwise, we thank you for your review and consideration and look forward to your response.

Thank you,

Wesley Miller, PAHM, Notary Public
Medicare Compliance Officer
Louisiana Blue
o (225) 298-7965

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[1] Similarly, when CMS changed the weights given to certain measures, it amended the regulation to specify that the new weights would go into effect starting with the 2026 STAR Ratings year. 42 CFR § 422.166(e)(1)(iii)-(iv).

[2] In the alternative, CMS has the authority, in the absence of any regulatory requirement to the contrary, to calculate the CAI in this manner following a consolidation. In light of the limited number of consolidations that occur in any given year, this rule could easily be applied to any other similarly situated organizations. For CMS to take the alternative approach for CY 2025 STAR Ratings, after already articulating that this was the "more accurate" approach, would be arbitrary and capricious.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	)	Case No. 24-2931-CRC

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Plaintiff HMO Louisiana, Inc. ("HMOLA"), respectfully moves this Court for summary judgment under Federal Rule of Civil Procedure 56. As set forth more fully in its accompanying brief in support of its motion, HMOLA is entitled to summary judgment because Defendants unlawfully calculated HMOLA's 2025 Star Rating in a manner that was arbitrary and capricious and contrary to law. HMOLA further respectfully requests oral argument regarding its Motion for Summary Judgment.

Dated: February 14, 2025

By:_____

Paul Werner (D.C. Bar #482637)
Imad Matini (D.C. Bar # 1552312)
Hannah Wigger (D.C. Bar # 208851)
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Counsel for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on February 14, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Paul Werner
Paul Werner

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	)	Case No. 24-2931-CRC

PLAINTIFF'S MEMORANDUM IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases — Page(s)

Statutes

Other Authorities

INTRODUCTION

This is yet another case in which CMS miscalculated a Medicare Advantage Plan's ("MA Plan's") Star Ratings, costing it hundreds of millions of dollars, damaging its goodwill and reputation in the marketplace, and undermining its ability to provide beneficiaries with access to additional quality services. In doing so, CMS irrationally applied its own regulations, and the Court should now order the agency to recalculate HMO Louisiana, Inc.'s ("HMOLA's"), Star Ratings in accordance with its regulations.

HMOLA is a MA Plan serving thousands of beneficiaries in Louisiana. To improve its services and maximize its offerings to its members, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated two of its Medicare Advantage contracts in 2024 – H5576 and H6453, with H6453, HMOLA's contract, to survive the consolidation. HMOLA expected its plan rating, or "Star Ratings," to positively reflect the consolidation and encourage beneficiaries to select HMOLA's surviving plan. Star Ratings are intended to provide current and prospective beneficiaries with a "a true reflection of the plan's quality." As such, beneficiaries use Star Ratings – which are widely available online and in print resources – to make informed decisions about which plan to choose. Star Ratings also impact the amount of funds CMS pays each MA Plan, which are used to provide additional benefits and services to enhance member care.

In calculating Star Ratings, CMS is bound by its regulations, including the Technical Notes that are incorporated by reference into the regulations. The Technical Notes direct CMS's collection of various data, including data related to a supplemental Special Needs Plan ("SNP") (CMS Measure C05). SNPs are designed for beneficiaries with chronic diseases, concurrently on Medicaid, or living in an institution such as a nursing home, and are not offered by all MA Plans. CMS's Measure C05 recognizes this reality and directs the agency to calculate C05 only

for plans with at least 30 eligible beneficiaries. Thus, for MA Plans that do not offer a SNP, like HMOLA's H6453 contract, CMS must exclude C05 as a "no score" from the Star Ratings calculation.

In calculating HMOLA's consolidated Star Ratings, however, CMS ignored this instruction and the regulation's policy. Instead, the agency combined HMOLA's "no score" for Measure C05 with the 3.0 Stars associated with the SNP of the consumed H5573 contract, which, in effect, reduced HMOLA's Star Ratings from 4.0 to 3.5 stars. This reduction is a direct result of CMS violating its own Technical Notes – failing to exclude Measure C05 from consideration – and flouting their animating purpose to provide beneficiaries "a true reflection of the plan's quality."

CMS's unlawful actions have caused HMOLA substantial, abiding, and irreparable harms. CMS's mistaken Star Ratings will cause HMOLA to lose millions in quality bonus payments used to provide supplemental services and cost-sharing opportunities to its more than 34,000 Medicare beneficiaries. And CMS's lower Star Ratings, which falsely indicate to Medicare Advantage participants that the quality of HMOLA's plan is lower than it truly is, has also impaired HMOLA's goodwill, reputation, and competitive and market positions.

Because CMS has refused to correct HMOLA's mistaken Star Ratings, it therefore has sought this Court's assistance in requiring CMS to comply with its regulations and properly recalculate HMOLA's Star Ratings.

STATEMENT OF FACTS

A. CMS Uses Its Star Ratings Program To Indicate The Quality Of Medicare Advantage Programs And Award Them Additional Funds.

Administered by CMS, the Medicare program is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42

U.S.C. §§ 1395 *et seq*. As an alternative to traditional, government-managed Medicare, enrollees may elect to receive benefits under Part C of Medicare, commonly known as the "Medicare Advantage" program. *See* 42 U.S.C. § 1395w-21. Under Part C, CMS contracts with private insurance payors, MA Plans, to provide and arrange for Medicare-covered benefits for beneficiaries who enroll in their benefit plans. *See* 42 C.F.R. § 422.4; 42 U.S.C. § 1395w-23. In addition to arranging and paying Medicare-covered benefits, MA Plans typically provide supplemental benefits as well as lower co-payments and other cost-sharing, which further reduce the cost of covered services for beneficiaries. *See* 42 U.S.C. § 1395w-22(a)(3).

To evaluate the performance of MA Plans and provide beneficiaries with information for comparing plans in the marketplace, CMS issues "Star Ratings" to MA Plans. *See generally* 42 C.F.R. § 422.160. The Star Ratings are intended to be "a true reflection of [the] plan['s] quality" and therefore must be based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. 16,440, 16,520–21 (Apr. 16, 2018). To that end, CMS is statutorily required to measure "health outcomes and other indices of quality" that are used to develop the Star Ratings pursuant to methodologies set forth in its regulations. 42 U.S.C. § 1395w-22(e)(3)(A)(i). CMS therefore created the Star Ratings program to study and survey MA Plans for quality, compliance, and other metrics to develop numerical ratings for each MA Plan. *See* 83 Fed. Reg. at 16,520.

The Star Ratings are based on a five-star scale, with 1 star being the lowest rating and 5 stars being the highest. *See* 42 C.F.R. §§ 422.166(b)(2)(ii). CMS prominently displays Star Ratings for available MA Plans in its online and print resources so that Medicare beneficiaries can compare health plans based on quality when choosing to enroll in a MA Plan. *See, e.g.*, 42 C.F.R. § 422.166(h). Through the online Medicare Plan Finder tool, CMS in fact prominently

displays MA Plans in highest to lowest Star Ratings order to prospective members, with the express purpose of guiding beneficiaries to higher-rated plans.[1]

The Star Ratings also impact the bonuses CMS pays to each MA Plan. MA Plans use Star Ratings to target areas of improvement and investment to ensure they are maximizing their services for beneficiaries, and in turn, earn higher Star Ratings. CMS allocates quality bonuses to MA Plans based on their Star Ratings and awards additional funds to MA Plans rated at or above 4.0 stars. *See* 42 U.S.C. § 1395w–23. MA Plans use these bonuses, which are often in the tens, if not hundreds, of millions of dollars to provide additional benefits and services to further improve care to their members. *See* Declaration of Benjamin Vicidomina ("Vicidomina Decl.") ¶ 16.

Any changes to how Star Ratings are calculated can have serious and dramatic impacts on MA Plans. When Star Ratings fluctuate because of changes in criteria and methodology, MA Plans may be disqualified from receiving quality bonus payments or removed from the Medicare Advantage program altogether, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries. *See* 42 C.F.R. §§ 422.160(b)(2) & 422.510(a)(1)(iv). Thus, the Star Ratings serve as strong incentives for plans to provide quality care and comprehensive benefits to their members, and allow plans to compete in the marketplace, receive higher compensation, and even remain eligible to continue to participate in the Medicare Advantage program.

[1] *See* CMS Medicare Plan Finder, *available at* https://www.medicare.gov/plan-compare/#/?year=2025&lang=en (last visited Feb. 14, 2025).

B. CMS Calculates Star Ratings Based On A Set Methodology.

CMS promulgated regulations that establish the specific methodology used to calculate annual Star Ratings for MA Plans. *See* 42 C.F.R. §§ 422.162(b) & 422.166. The Star Ratings are calculated based on the data reported for the full year prior to collection.[2] In developing and applying each MA Plan's Star Ratings, CMS must treat each MA Plan "fairly and equally." 83 Fed. Reg. at 16,521. Thus, CMS must consider criteria that are "under the control of the health or drug plan" and in a system that will "minimize unintended consequences" adopted through a "process of developing [a ratings methodology that] is transparent and allows for multi-stakeholder input." *Id.*

CMS also publishes Technical Notes to explain the measure included in the "methodology for creating the Part C & D Star Ratings." AR 9; 42 C.F.R. § 422.164(a). The Technical Notes set forth how CMS calculates the relevant "measures" that are "used for a particular Star Rating." 42 C.F.R. § 422.164(a); *see* AR 11–12 & 38–113. CMS has incorporated its Technical Notes into its operative regulations. 42 C.F.R. § 422.164(a).

CMS calculates Star Ratings based on numerous performance measures and data designed to assess member satisfaction and receipt of care. *See* AR 1–214. Among other measures, CMS assesses an applicable plan's offering of Special Needs Plan ("SNP") Care Management, known as Measure C05. *See* AR 45–47. SNPs are designed for beneficiaries suffering from chronic diseases and conditions as well as those who also receive Medicaid coverage or live in an institution, such as a nursing home. *Id.* However, for CMS to consider a

[2] For example, the 2025 Star Ratings are calculated in late 2024 using data primarily from measurement year 2023. AR 21.

plan's Measure C05 data as part of its Star Ratings, the plan "must have 30 or more enrollees." AR 46.

If a Plan does not offer a SNP, or has a SNP with fewer than 30 enrollees, CMS will treat Measure C05 for that plan as a "no score," formally designated as "no data available." AR 46 & 127. To ensure the absence of a score does not skew the ratings, CMS will thus not issue a rating for Measure C05 and "exclude" consideration of that measure as a "no score." AR 127. CMS also excludes from its calculation "[c]ontracts and [Plan Benefits Packagaes or "PBPs"] with an effective termination date on or before . . . June 15, 2024." AR 45–46.

MA Plans may consolidate their contracts by "combin[ing] multiple contracts into a single contract for the start of the subsequent contract year." 42 C.F.R. § 422.162(a). When contracts are consolidated, CMS develops the Star Ratings for the surviving contract by using a weighted average of the measures of the consumed contract and surviving contract. *See* 42 C.F.R. § 422.162(b)(3)(iv); AR 122. That weighted average methodology applies for the two years after consolidation. *See* 42 C.F.R. § 422.162(b)(3)(iv); AR 122. When either the surviving or consumed contract has a measure that receives a "no score," the measure is properly treated as a "no score" for both contracts. *See* 42 C.F.R. § 422.162(b)(3); AR 45–47.

C. CMS Improperly Calculated HMOLA's 2025 Star Ratings In Violation Of Its Own Regulations.

Based on its high-quality care and services, HMOLA has historically received high Star Ratings, which are critical to its operations and member care. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024 and expected similar ratings for its 2025 Star Ratings. Vicidomina Decl. ¶¶ 14 & 25.

On January 1, 2024, HMOLA's parent company, BCBSLA, consolidated two of its contracts – H5576 and H6453. AR 216. Following that contract consolidation, HMOLA's

contract H6453 survived. *Id.* In September 2024, CMS notified HMOLA of its plan preview for their 2025 Star Ratings. Vicidomina Decl. ¶ 26. HMOLA's 2025 Star Ratings dropped precipitously to 3.5 Stars – instead of its expected 4.0 Stars. Vicidomina Decl. ¶ 27. HMOLA contacted CMS for an explanation of the sudden and surprising drop in its Star Ratings. *See* AR 315–16 & 317–20. In its response, the agency explained it considered data from HMOLA's subsumed contract H5576 in the calculation of Measure C05 for HMOLA's surviving contract H6453. AR 315–16.

In 2023 – the measuring period for 2025 Star Ratings – HMOLA's consumed contract, H5576, offered a SNP for 2023 and received a 3.0 Star Ratings for Measure C05. AR 215. But for the same 2023 period, HMOLA's surviving contract, H6453, did not offer a SNP. *Id.* Thus, under CMS's regulation, CMS should have treated Measure C05 as a "no score," excluding it from consideration in the calculation of HMOLA's Star Ratings. AR 45–46. Instead, CMS calculated HMOLA's Measure C05 by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings for C05, which generated a lower overall Star Ratings for HMOLA. *See* AR 315–316. By considering the measure for both contracts instead of excluding the measure altogether, CMS therefore issued a Star Ratings for *services not actually offered by the surviving H6453 contract*. Had CMS properly applied its regulations, consistent with their intended purpose and policy, and treated Measure C05 as a no score, HMOLA's Part C Star Ratings would properly have been 4.0 Stars.

D. CMS's Unlawful Conduct Has Caused – And Will Continue To Cause – HMOLA Substantial And Irreparable Harm.

CMS's fundamentally flawed 2025 Star Ratings for HMOLA has caused, and will continue to cause, it to suffer substantial and irreparable harms. Its mistakenly low Star Ratings have harmed HMOLA's competitive position, reputation, and goodwill, and undermined its

ability to compete against other plans. Vicidomina Decl. ¶¶ 31–40. Additionally, because of CMS's flawed rating methodology and reliance on improper data, beneficiaries may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans. Vicidomina Decl. ¶ 35. And by reducing HMOLA's 2025 Star Ratings, CMS has rendered HMOLA ineligible for quality bonus payments worth approximately $23 million in 2026, thereby impacting its operations and ability to provide enhanced benefits and lower premiums to beneficiaries. Vicidomina Decl. ¶¶ 32–33.

Because CMS has informally refused to recalculate HMOLA's Star Ratings, HMOLA seeks judicial relief. It requests the Court to require CMS to vacate the agency's unlawful 2025 Star Ratings, enjoin CMS from relying on the unlawful 2025 Star Ratings in connection with any other agency action, and require CMS to recalculate HMOLA's 2025 Star Ratings in accordance with the text, purpose, and policy of its regulations.

STANDARD

HMOLA's motion is governed by familiar standards. An agency action violates the Administrative Procedure Act ("APA") if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A) & (C); *see also* 5 U.S.C. § 702. Thus, Courts set aside an agency action that "disregard[s] rules that are still on the books," "irrationally departs from an agency's governing policy," or "frustrate[s] the policy that Congress sought to implement." *Beaty v. Food & Drug Admin.*, 853 F. Supp. 2d 30, 41 (D.D.C. 2012) (quoting *FEC v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981)); *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

In reviewing a motion for summary judgment in an APA case, the Court may not merely "rubberstamp" administrative decisions, especially where they are "inconsistent with a statutory

mandate" or "frustrate the congressional policy underlying a statute." *Bureau of Alcohol, Tobacco and Firearms v. Fed. Lab. Rels. Auth.*, 464 U.S. 89, 97 (1983) (quoting *NLRB v. Brown*, 380 U.S. 278, 291–92 (1965)). Instead, arbitrary and capricious review "has a serious bite," and irrational actions are properly set aside. *UnitedHealthcare Benefits of Tex., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, 2024 WL 4870771, at *3 (E.D. Tex. Nov. 22, 2024).

ARGUMENT

I. CMS Irrationally And Erroneously Calculated HMOLA's 2025 Star Ratings.

CMS's reliance on Measure C05 to calculate HMOLA's 2025 Star Ratings is arbitrary and capricious because it violates the clear language of its own regulations. Under the APA, an agency action that violates its own regulations is a quintessential example of arbitrary and capricious decision making. *See Scott & White Health Plan v. Becerra*, No. 22-cv-3202 (CRC), 2023 WL 6121904, at *10 (D.D.C. Sept. 19, 2023) (setting aside agency action as contrary to law because the agency acted "contrary to [the operative regulation's] plain language") (citation omitted); *Exportal Ltda v. United States*, 902 F.2d 45, 46 (D.C. Cir. 1990) (reversing agency action "flatly inconsistent with the plain terms" of its regulations).

Here, CMS plainly violated its own regulations. To provide plans with notice regarding its Measure C05 calculations, CMS publishes its Technical Notes, which are incorporated into its regulations. 42 C.F.R. § 422.164(a); *UnitedHealthcare*, 2024 WL 4870771, at *3-4 (holding CMS action arbitrary and capricious where it deviates from its Technical Notes); *see* AR 1–214. Those regulations require CMS to exclude from its calculation "[c]ontracts and PBPs with an effective termination date on or before . . . June 15, 2024" and contracts with fewer than "30 enrollees." AR 45–46. HMOLA's subsumed contract effectively terminated at its merger on January 1, 2024. AR 216 & 226. And its surviving contract did not offer a SNP at all. AR 224.

As a result, CMS should not have included the data for the subsumed contract related to Measure C05 in HMOLA's Star Ratings calculation.

Nor should the agency have issued Star Ratings for a plan that did not actually provide the services supposedly reflected in the ratings. But rather than follow its own regulations, CMS combined Measure C05 data for HMOLA's surviving and consumed contracts and issued HMOLA an overall 3.0 Star Ratings for Measure C05. AR 316; *supra* at Section C. That departure from the plain language of the regulation is a textbook example of arbitrary and capricious agency action. *Nat'l Env't Dev. Assn.'s Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014) (stating an agency is not free to "violate its regulations while they remain in effect"); *Scan Health Plan*, 2024 WL 2815789, at *5 (holding that CMS must abide "the plain text" of its regulations); *Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 13 (D.D.C. 2024) (same).

CMS's consideration of Measure C05 is also arbitrary and capricious because it is "inconsistent with the statutory mandate," *FEC*, 454 U.S. at 32, to provide beneficiaries with a "true reflection of plan quality and enrollee experience," 83 Fed. Reg. at 16,521. The Star Ratings are intended to provide "information about plan quality and performance indicators" to "beneficiaries to help them make informed plan choices." *Id.* at 16,520; *see* 42 U.S.C. § 1395w-21. Accordingly, CMS must issue Star Ratings that "treat contracts fairly and equally" while "minimizing unintended consequences." 83 Fed. Reg. at 16,521. Thus, Star Ratings are designed to be "true reflection[s] of plan quality and enrollee experience" and targeted on "measures under the control of the" MA Plan. *Id.*; *see* AR 9.

But here, CMS "frustrate[d] the policy that Congress sought to implement" by issuing Star Ratings that do not accurately reflect HMOLA's plan. *See Beaty*, 853 F. Supp. 2d at 41

(quoting *FEC*, 454 U.S. at 32). By issuing 2025 Star Ratings that relied on ratings for plans HMOLA did not *even offer* during the measuring period, the agency issued Star Ratings that do not represent a "true reflection" of HMOLA's services and care. 83 Fed. Reg. at 16,521; *supra* at Section C. Nor does HMOLA have "control" over the quality of a non-existent SNP plan. 83 Fed. Reg. at 16,521. As a result of this flawed approach, the Star Ratings for the consolidated plan does not "fairly" capture its true quality of services and care for beneficiaries for the year. *Id.* Rather, it misleads beneficiaries about the plan's true quality and prevents them from making informed decisions about which plan to choose. *Supra* at Section D.

II. The Court Should Require CMS To Recalculate HMOLA's Star Ratings And Publish Its Errors.

HMOLA is entitled to injunctive relief. *Nw. Immigrant Rights Project v. U.S. Citizenship & Immigration Servs.*, 496 F. Supp. 3d 31, 45 (D.D.C. 2020). Injunctive relief is particularly appropriate where HMOLA has suffered an "irreparable injury" resulting from a plainly unlawful agency action that violates the public interest. *Id.*; *see Scan Health Plan*, No. 1:23-CV-03910 (CJN), 2024 WL 2815789, at *7 (granting injunctive relief); *see also* 5 U.S.C. § 706. By erroneously calculating HMOLA's 2025 Star Ratings and issuing a flawed 3.5 stars, CMS has rendered HMOLA ineligible to receive quality bonus payments for 2026, amounting to approximately $23 million. Vicidomina Decl. ¶¶ 32–33. In so doing, CMS has also impaired HMOLA's ability to provide existing, much less enhanced, services to its beneficiaries. Vicidomina Decl. ¶ 33. HMOLA cannot now provide as robust supplemental benefits or as low co-payments or other cost-sharing, which would have further reduced the cost of covered services for beneficiaries. Vicidomina Decl. ¶ 33.

Additionally, HMOLA has suffered ongoing harm to its competitive position, reputation and goodwill, which is also irreparable and warrants injunctive relief. *See, e.g., Bell Helicopter*

Textron, Inc. v. Airbus Helicopters, 78 F. Supp. 3d 253, 274–75 (D.D.C. 2015) (finding "risk of future reputational harm, lost sales, and lost customers" irreparable). Since November 2024, CMS has widely publicized HMOLA's flawed 3.5-star Star Ratings. Vicidomina Decl. ¶ 30. As a result, HMOLA's plan appears less attractive to beneficiaries. Vicidomina Decl. ¶¶ 35–36.

If CMS does not correct HMOLA's 2025 Star Ratings, these harms will only worsen as beneficiaries continue to erroneously believe HMOLA offers an inferior plan – with a low-performing SNP that HMOLA *did not even offer*. Vicidomina Decl. ¶¶ 29 & 35. Absent relief, beneficiaries will also switch to competitors' plans, because the loss of approximately $23 million in funding will require HMOLA to significantly cut supplemental benefits, increase member cost-sharing, and reduce reimbursements to providers. Vicidomina Decl. ¶¶ 33 & 36; *see League of Women Voters v. Newby*, 838 F. 3d 1, 9 (D.C. Cir. 2016) (finding irreparable harm when agency action "ma[de] it more difficult for [organizations] to accomplish their primary mission"). HMOLA has expended, and will continue to expend, significant time and resources only to partially remediate these harms. Vicidomina Decl. ¶ 40.

In addition to the harms associated with CMS's unlawful actions, "[CMS's] sovereign immunity" makes HMOLA's injuries "irreparable *per se*." *See, e.g.*, *Nalco Co. v. EPA*, 786 F. Supp. 2d 177, 188 (D.D.C. 2011); *O'Donnell Constr. Co. v. District of Columbia*, 963 F.2d 420, 428 (D.C. Cir. 1992) (finding such a bar "weighs heavily in favor of granting the injunction"). Because of CMS's sovereign immunity, HMOLA will be unable to recover monetary damages from the government, much less recover for the reputational, competitive, and operational harms identified above. *See, e.g.*, *Nat'l Min. Ass'n v. U.S. Army Corps of Eng'rs.*, 145 F.3d 1399, 1408–09 (D.C. Cir. 1998) (finding no adequate remedy at law given no suggestion government

had "waived its sovereign immunity"). Therefore, HMOLA cannot be compensated by the government for its losses caused by the erroneous Star Ratings. *Nalco*, 786 F. Supp. 2d at 188.

HMOLA clearly satisfies the remaining elements for injunctive relief as well. *Nw. Immigrant Rights Project*, 496 F. Supp. 3d at 45. As explained above, HMOLA is likely to succeed on the merits of its APA and declaratory judgment claims because CMS calculated HMOLA's Star Ratings in violation of the plain language and purpose of its own regulations. *Supra* at Section I. The balance of equities and public interest also support injunctive relief. *Nw. Immigrant Rights Project*, 496 F. Supp. 3d at 81. Issuing an injunction will harm no one, including the Defendants, who would only be required to recalculate a Star Ratings in accordance with their own regulations. But, absent injunctive relief, HMOLA will continue to suffer irreparable harm to its competitive position, reputation, and goodwill in the market and its beneficiaries and potential beneficiaries will see a diminution in their benefits and increases in cost-sharing. Vicidomina Decl. ¶¶ 31–33. And there is, of course, "no public interest in the perpetuation of unlawful agency action." *League of Women Voters*, 838 F.3d at 12. Rather, the public has a strong interest in "having governmental agencies abide by the federal laws that govern their existence and operations." *Id*. (citations omitted). Absent an injunction, Defendants will continue to violate their own regulations. The public interest does not support that result.

CONCLUSION

For the foregoing reasons, this Court should:

- Grant HMOLA summary judgment;
- Vacate CMS's determination of HMOLA's 3.5-star Star Ratings;
- Order CMS to redetermine HMOLA's 2025 Star Ratings related to Measure C05 in accordance with the test, purpose, and policy of its regulations; and
- Order Defendants to take remedial action to ensure HMOLA does not continue to be competitively harmed by CMS's actions, including:

- Issue a public statement of its error and the correction of HMOLA's 2025 Star Ratings, to be posted on the CMS website;

- Engage in specific outreach to HMOLA's enrollees those who disenrolled with an effective date of November 21, 2024, through to the release of CMS's correction notice; and

- Take all actions necessary to ensure that HMOLA is not competitively disadvantaged as a result of CMS's corrective actions to cure its unlawful Star Ratings calculations, including, but not limited to, awarding HMOLA the appropriate quality bonus payments for its recalculated 2025 Star Ratings.

Dated: February 14, 2025

By:_____

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CERTIFICATE OF SERVICE

I hereby certify that on February 14, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Paul Werner
Paul Werner

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 24-2931-CRC

DECLARATION OF BENJAMIN VICIDOMINA IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Benjamin Vicidomina, declare as follows:

1. I submit this declaration in support of Plaintiff HMO Louisiana, Inc.'s ("HMOLA's"), Motion for Summary Judgment.

2. I am over the age of 18 years, and this Declaration is based upon my personal knowledge and review of relevant documents.

3. I am fully familiar with the facts and circumstances set forth herein. If called as a witness, I could and would testify competently thereto.

Background

4. I am the informatics and diagnosis coding-accuracy leader of HMOLA. I have held this position since August 16, 2018.

5. I have worked in the healthcare industry for over 15 years and have extensive experience with commercial and Medicare Advantage health plans.

6. In my role as Vice President, Analytics and Quality Improvement of HMOLA, I am responsible for providing reporting, information, statistical models, and econometric data used to drive operational decisions. I am also responsible for diagnosis coding-accuracy operations as it pertains to Qualified Health Plan and Medicare Advantage-related lines-of-business.

7. I am also familiar with the Centers for Medicare and Medicaid Services ("CMS"), Medicare Part C and D programs, CMS's Star Ratings (including the calculation thereof), and CMS's Quality Bonus Payment program.

8. Additionally, I am familiar with the impact of HMOLA's Star Ratings on its business operations and members.

HMOLA

9. HMOLA is a not-for-profit organization that offers Medicare Advantage plans ("MA Plans") for people aged 65 and older or otherwise eligible for Medicare.

10. HMOLA offers MA Plans, currently serving approximately 34,000 members in Louisiana.

11. HMOLA derives revenue from the Medicare Advantage program.

12. For HMOLA to remain viable and fulfill its mission, HMOLA must have beneficiaries select HMOLA's Medicare Advantage plan, rather than other competing plans, by providing high-quality care, a superior member experience, and leading supplemental benefits, all while minimizing premiums and cost-sharing to members.

