From: Cindy Oppel
To: CMS CallCenterMonitoring
Cc: Jenna Pinardo; Conor Duffy; Colleen O"Neil; Amy Heilman
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Thursday, September 12, 2024 2:02:18 PM

Good Afternoon,

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for one (1) call which we contend is not a performance failure on our part. We respectfully request that CMS review the information provided for the identified call and advise regarding potential changes in results data.

1. **Humana MAPD Part C**

Case ID: C0701002
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code	ERC Description	Finish Note *(K)*
2/15/2024	03:09:50 p:m	293.5	Plan Call Center Dropped Call – Disconnected	Hold was silent, then call disconnected

Humana Response: The CMS caller remained silent throughout the duration of the call, which is highly unusual compared to a typical exchange between a prospective enrollee and a call center agent. As a result, the Humana CSR was unable to identify the needs of the caller. The December 1, 2023 HPMS Memo on "2024 Part C and Part D Call Center Monitoring" states on page 2 that "Interpreter availability is defined as the *ability of a caller to communicate with someone* and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits." Further, as indicated on page 11 in the Call Center Monitoring Accuracy and Accessibility Technical Study Technical Notes, "A call is considered *connected* when the caller confirms that the call connects to the CSR." In this case, the CMS caller did not attempt any communication whatsoever, and thus never confirmed that the call was connected to the CSR, which strongly indicates a mistake was made by the CMS caller or the vendor CMS used to perform the call. We do not believe this call should be considered connected as there was no dialogue between the CMS caller and CSR, and as such, we are requesting the call be excluded from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

Humana
500 W. Main St. | Louisville, KY 40202

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F 502.508.7929
coppel@humana.com

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From: CMS CallCenterMonitoring
To: Jody Dougherty; Robin Bender
Subject: FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Thursday, September 12, 2024 2:10:00 PM

Please see the below request.

From: Cindy Oppel <coppel@humana.com>
Sent: Thursday, September 12, 2024 3:02 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Good Afternoon,

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for one (1) call which we contend is not a performance failure on our part. We respectfully request that CMS review the information provided for the identified call and advise regarding potential changes in results data.

1. **Humana MAPD Part C**

Case ID: C0701002
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
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2/15/2024	03:09:50 p:m	293.5	Plan Call Center Dropped Call – Disconnected	Hold was silent, then call disconnected

Humana Response: The CMS caller remained silent throughout the duration of the call, which is highly unusual compared to a typical exchange between a prospective enrollee and a call center agent. As a result, the Humana CSR was unable to identify the needs of the caller. The December 1, 2023 HPMS Memo on "2024 Part C and Part D Call Center Monitoring" states on page 2 that "Interpreter availability is defined as the *ability of a caller to communicate with someone* and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits." Further, as indicated on page 11 in the Call Center Monitoring Accuracy and Accessibility Technical Study Technical Notes, "A call is considered

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Thank you,

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From: Robin Bender
To: CMS CallCenterMonitoring
Cc: Jody Dougherty; Robin Bender
Subject: FW: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Friday, September 13, 2024 10:13:02 AM
Attachments: SII_RawCallLog_2024_Full_C0701002.xlsx

Hello-

CaseID: **C0701002**
Date/Time of call: 2/15/2024 3:09:45 PM
ERC Code: 293.5
ERC Description: Plan Call Center Dropped Call - Disconnected
Language: TL
CallNote: Hold was silent, then call disconnected

AIR Review: The CMS caller dialed the correct number and connected with the plan, however before the CMS caller could make contact with a CSR the call disconnected. Reviewing the CMS call log shows that the disconnect was not initiated by the CMS caller. **Recommend keeping outcome as is.**

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Thursday, September 12, 2024 3:11 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Robin Bender <Robin.Bender@hendall.com>
Subject: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Please see the below request.