HMOLA's Star Ratings

13. Based on its high-quality care and services, HMOLA has historically received top-tier Star Ratings that are critical to its operations and ability to serve its members.

14. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024.

15. As a result of its excellent overall Star Ratings, HMOLA has in recent years qualified for roughly $20 million to $22 million per year in quality bonus payments.

16. HMOLA has, in turn, used those payments to reduce beneficiary cost sharing, eliminate Part D premiums, and fund supplemental benefits not included in traditional Medicare, such as dental, vision, hearing aids, medical transportation, and over-the-counter drug coverage allowances.

17. Star Ratings represent a clear signal to beneficiaries of the quality of HMOLA's services.

18. And a Star Ratings of 4.0 stars or higher provides HMOLA additional payments that allow HMOLA to offer additional services as part of its plan and lower premiums and cost sharing.

19. As such, HMOLA's Star Ratings is critical to HMOLA's ability to maintain its existing operations and compete in the marketplace for members.

CMS Improperly Reduces HMOLA's 2025 Star Ratings

20. HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") offered five different MA Plans.

21. On January 1, 2024, BCBSLA consolidated contracts H5576 and H6453.

22. Following that contract consolidation, HMOLA's contract H6453 survived.

23. In 2023 – the measuring period for 2025 Star Ratings – HMOLA's H5576 contract offered a Special Needs Plan ("SNP") for 2023 and received a 3 Star Ratings for Measure C05.

24. For the same 2023 period, HMOLA's surviving contract, H6453, did not offer an SNP.

25. In advance of the release of 2025 Star Ratings, HMOLA expected an overall Star Ratings of 4.0 stars in light of its recent consolidation of two contracts, which was designed to improve the quality of its offerings.

26. In September 2024, CMS informed HMOLA of CMS's determination of HMOLA's overall Star Ratings.

27. CMS determined a 2025 Star Ratings of 3.5 stars for HMOLA – a significant drop from the 4.0 stars it expected.

28. Shortly after CMS notified HMOLA that its overall Star Ratings had fallen from 4.0 stars to 3.5 stars, HMOLA assessed that CMS calculated HMOLA's C05 measure by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings for C05, resulting in lower overall Star Ratings for HMOLA.

29. Contract H6453 did not offer an SNP for the 2023 measuring period.

CMS's 2025 Star Ratings Has Irreparably Harmed HMOLA

30. CMS made public the 2025 Star Ratings, including HMOLA's erroneous 3.5-star Star Ratings, on or about November 21, 2024.

31. CMS's reduction of HMOLA's 2025 Star Ratings from 4.0 stars to 3.5 stars has resulted in grave consequences to HMOLA's finances and has seriously harmed HMOLA's reputation and competitive position in the marketplace.

32. HMOLA estimates that if it had received a 2025 Star Ratings of 4.0 stars, HMOLA would be eligible for approximately $23 million of quality bonus payments for the 2026 plan year, based on its current membership.

33. The loss of approximately $23 million in quality bonus payments will mean that HMOLA must significantly cut supplemental benefits, increase member cost sharing, and reduce reimbursements to healthcare providers, causing them a significant hardship.

34. CMS's assignment of 3.5 stars to HMOLA has also already caused serious harm to HMOLA's competitive position, reputation, and goodwill.

35. As a result of CMS's flawed determination and publication of the 3.5-star Star Ratings, prospective members who are shopping for a MA Plan may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans

36. It also makes existing members more likely to disenroll from HMOLA to switch to another plan with a Star Ratings of 4.0 stars or higher.

37. Once HMOLA's members switch to other MA Plans, it is very difficult for HMOLA to reattract those members.

38. Once a member has expended the time and effort to change from HMOLA to a higher-rated plan, it is unlikely they will again expend the same effort to switch back to HMOLA in the future, even if HMOLA were to later revert to a Star Ratings of 4.0 Stars.

39. As a result, even if HMOLA were to later return to a 4.0 Star Ratings, it is highly unlikely that HMOLA's former members will expend the time and undertake the burden of transitioning back to HMOLA.

40. HMOLA has – and will continue to – expend significant time and resources only to partially remediate these harms.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 14th day of February, 2025.

Benjamin Vicidomina
Vice President, Analytics and Quality Improvement
HMO Louisiana, Inc.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC.,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Civil Action No. 24-2931 (CRC)

DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes, Regulations, and Federal Register

Pursuant to Federal Rule of Civil Procedure 56(a), Defendants, by and through undersigned counsel, respectfully cross-move for summary judgment. A memorandum of points and authorities in support of this cross motion and in opposition to Plaintiff's motion for summary judgment (ECF No. 17) follows.

INTRODUCTION

Pursuant to Congress's mandate, the Centers for Medicare & Medicaid Services ("CMS") calculates Medicare Advantage Star Ratings on a one through five-star scale in half-star increments, which allows Medicare beneficiaries to comparison shop among hundreds of private health insurance plans. CMS bases Medicare Advantage Organizations' Star Ratings scores on their contracts' performance on up to forty unique quality measures. This matter concerns CMS's Star Ratings calculation for one such measure: C05—Special Needs Plan Care Management. The issue in this case is whether CMS correctly calculated Plaintiff's C05 score for 2025 when the contract being evaluated is a result of the consolidation of multiple contracts.

On January 1, 2024, Plaintiff HMO Louisiana's ("HMOLA") parent company, Blue Cross Blue Shield of Louisiana ("BCBSLA"), consolidated two of its contracts, one that covered Special Needs Plans in 2023 and one that did not. The contract that did not cover Special Needs Plans in 2023 became the "surviving contract" following the consolidation, and the contract that did cover Special Needs Plans became the "consumed contract." The surviving, consolidated contract offered Special Needs Plans in 2024 and offers Special Needs Plans for 2025. The 2025 Star Ratings at issue here, however, are calculated based on 2023 measurement-year data, so the issue is how to evaluate the consolidated contract for 2025 on measure C05 when, in 2023, the consumed contract included Special Needs Plans and the surviving contract did not. In this situation, under CMS regulations, CMS assigns scores to the consolidated contract based on the "enrollment-weighted mean of the measure scores of the surviving and consumed contracts" for the first and

second years following the consolidation. 42 C.F.R. §§ 422.162(b)(3), 423.182(b)(3). That is precisely what CMS did here.

CMS followed its regulations when evaluating Plaintiff HMOLA's consolidated contract on measure C05. Because the surviving contract had no C05 score, the enrollment mean of the measure scores of the surviving and consumed contracts equaled the C05 score of the consumed contract. HMOLA contends that because its consolidation terminated the consumed contract on the date of the consolidation, the consumed contract's scores should have been excluded from measure C05. But under applicable regulations, while the two contracts are combined into a single contract for the start of the subsequent contract year, scores on applicable quality measures, such as measure C05, from the consumed contract are factored into the consolidated contract scores for two years following the consolidation. Nothing about CMS's calculation of the Star Ratings was arbitrary or capricious; CMS merely followed rules it had properly promulgated, and HMOLA's dissatisfaction with the result does not render CMS's decision improper.

BACKGROUND

I. Statutory and Regulatory Background

Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq*. ("Medicare statute"), establishes the Medicare program, a federally funded and administered health insurance program for eligible elderly and disabled persons and certain individuals with end stage renal disease. 42 U.S.C. § 1395c. The Secretary administers the Medicare program through CMS, a component agency of the United States Department of Health and Human Services.

The Medicare program is divided into four major components. Part A, the hospital insurance benefit program, provides health insurance coverage for certain inpatient hospital care, post-hospital care in a skilled facility, post-hospital home care services, and other related services. 42 U.S.C. §§ 1395c, 1395d. Part B, the supplemental medical insurance benefit program, generally

pays for a percentage of certain medical and other health services, including physician services, supplemental to the benefits provided by Part A. 42 U.S.C. §§ 1395j, 1395k, 1395l. Under Part C, the Medicare Advantage program, a Medicare beneficiary can elect to receive his or her Medicare benefits through a public or private healthcare plan. 42 U.S.C. § 1395w-21 *et seq*. Finally, Part D is the voluntary prescription drug benefit program.

Under Part C's Medicare Advantage program, the federal government pays insurers to provide the coverage that participating beneficiaries would otherwise receive through Parts A and B (sometimes known, collectively, as "traditional" Medicare). *Id.* § 1395w-22(a). These insurers, known as Medicare Advantage Organizations, contract to provide coverage in a particular geographic area. Beneficiaries can then choose among the plans available where they reside. *Id.* § 1395w-21(b). Medicare Advantage Organizations receive a predetermined sum for providing coverage to each beneficiary, based in part on the demographic and health characteristics of that beneficiary. *Id.* § 1395w-23(a)(1)(A), (C).

To calculate payments to Medicare Advantage Organizations, CMS first determines its "benchmark," based on the per-capita cost of covering Medicare beneficiaries under Parts A and B in the relevant geographic area. *Id.* § 1395w-23(n); 42 C.F.R. § 422.258. Each Medicare Advantage Organization then submits a "bid," telling CMS what payment the Medicare Advantage Organization will accept to cover a beneficiary with an average risk profile in that area. 42 C.F.R. § 422.254. If the insurer's bid is less than the benchmark, the bid becomes its "base payment"—the amount it is paid for covering a beneficiary of average risk—and the insurer receives a portion of the difference between its bid and the benchmark as a "rebate" that the Medicare Advantage Organization can use to fund supplemental benefits for beneficiaries or reduce plan premiums. 42 U.S.C. § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260. If the Medicare Advantage Organization's bid

is greater than the benchmark, then the benchmark becomes its base payment, and the insurer must charge beneficiaries a premium to make up the difference. 42 U.S.C. §§ 1395w-23(a)(1)(B)(ii), 1395w-24(b)(2)(A).

Star Ratings are a means by which CMS measures the quality of Medicare Advantage plans on a scale of one to five "stars" in half-star increments based on Medicare Advantage data collected by CMS. 42 U.S.C. § 1395w-23(o)(4)(A); *see also* § 1395w-22(e)(3). Star Ratings reflect the experiences of beneficiaries in these plans and assist beneficiaries in finding the best plans for their needs. Advance Notice of Methodological Changes for 2026 for Medicare Advantage Capitation Rates & Part C & Part D Payment Policies, at 109 (Jan. 10, 2025), *available at* https://perma.cc/KWB8-VLWK.

CMS has released Star Ratings for Medicare Advantage contracts since 2008. Contract Year 2019 Policy & Technical Changes to the Medicare Advantage Program, 83 Fed. Reg. 16,440, 16,520 (Apr. 16, 2018). In 2018, CMS adopted the regulatory framework for the Star Ratings and since then has used rulemaking to adopt changes in the methodology and add new measures. *Id.*; *see also* 42 C.F.R. §§ 422.164(c),(d), 423.184(c),(d). The 2018 final rule describes the purpose of the Star Ratings system: it "is designed to provide information to the beneficiary that is a true reflection of the plan's quality and encompasses multiple dimensions of high-quality care." 83 Fed. Reg. at 16,520.

Star Ratings are assigned to each individual contract held by a Medicare Advantage Organization. The overall Star Ratings are based on a 5-star scale, set in half-star increments, with 1 star being the lowest rating and 5 stars being the highest. 42 U.S.C. §§ 1395w-23(o)(4)(A), 1395w-24(b)(1)(C)(v); 42 C.F.R. §§ 422.162(b); 422.166(h)(1)(ii), 423.182(b), 423.186(h)(1)(ii). Star Ratings affect payments to Medicare Advantage Organizations in two main ways. First,

Medicare Advantage plans that earn a rating of four stars or higher qualify for Medicare Advantage Quality Bonus Payments in the form of an increased benchmark for the contract year following the ratings year (*e.g.*, the 2025 Star Ratings can increase the Medicare Advantage bidding benchmarks for contract year 2026). 42 U.S.C. § 1395w-23(o)(1) (increasing, for qualifying plans, the applicable percentage that calculates the benchmark); § 1395w-23(o)(3)(A)(i) (a qualifying plan is one that earns a rating of four stars or higher). This in turn can allow a Medicare Advantage plan to increase its bid, receive higher rebates, or lower premiums. *See id.* § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260.

Second, Star Ratings affect the level of rebate received by plans that bid below their benchmarks for the contract year following the ratings year (e.g., the 2025 Star Ratings are used to set plans' rebate percentages for contract year 2026). Plans that earn a rating of four-and-a-half stars or higher receive a rebate of seventy percent of the difference between their bid and the benchmark, while plans that earn three-and-a-half or four stars receive a rebate of sixty-five percent of that difference, and plans that earn less than three-and-a-half stars are eligible for a rebate of fifty percent of that difference. 42 U.S.C. § 1395w-24(b)(1)(C)(v) (listing the "final applicable rebate percentage[s]" by rating); 42 C.F.R. §§ 422.166(a)(2)(ii), 423.186(a)(2)(ii) (same).

CMS publishes the Star Ratings each October for the upcoming year at the contract level, with each plan offered under that contract assigned the contract's rating. 42 C.F.R. §§ 422.162(b), 422.166, 423.182(b), 423.186. It published the 2025 Star Ratings, for example, in October 2024. CMS, Fact Sheet – 2025 Medicare Advantage and Part D Star Ratings (Oct. 10, 2024) ("Fact Sheet"), *available at* https://perma.cc/8TLH-G7ZL. The 2025 Star Ratings are calculated based mostly on 2023 measurement year data. A.R. 28-105 (indicating "data time frame" for each quality

measure is primarily 2023). The 2024 Star Ratings are calculated on mostly 2022 measurement year data. Tech Guidance, 34-111 (indicating "data time frame" for each quality measure is primarily 2022).

To calculate overall Star Ratings, CMS scores Medicare Advantage contracts on approximately 30 to 40 unique quality measures, depending on whether the plan is Medicare Advantage-only or also includes Part D coverage. A.R. 13.[1] These measures relate to five broad categories—outcomes, intermediate outcomes, patient experience, access, and process, *see id.* at 9—and CMS uses a variety of data including administrative and medical record review data collected as part of the Healthcare Effectiveness Data and Information Set ("Healthcare Effectiveness Data" or "HEDIS") and survey-based data from the Health Outcomes Survey and from the Consumer Assessment of Healthcare Providers and Systems ("CAHPS"). 83 Fed. Reg. at 16,520, 16,525. These measure-level scores are also expressed in "stars" but are awarded in whole-star increments, not half stars like the overall Star Ratings. 42 C.F.R. §§ 422.166(a)(4), 423.186(a)(4).

A. Special Needs Plan Measures

Some quality measures relate specifically to Special Needs Plans. Special Needs Plans are Medicare Advantage plans designed to provide targeted care to special needs individuals. A.R. 25. Special Needs Plans are for those with certain chronic diseases and conditions, who have both Medicare and Medicaid, and for those who live in an institution such as a nursing home. There are three specific Special Needs Plan measures in the 2025 Star Ratings: C05—Special Needs Plan Care Management; C06: Care for Older Adults—Medication Review; and C07: Care for Older

[1] CMS references its Technical Notes in its operative regulations. 42 C.F.R. §§ 422.164(a) & 423.184(a).

Adults—Pain Assessment. *Id.* This case primarily concerns measure C05, entitled Special Needs Plan Care Management. Unless an exclusion applies, *see* A.R. 37-38, a contract offering Special Needs Plans is evaluated on all three measures, including measure C05.

In the 2025 Technical Guidance, CMS provides more details about each of the specific quality measures, including measure C05. Measure C05 evaluates the percentage of members whose plan did an assessment of their health needs and risks in the past year. *Id.* at 37. Measure C05 is based on data reported by contracts through the Medicare Part C Reporting Requirements. *Id.* This is data that CMS has required Medicare Advantage Organizations to report pursuant to its authority under 42 C.F.R. § 422.516(a). CMS's guidance states that data reported by contracts to CMS per the 2023 Part C Reporting Requirements are validated retrospectively during the 2024 data validation cycle. *Id.* "Contracts and [plan benefit packages] with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as 'No data available.'" *Id.* If a Special Needs Plan benefit package under a contract terminates "at any time in the [contract year] reporting period and the contract remains active through July 1 of the following year, the contract must still report data for all [plan benefit packages], including the terminated [plan benefit packages]." *Id.* at 119.

B. Star Ratings Calculation Methodology

CMS calculates summary and overall ratings[2] using the 40 unique quality measures. The overall rating for a contract is calculated using the average of the Part C Star Ratings. 42 C.F.R.

[2] This brief will use the phrase "overall ratings" to refer to both summary and overall ratings. Technically, they are different 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. A.R. 20. For Medicare Advantage Prescription Drug plans to receive an overall rating, the contract must have stars assigned to both the Part C and Part D summary ratings. Plans that do not only receive a summary rating.

§§ 422.166(d)(1), 423.186(d)(1); A.R. 20. The average is weighted based on measure type because not all measures are equally weighted. CMS assigns the highest weight to the improvement measures, followed by patient experience, complaints and access measures, then outcome and intermediate outcome measures, and finally process measures. 42 C.F.R. §§ 422.166(e), 423.186(e); A.R. 20. New measures are weighted the same as process measures for the first year in the Star Ratings. 42 C.F.R. §§ 422.166(e)(2), 423.186(e)(2); A.R. 20. CMS includes the Star Ratings measures in the overall ratings that are associated with the contract type for the Star Ratings year. 42 C.F.R. §§ 422.162(b)(1), 423.182(b)(1). This means that if, for example, a plan offered Special Needs Plan Care Management in the 2023 measurement year but is no longer offering Special Needs Plan Care Management in 2025, the Special Needs Plan-related quality measures would be excluded in the calculation of the 2025 Star Ratings for that plan. A.R. 13. Overall ratings are calculated "with at least six digits of precision after the decimal whenever the data allow it." *Id.* at 22.

C. Star Ratings Following Consolidation

CMS's regulations governing the calculation of Star Ratings address consolidations. Consolidation means "when a [Medicare Advantage] organization that has at least two contracts for health and/or drug services of the same plan type under the same parent organization in a year combines multiple contracts into a single contract for the start of the subsequent contract year." 42 C.F.R. §§ 422.162(a), 423.182(a). The consumed contract "means a contract that will no longer exist after a contract year's end as a result of a consolidation." *Id.* The surviving contract "means the contract that will still exist under a consolidation, and all of the beneficiaries enrolled in the consumed contract(s) are moved to the surviving contracts." *Id.*

When two plans consolidate, CMS assigns Star Ratings for the first and second years following the consolidation "based on the enrollment-weighted mean of the measure scores of the

surviving and consumed contracts." *Id.* §§ 422.162(b)(3), 423.182(b)(3); A.R. 25. For the first year and second years after the consolidation, "CMS uses enrollment-weighted measure scores using the July enrollment of the measurement period of the consumed and final contracts for all measures," with certain exceptions not relevant here. 42 C.F.R. §§ 422.162(b)(3)(iv)(A)(1), (B)(1), 423.182(b)(3)(iv)(A)(1), (B)(1). Because Star Ratings following a consolidation are based on "the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s)," *id.* §§ 422.162(b)(3)(i), 423.182(b)(3)(i), if a contract was not evaluated on a particular quality measurement for a measurement year, there would be no score for that measure and it would not factor into the mean for that measure score Star Rating.

II. Factual And Procedural Background

On January 1, 2024, HMOLA's parent company, BCBSLA, consolidated two of its contracts—H6453 and H5576. Pl. Mem. (ECF No. 17-1) at 6. H6453 is the surviving contract; H5576 is the consumed contract. *Id.* For the 2024 Star Ratings year—the first year of consolidation—CMS combined the data from contracts H6453 and H5576. Ex. 1 (Goldstein Decl.) ¶ 2. That data was from 2022. In 2022, only contract H5576 offered a Special Needs Plan benefit package. Per CMS's regulation, CMS took the "weighted mean of the measure scores of the surviving and consumed contracts," not counting in the mean any contracts that did not have scores for a particular measure. 42 C.F.R. §§ 422.162(b)(3), 423.182(b)(3). CMS calculated the mean of contracts H6453 and H5576's surviving contracts' C05 measure scores to be contract H5576's C05 score, and this resulted in a rating of 4 stars on the measure. Ex. 1 (Goldstein Decl.) ¶ 2.

On September 12, 2024, HMOLA requested that CMS include data from both contract H5576 and H6453 in calculating measure C05, citing § 422.162(b)(3)(ii). A.R. 317-19. CMS received from HMOLA contract H5576's Special Needs Plan data on October 24, 2024, and its data validation findings on October 30, 2024. A.R. 316. For the 2025 Star Ratings year—the

second year of consolidation—CMS combined this validated data from contracts H6453 and H5576. A.R. 315-16. That data was from 2023. In 2023, only contract H5576 offered a Special Needs Plan benefit package. Per CMS's regulation, CMS calculated the weighted mean of contracts H6453 and H5576's surviving contracts' C05 measure scores to be contract H5576's C05 score, and this resulted in a rating of 3 stars on the measure. Following their formula for calculating an overall Star Ratings score, CMS combined HMOLA's C05 score with the other applicable quality measures and calculated a final overall score of 3.603658. Ex. 1 (Goldstein Decl.) ¶ 3.

Plaintiff HMOLA filed its Amended Complaint on December 10, 2024. Pl. Am. Compl. (ECF No. 12). HMOLA argues that by including measure C05 to calculate HMOLA's 2025 Star Rating, CMS violates its own regulations. Pl. Mem. (ECF No. 17-1) at 9.

STANDARD OF REVIEW

In this action proceeding under the Medicare statute, judicial review is governed by the standards of the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, and decided on an administrative record. *Se. Ala. Med. Ctr. v. Sebelius*, 572 F.3d 912, 916-17 (D.C. Cir. 2009). Accordingly, "'the district court does not perform its normal role' but instead 'sits as an appellate tribunal'" resolving legal questions. *County of Los Angeles v. Shalala*, 192 F.3d 1005, 1011 (D.C. Cir. 1999) (quoting *PPG Indus., Inc. v. United States*, 52 F.3d 363, 365 (D.C. Cir. 1995)). Although the parties move for summary judgment, the "standard set forth in Rule 56(c) . . . does not apply." *Gentiva Healthcare Corp. v. Sebelius*, 857 F. Supp. 2d 1, 6 (D.D.C. 2012), *aff'd*, 723 F.3d 292 (D.C. Cir. 2013). Rather, summary judgment "serves as the mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review." *Id.*

The APA provides for courts to "hold unlawful and set aside agency action, findings, and conclusions" if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), or "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," *id.* § 706(2)(C). Under the APA's "arbitrary or capricious" standard, the Court "must consider whether the [agency's] decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Marsh v. Or. Nat. Res. Council*, 490 U.S. 360, 378 (1989). An agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted). Even a decision that is not fully explained may be upheld "if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Ark.-Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974).

The "arbitrary or capricious" standard is "narrow . . . as courts defer to the agency's expertise." *Ctr. for Food Safety v. Salazar*, 898 F. Supp. 2d 130, 138 (D.D.C. 2012) (quoting *Motor Vehicle*, 463 U.S. at 43). The Court "is not to substitute its judgment for that of the agency." *Id*. In Medicare cases, the "'tremendous complexity of the Medicare statute" "adds to the deference which is due to the Secretary's decision.'" *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 60 (D.C. Cir. 2015) (quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C. Cir. 1994)). The question is not whether the agency's policy is the "best" or only solution, but whether it is a "reasonable solution." *Petal Gas Storage, L.L.C., v. FERC*, 496 F.3d 695, 703 (D.C. Cir. 2007).

ARGUMENT

On January 1, 2024, BCBSLA consolidated two of its contracts, one that offered Special Needs Plans in 2023 and one that did not. The contract that did not offer a Special Needs Plan became the surviving contract. After the consolidation, the surviving, consolidated contract offered Special Needs Plans in 2024 and offers Special Needs Plans today for Star Ratings year 2025. Under the applicable regulations, because the consumed contract offered Special Needs Plans in 2023 and the surviving, consolidated contract offered Special Needs Plan coverage in 2025, CMS properly evaluated HMOLA's surviving, consolidated contract on the C05 quality measure.

I. CMS Calculated HMOLA's Consolidated Contract Score by Following Its Regulations

In the event of a consolidation, CMS's regulations require that if a quality measure is applicable to either the consumed or the surviving contract during the relevant measurement year and those applicable quality measures are associated with the surviving, consolidated contract's type for the Star Ratings year, that measure will count towards the surviving, consolidated contract's overall score. *See* 42 C.F.R. §§ 422.162(b)(1), (b)(3). Consistent with this directive, in determining whether measure C05 should apply to a consolidated contract's overall Star Ratings, CMS asks whether either the consumed or surviving contract should be evaluated on measure C05 during the measurement year because they offered a Special Needs Plan. *Id.* § 422.166(d) (overall rating "will be calculated using a weighted mean of the Part C and Part D measure-level Star Ratings"). If the answer is no, CMS does not include measure C05 in a contract's overall score. *Id.* If the answer is yes, CMS proceeds to step two. CMS next asks whether the surviving, consolidated contract is offering any Special Needs Plans during its Star Ratings year. *Id.* § 422.162(b)(1) ("CMS includes the Star Ratings measures in the overall and summary ratings that

are associated with the contract type for the Star Ratings year."). If not, CMS does not count measure C05 towards that contract's overall rating. *Id.* If it does, CMS must include measure C05 in the consolidated contract's overall rating. *Id.* CMS's regulations require it to then calculate the enrollment-weighted mean of the measure scores of the surviving and consumed contracts. *Id.* § 422.162(b)(3).

CMS followed these steps and determined that HMOLA's consolidated contract H6453 should be evaluated on measure C05 and assigned a Star Rating of 3.0. A.R. 316. CMS first determined that HMOLA's consumed contract, H5576, offered Special Needs Plans in 2023, for which it received a score of 70 percent. *Id*. HMOLA's surviving contract, H6453, did not receive a score because it did not offer such a plan in 2023. *Id.* HMOLA's surviving, consolidated contract is offering Special Needs Plans in 2025. As a result, CMS scored contract H6453 on measure C05. *See* 42 C.F.R. § 422.162(b)(1). To find the score to be assigned to the consolidated contract, under CMS regulations, CMS assigns Star Ratings for the first and second years following the consolidation "based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts." *Id.* § 422.162(b)(3). There is not a requirement that both plans need to have qualified for a specific quality measure. Under the regulation, therefore, because the surviving contract had no C05 score, the enrollment-weighted mean of the measure scores of the surviving (null) and consumed contracts equaled 70 percent for C05 for the consolidated contract. Consequently, the score of 70 percent translated into 3 stars for the surviving contract.

HMOLA asserts that "CMS plainly violated its own regulations." Pl. Mem. (ECF No. 17-1) at 9. Not so. As explained, CMS followed its regulations pertaining to consolidations. HMOLA argues that because contract H6453 (the surviving, consolidated contract) was not the contract to offer Special Needs Plans in the 2023 measurement year, it should not be evaluated on measure

C05: "CMS should have treated measure C05 as a 'no score.'" *Id.* The regulations do not support HMOLA's argument. CMS's regulations simply do not require the surviving contract to be the contract that offered Special Needs Plans in the 2023 measurement year to be used to determine the rating for the surviving, consolidated contract in 2025. It is sufficient that the consumed contract, H5576, offered a Special Needs Plan in the 2023 measurement year. *See* 42 C.F.R. § 422.162(b)(3).

HMOLA argues, quoting from CMS's 2025 Technical Guidance, that CMS's regulations require it to "exclude from its calculation '[c]ontracts and [plan benefit packages] with an effective termination date on or before . . . June 15, 2024.'" Pl. Mem. (ECF No. 17-1) at 9. HMOLA contends that its "subsumed contract effectively terminated at its merger on January 1, 2024" and that, consequently, its contract should be excluded from evaluation on the C05 cost measure. *Id.* The full sentence from the Technical Guidance provides, however: "Contracts and [plan benefit packages] with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as '*No data available*.'" A.R. 37 (emphasis added). This sentence provides an exclusion for contracts whose termination prevents it from submitting data validation results of the 2023 measurement year data. *Id.* That is not the situation with HMOLA's surviving, consolidated contract. HMOLA's alleged contract termination did not prevent it from submitting data. It submitted Special Needs Plan data for contract H5576's to CMS on October 24, 2024, and the data validation findings on October 30, 2024. A.R. 315-16. Here, the consumed contract's 2023 data were able to be validated, and so exclusion of data on the basis that there is "no data available" makes no sense.

Contract H5576 (the consumed contract) was combined into a single, active contract, contract H6453, under the regulations. *See* 42 C.F.R. § 422.162(a) ("Consolidation means when

an [Medicare Advantage] organization that has at least two contracts for health and/or drug services of the same plan type under the same parent organization in a year combines multiple contracts into a single contract for the start of the subsequent contract year."). CMS's regulations are clear that following a consolidation, the acquired contract becomes a "consumed contract." *Id.* Under a consolidated contract, the consumed contract's measure scores do not simply disappear. Instead, "CMS assigns Star Ratings for the first and second years following the consolidation based on the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s)." *Id.* § 422.162(b)(3)(i). Whether HMOLA regards its contract H5576 terminated or not, a consumed contract's enrollment and quality measures during its two measurement years preceding a consolidation, therefore, are relevant for purposes of determining a consolidated entity's overall Star Ratings. *See id.* § 422.162(b)(3)(iv)(A)(1), (b)(1); *see also* A.R. 28-105.

II. CMS's Calculation of HMOLA's Consolidated Contract Score Is Consistent with the Statute

HMOLA argues that in evaluating contract H6453 (the surviving contract) on measure C05, CMS acted inconsistently with its statutory mandate. Pl. Mem. (ECF No. 17-1) at 10. But HMOLA fails to cite to any specific statutory language. Instead, HMOLA quotes from "guiding principles" set out in CMS's 2018 final rulemaking pertaining to, among other things, Star Ratings. *Id.* These guiding principles are: providing beneficiaries with a "true reflection of plan quality and enrollee experience," providing "information about plan quality and performance indicators," and helping beneficiaries "make informed plan choices." 83 Fed. Reg. at 16,520-21. CMS must issue Star Ratings that "treat contracts fairly and equally" while "minimizing unintended consequences." *Id*. at 16,521.

HMOLA contends that CMS has acted inconsistently with these principles by "issuing Star Ratings that do not accurately reflect HMOLA's plan." Pl. Mem. (ECF No. 17-1) at 10-11. But

CMS's 2025 Star Ratings for contract H6453 do accurately and fairly reflect HMOLA's plan. As noted above, CMS averages the measure scores of the surviving and consumed contracts, weight-adjusted for enrollment. 42 C.F.R. § 422.162(b)(3). HMOLA is proposing a scheme whereby CMS evaluates its consolidated contract on measure C05 during the 2023 performance period only on the basis of the performance of contract H6453 and not on the performance of its consumed contract, H5576. But for CMS not to include measure C05 in the H6453's overall score would constitute a failure to account for a major contributor in its 2025 overall score for the 2023 measurement year. For the 2024 Star Ratings year, CMS included measure C05 from the consumed contract and, presumably satisfied with its overall rating, HMOLA did not object. HMOLA now argues that "[b]y issuing 2025 Star Ratings that relied on ratings for plans HMOLA did not *even offer* during the measuring period, the agency issued Star Ratings that do not represent a 'true reflection' of HMOLA's services and care." Pl. Mem. (ECF No. 17-1) at 11 (emphasis in original). But HMOLA did offer Special Needs Plans for measurement year 2023 through its consumed contract, H5576. HMOLA's surviving, consolidated contract, H6453 is still offering Special Needs Plans that were originally offered under consumed contract H5576. Accounting for HMOLA's consumed contract provides beneficiaries with a truer reflection of plan quality and enrollee experience for the 2023 measurement period than excluding it from measure C05. This is why CMS regulations take into account data from the consumed contract for two years after consolidation, after which time the data are from measurement years that reflect the surviving contract after consolidation.

While HMOLA did not object to the inclusion of the consumed contract's measure score resulting in a rating of 4 stars for the 2024 Star Ratings, HMOLA now takes issue with the inclusion of that same measure score for Star Ratings year 2025 because its C05 measure rating

went down to 3 stars. It would prefer that CMS not count measure C05 for 2025, arguing essentially that surviving contracts should never be evaluated for plans only offered by consumed contracts during the measurement year. *See* Pl. Mem. (ECF No. 17-1) at 11 ("By issuing 2025 Star Ratings that relied on ratings for plans HMOLA did not *even offer* during the measuring period, the agency issued Star Ratings that do not represent a 'true reflection' of HMOLA's services and care."). But this is not what the regulations provide. Under HMOLA's logic, CMS should also exclude the two other Special Needs Plan-specific measures—C06: Care for Older Adults–Medication Review and C07: Care for Older Adults–Pain Assessment—from the consumed contract. But HMOLA's overall ratings score would slightly decrease compared to the published 2025 Star Ratings if CMS did this because for both measures H6453 was rated 5 stars, so HMOLA chose to cherry-pick C05 for exclusion. Ex. 1 (Goldstein Decl.) ¶ 4. HMOLA cannot have it both ways.

III. HMOLA Is Not Entitled to Relief

HMOLA argues that it "is likely to succeed on the merits of its APA and declaratory judgment claims" and requests that this Court enter injunctive relief. Pl. Mem. (ECF No. 17-1) at 13. HMOLA conflates the standard for a preliminary injunction and permanent injunction. "Unlike a preliminary injunction, actual success on the merits is required to obtain permanent injunctive relief." *Smirnov v. Clinton*, 806 F.Supp.2d 1, 13 (D.D.C. 2011). For the reasons stated above, HMOLA has failed to demonstrate actual success on the merits, and accordingly is not entitled the requested relief.

* * *

CONCLUSION

For these reasons, the Court should grant Defendants' cross-motion for summary judgment and deny Plaintiff's motion for summary judgment.

Dated: March 21, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,, *Defendant*.	Civil Action No. 24-2931-CRC

DECLARATION OF ELIZABETH GOLDSTEIN

I, Elizabeth Goldstein, declare pursuant to 28 U.S.C. § 1746 as follows:

1. I am the 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. I have held this position since October 2000. In my role, I oversee and administer the calculation of Star Ratings for Medicare Advantage and Medicare Part D Plans. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

2. For the 2024 Star Ratings year—the first year of consolidation of HMOLA's contracts H5576 and H6453—CMS combined the data from contracts H6453 and H5576. When CMS calculated the surviving contract's C05 measure score by taking the weighted mean of the measure scores for contracts H6453 and H5576, the surviving contract's C05 measure score was the C05 measure score of contract H5576 since H6453 was not scored on this measure. This resulted in a rating of 4 stars on the measure.

3. For the 2025 Star Ratings year—the second year of consolidation—CMS combined data from contracts H6453 and H5576. A.R. 315-16. When CMS calculated the surviving contract's C05 measure score by taking the weighted mean of measure scores for contracts H6453 and H5576, the surviving contract's C05 measure score was the C05 measure score of contract H5576, and this resulted in a rating of 3 stars on the measure. Following the formula for calculating an overall Star Ratings score, CMS combined HMOLA's C05 score with the other applicable quality measures and calculated a final overall score of 3.603658.

4. For 2025, HMOLA was rated 5 stars for the two other Special Needs Plan measures it does not challenge—C06: Care for Older Adults–Medication Review and C07: Care for Older Adults–Pain Assessment. If CMS calculated HMOLA's overall Star Ratings score without any of the three Special Needs Plan measures, HMOLA's overall score would decrease slightly to 3.582565.

In accordance with 28 U.S.C. § 1746, I hereby declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 20th day of March, 2025, in Baltimore, Maryland.

_____
Elizabeth Goldstein

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	)	Case No. 24-2931-CRC

PLAINTIFF'S OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND REPLY IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases — Page(s)

Other Authorities

INTRODUCTION

HMOLA brought this case to correct CMS's arbitrary and unlawful calculation of its Medicare Advantage Plan's ("MA Plan's") Star Ratings. As CMS explained in its opening brief, CMS's Star Ratings calculation violates its own regulations and assigns HMOLA's surviving H6453 contract Star Ratings for a program *it never even provided*. That agency action caused dramatic adverse consequences. It reduced HMOLA's Star Ratings from 4.0 to 3.5 stars, causing HMOLA – and its members – substantial harm by depriving it of hundreds of millions of dollars in funds and harming its reputation and goodwill in the marketplace.

CMS's opposition and cross motion to HMOLA's motion makes clear that CMS fundamentally agrees with HMOLA on key facts and the proper understanding and applications of its regulations. Critically, CMS does not dispute that:

- CMS must use the *July enrollment* data for the measurement period of the consumed and final contracts to calculate enrollment-weighted measure scores;
- Data related to plan quality are "not collected and validated for contracts that terminate prior to July 1";
- If a contract did not offer a Special Needs Plan ("SNP") during the measurement year, "CMS does not include measure C05 in a contract's overall score";
- "[I]f a contract was not evaluated on a particular quality measurement for a measurement year, there would be no score for that measure and it would not factor into the mean for that measure score Star Ratings";
- HMOLA's surviving H6453 contract "did not receive a score because it did not offer [an SNP] in 2023"; and
- CMS did not originally assign HMOLA's consumed contract any score because it has no July enrollment data.

Despite these critical concessions that support HMOLA's challenge and demonstrate how unreasonable CMS's action is, the agency continues to argue it properly followed its own regulations when it combined the Measure C05 scores for both the consumed and surviving

contracts. It did not, and it cannot support that unlawful action with belated rationalizations as it attempts on brief. Rather, CMS disregards its own regulations and policies when it combined HMOLA's "no score" for Measure C05 with the 3.0 Stars associated with the SNP of the consumed H5573 contract. That arbitrary and capricious action is unsupported by the text of CMS's regulations and Technical Notes, unjustified by CMS's impermissible *post hoc* arguments now, and makes no sense. The agency's action further obviously violates the purpose of the Star Ratings program to provide current and prospective beneficiaries with an accurate assessment of a plan's quality.

HMOLA is therefore entitled to injunctive relief requiring CMS to recalculate its Star Ratings for Measure C05 in compliance with the agency's regulations and to take remedial action to ensure HMOLA does not continue to be competitively harmed by CMS's unlawful actions. Accordingly, the Court should grant HMOLA's motion for summary judgment and deny CMS's cross-motion.

ARGUMENT

1. CMS argues that, because HMOLA's "contract termination did not prevent it from submitting data," it is improper to exclude the data. Opp. at 14. But the Star Ratings regulations do not "mea[n]" what CMS now "says." *Loper Bright Enter. v. Raimondo*, 603 U.S. 369, 392 (2024). Rather – as CMS concedes on brief – its regulations and Technical Notes say that if a contract – like HMOLA's surviving contract – "was not evaluated on a particular quality measurement for a measurement year, there would be no score for that measure and it *would not factor* into the mean for that measure score Star Rating." Opposition to Plaintiff's Motion for Summary Judgment And Defendants' Cross Motion for Summary Judgment ("Opp."), ECF No. 19, at 9 (emphasis added). For a consumed contract – including HMOLA's consumed contract –

the Technical Notes require CMS to collect data "us[ing] enrollment-weighted measure scores using the *July enrollment* of the measurement period of the consumed and final contracts for all measures." Opp. at 9 (emphasis added); 42 C.F.R. § 422.162(b)(3)(iv)(B)(1).

Here, CMS initially applied its regulations as written, explaining to HMOLA via email that HMOLA's consumed contract effectively terminated at its merger on January 1, 2024, and therefore had no "July enrollment" data for consideration. AR 224 (CMS stating "[d]ata are not collected and validated for contracts that terminate prior to July 1"). And HMOLA's surviving contract did not offer an SNP at all. AR 224. Thus, as CMS initially explained to HMOLA, since it "did not receive data for [the consumed contract] to use for these measures in the 2025 Star Ratings," and the surviving contract "did not offer SNP plans during the measurement year, there are no data" for the SNP measure. AR 224.

Despite this acknowledgment, CMS ultimately issued Star Ratings based on measuring services not actually offered by the surviving H6453 contract anyway. That is the textbook definition of arbitrary and capricious agency action, and no amount of pleading "defer[ence]" for a "complex[ ] . . . statute" should be allowed to cure it. Opp. at 11; *see Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 60 (D.C. Cir. 2015) (explaining, even in complex regulatory schemes, "deference 'is not unlimited' . . . if [CMS] fails to apply its 'expertise in a reasoned manner' "); *Panhandle E. Pipe Line Co. v. FERC*, 613 F.2d 1120, 1135 (D.C. Cir. 1979) (holding agency does not have authority to "play fast and loose with its own regulations").

2. Ignoring its own regulation and Technical Notes, CMS on brief puts forward a new *post hoc* rationalization for its improper calculation, inventing a two-step process for calculating a plan's Star Ratings. *See* Opp. at 12–13; *Am. Textile Mfrs. Inst., Inc. v. Donovan*, 452 U.S. 490, 539 (1981) (holding agency's post hoc rationalizations "cannot serve as a sufficient predicate for

agency action"); *Thornton v. Wormuth*, Case No. 23-3665, 2025 WL 27351, at *3 (D.D.C. Jan. 3, 2025) (same). As part of that process, CMS now asserts it "must include measure C05 in the consolidated contract's overall rating," Opp. at 13, if the "surviving, consolidated contract is offering any Special Needs Plans," *id.* at 12. CMS does not cite any statute or regulations in support of its new requirement – because there are none. Instead, CMS generically cites the regulations that establish the Star Ratings and set forth the methodology for calculating them. *Id.* at 12–13; 42 C.F.R. §§ 422.162(b) & 422.166(d). But those regulations do not require (or even reference) CMS using current offerings to decide whether to use data from prior years. 42 C.F.R. §§ 422.162(b) & 422.166(d). CMS cannot now in this litigation – as it blatantly is attempting – "rewrite the regulation to reach its desired outcome in this case." *Scott & White Health Plan v. Becerra*, 693 F. Supp. 3d 1, 14 (D.D.C. 2023) (Cooper, J.).

3. Nor does CMS's reading or application of the regulation comply with its statutory mandate. In issuing Star Ratings, CMS must ensure its ratings are a "true reflection of plan quality and enrollee experience" and provide real "information about plan quality and performance indicators." 83 Fed. Reg. 16,440, 16,520–21 (2018). Assigning a Star Ratings based on ratings for plans HMOLA did *not even offer* during the measuring period flouts that mandate. *See Beaty v. Food & Drug Admin.*, 853 F. Supp. 2d 30, 41 (D.D.C. 2012) (quoting *FEC v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981)). And conflating the current offerings of an MA Plan with those offered by a different contract or in different measuring periods would only serve to confuse Medicare beneficiaries, who cannot be expected to parse through the individual data points to understand how differing measuring periods affect the quality of each program offered and the resulting Star Ratings. CMS's flawed calculations are seriously misleading, were calculated in violation of the controlling regulations, and are

properly vacated.[1] *See Bureau of Alcohol, Tobacco & Firearms v. Fed. Lab. Rels. Auth.*, 464 U.S. 89, 97 (1983) (explaining courts may not "rubber-stamp" administrative decisions, especially where they are "inconsistent with a statutory mandate" or "frustrate the congressional policy underlying a statute").

4. HMOLA is plainly entitled to injunctive relief ordering CMS to recalculate HMOLA's 2025 Star Ratings related to Measure C05 and to take remedial action to ensure it is no longer competitively harmed by CMS's unlawful actions. Mot. at 11–14. CMS in fact concedes – as it must – that HMOLA has suffered irreparable harm and the balance of equities and public interest support injunctive relief. *See* Opp. at 17; *Hopkins v. Women's Div., Gen. Bd. Of Glob. Ministries*, 284 F. Supp. 2d 15, 25 (D.D.C. 2003) (holding party concedes arguments it "fail[s] to address"). CMS's flawed Star Ratings calculation has cost HMOLA approximately $23 million in quality bonus payments and seriously harmed HMOLA's reputation in the marketplace. *See* ECF No. 17 ("Mot.") at 7–8 & 11–12; *Bell Helicopter Textron, Inc. v. Airbus Helicopters*, 78 F. Supp. 3d 253, 274–75 (D.D.C. 2015). And CMS does not have a public interest in "the perpetuation of unlawful agency action," while the public has a strong interest in "having governmental agencies abide by the federal laws." *League of Women Voters v. Newby*, 838 F. 3d 1, 12 (D.C. Cir. 2016).

CMS nevertheless argues that HMOLA has "conflate[d]" the standards for preliminary and permanent injunctive relief through its analysis of its likelihood of success on the merits.

---

[1] Because it cannot support its position with regulatory or statutory support, CMS attempts to create confusion by raising issues with other CMS measures that are not properly before the Court. *See* Opp. at 17. HMOLA's Amended Complaint and the relief it seeks are limited to the consideration of Measure C05 in calculating HMOLA's H6453 consolidated 2025 Star Rating. *See* ECF No. 12. Because HMOLA does not challenge measures other than C05 in this action, other measures are not properly before this Court. *See* Mot. at 13–14.

Opp. at 17. Not so. As explained in HMOLA's motion for summary judgment and here, HMOLA is likely to succeed on the merits of its claims because CMS's actions are arbitrary and unlawful. *See supra* at 1–4; ECF No. 17; *Am. C.L. Union v. Mineta*, 319 F. Supp. 2d 69, 87 (D.D.C. 2004) ("In determining whether to enter a permanent injunction, the Court considers a modified iteration of the factors it utilizes in assessing preliminary injunctions.").

CONCLUSION

For the foregoing reasons, this Court should:

(1) Deny Defendants' motion for summary judgment;

(2) Grant HMOLA summary judgment;

(3) Set aside CMS's determination of HMOLA's 3.5-star Star Rating;

(5) Order CMS to redetermine HMOLA's 2025 Star Rating; and

(6) Order Defendants to take remedial action to ensure HMOLA does not continue to be competitively harmed by CMS's actions.

Dated: April 18, 2025

By:_____

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CERTIFICATE OF SERVICE

I hereby certify that on April 18, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Paul Werner
Paul Werner

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC.,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Civil Action No. 24-2931 (CRC)

REPLY IN SUPPORT OF
DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

Defendants, by and through undersigned counsel, respectfully submit this reply in further support of their cross-motion for summary judgment (Defs. Mot., ECF No. 20).

INTRODUCTION

In its opposition (Pl. Opp'n, ECF No. 21), Plaintiff HMO Louisiana ("HMOLA") fails to acknowledge that it asked the Centers for Medicare & Medicaid Services ("CMS") to include Special Needs Plan data for its consumed contract, H5576, in calculating the C05 measure for its surviving contract, H6453. CMS agreed to do so, finding that granting HMOLA's request was consistent with its regulations, which require CMS to assign Star Ratings for the first and second years following the consolidation based on the enrollment-weighted mean of available measure scores of the surviving and consumed contracts. CMS's recalculation of the overall rating for HMOLA's contract H6453, the consolidated contract, resulted in no change, i.e., including the C05 Special Needs Plan measure resulted in an overall rating of 3.5 stars, the same as when CMS excluded this measure. Now in this litigation, HMOLA does an about-face, contending that CMS should not have followed HMOLA's requested approach. This Court should reject HMOLA's

attempt to manipulate H6453's Star Rating; the approach CMS used—which HMOLA specifically requested—is entirely consistent with its regulations and not arbitrary or capricious.

ARGUMENT

HMOLA contends that CMS "reduced HMOLA's Star Ratings from 4.0 to 3.5 stars." Pl. Opp'n (ECF No. 21) at 1. This is incorrect. The 2025 Star Rating for contract H6453 was 3.5 stars before HMOLA requested that CMS make any corrections. A.R. 215. HMOLA expected that if CMS made three changes (including two changes not relevant to the Special Needs Plan measure C05), its overall score would increase from 3.74957 to 3.80839, *i.e.*, from 3.5 to 4.0 stars. *Id.*; *see also* Vicidomina Decl. (ECF No. 17-2) ¶ 27 ("CMS determined a 2025 Star Ratings of 3.5 stars for HMOLA—a significant drop from the 4.0 stars it *expected*" (emphasis added)). In short, HMOLA's overall rating was 3.5 stars before CMS added the additional data that HMOLA requested that CMS include. After adding those data, the overall rating remained at 3.5 stars. This lawsuit is HMOLA's effort to pick and choose which data CMS should add with the only purpose of increasing its contract score to 4.0 stars.

CMS included the data that HMOLA specifically requested be included, and now it claims that CMS's resulting Star Ratings calculation was arbitrary and capricious. On September 12, 2024, a representative of HMOLA wrote to CMS that "to accurately calculate the Star Rating for contract H6453, CMS *must include* data from both contract H5576 [the consumed contract] and H6453 [the surviving contract] in its calculations. However, only data from H6453 was considered in the calculation of C05 [measure score]." A.R. 216 (emphasis added). This assertedly was because "HMOLA was unable . . . to submit measurement information relating to measurement . . . C05 'Special Needs Plan (SNP) Care' for contract H6453." A.R. 217. Consequently, HMOLA argued that "CMS used only partial information for these measures and, in doing so, failed to

adhere to its own regulations." *Id.* HMOLA contended that "[b]oth the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the Star Rating for the surviving contract." *Id.*

CMS agreed that inclusion of the data in the 2025 Star Ratings calculation for H6453 was consistent with the applicable regulations. On October 23, 2024, CMS notified HMOLA that it was providing an alternative method to allow submission of H5576's Special Needs Plan data, as well as submission of the validation of those data. A.R. 254-57. CMS received the relevant data and data validation on October 30, 2024. A.R. 315-16. When CMS recalculated H6453's score for the C05 measure using the H5576 data, it found that the score for C05 for H6453 was updated to 70%—a 3-star measure rating. However, this caused a different measure, the Part C improvement measure score—that is, the measure derived through comparisons of a contract's current and prior year Part C measure scores, A.R. 13—to "decrease[] from 4 to 3 stars since there was a significant decline in the [C05] measure score from the prior year, decreasing from 76% to 70%." A.R. 316. CMS calculated the overall rating for H6453 to be "3.603658, which rounds to 3.5 stars." *Id.*

To summarize, HMOLA asked CMS to include Special Needs Plan data for its consumed contract, H5576, in calculating the C05 measure for its consolidated contract. CMS agreed to do so, finding that HMOLA's requested approach was consistent with its regulations. *See* 42 C.F.R. § 422.162(b)(3)[1] (when two plans consolidate, CMS assigns Star Ratings for the first and second years following the consolidation "based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts"). HMOLA's approach resulted in its overall rating to

[1] For ease of reference, this brief omits reference to the parallel citations in 42 C.F.R. § 423.182 *et seq*.

stay the same, at 3.5 stars. In this litigation, HMOLA now contends that CMS should not have followed HMOLA's preferred approach. This Court should reject HMOLA's attempt to manipulate H6453's overall Star Rating.

In its opposition, HMOLA contends that because CMS initially determined that "[d]ata are not collected and validated for contracts that terminate prior to July 1," CMS should not have considered the H5576 data that HMOLA requested be submitted. Pl. Opp'n (ECF No. 21) at 3. In contrast to its argument before this Court, HMOLA argued in October 2024 that "CMS failed to collect data for [the C05 measure] based on the mistaken premise that the Consumed Contract was terminated prior to July 1 and that terminated contracts are not required to report data for the reporting period and the following years." A.R. 241. "The consumed contract was not terminated, however; it was consumed during a consolidation, and its measure data is necessary for evaluation of the performance of the surviving contract, as required by 42 CFR § 422.162(b)(3)(ii)." *Id.* As HMOLA recognized in October 2024, the consolidation process "aims to prevent [Medicare Advantage Organizations] from consolidating a low performing contract into a higher performing contract in order to shed the low scores." A.R. 242. The approach HMOLA advocates in this litigation would be at odds with the approach it originally insisted that CMS take and the one that CMS ultimately took. As established previously, Defs. Mot. (ECF No. 20) at 12-15, 42 C.F.R. § 422.162(b)(3) mandates that CMS determine the enrollment-weighted average of process measures—including C05—when calculating the 2025 Star Ratings for the surviving contract.

HMOLA contends that CMS does not cite any regulations in support of the requirement that it must include measure C05 in the consolidated contract's overall rating if the surviving contract is offering any Special Needs Plans. Pl. Opp'n (ECF No. 21) at 4. Not so. CMS points to 42 C.F.R. § 422.162(b)(1), which states that "CMS includes the Star Ratings measures in the

overall and summary ratings that are associated with the contract type for the Star Ratings year." Defs. Mot. (ECF No. 20) at 12-13. HMOLA renews its argument that, consistent with the statute, CMS "must ensure its ratings are a 'true reflection of plan quality and enrollee experience' and provide real 'information about plan quality and performance indicators.'" Pl. Opp'n (ECF No. 21) at 4. But as discussed in CMS's summary judgment brief, "[a]ccounting for HMOLA's consumed contract provides beneficiaries with a truer reflection of plan quality and enrollee experience for the 2023 measurement period than excluding it from measure C05." Defs. Mot (ECF No. 20) at 15-16; *see also* 42 C.F.R. § 422.162(b)(3).

CMS's regulations do not require the surviving contract to be the contract that offered Special Needs Plans in the 2023 measurement year to determine the rating for the surviving, consolidated contract in 2025. *See* 42 C.F.R. § 422.162(b)(3) (CMS assigns Star Ratings for the first and second years following the consolidation "based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts."). It is sufficient that the consumed contract, H5576, offered a Special Needs Plan in the 2023 measurement year and that the relevant data were available. *See id.* That is what happened here. As a result, HMOLA is not entitled to injunctive relief because its claims fail on the merits.

CONCLUSION

For the reasons herein and in Defendants' cross-motion for summary judgment, Defendants respectfully request that the Court grant Defendants' cross-motion for summary judgment and deny Plaintiffs' motion for summary judgment.

Dated: May 2, 2025

Respectfully submitted,

EDWARD R. MARTIN, JR., D.C. Bar #481866
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., Plaintiff, v. **DEPARTMENT OF HEALTH AND HUMAN SERVICES,** Defendants.	Case No. 24-cv-2931 (CRC)

ORDER

For the reasons stated in the accompanying Memorandum Opinion, it is hereby

ORDERED that [ECF No. 17] Plaintiff's Motion for Summary Judgment is DENIED. It is further

ORDERED that [ECF No. 20] Defendant's Cross-Motion for Summary Judgment is GRANTED. It is further

ORDERED that the complaint and case are dismissed.

This is a final appealable Order.

SO ORDERED.