From: Cindy Oppel <coppel@humana.com>
Sent: Thursday, September 12, 2024 3:02 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Good Afternoon,

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1. **Humana MAPD Part C**
Case ID: C0701002

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code	ERC Description	Finish Note *(K)*
2/15/2024	03:09:50 p:m	293.5	Plan Call Center Dropped Call – Disconnected	Hold was silent, then call disconnected

Humana Response: The CMS caller remained silent throughout the duration of the call, which is highly unusual compared to a typical exchange between a prospective enrollee and a call center agent. As a result, the Humana CSR was unable to identify the needs of the caller. The December 1, 2023 HPMS Memo on "2024 Part C and Part D Call Center Monitoring" states on page 2 that "Interpreter availability is defined as the *ability of a caller to communicate with someone* and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits." Further, as indicated on page 11 in the Call Center Monitoring Accuracy and Accessibility Technical Study Technical Notes, "A call is considered *connected* when the caller confirms that the call connects to the CSR." In this case, the CMS caller did not attempt any communication whatsoever, and thus never confirmed that the call was connected to the CSR, which strongly indicates a mistake was made by the CMS caller or the vendor CMS used to perform the call. We do not believe this call should be considered connected as there was no dialogue between the CMS caller and CSR, and as such, we are requesting the call be excluded from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

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From: CMS CallCenterMonitoring
To: Robin Bender
Cc: Jody Dougherty
Subject: RE: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Friday, September 13, 2024 12:17:00 PM

Thank you, I agree with keeping the call as is.

From: Robin Bender <Robin.Bender@hendall.com>
Sent: Friday, September 13, 2024 11:11 AM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jody Dougherty <jody.dougherty@hendall.com>; Robin Bender <Robin.Bender@hendall.com>
Subject: FW: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Hello-

CaseID: **C0701002**
Date/Time of call: 2/15/2024 3:09:45 PM
ERC Code: 293.5
ERC Description: Plan Call Center Dropped Call - Disconnected
Language: TL
CallNote: Hold was silent, then call disconnected

AIR Review: The CMS caller dialed the correct number and connected with the plan, however before the CMS caller could make contact with a CSR the call disconnected. Reviewing the CMS call log shows that the disconnect was not initiated by the CMS caller. **Recommend keeping outcome as is.**

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Thursday, September 12, 2024 3:11 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Robin Bender <Robin.Bender@hendall.com>
Subject: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

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Sent: Thursday, September 12, 2024 3:02 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

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1. **Humana MAPD Part C**

Case ID: C0701002

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code	ERC Description	Finish Note *(K)*
2/15/2024	03:09:50 p:m	293.5	Plan Call Center Dropped Call – Disconnected	Hold was silent, then call disconnected

Humana Response: The CMS caller remained silent throughout the duration of the call, which is highly unusual compared to a typical exchange between a prospective enrollee and a call center agent. As a result, the Humana CSR was unable to identify the needs of the caller. The December 1, 2023 HPMS Memo on "2024 Part C and Part D Call Center Monitoring" states on page 2 that "Interpreter availability is defined as the *ability of a caller to communicate with someone* and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits." Further, as indicated on page 11 in the Call Center Monitoring Accuracy and Accessibility Technical Study Technical Notes, "A call is considered *connected* when the caller confirms that the call connects to the CSR." In this case, the CMS caller did not attempt any communication whatsoever, and thus never confirmed that the call was connected to the CSR, which strongly indicates a mistake was made by the CMS caller or the vendor CMS used to perform the call. We do not believe this call should be considered connected as there was no dialogue between the CMS caller and CSR, and as such, we are requesting the call be excluded from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

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From: CMS CallCenterMonitoring
To: Cindy Oppel
Cc: Jenna Pinardo; Conor Duffy; Colleen O"Neil; Amy Heilman
Subject: RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Monday, September 16, 2024 1:44:00 PM
Attachments: SII_RawCallLog_2024_Full_C0701002.xlsx

Good afternoon,

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

Call C0701002 will remain as is. The attached raw data and call log confirm that the CMS interviewer dialed the correct number and connected with the plan, however before the CMS caller could make contact with a CSR the call disconnected. Reviewing the call log shows that the disconnect was not initiated by the CMS caller, see column O HangUpBy = Resp. This was an LEP call, testing Tagalong, so it is not unusual for the interviewer to remain silent while waiting for a CSR as they would not understand anything being presented in English.

Thank you again for reaching out with your questions.

Very respectfully,

Steve

From: Cindy Oppel <coppel@humana.com>
Sent: Thursday, September 12, 2024 3:02 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
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1. **Humana MAPD Part C**
Case ID: C0701002
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
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Thank you,

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Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

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From: Cindy Oppel
To: CMS CallCenterMonitoring
Cc: Jenna Pinardo; Conor Duffy; Colleen O"Neil; Amy Heilman
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Friday, September 13, 2024 1:36:02 PM

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for three (3) calls which we contend are is not performance failures on our part. We respectfully request that CMS review the information provided for the identified calls and advise regarding potential changes in results data.