CHRISTOPHER R. COOPER
United States District Judge

Date: July 9, 2025

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., Plaintiff, v. **DEPARTMENT OF HEALTH AND HUMAN SERVICES**, Defendant.	Case No. 24-cv-2931 (CRC)

MEMORANDUM OPINION

Plaintiff HMO Louisiana, Inc. ("HMOLA") offers private insurance plans to Medicare beneficiaries as an alternative to traditional government-managed plans. Each year, the Centers for Medicare and Medicaid Services ("CMS") issue "star ratings" evaluating the quality of these plans. The ratings help beneficiaries compare plans in the marketplace.

In late 2024, after HMOLA combined two of its plans, CMS issued a 3.5 star rating to the consolidated plan. Dissatisfied with this rating, HMOLA challenges CMS's method of calculating it under the Administrative Procedure Act ("APA"). Before the Court are the parties' dueling motions for summary judgment. For the following reasons, the Court will grant the government's cross-motion for summary judgment and deny HMOLA's motion.

I. Background

A. The Star Ratings Program

Medicare enrollees may elect to receive benefits under Part C of Medicare, commonly known as the "Medicare Advantage" ("MA") program. See 42 U.S.C. § 1395w-21. Under that program, CMS contracts with private insurance companies—MA Plans—to provide Medicare-covered benefits to enrollees. See 42 C.F.R. § 422.4; 42 U.S.C. § 1395w-23.

MA Plans receive annual star ratings from CMS evaluating the quality of their services. Am. Compl. ¶ 4. These ratings, in turn, are used by Medicare beneficiaries to shop for plans. Id. The ratings are intended to be "a true reflection of plan quality and enrollee experience" based on "complete, accurate, and reliable" data. 83 Fed. Reg. 16,440, 16,520–21 (Apr. 16, 2018). CMS displays the star ratings in its online and print resources available to Medicare beneficiaries, including the online Medicare Plan Finder tool. See, e.g., 42 C.F.R. § 422.166(h). CMS also uses the star ratings to determine the bonuses paid to MA Plans. See 42 U.S.C. § 1395w-23(o); 42 C.F.R. § 422.160(b)(2). If a plan's star ratings drop too low, CMS may terminate it from the MA program altogether. Id. § 422.510(a)(4)(xi).

CMS regulations establish the methodology used to calculate annual star ratings. See 42 C.F.R. §§ 422.162(b), 422.166. The ratings strive to treat each contract "fairly and equally." 83 Fed. Reg. at 16,521. CMS also publishes Technical Notes containing more granular detail on how ratings are calculated, including those for the up to 40 performance measures that comprise the overall rating for each plan. Joint Appendix ("JA") 9; 42 C.F.R. § 422.164(a). Star ratings primarily use measurement data from two years before their label year. For example, the 2025 star ratings were published in late 2024, using mostly 2023 measurement-year data. JA 36–113; HHS Opp'n at 5–6.

MA Plans may consolidate two or more contracts—that is, combine them into a single contract beginning the next contract year. 42 C.F.R. § 422.162(a). Combined contracts that no longer exist at a contract year's end are known as consumed contracts. JA 33. The contract that continues after consolidation is known as the surviving contract. Id. Following consolidation, all beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract. Id.

For the first two years after consolidation, while the agency is still relying on pre-consolidation measurement data, CMS averages the scores of the consolidated contracts. 42 C.F.R. § 422.162(b)(3); 42 U.S.C. 1395w-23(o)(4)(D). Specifically, it calculates the enrollment-weighted mean of each contract's scores using its July enrollment. 42 C.F.R. § 422.162(b)(3)(iv).

B. HMO Louisiana

HMOLA is one of the nation's largest MA health plans, currently serving approximately 30,000 members in Louisiana. Am. Compl. ¶ 2. In 2024, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, consolidated two of its contracts—H6453 and H5576. Id. ¶ 3. H6453 is the surviving contract. Id.

During 2023, contract H5576 offered a Special Needs Plan ("SNP"). Id. ¶ 67. SNPs provide benefits and care designed specifically for people with enumerated chronic diseases, those living in institutions such as nursing homes, and those who also have Medicaid. JA 45, 196. Contract H6453 did not offer an SNP during that period. Am. Compl. ¶ 68. Star rating measure C05, "Special Needs Plan Care Management," assesses the quality of the SNP offered by a contract. Am. Compl. ¶ 51. When a contract does not offer an SNP, or its SNP has fewer than 30 enrollees, measure C05 is marked as "no data available" and excluded from the final rating calculation. JA 46; HMOLA Mot. Summ. J. at 2. H6453, the contract that survived after consolidation, offers an SNP for 2025. HHS Opp'n at 1.

When CMS initially calculated contract H6453's 2025 star rating, it did not include a score for measure C05, having interpreted its Technical Notes to exclude the consumed contract's data for that measure. JA 215, 217. HMOLA notified CMS of this potential error,

asking CMS to permit it to submit C05 data which it claimed would result in an increase of this measure "from no star rating to 96% (5 Stars)." Id. HMOLA believed that if CMS included the C05 data, the overall rating for its surviving contract would increase from 3.5 to 4 stars. Id.

CMS initially refused HMOLA's request. JA 217. But after HMOLA put forth a strong argument that excluding C05 conflicted with the applicable regulations and made no sense, see JA 219–20, CMS agreed to accept HMOLA's 2023 C05 data corresponding to the consumed contract, H5576. JA 225–26. That data earned a three-star rating. Id. Since the surviving contract, H6453, did not offer SNPs in 2023, it did not factor into the enrollment-weighted average. Id. Therefore, CMS gave the consolidated contract a three-star rating on measure C05, noting "a significant decline in the measure score from the prior year[.]" Id. Dismayed by the unexpectedly low rating, HMOLA did an about face: It now argues that the C05 data it explicitly asked CMS to consider should not have been factored in, after all. Am. Compl. ¶ 6.

II. Legal Standard

At summary judgment, the Court must determine whether the challenged agency action complies with the APA and is supported by the administrative record. Richards v. INS, 554 F.2d 1173, 1177 (D.C. Cir. 1977). Under the APA, "[t]he reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law[.]" 5 U.S.C. § 706(2)(A). Arbitrary and capricious review is "narrow," Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971), and precludes the Court from "substitut[ing] its judgment for that of the agency," Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983). Rather, the Court must determine whether the agency "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a rational connection between the

facts found and the choice made." Id. (internal quotation marks omitted). Even if the agency did not fully explain its decision, the Court may uphold it "if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc., 419 U.S. 281, 286 (1974) (citing Colo. Interstate Gas Co. v. Fed. Power Comm'n, 324 U.S. 581, 595 (1945)). The Court's review is limited to the administrative record, Holy Land Found. for Relief & Dev. v. Ashcroft, 333 F.3d 156, 160 (D.C. Cir. 2003), and the party challenging an agency's action bears the burden of proof, City of Olmsted Falls v. FAA, 292 F.3d 261, 271 (D.C. Cir. 2002).

III. Analysis

HMOLA asserts that CMS acted arbitrarily and capriciously by including data on measure C05 in its star rating, in violation of CMS regulations, the applicable statute, and the agency's technical guidance. HMOLA Mot. for Summ. J. at 9–10. HMOLA further contends that CMS's explanation for accepting its request to include the data was insufficient. Am. Compl. ¶ 96. Because none of CMS's rules, the relevant statute, or the Technical Notes supports C05's exclusion, HMOLA's argument fails.

A. CMS's Statutes and Rules

HMOLA first contends that CMS's inclusion of measure C05 data from the consolidated contract conflicts with its governing statute and regulations. Am. Compl. ¶ 74. To the contrary, CMS's inclusion of measure C05 in its calculation is entirely consistent with both.

The statute provides that, following consolidation, star ratings shall be adjusted "to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts." 42 U.S.C. 1395w-23(o)(4)(D). The regulations add further specificity, mandating that, "[i]n the case of contract consolidations involving two or more contracts for health or drug services of the same plan type under the same parent organization, CMS assigns Star Ratings for the first and

second years following the consolidation based on the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s)[.]" 42 C.F.R. § 422.162(b)(3)(i). As relevant here, for the second year after consolidation, "CMS uses the enrollment-weighted measure scores using the July enrollment of the measurement year of the consumed and surviving contracts for all measures[.]" 42 C.F.R. § 422.162(b)(3)(iv)(B)(1).

Here, the consumed contract earned three stars for measure C05 based on the applicable enrollment data, while the surviving contract did not offer SNPs and accordingly had no data available for that measure. JA 217. Thus, the "enrollment-weighted mean" of the two scores is three stars—three stars for the consumed contract, and no score for the surviving contract. That is precisely what the regulation requires.

In the face of this plain language, HMOLA argues that it is somehow inconsistent with CMS regulations to "issue[] Star Ratings for a plan that did not actually provide the services supposedly reflected in the ratings." HMOLA Mot. for Summ. J. at 10. But as just explained, the regulations explicitly contemplate the use of data from a consumed contract in calculating a consolidated contract's scores for the first two years. 42 C.F.R. §§ 422.162(b)(3)(i), (iv)(B)(1).

Broadening its argument, HMOLA complains that CMS's calculation is "inconsistent with [its] statutory mandate" because it does not represent a "true reflection" of HMOLA's "services and care." HMOLA Mot. for Summ. J. at 10–11. Once again, HMOLA's argument relies on the fact that the surviving contract "did not *even offer* [SNPs] during the measuring period[.]" Id. at 11 (emphasis in original). But the consolidated contract is made up of two components. One of them *did* offer SNPs in 2023. Not scoring C05 would therefore render the overall rating less reflective of the contract's quality, not more.

Worse, HMOLA's methodology would encourage MA Plans to artificially inflate their scores by strategically consolidating contracts. The relevant statute appears designed squarely to prevent such gamesmanship. It is titled: "Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization." 42 U.S.C. 1395w-23(o)(4)(D). Without at all suggesting that HMOLA combined the two contracts to whitewash the performance of contract H5576's legacy SNP, accepting HMOLA's current litigation position would bring about precisely that result.

B. The Technical Notes

HMOLA claims that the consideration of measure C05 also violated the agency's 2025 Technical Notes. HMOLA predicates this argument on the assertion that the Technical Notes bind CMS. Am. Compl. ¶ 50. CMS does not disagree. Rough Tr. at 27:7–21. Even assuming the Technical Notes are binding, however, CMS did not violate them here.

HMOLA first maintains that the inclusion of C05 data contravenes a provision of the Technical Notes stating that "[c]ontracts and [plan benefit packages] with an effective termination date on or before [June 15, 2024] are excluded and [the C05 measure is] listed as 'No data available.'" JA 45. Because H5576 "effectively terminated at its merger on January 1, 2024," says HMOLA, including its C05 data violates the provision. HMOLA Reply at 3; HMOLA Mot. for Summ. J. at 6.

Contrary to HMOLA's argument, contracts cannot possibly "terminate" for purposes of this provision when consumed. As just explained, the regulatory scheme requires CMS to consider data from a consumed contract for two years post-consolidation. 42 C.F.R. § 422.162(b)(3)(i). Contract consolidations are always effective January 1. See JA 220.

Accordingly, if this provision of the Technical Notes applied to consumed contracts, their data could *never* be considered—in violation of CMS's regulations.

HMOLA itself made this point before its change in position. It observed that termination upon consumption "would negate the entire regulatory framework for calculating Star Ratings following a contract consolidation, which aims to prevent [MA organizations] from consolidating a low performing contract into a higher performing contract in order to shed the low scores." JA 220. That position makes good sense. As already noted, a consumed contract does not stop providing services upon consolidation—it continues to offer them through the consolidated contract.

At oral argument, HMOLA countered that while the regulations generally require consideration of data from consumed and surviving contracts, each measure's specific exclusions control. Rough Tr. at 10:8–24. Here, per the Technical Notes, measure C05 excludes data from contracts terminated before June 15, 2024. HMOLA says that trumps the general requirement to base star ratings on the consolidated and surviving contracts' enrollment-weighted average.

HMOLA misapplies the specific-governs-the-general canon, however. The regulations governing the calculation of ratings following a contract consolidation cover the specific situation at issue here. The Technical Notes' C05 termination provision, on the other hand, applies across the board, irrespective of consolidation. JA 45. And another provision of the Technical Notes clarifies exactly which measures require consideration of data from both the consumed and surviving contract 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, the measure values for the surviving contract of a consolidation are calculated as the enrollment weighted mean of all contracts in the consolidation.

JA 122. The provision explicitly lists the measures to be excluded from ordinary post-consolidation calculations, then reiterates that the general enrollment-weighted mean rule applies to *all other measures*. Given that C05 is not excluded, the general consolidation formula applies to that measure like any other.

Taking a different tact to argue that contract H5576 was "terminated," HMOLA insists that the definition of "consumed contract" implies termination. Rough Tr. at 9:16–23. The regulatory definition of "consumed contract" is "a contract that will no longer exist after a contract year's end as a result of a consolidation." 42 C.F.R. § 422.162(a); Rough Tr. at 9:16–23. But conflating consumed and terminated contracts is inconsistent with CMS's regulations, which set forth only three types of termination: (1) by "written mutual consent" between CMS and the MA organization; (2) by CMS's sole determination; or (3) by the MA organization if "CMS fails to substantially carry out the terms of the contract." 42 C.F.R. § 422.508–12. Consolidation is not among them. And HMOLA has given no indication that any of the listed scenarios applies here. Moreover, all contemplated terminations carry sanctions or conditions on the MA organization, none of which appear to apply to HMOLA. See, e.g., 42 C.F.R. § 422.508(c), (d); id. § 422.510(e); id. § 422.512(e).

Finally, HMOLA argues that the Technical Notes prohibit CMS from considering data for services that the surviving contract did not offer pre-consolidation. Am. Compl. ¶ 59. But as already explained, HMOLA's consolidated contract effectively offered SNPs during the measurement period through one of the two component contracts, H5576. Nowhere do the Technical Notes distinguish between whether a service was offered by the surviving or consumed contract pre-consolidation. Accordingly, the Technical Notes offer no additional support for HMOLA's claims.

C. CMS's Explanation for Changing Course

In a last-ditch effort, HMOLA shifts gears, focusing not just on CMS's supposedly incorrect methodology, but the contention that it insufficiently explained its change in approach. Rough Tr. at 30:4–17; id. at 31:4–10. As an initial matter, is not entirely clear that the change-in-position doctrine applies to an agency's preliminary position during an informal adjudication of the sort that CMS engaged in to calculate HMOLA's star rating. That doctrine traditionally applies "when an agency shifts from a position expressed in a more formal setting." Food & Drug Admin. v. Wages & White Lion Invs., L.L.C., 145 S. Ct. 898, 918 n.5 (2025) (citing FCC v. Fox Television Stations, Inc., 556 U.S. 502, 517 (2009)). Nevertheless, the Supreme Court recently assumed without deciding "that the change-in-position doctrine applies to an agency's divergence from a position articulated in nonbinding guidance documents." Id. But HMOLA's challenge goes a step further than that. HMOLA is not arguing that CMS diverted from a position laid out explicitly in the Technical Notes, merely that the agency changed its interpretation over the course of a single informal adjudication. HMOLA cites no evidence indicating that CMS had an "existing policy" of excluding the consumed contract's C05 data after consolidation. Indeed, CMS's initial calculation here appears to be best understood as a one-off error[1]—not an "existing precedent" as is typically at issue in change-in-position challenges. E.g., Fox Television, 556 U.S. at 510. Accordingly, the Court doubts that the change-in-position doctrine applies under these circumstances.

[1] Although not part of the administrative record, the government indicated at oral argument that permitting HMOLA to submit the data required CMS to make changes to its online portal. That may either support that the agency changed its policy or indicate that the agency has not confronted this issue before. Rough Tr. at 28:6–9. Either way, it does not change the Court's conclusion.

Still, even if HMOLA's shift is viewed as a change in an established policy, CMS has done just enough to explain its shift. "[A]gencies are free to change their existing policies as long as they provide a reasoned explanation for the change, display awareness that they are changing position, and consider serious reliance interests." White Lion, 145 S. Ct. at 917 (cleaned up). After HMOLA requested that CMS recalculate its scores using the C05 data, the agency agreed: "At Louisiana Blue's request and after further consideration, CMS agreed to accept H5576's 2023 SNP [data]." JA 225; Rough Tr. at 18:12–20. To be sure, this explanation standing alone does not shed much light on the agency's reasoning. In context, however, CMS essentially adopted HMOLA's rationale for requesting the inclusion of C05 data. In the same exchange, just prior, HMOLA explained that under CMS's regulations, H5576 had not been terminated and its data was not subject to the Technical Note requiring exclusion. JA 219–20. Although CMS could have provided a more fulsome explanation for its actions, the Court "may reasonably [] discern[]" that CMS acquiesced to HMOLA's request for the reasons it gave the agency.[2] Bowman, 419 U.S. at 286.

[2] Further supporting the Court's holding is the practical reality that, if CMS's explanation were found to be insufficient, the Court would remand for further explanation, not vacate the rating. See Massachusetts v. U.S. Nuclear Regul. Comm'n, 924 F.2d 311, 336 (D.C. Cir. 1991) ("In appropriate cases, we will remand without vacating an agency's order where the reason for the remand is a lack of reasoned decisionmaking."). At that point, CMS would likely be able to easily cure any defect by explaining that it adopted HMOLA's reasoning in making the requested change.

IV. Conclusion

For these reasons, the Court will grant the government's cross-motion for summary judgment and deny HMOLA's motion. A separate order accompanies this Opinion.

CHRISTOPHER R. COOPER
United States District Judge

Date: July 9, 2025

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 24-2931-CRC

NOTICE OF APPEAL

Notice is hereby given that Plaintiff HMO Louisiana, Inc. ("HMOLA"), in the above named case, hereby appeals to the United States Court of Appeals for the District of Columbia Circuit from this Court's Order denying Motion for Summary Judgment for the Plaintiff and granting Cross-Motion for Summary Judgment for the Defendant (Dkt. 28) on the 9th of July, 2025. This notice of appeal is timely because it was filed within 60 days of entry of final judgment in a case in which one of the parties is a United States agency. Fed. R. App. P. 4(a)(1)(B).

Dated: July 21, 2025

Respectfully submitted,

By:_____

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CERTIFICATE OF SERVICE

I hereby certify that on July 21, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ *Paul Werner*
Paul Werner

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

- - - - - - - - - - - - - - - - - x

HMO LOUISIANA, INC.,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

- - - - - - - - - - - - - - - - - x

CA No: 1:24-cv-02931-CRC

Washington, D.C.
Wednesday, July 2, 2025
3:08 p.m.

TRANSCRIPT OF MOTION HEARING
HELD BEFORE THE HONORABLE CHRISTOPHER R. COOPER
UNITED STATES DISTRICT JUDGE

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P R O C E E D I N G S

THE COURTROOM DEPUTY: Good afternoon. We're here today for a motion hearing in Civil Action 24-2931, *HMO Louisiana, Inc. v. The Department of Health and Human Services, et al.*

Beginning with counsel for the plaintiff, if you would approach the lectern and identify yourself for the record.

MS. WIGGER: Thank you. Good afternoon, Your Honor; my name is Hannah Wigger, and I represent HMO Louisiana in this matter. I'm joined by my co-counsel, Paul Werner, Tifenn Drouaud, and Imad Matini.

THE COURT: Okay. Did you guys get an earful before?

MS. WIGGER: Not yet.

THE COURT: At the hearing before?

MR. MATINI: We did not.

THE COURT: I was going to say welcome to my world, but...

MR. BARDO: Good afternoon, Your Honor; John Bardo on behalf of the government. I'm joined at counsel table by Ken Whitley and Kristin Roddy. Mr. Whitley is a Special Assistant U.S. Attorney so he's going to be taking the lead on the argument.

THE COURT: Very well. Welcome, everybody.

MR. BARDO: Thank you, Your Honor.

THE COURT: All right. Ms. Wigger, it's your challenge so why don't we start with you.

MS. WIGGER: Thank you, Your Honor.

THE COURT: All right.

MS. WIGGER: Your Honor, we are here today because CMS issued a Star Rating for services not actually offered in violation of its own regulations and the APA. That error has cost HMO Louisiana tens of millions of dollars in Quality Bonus Payments that it needs to provide supplemental services to its members, including things like reduced cost sharing, vision services, dental, hearing aids, that kind of stuff.

HMO Louisiana is entitled to summary judgment on its APA and declaratory judgment claims because CMS's actions violate the plain text of its regulations and undermine the basic statutory objective to provide Star Ratings that are a true reflection of the plan's quality. And I would like to take each of those in turn.

First, CMS's calculation of HMO Louisiana's --

THE COURT REPORTER: I'm going to ask you to slow down because I see that you're reading.

MS. WIGGER: Sorry. It's a problem I have so feel free to interrupt me.

THE COURT: We've got plenty of time.

MS. WIGGER: CMS's calculations of HMO Louisiana's 2025 Star Rating is contrary to its own regulations. HMO Louisiana contracts with CMS to provide an alternative to traditional government managed Medicare.

THE COURT: Okay. So contrary to -- the regulation that you're saying it's contrary to is 42 CFR 422.161(b)(3)?

MS. WIGGER: Correct, and technical notes that are incorporated as well --

THE COURT: Let's start with the main regulation.

MS. WIGGER: Yes, Your Honor.

THE COURT: All right. And didn't HMOLA take the position in the negotiation process that that regulation, in fact, required consideration of measure CO2 or CO5?

MS. WIGGER: Yes, sir.

THE COURT: And why weren't you right then as opposed to being right now?

MS. WIGGER: Yes, Your Honor. When this dispute started between the parties, there were several measures that were at issue between the parties.

THE COURT: Right.

MS. WIGGER: And HMO Louisiana was trying to work with CMS to come to a global resolution of this case in the context of settlement discussions and to understand how CMS actually treated several of these measures. In that

context, they did ask CMS to collect data for different measures, but the issue here is how CMS actually applied that data to the one measure that's at issue here.

THE COURT: Okay. Let's just pause. So that regulation says that for the first two years after consolidation CMS calculates the Star Rating based on enrollment weighted averages of the scores of the consolidated contracts. Enrollment is calculated as of July.

Why doesn't that directly cover the situation with respect to Measure CO5?

MS. WIGGER: Because that is a general provision that is made more specific in the technical notes that are also incorporated by the -- in the Federal Code that directly relate to the way that data is applied to Measure CO5.

THE COURT: Okay. And so the technical note is at Page 37 of the AR.

MS. WIGGER: It begins there, Your Honor, yes, and I can point you to specific provisions at issue here.

THE COURT: Hold on.

MS. WIGGER: So for Measure CO5, that begins on JA45. I believe that's the same AR number for the earlier numbers.

THE COURT: Okay.

MS. WIGGER: So JA45 speaks to how data is applied to Measure CO5. And, again, this is incorporated into the operative regulations at 42 CFR 422.164(a).

So under its regulations at AR45, CMS is required to exclude from its calculation of Measure CO5 contracts with an effective termination date on or before June 15, 2024.

Attachment E to these technical notes, which is at JA127, reiterates that same calculation. So at JA127, CMS sets forth a two-step process; not the two-step process that they reference in their opposition brief, but the two-step process in their regulation for how they calculate Measure CO5.

That two-step process under Step 1, they start with all contracts that offer at lease one SNP plan. Now, here that's only the consumed contract. The surviving contract never offered an SNP plan so it was never evaluated for it.

Step 2 at JA127 is to, quote, exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS, which is, again, June 15th of 2024.

THE COURT: But you took the position in your October 14, '24, letter objecting to CMS's exclusion of Measure CO5 data that Contract 5576 was not terminated

because it was consumed after the consolidation with Contract 6453.

You're now taking the opposite position. You convinced CMS to adopt your position. They did. Now you're complaining about it.

MS. WIGGER: Your Honor, again, at the beginning of this case HMO Louisiana was trying to understand what CMS had done and how they could resolve it.

THE COURT: Well, you were doing more than trying to understand it. You were urging them to accept your position, which they did. And you objected to their interpretation of the technical note to prohibit inclusion of data from terminated contracts.

MS. WIGGER: That's true. HMO Louisiana did do that. However, looking at these regulations --

THE COURT: Now, you can tell me you're entitled to change your position. They're not. That's what I expected to hear. But you can't say that wasn't your position because you were just trying to understand the issues. Right?

MS. WIGGER: It's what was in the letter that is in the record from HMO Louisiana at the beginning of this case.

THE COURT: Okay.

MS. WIGGER: But the issue is that what CMS

actually did still has to comply with the APA. And when you look at the APA --

THE COURT: And why doesn't it comply with regulation?

MS. WIGGER: Because the regulation says that data from contracts with an effective termination date on or before June of 2024 has to be excluded. This contract --

THE COURT: That's the technical note.

MS. WIGGER: Correct.

THE COURT: Why don't we get there.

First of all, is it binding, or is it not binding? Is it agency guidance that's not binding, or is it something the agency has to adhere to?

MS. WIGGER: No, it's binding. It's been incorporated into the regulations.

THE COURT: Okay. And if it weren't incorporated into the regulations, would it still be binding?

MS. WIGGER: Yes, it's still binding on the agency. The agency --

THE COURT: What authority -- what's your best authority for that proposition?

MS. WIGGER: The APA. Because when the agency sets out regulations and says, "This is how I'm going to calculate" --

THE COURT: Well, wait, wait, wait. We've got

regulations, notice and comment, et cetera, right?

We have informal agency internal guidance via a technical note, right?

Let's say that they're not incorporated into the regulations. Are they binding?

MS. WIGGER: Yes.

THE COURT: What authority do you have for that?

MS. WIGGER: The APA. Because under the decisions that interpret the APA, the agency cannot act arbitrary and capriciously, and part of that is that it can't treat parties differently. So if it says this is how I'm going to calculate data and validate it in order to determine the substantial benefits, these tens of millions of dollars I'm going to hand out under the Star Rating program, it has to do the same for every program.

THE COURT: So if an agency deviates from nonbinding agency guidance, that's nevertheless arbitrary and capricious under the APA in all cases.

MS. WIGGER: It is in this case.

THE COURT: Is that your position?

MS. WIGGER: It would be in this case at least. I'm not going to say in all cases, but it would at least be in this case because they would not be treating programs the same way. They would be arbitrarily treating this programming differently.

THE COURT: Okay. So as I understand it, your position or HMOLA's positions in the negotiations was that that technical note really did not apply because this contract had not been terminated.

So having accepted that position, isn't it fair to say that the agency changed its position because it agreed that that technical note doesn't apply to situations where there's a consolidation of a contract.

MS. WIGGER: I don't know why the agency changed its position, but --

THE COURT: Okay.

MS. WIGGER: -- I would like to say something on the termination piece of this.

THE COURT: Okay.

MS. WIGGER: There doesn't seem to be any real dispute that this contract has actually terminated, the subsumed contract.

The agency's regulations do not define "termination" as a distinct concept from consolidation, but they do define "consumed contract," and that's at 42 CFR 422.162(a). And in that definition, they defined a consumed contract as one that will no longer exist after a contract year's end as a result of consolidation. That has to mean terminated. If it doesn't exist anymore, that has to mean that it terminated it.

And, again, that is how the agency itself referred to this contract. They referred to it as a terminated contract at JA217 in that same correspondence.

THE COURT: Okay. So let's assume you're correct. Let's assume that the subsumed contract was terminated. Then isn't that flatly inconsistent with the agency's obligation to, you know, take data from both contracts in assessing the quality of a consolidated contract for the first two years?

MS. WIGGER: No, I don't read it that way, and here's why. When you look at the technical notes for each of these measures, it lists specific exclusion. There's a general rule that you would consider all the data and then there's a specific way in the technical notes that the agency is to look at each of these measures.

When you look at each of the measures, there's specific exclusions to each measure.

THE COURT: Okay.

MS. WIGGER: The exclusion for CO5 happens to have that date as June 15th. The exclusion for other measures doesn't, and some of them aren't even date related.

THE COURT: Okay.

MS. WIGGER: And so there may be a general directive that they would consider data, but the way that they do that is more specifically defined and they have more

specific controls.

THE COURT: Okay. So the agency, through notice and comment, decided that we're going to consider both contracts or, you know, the consumed and the surviving contracts' data for some measurements, but just not for CO5. That's your --

MS. WIGGER: I think it's a little bit more nuanced than that. So it's not that we're going to consider some data from some and not others. It's just that they have different cutoffs or exclusions for different measures.

THE COURT: Okay.

MS. WIGGER: Some are dates -- tied to dates. Some are tied to when different visits took place.

THE COURT: Okay.

MS. WIGGER: But, Your Honor, I think that CO5 is also a unique measure, because CO5, unlike some of the other measures, including the other one that was at issue between the parties, relates to the presence of a specific program as opposed to something like a quality measure that both contracts would have. And so in this case the problem is that you have the surviving contract that actually should be being evaluated because that's what people will be signing up for --

THE COURT: Okay. Let's stop there.

MS. WIGGER: Yes.

THE COURT: I want to -- so let's go to 30,000 feet.

MS. WIGGER: Okay.

THE COURT: When two contracts combine --

MS. WIGGER: Yes.

THE COURT: -- and one contract offered a special needs plan, that contract is subsumed within a surviving plan. The surviving plan continues to offer a special needs plan or the surviving contract continues to offer a special needs plan.

In effect, isn't that just a continuation of the same plan? It has the same enrollees, correct?

MS. WIGGER: It would likely have --

THE COURT: Many would overlap with the same enrollees, the same plan administrators, the same nursing homes where people are getting care. Correct?

MS. WIGGER: Potentially.

THE COURT: Okay.

MS. WIGGER: I think that there would be a different pool when you put the contracts together, potentially different management, different policies.

THE COURT: Okay.

MS. WIGGER: I don't think it's fair to say that the plan that existed in the subsumed contract exists exactly how it did in the surviving contract.

THE COURT: It may not be exact, but it certainly shares some attributes of the consumed plan that used to offer special need plans. Is that fair?

MS. WIGGER: It could.

THE COURT: Okay.

MS. WIGGER: Or there could be a reason that they combined contracts and that they believe that the contract that is going to survive is stronger.

THE COURT: Okay. But there is some overlap, some continuation of services, doctors, facilities, contract administration. You know, if I'm signing up for, you know, that surviving plan and I -- or surviving contract and I need special needs services, shouldn't consumers be able to consult a Star Rating, or wouldn't it be helpful to have a Star Rating for that plan that considers those special needs services that are continuing even though the surviving or the consumed plan has been discontinued?

MS. WIGGER: There's nothing in the record that shows that those special needs services are the same or unchanged in the surviving contract. So that Star Rating is not a fair reflection of the actual quality of the surviving contract.

THE COURT: Okay. Well --

MS. WIGGER: The Star Rating of the overall program I think is more instructive, and the problem here is

that the Star Rating of the overall program took a massive hit because of an SNP program that it didn't control at all, and that is fundamentally unfair.

THE COURT: Okay. There was one thing from the record that I want you to -- that I had difficulty understanding. Just hold on. Bear with me.

(Pause)

THE COURT: Okay. In the September 12, '24, email from Mr. Miller to CMS, which is at AR317 to '19, at AR319 Mr. Miller writes, "Despite its relevance to the Star Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for Contract H5576 due to a technical issue with HPMS."

What is the technical issue with HPMS? Was this a computer issue or an issue on CMS's side? Why did he refer to it as a technical issue?

MS. WIGGER: My understanding is it was an issue on CMS's side such that they literally could not upload data, which, again, we think is consistent with the technical notes.

THE COURT: Okay. And so if CMS makes a determination that a particular piece of data is -- should not be factored into the Star Rating system, it prevents plans from even submitting that data. Is that what that refers to?

MS. WIGGER: I don't know that is actually true.
THE COURT: Okay.
MS. WIGGER: I just know in this case they literally could not upload their --
THE COURT: And remind me what "HPMS" stands for.
MS. WIGGER: That I do not know off the top of my head.
THE COURT: Okay.
Okay. So your central argument is that the technical notes are incorporated into the regs; that, notwithstanding what HMOLA's position was initially, the inclusion of CO5 data should not occur because the consumed contract had been terminated consistent with CMS's original position; and therefore the action is arbitrary and capricious.
MS. WIGGER: That is correct. And we'd ask the Court to set aside the Star Rating and order CMS to recalculate it.
THE COURT: Okay. Thank you.
MS. WIGGER: Thank you.
THE COURT: All right. So you're Mr. Whitley? Is that right?
MR. WHITLEY: That's right, Your Honor.
THE COURT: Where are you on detail from?
MR. WHITLEY: I'm in the office of general counsel

at the Department of Health and Human Services.

THE COURT: All right. So you probably know what "HPMS" stands for.

MR. WHITLEY: Yes, Your Honor. For your information, it's health plan management system. I'm happy to discuss it further.

I'm Special Assistant United States Attorney Kenneth Whitley on behalf of the defendants. Good afternoon. May it please the Court.

Your Honor, we're here today because HMOLA won't take yes for an answer. In September 2024 HMOLA asked CMS to include special needs plan data from its consumed contract in calculating the CO5 measure for its surviving contract. CMS agreed to do so.

HMOLA expected its overall score to increase from 3.5 to 4 stars. When CMS permitted HMOLA to submit its data, its Star Rating remained the same at 3.5 stars.

In this litigation, HMOLA is asking this Court to require CMS to calculate its Star Rating for the consolidated contract without the CO5 measure, which was three stars, but to maintain the five stars it achieved on the D11 measure. This Court should reject this effort to cherry-pick beneficial measure scores and jettison adverse ones.

HMOLA was correct the first time. The approach

CMS took was consistent with its regulations.

THE COURT: Okay.

MR. WHITLEY: Your Honor, I -- I'm sorry.

THE COURT: Hold on. So both sides have changed their position obviously, right? CMS started with the part that the technical note required not -- you know, required that CO5 data not be considered for the consumed contract, all right. At some point CMS changed its mind.

Now they changed their mind as well, but they're a private party. They're entitled to do that. They're not subject to the APA. CMS is.

And so I guess my first question is, where in the record does the government explain -- or where in the record did CMS explain why it changed its position that the technical note on terminated contracts prohibited consideration of data on measurement CO5 in calculating the 25 Star Rating?

MR. WHITLEY: Your Honor --

THE COURT: Was it required to explain why it changed its mind?

MR. WHITLEY: The regulation set out a plan preview process, Section 422.166(h)(2). To set out the plan preview process there are two planned previews that occur, first in August and September, and that process exists to allow individual contracts to, you know, ask for corrections

or clarifications about their Star Ratings.

CMS responded and accepted the corrections that HMOLA asked for, and that explanation is at Pages 315 and '16 of the record.

THE COURT: Hold on. 315 and 316.

All right. I have 315 and 316. Where does CMS explain why it changed its position and adopted HMOLA's position?

MR. WHITLEY: Sorry, just one second, Your Honor.

THE COURT: Take your time.

The last sentence on 315?

MR. WHITLEY: Yes, that's right.

THE COURT: Okay. So it basically says that it's Louisiana Blue's request, and after further consideration CMS agreed to accept Contract H5576's 2023 SNP data.

MR. WHITLEY: That's right, Your Honor.

THE COURT: Is that the sum and substance of CMS's explanation for why it changed its position that the technical note concerning terminated contracts applied?

MR. WHITLEY: That's the sum of the explanation in the record. CMS's explanation is that the exclusion did not apply. CMS excluded special needs plan data from the consumed contract because it improperly regarded that contract as terminated. That was incorrect.

THE COURT: Okay.

MR. WHITLEY: Because it regarded the consumed contract as terminated, the line and guidance applied regarding the data validations deadline and how it regarded terminated contracts.

THE COURT: Okay. So an agency can change its position, of course. But doesn't it have to explain the change under the APA? And if so, the question then becomes whether -- and this is -- I take it it's a form of informal adjudication. There's an adjudication over whether one rating or another rating should apply.

To what extent does the agency have to explain its change, and has it sufficiently explained it by way of this sentence?

MR. WHITLEY: Your Honor, the explanation CMS gave was sufficient. It is sufficient for CMS to say it agreed with the request, HMOLA's request.

This is an informal adjudication, as you stated, and so, you know, the plan preview process is meant to be sort of an iterative process, a back-and-forth to allow plans to express their questions about their -- and objections to the way Star Ratings are calculated. There's no formal requirements that CMS issue an extensive decision.

Again, I direct you to Section 422.166(h)(2) of the regulations that discuss the plan preview process. There are no formal requirements for CMS to issue some kind

of extensive written opinion.

THE COURT: So implicit in the -- I take it your argument is implicit in the statement "CMS agreed to accept Contract H5576's '23 SNP data" is "We agree with the rationale that HMOLA offered during this consultative process."

MR. WHITLEY: Yes, Your Honor, that's correct.

I take HMOLA to be making two arguments in this litigation.

The first is that if a surviving contract is not the contract to have offered a special needs plan during the measurement year, then that consolidated contract should not be evaluated on the CO5 measure. That's not supported by CMS's regulations anywhere.

As Your Honor alluded to already, Sections 422.162(b)(3)(i) and 422.162(b)(3)(iv)(B)(1) create a requirement that consolidated contracts be evaluated on measure scores during a measure year for the consumed and the surviving contract.

THE COURT: Okay. Well, address your colleague's argument that while that may be generally so, the technical notes create some specific exclusions to that general principle, including one involving specifically Measure CO5.

MR. WHITLEY: Your Honor, that's respectfully just wrong. The guidance creates an exception for terminated

contracts.

Again, the error that CMS made was in regarding the consumed contract as terminated. But the consumed contract wasn't terminated for some of the reasons --

THE COURT: What does it mean for a -- in the normal course, putting aside consolidated contracts, what does it mean to -- or under what circumstances is a contract terminated?

MR. WHITLEY: Your Honor, Sections 422.508, 510, and 512 lay out the grounds for termination, and they are varied. Terminations can occur by agreement of the parties; they can occur at CMS's initiation alone; or they can occur because of the reason -- at the sort of initiation of the Medicare Advantage organization.

There are various reasons that a contract might terminate, but I would point out that a contract can terminate any time during the year. Not so with a consumed contract. Contract consolidation only occurs at the end of a planned year, and as you already suggested, during a contract consolidation enrollees from the consumed contract become enrolled in the surviving consolidated contract.

When a contract is terminated, which, again, can happen at any time during the year, there's a special enrollment period. Individuals can enroll in any plan or no plan at all. It's quite different than a consumed contract

which lives on in the surviving consolidated contract.

It really would make no sense for CMS to treat a consumed contract the same way it does a terminated contract, and the regulatory definitions make that clear. A consumed contract means a contract that will no longer exist after a contract year's end as a result of consolidation.

This guidance is unique to termination, and it's unique to termination for a reason, and that's that unlike a contract consolidation, if there's a contract termination before June 15th -- that's the date laid out in this line and guidance -- the terminated contract will not receive a Star Rating at all.

If it terminates after that date, the terminated contract will likely receive a Star Rating, but that Star Rating will not be made public. It will be, you know, part of the internal system for CMS and for the utility of the plan.

THE COURT: Okay.

MR. WHITLEY: And so fundamentally, a consumed contract is just different than a terminated contract, and CMS was convinced by the rationale set forth in HMOLA's communication.

THE COURT: And the initial interpretation was just erroneous.

MR. WHITLEY: Your Honor, CMS's error was in

classifying the consumed contract as terminated. Its reading of the guidance is -- I mean, insofar as it read the word "terminated" to cover consumed contract, that interpretation was erroneous.

THE COURT: Okay. And it wasn't quite clear from the papers, but how did that error get surfaced? You know, is there sort of an elevation process? Does it go to the general counsel's office or --

MR. WHITLEY: That's right. This instance is the first time that this issue has ever been raised with CMS, and that's just because there are not that many contract consolidations in a year. There are not that many contract consolidations that involve special needs plans, and, of course, it's even less likely that there's a consumed contract that offers special needs plans, and a surviving contract does not.

Lastly, to further narrow this sort of range of cases just for your information, this only occurs in the second year after a consolidation. So this isn't a frequent problem, but yes, the HMOLA brought this problem to CMS for the first time, and CMS brought this issue to the office of general counsel.

THE COURT: Okay.

MR. WHITLEY: Your Honor, what I really want to make clear is that either approach that HMOLA is advocating

here amounts to sort of a picking and choosing of measure scores a la carte, and what I mean by that is if it's true that the consumed contract really terminated on January 1, 2024, that means that, consistent with the guidance, they shouldn't be -- the consolidated contract shouldn't be evaluated on Measure CO5 but also Measure D11. Measure D11 includes the same exclusion guidance that was at issue here, but HMOLA's consolidated contract scored five stars on that, on the D11 measure. They're not before this Court asking, you know, CMS to require that D11 be excluded.

On the other side, with regard to the theory that --

THE COURT: I get your point, but the plaintiff is the master of his or her complaint, right? And they can challenge what they want to challenge.

MR. WHITLEY: That's precisely right, Your Honor, but what I'm saying -- what I'm articulating is that HMOLA is not able to articulate a principled position. The positions that it's articulated not only are at odds with CMS's rules, but are unprincipled. And just as another example, if HMOLA's consolidated contract, the surviving contract, was required to be the one to offer special needs plans in the 2023 measurement year, Measures CO6 and CO7 should also not apply because they're special needs plan measures as well. But, again, HMOLA scored five stars on

each of those measures.

I'm just trying to emphasize, Your Honor, that this litigation is really an effort to cherry-pick the beneficial measure scores and jettison the ones that are adverse to HMOLA.

THE COURT: Tell me this. What if the surviving plan did not offer -- or the surviving contract did not offer a special needs plan. Would it have been appropriate nevertheless to incorporate the CO5 data for the consumed plan?

MR. WHITLEY: Your Honor, you're asking if the consolidated contract didn't offer a special needs plan in 2025?

THE COURT: Yes.

MR. WHITLEY: It would be inappropriate for CMS to evaluate the consolidated contract based on the CO5 measure, and Section 422.162(b)(1) makes that clear. The rule is that if a plan in 2025 is offered a special needs plan in either its consumed or -- sorry, a surviving or consumed contract offered a special needs plan in 2023, that plan would be evaluated on CO5 for the 2025 Star Rating.

THE COURT: What sense would that make?

Well, if either of the consumed plan or the surviving plan continued to offer special needs coverage.

MR. WHITLEY: I'm sorry, your question --

THE COURT: If the regulation is in the disjunctive, all right? If the consumed plan or the consumed contract offered a special needs plan or the surviving contract offered a special needs plan, then the regulation requires CMS to consider the CO5 measure for the consumed plan even though going forward it's not -- no one's offering special needs services.

MR. WHITLEY: I think you're misunderstanding. If in 2025 the consolidated contract is not offering a special needs plan, then it would be inappropriate and at odds with CMS's regulations to evaluate that plan on the CO5 measure or any of the special needs plan measures.

THE COURT: Okay.

MR. WHITLEY: And, Your Honor, I really want to emphasize, because I think HMOLA said it best in its correspondence with the CMS, that for CMS to exclude the CO5 measure, quote, would negate the entire regulatory framework for calculating Star Ratings following a contract consolidation, which aims to prevent Medicare Advantage organizations from consolidating a low-performing contract into a higher-performing contract in order to shed the low scores. That's at Page 242 of the administrative record.

But, Your Honor, if this Court endorsed HMOLA's approach in this case, it would incentivize plans to consolidate the lower-performing plan into a higher

performing one. And that really doesn't make much policy sense, but more importantly it's at odds with CMS's regulations, which, together, stand for the proposition that consolidated contracts get evaluated on the basis of their constituent parts.

THE COURT: Okay. One last question. Do you consider the technical notes to be binding or not?

MR. WHITLEY: Your Honor, we do consider the technical notes to be binding. We do not consider the regulations to have incorporated the technical notes. Section 164A merely says that the measures are listed in guidance. That's not an incorporation of the guidance into regulations, it's just an instruction to list measures in the guidance.

I don't think that's an issue in this case because the guidance here does not actually conflict with the regulations.

THE COURT: Okay. So your position is that the guidance is binding, but does not conflict with the regulations and does not apply because this was not a terminated contract?

MR. WHITLEY: That is correct, Your Honor.

THE COURT: Got it. Okay.

MR. WHITLEY: I just wanted to touch on one question, which was why or what was the technical error?

Why was HMOLA unable to submit data? And that's because the health plan management system is keyed to the guidance, and CMS's interpretation of consumed contracts as terminated sort of governed that process, and as so it's correct that HMOLA was unable, through the sort of portal for health plans, to submit the relevant information.

THE COURT: Okay. So not only did you have to change your position with respect to HMOLA, but you had to reprogram the portal.

MR. WHITLEY: That's correct.

THE COURT: Okay. Which is probably no small task.

MR. WHITLEY: You know, there are a number of these portals that -- you know, for various CMS programs, and they're quite skilled at bringing things up to speed.

I do believe that in this case the data was submitted manually via email to CMS.

THE COURT: Okay. Right. Thank you.

MR. WHITLEY: If Your Honor has no further questions, we ask that you grant the government's motion for summary judgment and deny HMOLA's motion for summary judgment.

THE COURT: Ms. Wigger, last word.

MS. WIGGER: Thank you, Your Honor. I'd like to address just a few points that were raised by CMS, and I

want to start with the agency's explanation for why it changed its position in this case.

THE COURT: Uh-huh.

MS. WIGGER: So the agency, of course, if it is going to change a position, as the Court noted, must offer a reasoned basis for actually doing so.

THE COURT: And does that apply -- does that principle apply with full force in an informal adjudication like this that's a back-and-forth consultation negotiation?

MS. WIGGER: It does, because this didn't end in informal adjudication. This ended in a Star Rating, which is a final agency action that impacted millions of people who were receiving this healthcare service.

THE COURT: But it's not a rule making.

MS. WIGGER: It's not a rule making, but --

THE COURT: It's an adjudication. It's a determination that's based on disputed facts and interpretations of data, and there's a back-and-forth, and a final agency decision results from that, which is why you're able to come to court under the APA.

MS. WIGGER: Yes.

THE COURT: But it is nevertheless an informal adjudication.

It's not a court proceeding, right?

MS. WIGGER: That's true, Your Honor, but if the

agency is going to deviate from the regulations it puts out to every other player in the market, it still has to give a reasoned explanation for doing so.

THE COURT: Okay.

MS. WIGGER: And I want to look back at AR315 or JA225. The agency doesn't give and didn't give today any explanation whatsoever, no matter how strong, for its deviation.

THE COURT: But why isn't implicit in that rather terse -- granted -- explanation that we agree with the rationale that you all have provided to us?

MS. WIGGER: Because what the agency actually said -- it spends a paragraph reciting HMO Louisiana's position, which says nothing about its position very carefully, and then it says nevertheless, we agree, quote, to accept data along with your accompanying verifications.

There is a fundamental difference between accepting data and applying the data. And CMS has to actually apply the data in a way that's consistent with the regulations that it says it considers are binding and are, in fact, binding in this case. And our argument, as we discussed earlier, of course, is that it just didn't do that based on the plain text of those regulations.

THE COURT: But viewed in context, in the context of this, you know, months-long back-and-forth exchanging of

letters, exchanging of positions, why can't the Court, in the terms of the APA or APA authority, reasonably discern the agency's rationale and decision-making process?

MS. WIGGER: Because the agency said absolutely nothing about its rationale for its decision. There is no basis for the Court to do so because the agency didn't explain -- again, as the Court noted, it didn't explain the change that required it to accept data in a different way for one specific measure, and so there is nothing on which the Court can discern there.

THE COURT: Assuming I agree with you, all right, wouldn't the remedy not be vacatur but remand without vacatur to allow the agency to beef up its explanation?

MS. WIGGER: I think just a simple vacating and remanding would be more effective. As the Court, I'm sure, knows, you can't -- the agency cannot give post hoc justifications for its actions, and that's what it's done in this case and no doubt what it would do on remand. So the Court should vacate this.

And, Your Honor, the Court has vacated -- this Court, the District of Columbia, has vacated Star Ratings cases for very similar reasons, for not appropriately applying technical notes and other agency guidance. And those cases include the *Scan Healthcare* case, which was in 2024. That's not a published case, but it's at Westlaw

2815789, and it includes the *Elevance* case, also from 2024, also from this Court, at 736 Fed. Supp. 3d 1. In both cases the agency failed to apply its regulations, and the Court vacated the Star Rating and had the agency recalculate the Star Rating in that case.

There's another case out of Texas called *United Healthcare* --

THE COURT: Well, tell me this. If I were to do that, and the agency recalculated the Star Rating, wouldn't that recalculation have to entail the other measure that you all are not suing on? If this is a general principle that the agency misapplied in calculating HMOLA's Star Rating, why wouldn't that principle apply to the other challenged measure?

MS. WIGGER: For starters, Your Honor, that other measure, D11, is not before the Court, so the Court couldn't make any ruling related to it. And if that dispute were to materialize, that would be dealt with separately.

However, I do want to address this cherry-picking point that was raised by CMS, and I alluded to this earlier. Each of these measures in the technical notes, like 40 or 50 of them, are different, and the exclusions are different, and that includes CO5 and D11.

As I said earlier, CO5 relates to a specific program that is offered or not. D11 is a quality measure

that applies to every single plan. The language of the exclusion is different for the two of them.

So the exclusion language that we're relying on here to say that CMS violated the plain text of its regulations for CO5 says that the data is not available.

It has different language for D11. I think it says something to the effect of not required to report.

Those phrases, "data not available" and "not required to report" are separately defined in the regulations. It's at JA186 --

THE COURT: Okay.

MS. WIGGER: -- I believe, and what they indicate is that those measures are -- the application of data to those measures is treated differently, and what we're challenging here is the way the data was applied to Measure CO5; not necessarily the fact that CMS accepted the data per the letter that they sent after negotiations, but the way that they chose to apply it here. And our argument is that for Measure CO5, the way that they applied it pretty much indisputably violates the plain text of their binding technical notes.

That's something CMS has never addressed. They do not argue that it violates the plain text of their technical notes. They point back to the federal code. They say that there's a difference now that they've found between

"termination" and "consolidation," which, as I said earlier, is not supported by the definition of "consolidation" that's in the federal code. But they've never challenged that they violated the plain text of the technical notes, and because of that, their action is arbitrary and capricious.

THE COURT: Okay. Thank you.

MS. WIGGER: Thank you.

THE COURT: All right. The Court will take the matter under advisement. We'll get something out sooner rather than later, and we'll stand in recess.

(Whereupon the hearing was adjourned at 3:53 p.m.)

CERTIFICATE OF OFFICIAL COURT REPORTER

I, LISA A. MOREIRA, RDR, CRR, do hereby certify that the above and foregoing constitutes a true and accurate transcript of my stenographic notes and is a full, true and complete transcript of the proceedings to the best of my ability.

Dated this 11th day of August, 2025.

/s/Lisa A. Moreira, RDR, CRR
Official Court Reporter
United States Courthouse
Room 6718
333 Constitution Avenue, NW
Washington, DC 20001

Medicare 2025 Part C & D Star Ratings Technical Notes

Updated – 10/03/2024

Document Change Log

Previous Version	Description of Change	Revision Date

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

Table of Contents

Introduction

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

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

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

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

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

Note on References to the 2024 Star Ratings

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

Differences between the 2024 Star Ratings and 2025 Star Ratings

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

about the 2025 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 Part C Plan All-Cause Readmissions measure was increased to 3.
  b. Since the Medicare Plan Finder measure is no longer treated as a new measure, guardrails are now applied after mean resampling
- 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 2025 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2025 Organization Types Reported in the 2025 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:

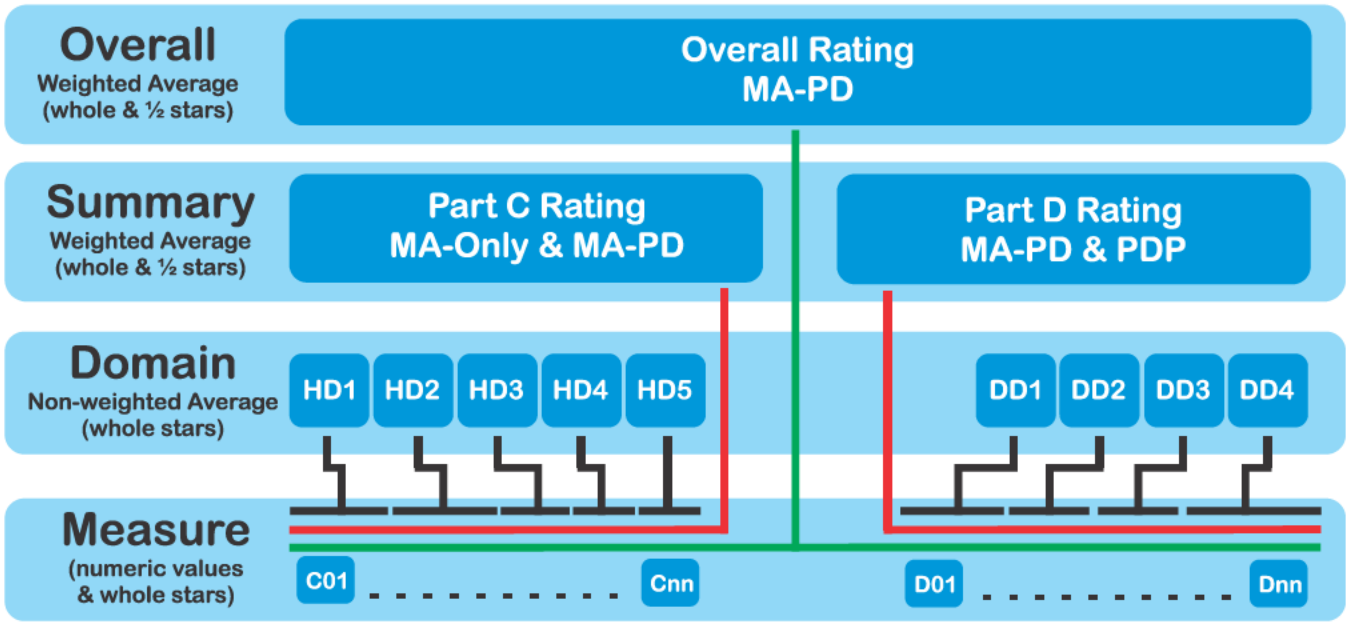
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 2025 Organization Types to Contract Types and Highest Rating in the 2025 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 2025 Star Ratings include a maximum of 9 domains comprised of a maximum of 42 measures.