1. **Humana MAPD Part D**

Case ID: D1100955

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
3/14/2024	12:10:45 p:m	296.05	Unexpected Breakoff: Disconnected	CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan. CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.

-

2. **Humana MAPD Part D**

Case ID: D0900533

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
2/27/2024	04:16:11	296.01	Unexpected	CSR put me on hold for interpreter.

			Breakoff: CSR hung up	Called person hung up while hold music played.

3. **CarePlus Part C**

Case ID: C1800301

Contract ID: H1019

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
04/29/2024	06:19:36	296.01	Unexpected Breakoff: CSR hung up	CSR placed me on hold for interpreter and a few min later the call go disconnected.

Humana Response: These three calls (Case IDs D1100955, D0900533, and C1800301) were identified as failing the Accuracy and Accessibility Study because the calls disconnected due to technical errors *while Humana's CSRs were actively connecting with an interpreter to join the call*. While Humana agrees that dropped calls pose risks to beneficiary access, CMS actively monitors call disconnect rates under a different arm of the Call Center Monitoring Program – the Timeliness Study. The purpose of the Accuracy and Accessibility Study, on the other hand, is to "determine (1) the availability of interpreters for individuals, (2) teletypewriter (TTY) functionality, and (3) the accuracy of plan information provided by customer service representatives (CSRs) in all languages." *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)*. And CMS isolates the results of this study in its Star Ratings reported under Measure C30 – "Foreign Language Interpreter and TTY Availability." CMS should focus its evaluation for purposes of Measure C30 based on the substantive requirements it is attempting to evaluate, and exclude calls for which callers experience technical difficulties, in order to avoid double counting technical call drop issues and preserve the integrity of the Star Ratings system as an indicator of plan performance on precise topics of importance to beneficiaries.

In the case of all three calls referenced above, Humana was unable to complete these calls due to technical limitations imposed by the CMS study that do not exist when Humana CSRs engage with actual Medicare beneficiaries. Specifically, Humana's standard calling system and process for prospective members allows for Humana to call a prospective member back in the event of a dropped call. However, it is Humana's understanding that CMS would not accept a call back attempt from the Humana CSR if the initial call was disconnected. Therefore, these calls terminated prior to the expiration of the eight-minute timeframe available under CMS rules for connecting a beneficiary with an appropriate interpreter.

CMS's Star Rating Technical Notes and CMS guidance on the 2024 Call Center Monitoring program both state that whether or not an interpreter is considered "available" for purposes of the Star Rating measure calculation is based on whether the beneficiary is connected with the interpreter and the CSR is able to answer questions about the plan *within eight minutes*. *See, e.g., CY 2024 Star*

Rating Technical Notes ("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; *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)* ("The measure is considered completed when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter.")

If Humana's CSRs had the opportunity to reconnect with the CMS testers, these calls could have been successfully "completed" within the 8-minute timeframe for purposes of the Star Rating measure based upon our historically strong performance/high pass rates within the Interpreter availability component of this measure. As CMS itself has stated, "the data used for CMS's Star Ratings must be accurate and reliable." *CY 2024 Star Rating Technical Notes, p. 14*. The determination that Humana failed these calls has a negative impact on Humana's CY 2025 Measure C30 Star Rating, results in double-counting of Humana's call disconnect errors and distorts the information available to beneficiaries about Humana's accessibility for individuals that need interpreter and TTY services. Therefore, Humana is requesting that CMS exclude Case IDs D1100955, D0900533, and C1800301from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
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From: CMS CallCenterMonitoring
To: Jody Dougherty; Robin Bender
Cc: CMS CallCenterMonitoring
Subject: FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Friday, September 13, 2024 1:43:40 PM

For your review.
Thanks

From: Cindy Oppel <coppel@humana.com>
Sent: Friday, September 13, 2024 2:36 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
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Case ID: D0900533
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533,

H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
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Case ID: C1800301

Contract ID: H1019

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
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From: Robin Bender
To: CMS CallCenterMonitoring
Cc: Jody Dougherty; Robin Bender
Subject: FW: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Monday, September 16, 2024 8:46:42 AM
Attachments: SII_RawCallLog_2024_Full_H1019-H0028.xlsx

Good morning-

CaseID: C1800301
Date/Time of call: 4/29/2024 6:19:30 PM
ERC Code: 296.01
ERC Description: Unexpected Breakoff: CSR hung up
Language: ES
CallNote: CSR placed me on hold for interpreter and a few min later the call go disconnected.