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

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

Figure 2: The Four Categories of Data Sources

Improvement Measures

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

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

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 2023 through December 2023) 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 2023 through December 2023), 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 2025 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 2025 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 specified two distinct thresholds of "25% or more" and "60% 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 either of the two thresholds.

- CAHPS adjustments:
  - All contracts were required to administer the 2024 CAHPS survey unless the contract requested and CMS approved an exemption.
  - All affected contracts with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster receive the higher of the 2024 or the 2025 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure).
  - 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 2023 were also affected by disasters in 2022. These doubly-affected contracts receive the higher of the 2025 Star Rating or what the 2024 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2022 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 2023 Star Rating on a given measure in the 2024 Star Ratings, the 2023 Star Rating is *not* used in determining the 2025 Star Rating. Rather the 2025 Star Rating is compared to what the 2024 Star Rating would have been absent any disaster adjustments.
- HEDIS-HOS adjustments:
  - The HEDIS-HOS data used in the 2025 Star Ratings are adjusted for 2022 disasters (see Attachment P of the 2024 Star Ratings Technical Notes for the identification of contracts affected by 2022 disasters).
  - All affected contracts (i.e., contracts affected by 2022 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2024 or the 2025 Star Rating (and corresponding measure score) for each 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 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2025 Star Rating or what the 2024 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2021 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).

- HEDIS adjustments:
    - All contracts were required to report HEDIS MY 2023 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 2024 or 2025 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 2023 were also affected by disasters in 2022. These doubly-affected contracts receive the higher of the 2025 Star Rating or what the 2024 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2022 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 any 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. Please note that there are no new or respecified measures for the 2025 Star Ratings.
    - A similar hold harmless provision is applied for the Part C and D summary ratings. If a contract has 25% or more affected members, the Part C and D summary ratings are calculated "with" and "without" any 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. Please note that there are no new or respecified measures for the 2025 Star Ratings.
- All other measures:
    - Contracts with 25% or more affected members receive the higher of the 2024 or 2025 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 2023 were also affected by disasters in 2022. These doubly-affected contracts receive the higher of the 2025 Star Rating or what the 2024 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2022 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 2024 or 2025 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.
- Reward Factor:
    - Affected contracts with 60% or more of their enrollees impacted by a 2023 disaster are excluded from the determination of the performance summary and variance thresholds for the Reward Factor.
- Cut points:
    - Clustering Methodology: For all measures that use the clustering methodology for cut point generation, the measure scores for contracts with 60% or more of their enrollment affected by a disaster are excluded from creating those cut points.

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.

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)	3 of 4	3 of 4	3 of 4	2 of 2	3 of 4	N/A	3 of 4
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 8	6 of 11	8 of 14	6 of 10	6 of 11	N/A	6 of 11
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 2025 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by patient experience/complaints and access measures, then by outcome and intermediate outcome 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	11 of 22	13 of 26	15 of 29	9 of 17	13 of 25	N/A	13 of 26
Part D summary	5 of 10*	6 of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

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

Methodology for Calculating the Overall MA-PD Rating

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

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

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

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

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

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

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

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

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

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

Completing the Summary and Overall Rating Calculations

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

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

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

Applying the Improvement Measure(s)

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

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

MA-PD Contracts

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

MA-Only Contracts

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

PDP Contracts

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

Applying the Reward Factor

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

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

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

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

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

Table 8: Performance Summary Thresholds

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

Table 9: Variance Thresholds

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

Categorical Adjustment Index (CAI)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Calculation Precision

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

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

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

Rounding Rules for Measure Scores

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

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

Rounding Rules for Summary and Overall Ratings

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

Table 22: Rounding Rules for Summary and Overall Ratings

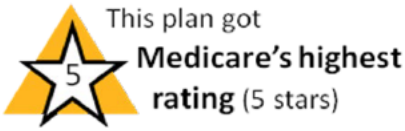
Raw Summary / Overall Score	Final Summary / Overall Rating
≥ 0.000000 and < 0.250000	0
≥ 0.250000 and < 0.750000	0.5
≥ 0.750000 and < 1.250000	1.0
≥ 1.250000 and < 1.750000	1.5
≥ 1.750000 and < 2.250000	2.0
≥ 2.250000 and < 2.750000	2.5
≥ 2.750000 and < 3.250000	3.0
≥ 3.250000 and < 3.750000	3.5
≥ 3.750000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

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

Methodology for Calculating the High Performing Icon

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

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

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

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

Figure 4: The Low Performing Icon

Table 23 shows example contracts which would receive an LPI.

Table 23: Example LPI Contracts

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

Mergers, Novations, and Consolidations

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

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

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

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

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

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

Reliability Requirement for Low-enrollment Contracts

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

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

Special Needs Plan (SNP) Data

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

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

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

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

Star Ratings and Marketing

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

Contact Information

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

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

If you have questions or require information about the specific subject areas associated with the Star Ratings please write to those contacts directly and cc the Part C & D Star Ratings mailbox.

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: CallCenterMonitoring@cms.hhs.gov
- Compliance Activity Module issues (Part C): PartCCompliance@cms.hhs.gov
- Compliance Activity Module issues (Part D): PartD_Monitoring@cms.hhs.gov
- Demonstration (Medicare-Medicaid Plan) Ratings: mmcocapsmodel@cms.hhs.gov
- Disenrollment Reasons Survey: DisenrollSurvey@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- HPMS Access issues: HPMS_Access@cms.hhs.gov
- HPMS Help Desk (all other HPMS issues): HPMS@cms.hhs.gov
- Marketing: marketing@cms.hhs.gov
- Part C Compliance Activity issues: PartCCompliance@cms.hhs.gov
- Part D Compliance Activity issues: PartD_Monitoring@cms.hhs.gov
- Plan Reporting (Part C): Partcplanreporting@cms.hhs.gov
- Plan Reporting (Part D): Partd-planreporting@cms.hhs.gov
- Plan Reporting Data Validation (Part C & D): PartCandD_Data_Validation@cms.hhs.gov

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

Framework and Definitions for the Domain and Measure Details Section

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

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

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

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

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

Part C Domain and Measure Details

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

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

Measure: C01 - Breast Cancer Screening

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C02 - Colorectal Cancer Screening

Title	Description

Label for Stars: Colorectal Cancer Screening

Label for Data: Colorectal Cancer Screening

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

HEDIS Label: Colorectal Cancer Screening (COL)

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

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

Primary Data Source: HEDIS Patient-level Data

Data Source Category: Health and Drug Plans

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

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

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

Title	Description
	– Members receiving palliative care during the measurement year. – Members who died during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00139-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C03 - Annual Flu Vaccine

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

Title	Description

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C04 - Monitoring Physical Activity

Title	Description
Label for Stars:	Monitoring Physical Activity
Label for Data:	Monitoring Physical Activity
Description:	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
HEDIS Label:	Physical Activity in Older Adults (PAO)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Specifications for the Medicare Health Outcomes Survey Volume 6, page 36
Metric:	The percentage of sampled Medicare members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase or maintain their level exercise or physical activity (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 24 Follow-up Data collection (2023) and Cohort 26 Baseline data collection (2023). HOS Survey Question 42: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. HOS Survey Question 43: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 42 are excluded from results calculations for Question 43. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/17/2023 – 11/01/2023

Title	Description

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00450-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

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

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

Title	Description

CMIT #: 00685-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C06 - Care for Older Adults – Medication Review

Title	Description

Label for Stars: Yearly Review of All Medications and Supplements Being Taken

Label for Data: Yearly Review of All Medications and Supplements Being Taken

Description: Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.
(Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

HEDIS Label: Care for Older Adults (COA) – Medication Review

Measure Reference: NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 115

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: SNP benefit packages whose enrollment was less than 30 as of February 2023 SNP Comprehensive Report were excluded from this measure.

Exclude members in hospice or using hospice services or who died any time during the measurement year.

General Notes: The formula used to calculate this measure can be found in Attachment E.

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C07 - Care for Older Adults – Pain Assessment

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

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

Reporting Requirements:

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

Cut Points:

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

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

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C09 - Diabetes Care – Eye Exam

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00203-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C10 - Diabetes Care – Blood Sugar Controlled

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00204-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C11 - Controlling Blood Pressure

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

Title	Description

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

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcomes Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00167-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C12 - Reducing the Risk of Falling

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C13 - Improving Bladder Control

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

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

Title	Description

Reporting Requirements:

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

Cut Points:

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

Measure: C14 - Medication Reconciliation Post-Discharge

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C15 - Plan All-Cause Readmissions

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

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

Title	Description

CMIT #: 00561-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description

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

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

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

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

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

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

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

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

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

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C17 - Transitions of Care

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00729-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

Domain: 3 - Member Experience with Health Plan

Measure: C19 - Getting Needed Care

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C20 - Getting Appointments and Care Quickly

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C21 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your health plan's customer service give you the

Title	Description
	information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00181-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C22 - Rating of Health Care Quality

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

Title	Description
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C23 - Rating of Health Plan

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C24 - Care Coordination

Title	Description
Label for Stars:	Coordination of Members' Health Care Services
Label for Data:	Coordination of Members' Health Care Services (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type):

- In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C25 - Complaints about the Health Plan

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C26 - Members Choosing to Leave the Plan

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C27 - Health Plan Quality Improvement

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C28 - Plan Makes Timely Decisions about Appeals

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

Title	Description

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 4

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

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00562-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C29 - Reviewing Appeals Decisions

Title	Description

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

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

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

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

Title	Description

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

Title	Description

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

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

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

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

Primary Data Source: Call Center

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

Data Source Category: Data Collected by CMS Contractors

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

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

Data Time Frame: 02/2024 – 05/2024

General Trend: Higher is better

Statistical Method: Clustering

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

Reporting Requirements:

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

Cut Points:

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

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

Domain: 1 - Drug Plan Customer Service

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

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

Title	Description

Weighting Value: 4

Major Disaster: No adjustment for 2022 or 2023 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: D02 - Complaints about the Drug Plan

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D03 - Members Choosing to Leave the Plan

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

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

Title	Description

Weighting Value: 4

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

Meaningful Measure Area: Person-Centered Care

CMIT #: 00446-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: D04 - Drug Plan Quality Improvement

Title	Description

Label for Stars: Improvement (if any) in the Drug Plan's Performance

Label for Data: Improvement (If any) in the Drug Plan's Performance

Description: This shows how much the drug plan's performance has improved or declined from one year to the next year.
If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse).
If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**.
If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**.

Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.

Metric: The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2024 and 2025 Star Ratings for this contract and had no specification changes).

Primary Data Source: Star Ratings

Data Source Description: 2024 and 2025 Star Ratings

Data Source Category: Star Ratings

Title	Description
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

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

Cut Points:

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

Domain: 3 - Member Experience with the Drug Plan

Measure: D05 - Rating of Drug Plan

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

Title	Description

CMIT #: 00641-01-C-PARTD

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: D06 - Getting Needed Prescription Drugs

Title	Description

Label for Stars: Ease of Getting Prescriptions Filled When Using the Plan

Label for Data: Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)

Description: Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.

Metric: This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source: CAHPS

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

- In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Data Source Category: Survey of Enrollees

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

Data Time Frame: 03/2024 – 06/2024

General Trend: Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00294-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: D07 - MPF Price Accuracy

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description

Label for Stars: Taking Diabetes Medication as Directed

Label for Data: Taking Diabetes Medication as Directed

Description: Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The plan, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug,* a *sulfonylurea drug,* a *thiazolidinedione drug*, a *DPP-4 inhibitor,* a *GIP/GLP-1 receptor agonist*, a *meglitinide drug,* or an *SGLT2 inhibitor*. Plan members who take insulin are not included.)

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GIP/GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator).

The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first.

The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA).

See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.

Primary Data Source: Prescription Drug Event (PDE) data

Data Source Description: The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D10 - Medication Adherence for Cholesterol (Statins)

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D11 - MTM Program Completion Rate for CMR

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

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

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

Title	Description

Weighting Value: 1

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

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00454-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

Title	Description

Label for Stars: The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol

Label for Data: The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol

Description: To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.

Metric: This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills on unique dates of service during the measurement period (denominator).

Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year or end of the enrollment episode.

The SUPD measure is adapted from the measure concept that was developed and endorsed by the PQA.

See the medication list for this measure. The SUPD measure is calculated using the NDC lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.

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

Title	Description
	episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00702-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

CAHPS Case-Mix Adjustment

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

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

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

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

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

Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items

Predictor	Getting needed care as soon as wanted	Getting routine care as soon as wanted
Age: 64 or under	0.0052	0.0177
Age: 65 – 69	0.0448	-0.0035
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0285	0.0115
Age: 80 – 84	0.0628	0.0301
Age: 85 and older	0.0724	0.0412
Education: Less than an 8th grade education	0.0703	-0.0390
Education: Some high school	0.0187	-0.0160
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.0269	-0.0469
Education: College graduate	-0.0042	-0.0517
Education: More than a bachelor's degree	-0.0735	-0.0857
General health rating: excellent	0.0512	0.0604
General health rating: very good	0.0377	0.0348
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0808	-0.0496
General health rating: poor	-0.1089	-0.0725
Mental health rating: excellent	0.0984	0.1447
Mental health rating: very good	0.0586	0.0665
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0341	-0.0278
Mental health rating: poor	-0.2374	-0.1584
Proxy helped	0.0194	0.0273
Proxy answered	0.1571	0.0589
Medicaid dual eligible	0.0120	0.0277
Low-income subsidy (LIS)	0.0166	-0.0116
Asian survey language	-0.1069	-0.2643

Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items

Predictor	Paperwork easy	Plan customer service gives information	Plan customer service courtesy and respect
Age: 64 or under	0.0067	-0.0433	-0.0186
Age: 65 – 69	0.0039	-0.0283	-0.0223
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0126	-0.0091	0.0032
Age: 80 – 84	-0.0191	0.0003	-0.0052
Age: 85 and older	-0.0239	0.0045	0.0078
Education: Less than an 8th grade education	-0.0235	-0.0688	-0.0201
Education: Some high school	-0.0090	-0.0231	-0.0195
Education: High school graduate	0.0000	0.0000	0.0000
Education: Some college	-0.0196	-0.0765	-0.0353
Education: College graduate	-0.0184	-0.1060	-0.0363
Education: More than a bachelor's degree	-0.0397	-0.1479	-0.0425
General health rating: excellent	0.0259	0.0870	0.0223
General health rating: very good	0.0134	0.0376	-0.0053
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0402	-0.0437	-0.0171
General health rating: poor	-0.0413	-0.0276	0.0087
Mental health rating: excellent	0.0509	0.1242	0.1019
Mental health rating: very good	0.0205	0.0551	0.0648
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0361	-0.0286	0.0012
Mental health rating: poor	-0.0703	-0.1172	-0.1081
Proxy helped	-0.0304	0.0160	0.0023
Proxy answered	0.0124	0.0268	0.0287
Medicaid dual eligible	-0.0443	0.0649	0.0278
Low-income subsidy (LIS)	-0.0180	0.0242	0.0426
Asian survey language	-0.0613	-0.0596	-0.1666

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	C22: Rating of Health Care Quality	C23: Rating of Health Plan
Age: 64 or under	-0.0683	-0.0969
Age: 65 – 69	-0.0669	-0.0754
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0311	0.0511
Age: 80 – 84	0.0347	0.0804
Age: 85 and older	0.0006	0.0934
Education: Less than an 8th grade education	0.0607	0.1276
Education: Some high school	0.0131	0.0340
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.1325	-0.2128
Education: College graduate	-0.1729	-0.3380
More than a bachelor's degree	-0.2509	-0.4173
General health rating: excellent	0.3339	0.2631
General health rating: very good	0.1949	0.1386
General health rating: good	0.0000	0.0000
General health rating: fair	-0.2529	-0.1497
General health rating: poor	-0.5774	-0.3155
Mental health rating: excellent	0.5053	0.3642
Mental health rating: very good	0.2545	0.1767
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1320	-0.1231
Mental health rating: poor	-0.4610	-0.4146
Proxy helped	-0.1008	-0.0850
Proxy answered	0.1089	0.0348
Medicaid dual eligible	0.0297	0.3065
Low-income subsidy (LIS)	0.0581	0.0833
Asian survey language	0.3586	-0.0170

Table A-5: Coefficients of Part C Care Coordination (C24) 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	-0.0404	-0.0041	0.0356	0.0425	-0.0061
Age: 65 – 69	-0.0251	-0.0170	-0.0259	0.0149	-0.0136
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0102	-0.0218	-0.0080	-0.0555	-0.0049
Age: 80 – 84	-0.0051	-0.0313	-0.0090	-0.1083	-0.0133
Age: 85 and older	-0.0266	-0.0063	-0.0133	-0.1635	-0.0106
Education: Less than an 8th grade education	-0.0246	0.0271	-0.0308	-0.0168	-0.0375
Education: Some high school	-0.0010	-0.0244	0.0147	0.0249	-0.0091
Education: High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Education: Some college	-0.0510	-0.0476	-0.0252	-0.0008	-0.0048
Education: College graduate	-0.0379	-0.1104	-0.0310	-0.0753	-0.0164
Education: More than a bachelor's degree	-0.0738	-0.0889	-0.0302	-0.0625	0.0017
General health rating: excellent	0.0385	-0.0025	0.0792	0.0775	0.0122
General health rating: very good	0.0009	0.0080	0.0469	0.0468	0.0154
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0492	0.0003	-0.0734	-0.0501	-0.0346
General health rating: poor	-0.0881	-0.0275	-0.1290	-0.1341	-0.0521
Mental health rating: excellent	0.0986	0.1768	0.1502	0.1614	0.0852
Mental health rating: very good	0.0071	0.0787	0.0791	0.0788	0.0450
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0564	-0.0687	-0.0206	-0.0232	-0.0299
Mental health rating: poor	-0.1419	-0.2305	-0.0954	-0.1066	-0.0564
Proxy helped	0.0165	0.0216	-0.0137	0.1030	0.0004
Proxy answered	0.0379	-0.0010	0.0008	0.0992	0.0375
Medicaid dual eligible	-0.0100	0.0766	-0.0199	0.0224	-0.0219
Low-income subsidy (LIS)	-0.0464	0.0204	-0.0139	0.0548	-0.0098
Asian survey language	0.1072	-0.0794	0.1495	-0.2609	-0.1476

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	-0.1745	-0.1359
Age: 65 – 69	-0.1126	-0.1746
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0812	0.1899
Age: 80 – 84	0.1529	0.2057
Age: 85 and older	0.1693	0.3164
Education: Less than an 8th grade education	-0.0030	0.0608
Education: Some high school	0.0428	-0.0614
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.2084	-0.2944
Education: College graduate	-0.3313	-0.1121
Education: More than a bachelor's degree	-0.4213	-0.4179
General health rating: excellent	0.2766	0.1603
General health rating: very good	0.1651	0.1845
General health rating: good	0.0000	0.0000
General health rating: fair	-0.1816	-0.2015
General health rating: poor	-0.3960	-0.4735
Mental health rating: excellent	0.3083	0.2269
Mental health rating: very good	0.1538	-0.0462
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0273	-0.2564
Mental health rating: poor	-0.3236	-0.0325
Proxy helped	-0.0567	-0.1165
Proxy answered	-0.0633	0.0282
Medicaid dual eligible	0.5296	0.7997
Low-income subsidy (LIS)	0.3751	0.8174
Asian survey language	-0.3403	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	-0.0361	-0.0220	-0.0216
Age: 65 – 69	-0.0437	-0.0178	-0.0322	-0.0191
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	0.0032	0.0069	0.0131	0.0043
Age: 80 – 84	0.0197	0.0014	0.0063	0.0059
Age: 85 and older	0.0158	-0.0083	0.0017	0.0091
Education: Less than an 8th grade education	-0.0518	-0.0477	-0.1331	-0.0453
Education: Some high school	0.0003	0.0033	-0.1127	-0.0492
Education: High school graduate	0.0000	0.0000	0.0000	0.0000
Education: Some college	-0.0366	-0.0400	-0.0942	-0.1147
Education: College graduate	-0.0405	-0.0579	-0.0563	-0.0801
Education: More than a bachelor's degree	-0.0638	-0.0784	-0.1285	-0.1741
General health rating: excellent	0.0200	0.0621	0.0942	0.1142
General health rating: very good	0.0530	0.0570	0.1182	0.0770
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0611	-0.0548	-0.0367	-0.0675
General health rating: poor	-0.0913	-0.0676	-0.1688	-0.0735
Mental health rating: excellent	0.0856	0.0862	0.0591	0.0890
Mental health rating: very good	0.0544	0.0532	0.0056	0.0065
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0299	-0.0438	0.0195	-0.0041
Mental health rating: poor	-0.1165	-0.1001	-0.0153	-0.0692
Proxy helped	0.0036	0.0117	0.0688	0.0576
Proxy answered	0.0331	0.0030	0.1382	0.1257
Medicaid dual eligible	0.0571	0.0223	0.0252	0.0005
Low-income subsidy (LIS)	0.0487	-0.0139	-0.0508	0.0457
Asian survey language	-0.0582	-0.0015	0.0000	0.0000

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 2025 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2024
Call Center	Average enrollment during the study period	Feb 2024 – May 2024
HOS	Enrollment at the time survey sample is pulled	April 2023
HEDIS-HOS	Enrollment at the time survey sample is pulled	April 2023
HEDIS	Enrollment in July of the measurement period	July 2023
All Other Measures	Enrollment in July of the measurement period	July 2023

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 2023 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, the measure values for the surviving contract of a consolidation are calculated as the enrollment weighted mean of all contracts in the consolidation.

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 2025 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	73%	3.4
C02	Colorectal Cancer Screening	73%	3.4
C03	Annual Flu Vaccine	69%	3.2
C04	Monitoring Physical Activity	50%	3.1
C05	Special Needs Plan (SNP) Care Management	75%	3.4
C06	Care for Older Adults – Medication Review	93%	4.1
C07	Care for Older Adults – Pain Assessment	93%	4.2
C08	Osteoporosis Management in Women who had a Fracture	43%	2.7
C09	Diabetes Care – Eye Exam	75%	3.4
C10	Diabetes Care – Blood Sugar Controlled	83%	3.7
C11	Controlling Blood Pressure	76%	3.0
C12	Reducing the Risk of Falling	57%	2.6
C13	Improving Bladder Control	45%	3.0
C14	Medication Reconciliation Post-Discharge	73%	3.6
C15	Plan All-Cause Readmissions	11%	3.1
C16	Statin Therapy for Patients with Cardiovascular Disease	86%	3.0
C17	Transitions of Care	59%	3.0
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	58%	3.2
C19	Getting Needed Care	81	3.3
C20	Getting Appointments and Care Quickly	84	3.5
C21	Customer Service	90	3.5
C22	Rating of Health Care Quality	87	3.5
C23	Rating of Health Plan	87	3.2
C24	Care Coordination	87	3.6
C25	Complaints about the Health Plan	0.23	4.2
C26	Members Choosing to Leave the Plan	17%	3.6
C27	Health Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.6
C28	Plan Makes Timely Decisions about Appeals	96%	4.2
C29	Reviewing Appeals Decisions	95%	3.7
C30	Call Center – Foreign Language Interpreter and TTY Availability	94%	4.0

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	94	4.0	97	3.6
D02	Complaints about the Drug Plan	0.23	4.2	0.04	4.6
D03	Members Choosing to Leave the Plan	17	3.6	10	3.7
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.3	Medicare only shows a Star Rating for this measure	3.0
D05	Rating of Drug Plan	87	3.4	84	3.5
D06	Getting Needed Prescription Drugs	89	3.3	89	3.7
D07	MPF Price Accuracy	98	3.4	97	3.1
D08	Medication Adherence for Diabetes Medications	86	3.2	86	2.4
D09	Medication Adherence for Hypertension (RAS antagonists)	89	3.3	89	2.9
D10	Medication Adherence for Cholesterol (Statins)	88	3.3	88	2.9
D11	MTM Program Completion Rate for CMR	87	3.7	55	3.0
D12	Statin Use in Persons with Diabetes (SUPD)	86	2.8	83	2.7

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

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

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	02/2024 – 05/2024
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2023 – 12/31/2023
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2023 – 12/31/2023
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2024 – 06/2024
D06	Getting Needed Prescription Drugs	CAHPS	03/2024 – 06/2024
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2023 – 09/30/2023
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2023 – 12/31/2023
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023

1. Medicare Part C Reporting Requirements Measure (C05: 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 2023.

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) ≥ 30] during contract year 2023.

Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024), or that were not required to participate in data validation. This exclusion is consistent with the statement from page 6 of the CY 2023 Medicare Part C Plan Reporting Requirements Technical Specifications Document: "**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 07/01/2024 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 contract 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 2023 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 2023 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 - (C06 – C07: 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 C15: Plan All-Cause Readmissions

All data are available in the CMS MY 2023 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 2025 Star Ratings was 0.110821345940212.

[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	Monitoring Physical Activity	Process Measure	1
C05	Special Needs Plan (SNP) Care Management	Process Measure	1
C06	Care for Older Adults – Medication Review	Process Measure	1
C07	Care for Older Adults – Pain Assessment	Process Measure	1
C08	Osteoporosis Management in Women who had a Fracture	Process Measure	1
C09	Diabetes Care – Eye Exam	Process Measure	1
C10	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C11	Controlling Blood Pressure	Intermediate Outcome Measure	3
C12	Reducing the Risk of Falling	Process Measure	1
C13	Improving Bladder Control	Process Measure	1
C14	Medication Reconciliation Post-Discharge	Process Measure	1
C15	Plan All-Cause Readmissions	Outcome Measure	3
C16	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C17	Transitions of Care	Process Measure	1
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
C19	Getting Needed Care	Patients' Experience and Complaints Measure	4
C20	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	4
C21	Customer Service	Patients' Experience and Complaints Measure	4
C22	Rating of Health Care Quality	Patients' Experience and Complaints Measure	4
C23	Rating of Health Plan	Patients' Experience and Complaints Measure	4
C24	Care Coordination	Patients' Experience and Complaints Measure	4
C25	Complaints about the Health Plan	Patients' Experience and Complaints Measure	4
C26	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
C27	Health Plan Quality Improvement	Improvement Measure	5
C28	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	4
C29	Reviewing Appeals Decisions	Measures Capturing Access	4
C30	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4

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	4
D02	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	4
D03	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
D04	Drug Plan Quality Improvement	Improvement Measure	5
D05	Rating of Drug Plan	Patients' Experience and Complaints Measure	4
D06	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	4
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.

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 2024 and 2025.

For measures where a higher score is better:

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

For measures where a lower score is better:

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

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

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

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

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

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

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

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

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 4

Process measure: Weight of 1

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

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

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

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

General Standard Error Formula

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

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

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

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

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

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

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

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

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

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

Improvement Change Score Standard Error Numerical Example

For measure C03, contract A:

$se(Y_{i2})$ = 2.805

$se(Y_{i1})$ = 3.000

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

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 2025 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. SEF for Measures: C01, C02, C04, C05, C08 – C14, C16, C18, C26, C28 – C30, D01, D03, D08 – D12

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2024, 2025

$Denominator_y$ is as defined in the Measure Details section for each measure.