CaseID: D0900533
Date/Time of call: 2/27/2024 4:16:06 PM
ERC Code: 296.01
ERC Description: Unexpected Breakoff: CSR hung up
Language: ES
CallNote: CSR put me on hold for interpreter. Called person hung up while hold music played.

CaseID: D1100955
Date/Time of call: 3/14/2024 12:10:40 PM
ERC Code: 296.05
ERC Description: Unexpected Breakoff: Disconnected
Language: TL
CallNote: CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.,CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.

AIR Review: The plan is disputing these calls as their procedure is to obtain the phone number of the prospective member and then to call them back if there is a disconnection. However, we do not allow callbacks from the plan as all questions should be answered in a single call. As the call log shows that each of these cases were not disconnected by the CMS caller, recommend keeping outcome as is.

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Friday, September 13, 2024 2:44 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Robin Bender <Robin.Bender@hendall.com>
Cc: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Subject: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and

Accessibility Study

For your review.
Thanks

From: Cindy Oppel <coppel@humana.com>
Sent: Friday, September 13, 2024 2:36 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
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Case ID: C1800301

Contract ID: H1019

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한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

From: CMS CallCenterMonitoring
To: Robin Bender
Cc: Jody Dougherty
Subject: RE: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Monday, September 16, 2024 9:12:00 AM

I agree with keeping all three calls as is.

From: Robin Bender <Robin.Bender@hendall.com>
Sent: Monday, September 16, 2024 9:44 AM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jody Dougherty <jody.dougherty@hendall.com>; Robin Bender <Robin.Bender@hendall.com>
Subject: FW: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Good morning-

CaseID: C1800301
Date/Time of call: 4/29/2024 6:19:30 PM
ERC Code: 296.01
ERC Description: Unexpected Breakoff: CSR hung up
Language: ES
CallNote: CSR placed me on hold for interpreter and a few min later the call go disconnected.

CaseID: D0900533
Date/Time of call: 2/27/2024 4:16:06 PM
ERC Code: 296.01
ERC Description: Unexpected Breakoff: CSR hung up
Language: ES
CallNote: CSR put me on hold for interpreter. Called person hung up while hold music played.

CaseID: D1100955
Date/Time of call: 3/14/2024 12:10:40 PM
ERC Code: 296.05
ERC Description: Unexpected Breakoff: Disconnected
Language: TL
CallNote: CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.,CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.

AIR Review: The plan is disputing these calls as their procedure is to obtain the phone number of the prospective member and then to call them back if there is a disconnection. However, we do not allow callbacks from the plan as all questions should be answered in a single call. As the call log shows that each of these cases were not disconnected by the CMS caller, recommend keeping

outcome as is.

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Friday, September 13, 2024 2:44 PM
To: Jody Dougherty <jody.dougherty@hendall.com>; Robin Bender <Robin.Bender@hendall.com>
Cc: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Subject: [External Sender] FW: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

For your review.
Thanks

From: Cindy Oppel <coppel@humana.com>
Sent: Friday, September 13, 2024 2:36 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for three (3) calls which we contend are is not performance failures on our part. We respectfully request that CMS review the information provided for the identified calls and advise regarding potential changes in results data.

1. **Humana MAPD Part D**

Case ID: D1100955
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
3/14/2024	12:10:45 p:m	296.05	Unexpected Breakoff: Disconnected	CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan. CSR put me on hold to get an interpreter with music playing in the background when the line

				unexpectedly disconnected by the plan.

-

2. **Humana MAPD Part D**

Case ID: D0900533

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
2/27/2024	04:16:11	296.01	Unexpected Breakoff: CSR hung up	CSR put me on hold for interpreter. Called person hung up while hold music played.

3. **CarePlus Part C**

Case ID: C1800301

Contract ID: H1019

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
04/29/2024	06:19:36	296.01	Unexpected Breakoff: CSR hung up	CSR placed me on hold for interpreter and a few min later the call go disconnected.