2. SEF for Measures: C06, C07

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 = 2024, 2025 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 = 2024, 2025. 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 = 2024, 2025. 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 2024, Contract Year 2025 and i = Contract i

3. SEF for Measure C15

$$SE_y = 100 * \text{National Observed Rate}_y * \sqrt{\frac{\text{Oberved Count}_y}{\text{Expected Count}_y^2}}$$

for y = 2024, 2025

National Observed Rate, Observed Count, and Expected Count as defined in Attachment F.

4. SEF for Measure C17

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.

$$\mathrm{Var}(\mathrm{Z_y}) = \frac{1}{16} * [\mathrm{Var}(\mathrm{T_{1y}}) + \mathrm{Var}(\mathrm{T_{2y}}) + \mathrm{Var}(\mathrm{T_{3y}}) + \mathrm{Var}(\mathrm{T_{4y}}) + 2\mathrm{Cov}(\mathrm{T_{1y}}, \mathrm{T_{2y}}) + 2\mathrm{Cov}(\mathrm{T_{1y}}, \mathrm{T_{3y}}) + 2\mathrm{Cov}(\mathrm{T_{1y}}, \mathrm{T_{4y}}) + 2\mathrm{Cov}(\mathrm{T_{2y}}, \mathrm{T_{3y}}) + 2\mathrm{Cov}(\mathrm{T_{2y}}, \mathrm{T_{4y}}) + 2\mathrm{Cov}(\mathrm{T_{3y}}, \mathrm{T_{4y}})]$$

$$\mathrm{SE_y} = \sqrt{\mathrm{Var}(\mathrm{Z_y})}$$

for y = 2024, 2025

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		2024 Correlation	2025 Correlation
Patient Engagement After Inpatient Discharge	Receipt of Discharge Information	0.5365156597	0.5723177632
Patient Engagement After Inpatient Discharge	Notification of Inpatient Admission	0.5772548760	0.4998099740
Patient Engagement After Inpatient Discharge	Medication Reconciliation Post-Discharge	0.6402980802	0.5632670669
Receipt of Discharge Information	Notification of Inpatient Admission	0.8834120211	0.7605860074
Receipt of Discharge Information	Medication Reconciliation Post-Discharge	0.4149497554	0.4270200633
Notification of Inpatient Admission	Medication Reconciliation Post-Discharge	0.5010530425	0.5317177847

5. SEF for Measures: C03, C19 – C24, and D05, D06

The CAHPS measure standard errors for 2024 and 2025 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: C25, D02

$$\mathrm{SE_y} = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{\text{NumDays}}$$

NumDays: 2024 = 365, 2025 = 365

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 = 2024, 2025.

    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.

2024 Correlation	2025 Correlation
0.6214825861	0.5681259498

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 = 2024, 2025

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	0.950135
C02	Colorectal Cancer Screening	Included	0.896510
C03	Annual Flu Vaccine	Included	0.888026
C04	Monitoring Physical Activity	Included	0.845098
C05	Special Needs Plan (SNP) Care Management	Included	0.889508
C06	Care for Older Adults – Medication Review	Included	0.651050
C07	Care for Older Adults – Pain Assessment	Included	0.472401
C08	Osteoporosis Management in Women who had a Fracture	Included	0.848314
C09	Diabetes Care – Eye Exam	Included	0.855310
C10	Diabetes Care – Blood Sugar Controlled	Included	0.779129
C11	Controlling Blood Pressure	Included	0.787937
C12	Reducing the Risk of Falling	Included	0.842070
C13	Improving Bladder Control	Included	0.480390
C14	Medication Reconciliation Post-Discharge	Included	0.818848
C15	Plan All-Cause Readmissions	Included	0.622494
C16	Statin Therapy for Patients with Cardiovascular Disease	Included	0.730543
C17	Transitions of Care	Included	0.845898
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Included	0.739526
C19	Getting Needed Care	Included	0.796622
C20	Getting Appointments and Care Quickly	Included	0.477681
C21	Customer Service	Included	0.709932
C22	Rating of Health Care Quality	Included	0.715693
C23	Rating of Health Plan	Included	0.859045
C24	Care Coordination	Included	0.670450
C25	Complaints about the Health Plan	Included	0.826982
C26	Members Choosing to Leave the Plan	Included	0.887075
C27	Health Plan Quality Improvement	Not Included	-
C28	Plan Makes Timely Decisions about Appeals	Included	0.329153
C29	Reviewing Appeals Decisions	Included	0.610325
C30	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.280278

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	0.303658
D02	Complaints about the Drug Plan	Included	0.832704
D03	Members Choosing to Leave the Plan	Included	0.881507
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.817940
D06	Getting Needed Prescription Drugs	Included	0.659200
D07	MPF Price Accuracy	Included	0.643115
D08	Medication Adherence for Diabetes Medications	Included	0.644643
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.812564
D10	Medication Adherence for Cholesterol (Statins)	Included	0.807284
D11	MTM Program Completion Rate for CMR	Included	0.867800
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.836392

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	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	C04	C06	C06	C06
C	Antidepressant Medication Management (6 months)	HEDIS	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	C30	C28	C28	DME08	C31	C31	C32
C	Breast Cancer Screening	HEDIS	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	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	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	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	DMC29											
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC26	DMC30											
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC27	DMC31											
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DMC28	DCM32											
C	Cardiovascular Care – Cholesterol Screening	HEDIS											C02	C03	C03	C03
C	Care Coordination	CAHPS	C24	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29	

Part	Measure Name	Data Source	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	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12	C14
C	Care for Older Adults – Medication Review	HEDIS	C06	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13
C	Care for Older Adults – Pain Assessment	HEDIS	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	C01	C02	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29	DMC29												
C	Complaints about the Health Plan	CTM	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	DMC04	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C11	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21
C	Customer Service	CAHPS	C21	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28
C	Diabetes Care – Blood Sugar Controlled	HEDIS	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	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	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	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	C18	C18	DMC15	DMC17	DMC17	DMC18								

Part	Measure Name	Data Source	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	C20	C20	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27
C	Getting Needed Care	CAHPS	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	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11	
C	Health Plan Quality Improvement	Star Ratings	C27	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33	
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24					
C	Improving Bladder Control	HEDIS-HOS	C13	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23
C	Improving or Maintaining Mental Health	HOS	DMC23	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09
C	Improving or Maintaining Physical Health	HOS	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												
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18		
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	DMC22	DMC22	DMC26											
C	Medication Management for People With Asthma	HEDIS									DMC26					
C	Medication Reconciliation Post-Discharge	HEDIS	C14	C14	C15	C15	C19	C19	C20	C20	DMC23					
C	Members Choosing to Leave the Plan	MBDSS	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	C04	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10
C	Osteoporosis Management in Women who had a Fracture	HEDIS	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	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17		

Part	Measure Name	Data Source	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	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16		
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC20	DMC24											
C	Plan All-Cause Readmissions	HEDIS	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	C28	C28	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07
C	Rating of Health Care Quality	CAHPS	C22	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29
C	Rating of Health Plan	CAHPS	C23	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30
C	Reducing the Risk of Falling	HEDIS-HOS	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	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	C05	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14	
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	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	C17	C17	DMC20	DMC22	DMC22	DMC23								
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC16	DMC18	DMC18	DMC19								
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC17	DMC19	DMC19	DMC20								
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC18	DMC20	DMC20	DMC21								

Part	Measure Name	Data Source	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	DMC21	DMC21	DMC22								

Table J-2: Part D Measure History

Part	Measure Name	Data Source	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	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	D06	D06	D06	DME08	D05	D07	D07	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	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	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	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	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	
D	Complaint Resolution	Complaints Tracking Module (CTM)															
D	Complaints – Enrollment	Complaints Tracking Module (CTM)															
D	Complaints – Other	Complaints Tracking Module (CTM)															

Part	Measure Name	Data Source	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	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	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	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	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												
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	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	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	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16	
D	Members Choosing to Leave the Plan	MBDSS	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

Part	Measure Name	Data Source	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	MPF – Stability	PDE Data, MPF Pricing Files	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	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	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12		
D	Persistence to Basal Insulin (PST-INS)	Prescription Drug Event (PDE) Data	DMD16	DMD16													
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	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	DMD20										
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	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	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13				
D	Reminders to take medications	CAHPS	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	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	
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

Part	Measure Name	Data Source	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
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	DMD18										
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	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	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	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	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	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	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	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	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	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.

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	< 80 %	>= 80 % to < 85 %	>= 85 % to < 87 %	>= 87 % to < 91 %	>= 91 %
PDP	< 84 %	>= 84 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 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 J-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	> 44 %	> 29 % to <= 44 %	> 16 % to <= 29 %	> 9 % to <= 16 %	<= 9 %
PDP	> 20 %	> 13 % to <= 20 %	> 9 % to <= 13 %	> 6 % to <= 9 %	<= 6 %

Figure J-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 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>=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 meet or exceed 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.

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 2025 Star Ratings. Tables K-5 and K-6 show the upper and lower Tukey outlier cutoffs.

Table K-3: 2025 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	< 58 %	>= 58 % to < 67 %	>= 67 % to < 75 %	>= 75 % to < 82 %	>= 82 %
C02	< 58 %	>= 58 % to < 67 %	>= 67 % to < 75 %	>= 75 % to < 83 %	>= 83 %
C04	< 41 %	>= 41 % to < 47 %	>= 47 % to < 52 %	>= 52 % to < 60 %	>= 60 %
C05	< 46 %	>= 46 % to < 63 %	>= 63 % to < 76 %	>= 76 % to < 89 %	>= 89 %
C06	< 83 %	>= 83 % to < 90 %	>= 90 % to < 94 %	>= 94 % to < 98 %	>= 98 %
C07	< 79 %	>= 79 % to < 86 %	>= 86 % to < 92 %	>= 92 % to < 96 %	>= 96 %
C08	< 27 %	>= 27 % to < 39 %	>= 39 % to < 52 %	>= 52 % to < 71 %	>= 71 %
C09	< 62 %	>= 62 % to < 70 %	>= 70 % to < 77 %	>= 77 % to < 83 %	>= 83 %
C10	< 69 %	>= 69 % to < 78 %	>= 78 % to < 84 %	>= 84 % to < 90 %	>= 90 %
C11	< 69 %	>= 69 % to < 74 %	>= 74 % to < 80 %	>= 80 % to < 85 %	>= 85 %
C12	< 50 %	>= 50 % to < 56 %	>= 56 % to < 63 %	>= 63 % to < 73 %	>= 73 %
C13	< 39 %	>= 39 % to < 44 %	>= 44 % to < 48 %	>= 48 % to < 52 %	>= 52 %
C14	< 42 %	>= 42 % to < 59 %	>= 59 % to < 73 %	>= 73 % to < 87 %	>= 87 %
C15	> 14 %	> 12 % to <= 14 %	> 10 % to <= 12 %	> 8 % to <= 10 %	<= 8 %
C16	< 81 %	>= 81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %
C17	< 44 %	>= 44 % to < 52 %	>= 52 % to < 63 %	>= 63 % to < 77 %	>= 77 %
C18	< 39 %	>= 39 % to < 53 %	>= 53 % to < 60 %	>= 60 % to < 69 %	>= 69 %
C25	> 0.66	> 0.41 to <= 0.66	> 0.24 to <= 0.41	> 0.12 to <= 0.24	<= 0.12
C26	> 36 %	> 24 % to <= 36 %	> 17 % to <= 24 %	> 8 % to <= 17 %	<= 8 %
C27	< -0.179809	>= -0.179809 to < 0	>= 0 to < 0.174445	>= 0.174445 to < 0.421057	>= 0.421057
C28	< 87 %	>= 87 % to < 91 %	>= 91 % to < 95 %	>= 95 % to < 99 %	>= 99 %
C29	< 88 %	>= 88 % to < 92 %	>= 92 % to < 96 %	>= 96 % to < 99 %	>= 99 %
C30	< 89 %	>= 89 % to < 94 %	>= 94 % to < 97 %	>= 97 % to < 100 %	= 100 %

Notes: These are not the final thresholds for the 2025 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2025 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	< 85 %	>= 85 % to < 92 %	>= 92 % to < 96 %	>= 96 % to < 100 %	= 100 %
D01	PDP	< 94 %	>= 94 % to < 97 %	>= 97 % to < 98 %	>= 98 % to < 100 %	= 100 %
D02	MA-PD	> 0.66	> 0.41 to <= 0.66	> 0.24 to <= 0.41	> 0.12 to <= 0.24	<= 0.12
D02	PDP	> 0.1	> 0.06 to <= 0.1	> 0.04 to <= 0.06	> 0.02 to <= 0.04	<= 0.02
D03	MA-PD	> 36 %	> 24 % to <= 36 %	> 17 % to <= 24 %	> 8 % to <= 17 %	<= 8 %
D03	PDP	> 22 %	> 16 % to <= 22 %	> 9 % to <= 16 %	> 5 % to <= 9 %	<= 5 %
D04	MA-PD	< -0.218869	>= -0.218869 to < 0	>= 0 to < 0.242468	>= 0.242468 to < 0.496603	>= 0.496603
D04	PDP	< -0.282500	>= -0.282500 to < 0	>= 0 to < 0.273334	>= 0.273334 to < 0.576667	>= 0.576667
D07	MA-PD	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	= 100
D07	PDP	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	= 100
D08	MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 87 %	>= 87 % to < 91 %	>= 91 %
D08	PDP	< 85 %	>= 85 % to < 87 %	>= 87 % to < 89 %	>= 89 % to < 93 %	>= 93 %
D09	MA-PD	< 83 %	>= 83 % to < 87 %	>= 87 % to < 90 %	>= 90 % to < 92 %	>= 92 %
D09	PDP	< 87 %	>= 87 % to < 89 %	>= 89 % to < 90 %	>= 90 % to < 92 %	>= 92 %
D10	MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 89 %	>= 89 % to < 93 %	>= 93 %
D10	PDP	< 86 %	>= 86 % to < 88 %	>= 88 % to < 89 %	>= 89 % to < 92 %	>= 92 %
D11	MA-PD	< 76 %	>= 76 % to < 84 %	>= 84 % to < 89 %	>= 89 % to < 93 %	>= 93 %
D11	PDP	< 30 %	>= 30 % to < 55 %	>= 55 % to < 68 %	>= 68 % to < 80 %	>= 80 %
D12	MA-PD	< 81 %	>= 81 % to < 86 %	>= 86 % to < 89 %	>= 89 % to < 93 %	>= 93 %
D12	PDP	< 80 %	>= 80 % to < 83 %	>= 83 % to < 85 %	>= 85 % to < 87 %	>= 87 %

Notes: These are not the final thresholds for the 2025 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2025 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	31	100
C02	24	100
C04	21	77
C05	0	100
C06	71	100
C07	66	100
C08	0	100
C09	29	100
C10	52	100
C11	48	100
C12	17	94
C13	24	66
C14	0	100
C15	4	18
C16	72	100
C17	0	100
C18	22	92
C25	0	1.08
C26	0	79
C27 (improve)	0	1
C27 (decline)	-0.582088	0
C28	80	100
C29	82	100
C30	82	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 C27 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the C27 (improved) group.

Table K-6: 2025 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Type	Lower Cutoff	Upper Cutoff
D01	MA-PD	74	100
D02	MA-PD	0	1.08
D03	MA-PD	0	79
D04 (improve)	MA-PD	0	1
D04 (decline)	MA-PD	-0.96875	0
D07	MA-PD	95	100
D08	MA-PD	72	100
D09	MA-PD	75	100
D10	MA-PD	74	100
D11	MA-PD	61	100
D12	MA-PD	68	100
D01	PDP	86	100
D02	PDP	0	0.22
D03	PDP	0	45
D04 (improve)	PDP	0	1
D04 (decline)	PDP	-1	0
D07	PDP	95	100
D08	PDP	76	97
D09	PDP	82	96
D10	PDP	81	95
D11	PDP	0	100
D12	PDP	76	90

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 weighted mean scores from all contracts (which determines the base group); statistical significance of the difference of the contract mean from the national mean along with the direction of the difference; the statistical reliability of the estimate (based on the ratio of sampling variation for each contract mean to between-contract variation); and the standard error of the mean score. All statistical tests, including comparisons involving standard errors, are computed using unrounded scores.

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

Table K-8: CAHPS Star Assignment Rules

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

Table K-9: 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
< 15th percentile by > 1 SE	1	1	1	2	2	2	2
< 15th percentile by ≤ 1 SE		2	1	2	2	2	2
≥ 15th to < 30th percentile	2	2	2	3	2	3	2
≥ 30th to < 60th percentile	3	2	2	3	3	4	4
≥ 60th to < 80th percentile	4	3	4	3	4	4	4
≥ 80th percentile by ≤ 1 SE	5	4	4	4	4	4	5
≥ 80th percentile by > 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (<0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability ≥0.60 but <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 ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. Table K-10 contains the 12% reliability cutoffs.

Table K-10: CAHPS Measure 12% Reliability Cutoffs

Measure	12% reliability cutoff
Annual Flu Vaccine	0.827223*
Getting Needed Care	0.712319
Getting Appointments and Care Quickly	0.605448
Customer Service	0.624047
Rating of Health Care Quality	0.603043
Rating of Health Plan	0.802531*
Care Coordination	0.575592*
Rating of Drug Plan (MA-PD)	0.729239
Getting Needed Prescription Drugs (MA-PD)	0.591102*
Rating of Drug Plan (PDP)	0.950393*
Getting Needed Prescription Drugs (PDP)	0.875199*

*Note: Reliabilities must be ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability to be designated as low reliability, thus these cutoffs did not affect low reliability designation.

Attachment L: Medication Adherence Measure Calculations

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 measurement 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	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX
Benazepril	15	16	15	13		
Captopril					15	16

PDC Calculation
Covered Days: 90
Measurement Period: 90
PDC: 90/90 = 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	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 59
Measurement Period: 90
PDC: 59/90 = 66%

Table L-3: After Overlap Adjustment

	January		February		March	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX
Lisinopril	15	16				
Lisinopril & HCTZ			15	13	3	
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 62
Measurement Period: 90
PDC: 62/90 = 69%

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 from the Medicare Enrollment Database (EDB) and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs. **NOTE:** Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database.

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 IP stays span all of the beneficiary's enrollment episodes within the measurement period, that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC.

Example 1: Gap in Coverage after IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 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
Measurement Period: 15
PDC: 12/15 = 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the measurement 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
Measurement Period: 13
PDC: 12/13 = 92%

Example 2: Gap in Coverage before IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 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
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the measurement 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. 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
Measurement Period: 13
PDC: 9/13 = 69%

Example 3: Gap in Coverage Before and After IP Stay

In this example, the measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 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
Measurement Period: 15
PDC: 11/15 = 73%

With the adjustment for the IP stay, days 6-9 are deleted from the measurement 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
Measurement 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 measurement period is 15 days and the beneficiary qualifies for inclusion in the measure by receiving at least 2 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
Measurement Period: 15
PDC: 9/15 = 60%

With the adjustment for the IP stay, days 2-4 are deleted from the measurement 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. 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
Measurement 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 Part D Star Ratings rely 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 cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the cost resulting from using the unit price reported on Plan Finder.[1] This comparison includes only PDEs for which a 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.
2. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.[2]
3. The reference NDC must be on the plan's formulary.
4. Because the retail unit cost reported on Plan Finder 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 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then

[1] Medicare Plan Finder 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 Medicare Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] Medicare Plan Finder 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 First Data Bank (FDB) and Medi-Span 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.

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.

5. 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]
6. PDEs for compound drugs or non-covered drugs are not included.
7. 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. 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.[5, 6] 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

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i, and

[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] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded MPF cost by at least a two cent ($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.

[6] 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_{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 (as assigned by the pharmacy cost file) and unit cost (as assigned by 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	Calculated Value 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	01/08/2023	3.82	2	60	60	01/06/23 - 01/19/23	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2023	0.98	2	30	60	01/20/23 - 02/02/23	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2023	10.48	1.5	24	28	02/03/23 - 02/16/23	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2023	47	1.5	90	30	02/17/23 - 03/01/23	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 2023. 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 2023.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024), or that were not required to participate in data validation.

- Contracts that terminate on or before 07/01/2024 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 2023 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 2023 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 2023 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 2025 Star Ratings are developed using the following sources of information:

- The 2022 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2022 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 2023 provided for beneficiaries who were alive at least through December 2023, 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 a) the monthly beneficiary dual status codes, b) identification of Low Income Part D enrollees who reside in the US Territories, and c) beneficiaries with Medicaid coverage/who are Medicaid eligible by the Point of Sale contractor. 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 2022 1-year data from ACS (https://www.census.gov/content/dam/Census/library/publications/2023/acs/acsbr-016.pdf, see Table 1). *The states identified are: Alabama, Arkansas, Kentucky, Louisiana, Mississippi, New Mexico, New York, Oklahoma, South Carolina, 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 2025 Star Ratings adjustment, the data used for the model development included a total of 150 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 LIS/DE for each contract in Puerto Rico and its DE percentage. 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 average percentage of LIS/DE in Puerto Rico. The expected 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 2022 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 2022. 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 0.946906.

$$\widehat{\text{LIS/DE}} = (0.946906 \times \text{contract's DE percentage}) + (\text{intercept})$$

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 (28.653926%) and y is an estimated expected average 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	59.100000%
Percent of residents in the 10 poorest US states below 150% of FPL	24.390525%
Observed average LIS/DE percentage in the 10 poorest US states	45.503047%
Observed average DE percentage in Puerto Rico contracts	28.653926%

The product thus becomes $\left(45.503047 \times \frac{59.100000}{24.390525}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(45.503047 \times \frac{59.100000}{24.390525}\right) - (0.946906 \times 28.653926)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.946906 \times \text{contract's DE percentage}) + \left(45.503047 \times \frac{59.100000}{24.390525}\right) - (0.946906 \times 28.653926)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 15%, the value of 15.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.946906 \times \text{contract's DE percentage}) + \left(45.503047 \times \frac{59.100000}{24.390525}\right) - (0.946906 \times 28.653926)$$

The contracts percentage of 15.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.946906 \times 15.000000) + \left(45.503047 \times \frac{59.100000}{24.3905251}\right) - (0.946906 \times 28.653926)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 15.000000% is 97.328178%.

The final adjustment category for the CAI adjustment is identified using the LIS/DE percentage 97.328178%.

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 2025 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 2025 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
3/27/2023	Severe Storms, Straight-Line Winds, and Tornadoes	Severe Storms, Straight-Line Winds, and Tornadoes	Mississippi	3/24/2023
6/2/2023	Typhoon Mawar	Typhoon Mawar	Guam	5/22/2023
8/11/2023	Wildfires	Wildfires	Hawaii	8/8/2023
8/30/2023	Hurricane Idalia	Hurricane	Florida	8/27/2023
9/12/2023	Hurricane Idalia	Hurricane	Georgia	8/30/2023

- 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-4697-MS	Mississippi	Carroll, Humphreys, Monroe, Montgomery, Panola, Sharkey
DR-4715-GU	Guam	Guam
DR-4724-HI	Hawaii	Maui
DR-4734-FL	Florida	Charlotte, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Hillsborough, Jefferson, Lafayette, Levy, Madison, Manatee, Pasco, Pinellas, Sarasota, Suwannee, Taylor
DR-4738-GA	Georgia	Berrien, Brooks, Cook, Glynn, Lowndes

- 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-4697-MS	Mississippi	3/24/2023	May 2023	April 7, 2023
DR-4715-GU	Guam	5/22/2023	July 2023	June 2, 2023
DR-4724-HI	Hawaii	8/8/2023	September 2023	August 4, 2023
DR-4734-FL	Florida	8/27/2023	October 2023	September 8, 2023
DR-4738-GA	Georgia	8/30/2023	October 2023	September 8, 2023

- 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 ≥25% and ≥60% thresholds 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

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
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
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%. Both flags for >=25% and >=60% are 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 (C28 & C29):

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 > 01/01/2023?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C19, C20, C21, C22, C23, & C24):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2023?
  - 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 (C30):

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 > 01/01/2024?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C25):

Is the contract effective date > 01/01/2023?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2023?
  - 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, C08 – C11, C14, C16, C18):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2023?
  - 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 > 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR 18 and older (C15)

Was the contract required to report HEDIS?

- Yes: Was the contract enrollment < 500 in July 2023?
  - 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 <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 > 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS TRC average (C17):

Was the contract required to report HEDIS?

- Yes: Was the contract enrollment < 500 in July 2023?
  - 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 > 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS SNP measures (C06 & C07):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2025?

- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2023?
  - 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 (C04, C12, & C13):

Is there a valid HEDIS-HOS numeric rate?

- Yes: Display the HEDIS-HOS numeric rate
- No: Is the contract effective date > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Is the February 2023 contract enrollment < 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

Members Choosing to Leave the Plan (C26):

Is there a valid numeric voluntary disenrollment rate?

- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date > 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Plan Reporting SNP measure (C05):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2025?

- 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 > 01/01/2023?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C27):

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 > 01/01/2023?
  - 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 > 07/01/2023?
  - 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 > 01/01/2024?
    - 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 > 01/01/2023?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2023?
  - 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 > 01/01/2023?
  - 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 > 01/01/2023?
  - 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 > 9/30/2023?
- 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 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 > 12/31/2023?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiary member years (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 > 12/31/2023?
- 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 > 01/01/2023?
  - 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 > 01/01/2023?
  - 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 > 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2025 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 > 1/1/2023?
- 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 2025 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
				01/01/2023 - 12/31/2023	01/01/2023 - 12/31/2023	03/2024 - 06/2024
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 (C25/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 = average enrollment < 800, No = average enrollment ≥ 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 (C28) and Reviewing Appeals Decisions (C29). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2025 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 (C05). 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 2023 (see section Contract Enrollment Data)

Table S-6: HEDIS 2023 Audit Designations and 2025 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 (C25/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
CMS Issue	Is the complaint designated as a CMS issue? (Yes/No)
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 (C26/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
>1000 Enrolled	Flag indicates contract non-employer group enrollment >1,000 members during the year or contracts that did not have any disenrollments meeting the inclusion criteria (True = Yes, False = 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 1/1/2023 and 12/31/2023. Scores are suppressed if they are measured with very low reliability (< 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 (C19), Getting Appointments and Care Quickly (C20), Customer Service (C21), Rating of Health Care Quality (C22), Rating of Health Plan (C23), Care Coordination (C24), 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 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 % 2023	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
>25% 2023	Flag that indicates if the contract has met the 25% threshold for 2023 disasters (Yes: >= 25 %, No: <25%)
>60% 2023	Flag that indicates if the contract has met the 60% threshold for 2023 disasters (Yes: >= 60 %, No: <60%)
Disaster Flag 2022	Indicates if the contract was affected by a 2022 disaster or not (valid values "Affected", "Not Affected" or "Too New")
Total Cnty in SA 2022	The total number of counties in the contract's 2022 service area (SA)
Num Cnty IA 2022	The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2022 disaster
IA Enrolled 2022	The number of members residing in the contract SA designated FEMA IA counties in a 2022 disaster
Total Enrolled 2022	The total number of members residing in the contract's 2022 SA
IA % 2022	The percent of members living in IA areas in a 2022 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2022	The percent of members living in IA areas in a 2022 disaster rounded to an integer
>=25% 2022	Flag that indicates if the contract has met the 25% threshold for 2022 disasters (Yes: >= 25 %, No: <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, C08 – C11, C14 – C18) data for contracts with ≥ 500 and < 1,000 members enrolled in July of the measurement year (July 01, 2023). 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 2023
Reliability	The computed reliability for the contract measure
Usable	The computed reliability ≥ 0.7 and rate is used = True, reliability < 0.7 and rate was not used = False

14. Measure Detail – C MD Results

The Part C Disaster Results page displays the measure level data handling results for contracts which had ≥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 2025 Star Ratings Part C measure ID
2024 Value	The numeric measure value for the contract from the 2024 Star Ratings
2024 Star	The measure star for the contract from the 2024 Star Ratings
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
Final Value	The measure value to be used in the 2025 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2025 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 ≥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 2025 Star Ratings Part D measure ID
2024 Value	The numeric measure value for the contract from the 2024 Star Ratings
2024 Star	The measure star for the contract from the 2024 Star Ratings
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
Final Value	The measure value to be used in the 2025 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2025 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
				01/01/2023 - 12/31/2023	01/01/2023 - 12/31/2023	03/2024 - 06/2024
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 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 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)
2025 Part C Summary Rating	The final rounded 2025 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 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 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)
2025 Part D Summary Rating	The final rounded 2025 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 2022	The percentage of members living in an Individual Assistance area in 2022 rounded to an integer
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 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
2025 Part C Summary Rating	The 2025 Part C Summary Rating
2025 Part D Summary Rating	The 2025 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)
2025 Overall Rating	The final 2025 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"
2023 C Summary	The 2023 Part C Summary Rating earned by the contract
2023 D Summary	The 2023 Part D Summary Rating earned by the contract
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
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 2025 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 2025 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 the Breast Cancer Screening Part C measure, the Rating of Health Plan Part C measure, the Complaints about the Plan Part C measure and the MTM Program Completion Rate for CMR Part D measure 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, and two flags identifying contracts with >= 25 percent and >= 60 percent of enrollees living in an area affected by a disaster. There is also a flag in the Breast Cancer Screening Part C measure file to identify HEDIS low enrollment contracts. There is also a flag in the MTM Program Completion Rate for CMR Part D measure file identifying contracts as MAPD or PDP. This downloadable is in Zip format and contains four Excel files.

From:	Miller, Wesley
To:	CMS PartC&DStarRatings
Cc:	Saporito, Mary; Faulk, Sheldon; Patalano, Lou
Subject:	Plan Preview #2 H6453
Date:	Thursday, September 12, 2024 7:17:23 PM
Attachments:	image005.jpg HMOLA (H6453) Notification of Calculation Errors.pdf HMOLA (H6453) Appendix to Notification of Calculation Errors.xlsx
Importance:	High

Good Afternoon,

Thank you for allowing Plans the opportunity to provide feedback on the Star Rating calculation prior to finalization.

Pursuant to the CMS Memorandum dated September 5, 2024 ("Second Plan Preview of 2025 Part C and D Star Ratings Data"), HMO Louisiana, Inc. ("HMOLA") is providing notice of three (3) calculation errors identified in the Second Plan Preview STAR Ratings for its contract H6453. These calculation errors impact HMOLA's contract H6453, which is the surviving contract following a consolidation in 2024, and result from the failure to account for data from the consumed contract (H5576). These errors include:

1) HMOLA was unable to submit relevant measurement information data relating to D11: "MTM Program Completion Rate for CMR," which data would have resulted in an increase of this measure from 92% (4 Stars) to 95% (5 Stars).

2) HMOLA was unable to submit relevant measurement information data relating to C05: "Special Needs Plan (SNP) Care Management," which data would have resulted in an increase of this measure from No Star Rating to 96% (5 Stars).

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

While we provided you with the additional information in the accompanying Appendix (including the data for measurements D11 and C05) that evidence the calculation errors, we

believe the summary below provides all of the information necessary for CMS to understand the errors we have identified and correct them prior to finalization of CY 2025 STAR Ratings data.

History of Contract H6453

Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") is the parent company to HMOLA. Prior to 2024, BCBSLA and/or its subsidiaries offered products under the following H-Contracts:

- Vantage Health Plan, Inc. offered a MA HMO-POS product under **H5576** contract
- HMOLA offered a MA HMO product under **H6453** contract
- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under **H7163** contract
- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

Errors # 1 and 2: Failure to Consider Relevant Data for Measures D11 and C05

When contracts are consolidated, the STAR Rating for the surviving contract for the first year after consolidation is determined through the enrollment-weighted average of the measures of both the consumed contract and the surviving contract for all measures except improvement measures. Both the regulation addressing STAR Ratings following contract consolidations as well as current technical instructions for STAR Ratings contain this requirement that data from both contracts be included for the first two years following a contract consolidation. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Appendix B, p. 115 (Draft) (Sept. 4, 2024) ("Technical Notes"). Thus, to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations. However, only data from HH6453 was considered in the calculation of D11 and C05.

Despite its relevance to the STAR Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for contract H5576 due to a technical issue with

HPMS. Specifically, HMOLA was unable was able to submit measurement information relating to measurements D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care," both of which are process measures. HMOLA was only able to submit information for these measures for contract H6453. As such, CMS used only partial information for these measures and, in doing so, failed to adhere to its own regulations. Again, had the relevant data been submitted relating to contract H5576, HMOLA's score for D11 would be 95%/5 Stars (as opposed to the calculated 92%/4 Stars), and HMOLA's score for C05 would be 96%/5 Stars (as opposed to the calculated No Star Rating). Both the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the STAR Rating for the surviving contract. Accordingly, HMOLA requests that CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576.

Error # 3: Incorrect Calculation of CAI

The consolidation of contracts H5576 and H6453 also led to an incorrect calculation of the CAI for HMOLA contract H6453. The regulation governing application of the CAI states that, for the first two years following a consolidation, CMS determines the CAI using enrollment data from both the surviving and consumed contracts in the consolidation. 42 CFR § 422.166(f)(2)(i)(B)(1). This requirement was added to the regulation in April 2024, and the text of the regulation indicates that it became effective immediately. This is in contrast to the language addressing the calculation of the HEI reward following contract consolidation, which the regulation specifies will go into effect beginning with the 2027 STAR Ratings year. 42 CFR § 422.166(f)(2).[1] In the case of the CAI, there is nothing in the text of the regulation that suggests that the methodology for applying the CAI following a contract consolidation should not go into effect immediately. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

To comply with the requirements in Section 422.166(f)(2), CMS must include in its CAI calculation the enrollment data from the consumed contract regarding beneficiaries who are dually eligible, receive the low-income subsidy, or have disability status. Using enrollment data from both the surviving and the consolidated contracts to determine the CAI adjustment factor is consistent with how CMS assesses plan performance in other contexts following a contract consolidation. As noted above, the regulations require CMS to combine measure-level data between contracts in the first two years following a consolidation. The purpose of this approach is to obtain a complete representation of plan performance when calculating STAR Ratings. Calculating a weighted average of performance data across contracts appropriately represents consolidated performance.

Prior to the April 2024 amendments, Section 422.166 did not address how to calculate the CAI

From:	CMS PartC&DStarRatings
To:	Miller, Wesley
Cc:	Saporito, Mary; Faulk, Sheldon; Patalano, Lou; CMS PartC&DStarRatings
Subject:	RE: Plan Preview #2 H6453
Date:	Thursday, October 3, 2024 2:15:56 PM
Attachments:	image001.jpg

For the first two issues you raised related to the MTM and SNP care management measures, we are following the technical specifications for these measures. Data are not collected and validated for contracts that terminate prior to July 1 in the following year after the contract year (CY) reporting period (i.e., terminated contracts are not required to report any data for the respective two years – the CY reporting period, and the following year). Based on this, we did not receive data for H5576 to use for these measures in the 2025 Star Ratings. Since H6453 did not offer SNP plans during the measurement year, there are no data for H6453 for the SNP care management measure. Based on this, H6453 received a missing data message of 'No data available' for this measure. For the MTM measure, we calculated the measure score for H6453 as we would whenever there are missing data not due to a data integrity issue for a contract in a consolidation. We calculated the enrollment weighted average score for all contracts in the consolidation with non-missing data. In this case, that resulted in only the measure score from H6453 being used.

For the third issue raised related to the CAI, we disagree that this change in methodology applies beginning with the 2025 Star Ratings. In the 2025 final rule, we finalized the change in methodology for calculating the CAI in the case of contract consolidations effective beginning with the 2027 Star Ratings, consistent with our policy of only applying Star Ratings calculation changes prospectively to future measurement years (here, the 2025 measurement year), and not to measurement periods that have already begun or been completed. At 89 FR 30644 we stated – "We proposed to calculate the percentage of LIS/DE enrollees and percentage of disabled enrollees used to determine the CAI adjustment factor in the case of contract consolidations based on the combined contract enrollment from all contracts in the consolidation beginning with the 2027 Star Ratings." At 89 FR 30645, we stated – "…we are finalizing the revision at §§422.166(f)(2)(i)(B) and 423.186(f)(2)(i)(B) to calculate the percentage LIS/DE enrollees and the percentage disabled enrollees for the surviving contract for the first 2 years following a consolidation by combining the enrollment data for the month of December for the measurement period of the Star Ratings year across all contracts in the consolidation as proposed without modification." CMS did not receive any comments to the proposed rule about the application of this change beginning with the 2027 Star Ratings. Since the updated CAI calculation methodology was finalized as proposed without modification, it applies beginning with the 2027 Star Ratings. Based on this, the CAI for H6453 for the 2025 Star Ratings was calculated using only data from H6453 consistent with current practice and what was displayed at the second plan preview period.

For the reasons explained above, we will not be making any changes to the 2025 Star Ratings for H6453.

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

While we provided you with the additional information in the accompanying Appendix (including the data for measurements D11 and C05) that evidence the calculation errors, we believe the summary below provides all of the information necessary for CMS to understand the errors we have identified and correct them prior to finalization of CY 2025 STAR Ratings data.

History of Contract H6453

Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") is the parent company to HMOLA. Prior to 2024, BCBSLA and/or its subsidiaries offered products under the following H-Contracts:

- Vantage Health Plan, Inc. offered a MA HMO-POS product under **H5576** contract
- HMOLA offered a MA HMO product under **H6453** contract
- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under **H7163** contract
- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

> the beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract." Technical Notes at p. 25.

The reason for this is simple: the process for calculating Star Ratings following a consolidation is distinct from the process following a termination. This distinction is necessary to allow CMS to continue to reflect performance of a consumed contract, which effectively continues as part of the surviving contract. The Technical Notes indicate that contracts with an effective termination date on or before the deadline to submit data validation results to CMS are excluded and listed as "No data available" or "Not required to report" for certain process measures (including measures C05 and D11). Technical Notes at pp. 37, 102. By contrast, in the case of a consolidation (which can only occur at the beginning of a contract year), CMS is required to collect and use data for consumed contracts for two years following the consolidation. Technical Notes at pp. 25, 114.

2. CAI Factor

CMS applies the categorical adjustment index (CAI) to adjust for within-contract disparities in performance associated with the percentages of beneficiaries who receive a low income subsidy or are dually eligible for Medicare and Medicaid (LIS/DE) or have disability status. 42 CFR § 422.166(f)(2). Contract enrollment for purposes of the CAI is determined using enrollment data for the month of December for the measurement period of the Star Ratings year. 42 CFR § 422.166(f)(2)(i)(B). As with the measures discussed in the preceding section, when contracts are consolidated, the CAI factor is calculated based on the enrollment data in both the surviving and consumed contracts:

> "For the first 2 years following a consolidation, for the surviving contract of a contract consolidation involving two or more contracts for health or drug services of the same plan type under the same parent organization, the enrollment data for the month of December for the measurement period of the Star Ratings year ***are combined across the surviving and consumed contracts in the consolidation***."

42 CFR § 422.166(f)(2)(i)(B)(1) (emphasis added).

CMS finalized this provision governing CAI calculations in the event of a consolidation on April 23, 2024 in 89 Fed. Reg. 30,448 (the "April 2024 Final Rule"). The regulation does not include a delayed implementation date. This is in contrast to regulatory provisions such Section 422.166(f)(3), which specifies that CMS will begin applying a health equity index (HEI) rating factor "[s]tarting with the 2027 Star Ratings year and subsequent Star Ratings year." 42 CFR § 422.166(f)(3). *See also* 42 CFR § 422.166(e)(1) (noting that certain measures will receive different weights "[s]tarting with the 2026 Star Ratings").

Errors In Application of Measures to the Surviving Contract:

<u>Measure Scores Errors</u>

The regulations and guidance governing contract consolidations require CMS to include measure data for the Consumed Contract when calculating the Star Ratings for the Surviving Contract. 42 CFR § 422.162(b)(3)(ii). In this case, CMS failed to collect data for certain process measures (C05 and D11) based on the mistaken premise that the Consumed Contract was terminated prior to July 1 and that terminated contracts are not required to report data for the reporting period and the following years. (Oct. 3, 2024 Email from CMS Part C & D Star Ratings to BCBSLA). The Consumed Contract was not terminated, however; it was consumed during a consolidation, and its measure data is necessary for evaluation of the performance of the Surviving Contract, as required by 42 CFR § 422.162(b)(3)(ii).

Under the rationale in CMS's October 3, 2024 email, CMS would never collect data for contracts consumed in a consolidation because contract consolidations are always effective January 1 (i.e., prior to the data validation window). Technical Notes at p. 25. This would negate the entire regulatory framework for calculating Star Ratings following a contract consolidation, which aims to prevent MAOs from consolidating a low performing contract into a higher performing contract in order to shed the low scores. The regulations do not authorize CMS to decide, unilaterally, not to collect certain measure data for consumed contracts. To the contrary, Section 422.162(b)(3) mandates that CMS determine the enrollment-weighted average of process measures – including C05 and D11 – when calculating the 2025 Star Ratings for the Surviving Contract.

The only regulatory basis for excluding a measure score for a consumed contract is if the score is missing due to a "data integrity issue." 42 CFR § 422.162(b)(3)(iv)(A)(2). CMS has not suggested that there are any data integrity issues with the data for the Consumed Contract. Here, any incompleteness in the data resulted solely and exclusively from CMS's failure to allow HMOLA to submit information that the regulations require be included in the calculation.[1]

HMOLA is entitled to have all relevant measures included in the Star Ratings calculation for the Surviving Contract, including D11 (MTM Program Completion Rate for CMR) and C05 (SNP Care Management). Inclusion of the data relating to D11 would result in an increase of this measure from 92% (4 Stars) to 95% (5 Stars), while inclusion of the data relating to C05 would result in an increase of this measure from No Star Rating to 96% (5 Stars). BCBSLA and HMOLA request that CMS recalculate the measure values for the Surviving Contract using the data for measurements D11 and C05 for the Consumed Contract, which data can be provided to CMS in any format acceptable to CMS.

CAI Factor

The regulatory provision governing application of the CAI similarly requires CMS to use enrollment data from both the Surviving Contract and the Consumed Contract when calculating the Star Rating for the Surviving Contract. 42 CFR § 422.166(f)(2)(i)(B)(1). Even though there is no language in the regulation suggesting that the process for calculating the CAI in a contract consolidation has a delayed implementation date, CMS's October 3, 2024 email asserts that CMS is not required to include enrollment data for a consumed contract in the CAI factor calculation until the 2027 Star Ratings. CMS points to language in the preamble to the April 2024 Final Rule suggesting that it did not intend this provision to become effective immediately and notes that it did not receive any comments to the proposed rule about applying the change beginning with the 2027 Star Ratings. (Oct. 3, 2024 Email from CMS Part C & D Star Ratings to BCBSLA). CMS cannot, however, rely on uncodified explanatory statements in preambles to contradict unambiguous regulatory language. Rather, the codified provisions of a final rule control. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 at p. 12 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

The regulation governing calculation of the CAI factor does not include ***any*** language suggesting it would not become immediately effective. Where CMS intends to delay an implementation date, CMS clearly codifies such date in the regulatory text. For example, when CMS finalized the addition of an HEI factor to the Star Ratings, it specified in the

[1] In its October 3, 2024 email, CMS noted that it calculated the measure score for the Surviving Contract "as we would whenever there are missing data ***not due to a data integrity issue***." (Oct. 3, 2024 Email from CMS Part C & D Star Ratings to BCBSLA) (emphasis added). It would be impossible for CMS determine that the data for the Consumed Contract is inaccurate, incomplete, or biased as to one or more specific measures, as CMS has not evaluated the data for the Consumed Contract.

From:	Miller, Wesley
To:	CMS PartC&DStarRatings; Patalano, Lou; Saporito, Mary; Faulk, Sheldon; Guillory, Daniel
Subject:	RE: H5576
Date:	Thursday, October 24, 2024 8:15:49 AM
Attachments:	image001.jpg

Confirming receipt.

Thank you,

Wesley Miller, PAHM, Notary Public
Medicare Compliance Officer
Louisiana Blue
o (225) 298-7965

Please visit us at lablue.com/social

Upcoming PTO:

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, October 24, 2024 6:51 AM
To: Miller, Wesley <Wesley.Miller@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Guillory, Daniel <Daniel.Guillory@lablue.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: H5576

The two contacts submitting information should have received information directly how to submit. If any issues, please let us know.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, October 23, 2024 5:20 PM
To: Miller, Wesley <Wesley.Miller@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Guillory, Daniel <Daniel.Guillory@lablue.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Subject: RE: H5576

Thank you very much! We will email each of these individuals when they can submit. Most likely it will not be until the morning.

From: Miller, Wesley <Wesley.Miller@lablue.com>
Sent: Wednesday, October 23, 2024 5:16 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Patalano, Lou <Lou.Patalano@lablue.com>; Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Guillory, Daniel <Daniel.Guillory@lablue.com>
Subject: RE: H5576

Good Afternoon,

Please see contact information below.

Data Submission Contact:
Sally Rainer – sally.rainer@lablue.com

Independent Data Validation Contractor
HealthSpective, Inc.
Contact: Scott Iannuccilli – scott.iannuccilli@healthspective.net

Thank you,

Wesley Miller, PAHM, Notary Public
Medicare Compliance Officer
Louisiana Blue
o (225) 298-7965

Please visit us at lablue.com/social

Upcoming PTO:

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, October 23, 2024 3:51 PM
To: Patalano, Lou <Lou.Patalano@lablue.com>; Miller, Wesley <Wesley.Miller@lablue.com>; Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Guillory, Daniel <Daniel.Guillory@lablue.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: H5576

Good afternoon,

CMS is providing an alternative method to allow submission of H5576's MTM and SNP data, as well as submission of Data Validation (DV) of these data by an independent data validation contractor. As a result, you will not go through HPMS' user interface for either the Plan reporting module (PRM) or Plan reporting data validation module (PRDVM) when providing CMS with these data submissions.

Your contract's MTM and SNP datasets and the corresponding data validation results must adhere to CMS requirements and comply with data checks. Failure to do so will delay CMS' processing and review of your reported data.

We need the name and email address of the person who will be submitting the SNP and MTM data. Please also provide us with the name of the data validation contractor that will be conducting the data validation of these SNP and MTM data for H5576. Additionally, we will need the name and email address for the data validation contractor contact, as they will submit the data validation results to CMS (EES). Once we have this information, we can grant access for the data submissions. We will alert both of these individuals by email when they can submit.

Please review the attached documents closely to ensure your files meet CMS requirements.

Please let us know if you have any questions.

Part C and D Star Ratings Team

please notify the sender and delete this e-mail from your computer. Thank you. Blue Cross and Blue Shield of Louisiana and its subsidiaries comply with applicable federal civil rights laws and do not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs and activities. You may access the Nondiscrimination and Accessibility Notice here . Information on Language Assistance is available here. Aquí encontrará información sobre asistencia lingüística. Des informations sur l'aide linguistique sont disponibles ici .

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From:	Miller, Wesley
To:	CMS PartC&DStarRatings
Cc:	Saporito, Mary; Faulk, Sheldon; Patalano, Lou; CMS PartC&DStarRatings
Subject:	Re: Plan Preview #2 H6453
Date:	Friday, November 15, 2024 12:39:55 PM
Attachments:	image001.jpg

Acknowledging receipt.

Thank you,

Wes Miller
Louisiana Blue

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Friday, November 15, 2024 11:35:13 AM
To: Miller, Wesley <Wesley.Miller@lablue.com>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 H6453

Good afternoon,

This is in further response to the notice of calculation errors HMO Louisiana, Inc. ("HMOLA") provided CMS on September 12, 2024, concerning the 2025 Star Ratings for its contract H6453.
In that notice, HMOLA claimed that those Star Ratings contained certain calculation errors arising out of "[t]he consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract)," effective January 1, 2024. HMOLA claimed that "to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations" of two performance measures, the SNP Care Management (C05) and the MTM Program Completion Rate (D11) measures. HMOLA claimed that "due to a technical issue with HPMS," it "was unable to submit relevant measurement information data" for each measure, which would have resulted in an increase on the C05 measure from No Star Rating to 96% (5 Stars) and an increase on the D11 measure from 92% (4 Stars) to 95% (5 Stars). HMOLA requested that "CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576."

At Louisiana Blue's request and after further consideration, CMS agreed to accept H5576's 2023 SNP and MTM data, along with the accompanying Data Validation findings, for

calculation of the SNP rate and MTM CMR rate for H6453. CMS received H5576's SNP and MTM data on 10/24/24 and the data validation findings on 10/30/24. The contract's SNP and MTM data passed data validation, and CMS calculated the resulting SNP rate and MTM CMR rate for H6453 per §§ 422.162(b)(3)(iv)(B)(*1*) and 423.182(b)(3)(ii)(B)(*1*).

Below are the updated 2025 Star Ratings for the H6453 contract based on the validated data submitted by HMOLA:

SNP Care Management (C05) Measure. For the data publicly released on Medicare Plan Finder on October 10, 2024, H6453 did not receive a score for the SNP Care Management (C05) measure and did not receive a measure-level Star Rating for C05. After we accepted the data for C05 for the consumed contract (H5576), the score for C05 for H6453 (the surviving contract) was updated to 70% and a 3 star measure rating for H6453. The updated data for SNP Care Management (C05) results in a decrease in the Part C improvement measure rating from 4 to 3 stars since there was a significant decline in the measure score from the prior year, decreasing from 76% to 70%.

MTM Program Completion Rate (D11) Measure. For the data publicly released on Medicare Plan Finder on October 10, 2024, H6453 received a score for the MTM Program Completion Rate (D11) measure of 92% and 4 stars. After we accepted the data for D11 for the consumed contract (H5576), the score for D11 was updated to 95% and increased to a 5 star measure rating for H6453.

After we accepted the data from H5576, as requested by Louisiana Blue, and updated the scores and measure-level stars for H6453, the overall rating is 3.603658 which rounds to 3.5 stars. The Part C Summary Rating decreases from 4 stars to 3.5 stars with the addition of the SNP Care Management measure and the decrease in the Part C improvement measure star. The Part D Summary Rating increases from 3.5 stars to 4 stars with the increase to the MTM measure star.

CMS plans to proceed with updating the measure scores and stars in HPMS and Medicare Plan Finder soon. If you have questions or wish to discuss, please let us know.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, September 12, 2024 7:41 PM
To: Miller, Wesley <Wesley.Miller@lablue.com>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Subject: RE: Plan Preview #2 H6453

Confirming receipt.

From: Miller, Wesley <Wesley.Miller@lablue.com>
Sent: Thursday, September 12, 2024 7:14 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>
Subject: Plan Preview #2 H6453
Importance: High

Good Afternoon,

Thank you for allowing Plans the opportunity to provide feedback on the Star Rating calculation prior to finalization.

Pursuant to the CMS Memorandum dated September 5, 2024 ("Second Plan Preview of 2025 Part C and D Star Ratings Data"), HMO Louisiana, Inc. ("HMOLA") is providing notice of three (3) calculation errors identified in the Second Plan Preview STAR Ratings for its contract H6453. These calculation errors impact HMOLA's contract H6453, which is the surviving contract following a consolidation in 2024, and result from the failure to account for data from the consumed contract (H5576). These errors include:

1) HMOLA was unable to submit relevant measurement information data relating to D11: "MTM Program Completion Rate for CMR," which data would have resulted in an increase of this measure from 92% (4 Stars) to 95% (5 Stars).

2) HMOLA was unable to submit relevant measurement information data relating to C05: "Special Needs Plan (SNP) Care Management," which data would have resulted in an increase of this measure from No Star Rating to 96% (5 Stars).

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality

bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

While we provided you with the additional information in the accompanying Appendix (including the data for measurements D11 and C05) that evidence the calculation errors, we believe the summary below provides all of the information necessary for CMS to understand the errors we have identified and correct them prior to finalization of CY 2025 STAR Ratings data.

History of Contract H6453

Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") is the parent company to HMOLA. Prior to 2024, BCBSLA and/or its subsidiaries offered products under the following H-Contracts:

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- HMOLA offered a MA HMO product under **H6453** contract
- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under **H7163** contract
- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

Errors # 1 and 2: Failure to Consider Relevant Data for Measures D11 and C05

When contracts are consolidated, the STAR Rating for the surviving contract for the first year after consolidation is determined through the enrollment-weighted average of the measures of both the consumed contract and the surviving contract for all measures except improvement measures. Both the regulation addressing STAR Ratings following contract consolidations as well as current technical instructions for STAR Ratings contain this requirement that data from both contracts be included for the first two years following a contract consolidation. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Appendix B, p. 115 (Draft) (Sept. 4, 2024) ("Technical Notes"). Thus, to accurately calculate the STAR Rating

for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations. However, only data from HH6453 was considered in the calculation of D11 and C05.

Despite its relevance to the STAR Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for contract H5576 due to a technical issue with HPMS. Specifically, HMOLA was unable was able to submit measurement information relating to measurements D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care," both of which are process measures. HMOLA was only able to submit information for these measures for contract H6453. As such, CMS used only partial information for these measures and, in doing so, failed to adhere to its own regulations. Again, had the relevant data been submitted relating to contract H5576, HMOLA's score for D11 would be 95%/5 Stars (as opposed to the calculated 92%/4 Stars), and HMOLA's score for C05 would be 96%/5 Stars (as opposed to the calculated No Star Rating). Both the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the STAR Rating for the surviving contract. Accordingly, HMOLA requests that CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576.

Error # 3: Incorrect Calculation of CAI

The consolidation of contracts H5576 and H6453 also led to an incorrect calculation of the CAI for HMOLA contract H6453. The regulation governing application of the CAI states that, for the first two years following a consolidation, CMS determines the CAI using enrollment data from both the surviving and consumed contracts in the consolidation. 42 CFR § 422.166(f)(2)(i)(B)(1). This requirement was added to the regulation in April 2024, and the text of the regulation indicates that it became effective immediately. This is in contrast to the language addressing the calculation of the HEI reward following contract consolidation, which the regulation specifies will go into effect beginning with the 2027 STAR Ratings year. 42 CFR § 422.166(f)(2).[1] In the case of the CAI, there is nothing in the text of the regulation that suggests that the methodology for applying the CAI following a contract consolidation should not go into effect immediately. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

To comply with the requirements in Section 422.166(f)(2), CMS must include in its CAI calculation the enrollment data from the consumed contract regarding beneficiaries who are dually eligible, receive the low-income subsidy, or have disability status. Using enrollment data from both the surviving and the consolidated contracts to determine the CAI adjustment factor is consistent with how CMS assesses plan performance in other contexts following a contract consolidation. As noted above, the regulations require CMS to combine measure-