Humana Response: These three calls (Case IDs D1100955, D0900533, and C1800301) were identified as failing the Accuracy and Accessibility Study because the calls disconnected due to technical errors *while Humana's CSRs were actively connecting with an interpreter to join the call*. While Humana agrees that dropped calls pose risks to beneficiary access, CMS actively monitors call disconnect rates under a different arm of the Call Center Monitoring Program – the Timeliness Study. The purpose of the Accuracy and Accessibility Study, on the other hand, is to "determine (1) the availability of interpreters for individuals, (2) teletypewriter (TTY) functionality, and (3) the accuracy of plan information provided by customer service representatives (CSRs) in all languages." *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)*. And CMS isolates the results of this study in its Star Ratings reported under Measure C30 – "Foreign Language Interpreter and TTY Availability." CMS should focus its evaluation for purposes of Measure C30 based on the substantive requirements it is attempting to evaluate, and exclude calls for which callers experience technical difficulties, in order to avoid double counting technical call drop issues and preserve the integrity of the Star Ratings system as an indicator of plan performance on precise

topics of importance to beneficiaries.

In the case of all three calls referenced above, Humana was unable to complete these calls due to technical limitations imposed by the CMS study that do not exist when Humana CSRs engage with actual Medicare beneficiaries. Specifically, Humana's standard calling system and process for prospective members allows for Humana to call a prospective member back in the event of a dropped call. However, it is Humana's understanding that CMS would not accept a call back attempt from the Humana CSR if the initial call was disconnected. Therefore, these calls terminated prior to the expiration of the eight-minute timeframe available under CMS rules for connecting a beneficiary with an appropriate interpreter.

CMS's Star Rating Technical Notes and CMS guidance on the 2024 Call Center Monitoring program both state that whether or not an interpreter is considered "available" for purposes of the Star Rating measure calculation is based on whether the beneficiary is connected with the interpreter and the CSR is able to answer questions about the plan *within eight minutes*. *See, e.g., CY 2024 Star Rating Technical Notes* ("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; *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)* ("The measure is considered completed when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter.")

If Humana's CSRs had the opportunity to reconnect with the CMS testers, these calls could have been successfully "completed" within the 8-minute timeframe for purposes of the Star Rating measure based upon our historically strong performance/high pass rates within the Interpreter availability component of this measure. As CMS itself has stated, "the data used for CMS's Star Ratings must be accurate and reliable." *CY 2024 Star Rating Technical Notes, p. 14*. The determination that Humana failed these calls has a negative impact on Humana's CY 2025 Measure C30 Star Rating, results in double-counting of Humana's call disconnect errors and distorts the information available to beneficiaries about Humana's accessibility for individuals that need interpreter and TTY services. Therefore, Humana is requesting that CMS exclude Case IDs D1100955, D0900533, and C1800301from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

Humana
500 W. Main St. | Louisville, KY 40202

T 502.498.9871

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From:	CMS CallCenterMonitoring
To:	Cindy Oppel
Cc:	Jenna Pinardo; Conor Duffy; Colleen O"Neil; Amy Heilman
Subject:	RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date:	Monday, September 16, 2024 1:38:00 PM
Attachments:	SII_RawCallLog_2024_Full_H1019-H0028.xlsx 2024 Part C and Part D Call Center Monitoring.pdf

Good evening,

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

Calls C1800301, D0900533, and D1100955 will remain as is. Your plan is disputing these calls as your procedure is to obtain the phone number of the prospective member and then to call them back if there is a disconnection. However, CMS does not allow callbacks from the plan as all questions should be answered in a single call. The attached call log shows that for each of these calls the disconnect source was not CMS, see column O HangUpBy = Resp. CMS states in our annual memo, attached to this response, on page 2 that "CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study."

Thank you again for reaching out with your questions.

Very respectfully,

Steve

From: Cindy Oppel <coppel@humana.com>
Sent: Friday, September 13, 2024 2:36 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for three (3) calls which we contend are is not performance failures on our part. We respectfully request that CMS review the information provided for the identified calls and advise regarding potential changes in results data.

1. **Humana MAPD Part D**

Case ID: D1100955
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
3/14/2024	12:10:45 p:m	296.05	Unexpected Breakoff: Disconnected	CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan. CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.

-

2. **Humana MAPD Part D**

Case ID: D0900533

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
2/27/2024	04:16:11	296.01	Unexpected Breakoff: CSR hung up	CSR put me on hold for interpreter. Called person hung up while hold music played.

3. **CarePlus Part C**

Case ID: C1800301

Contract ID: H1019

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
04/29/2024	06:19:36	296.01	Unexpected Breakoff: CSR hung up	CSR placed me on hold for interpreter and a few min later the call go disconnected.

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technical errors *while Humana's CSRs were actively connecting with an interpreter to join the call*. While Humana agrees that dropped calls pose risks to beneficiary access, CMS actively monitors call disconnect rates under a different arm of the Call Center Monitoring Program – the Timeliness Study. The purpose of the Accuracy and Accessibility Study, on the other hand, is to "determine (1) the availability of interpreters for individuals, (2) teletypewriter (TTY) functionality, and (3) the accuracy of plan information provided by customer service representatives (CSRs) in all languages." *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)*. And CMS isolates the results of this study in its Star Ratings reported under Measure C30 – "Foreign Language Interpreter and TTY Availability." CMS should focus its evaluation for purposes of Measure C30 based on the substantive requirements it is attempting to evaluate, and exclude calls for which callers experience technical difficulties, in order to avoid double counting technical call drop issues and preserve the integrity of the Star Ratings system as an indicator of plan performance on precise topics of importance to beneficiaries.

In the case of all three calls referenced above, Humana was unable to complete these calls due to technical limitations imposed by the CMS study that do not exist when Humana CSRs engage with actual Medicare beneficiaries. Specifically, Humana's standard calling system and process for prospective members allows for Humana to call a prospective member back in the event of a dropped call. However, it is Humana's understanding that CMS would not accept a call back attempt from the Humana CSR if the initial call was disconnected. Therefore, these calls terminated prior to the expiration of the eight-minute timeframe available under CMS rules for connecting a beneficiary with an appropriate interpreter.

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D1100955, D0900533, and C1800301from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

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

CENTER FOR MEDICARE

DATE: December 1, 2023

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

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

SUBJECT: 2024 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2024. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2024 call center information **no later than December 15, 2023**.

For 2024, CMS has contracted with Hendall Inc., and its subcontractor American Institutes for Research (AIR), to monitor the performance of plan sponsors' call centers with respect to the standards at 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1).

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk telephone lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5 percent or less.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the plan divided by the total number of calls made to the telephone number associated with the contract.

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

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2) teletypewriter (**TTY) functionality,** and (3) the **accuracy of plan information provided by**

customer service representatives (CSRs) in all languages. Languages tested in 2024 are unchanged from 2023 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2024.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter. The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures.

2. TTY functionality is defined as the ability of a caller using a TTY device to communicate with someone and receive answers to questions at the plan's call center directly or via a relay operator. A call is considered connected when the caller reaches a TTY/relay operator. The measure is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via the TTY/relay operator (before beginning the first of three general Medicare or plan-specific accuracy questions) within seven minutes of the TTY/relay operator reaching the plan. CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR. The percent of completed TTY calls (the number of completed TTY calls out of all TTY calls) is used for Part C and D Star Ratings measures.

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

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

In the event that an organization believes that CMS may have miscalculated its call center results based on data posted in HPMS, it may bring the relevant information to CMS' attention and ask for a review of the results. **We advise organizations that they should ask for this review within 2 weeks if they do not want the data reflected in compliance actions, public reporting, or star ratings.** CMS may not be able to make adjustments if issues aren't brought to its attention within 2 weeks. **CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study.**

IMPORTANT ACTION: Verify 2024 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2024 Part C and/or Part D call center telephone numbers in HPMS by **December 15, 2023**. This includes current and prospective enrollee **toll-free** beneficiary call center telephone numbers**, toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis and updated in the monitoring contractor's automated dialing software. If any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately, pursuant to 42 C.F.R. §§ 422.504(f)(2)(vii) and 423.505(f)(2)(vii). It is important that all organizations always keep these telephone numbers up-to-date in HPMS. Organizations should notify CallCenterMonitoring@cms.hhs.gov after an update is made. **If an organization achieves poor results on the measures due to calls to an inaccurate telephone numbers, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is available in HPMS prior to the launch of the studies.** Use the paths outlined below to verify and/or update the telephone numbers.

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

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: > Plan Bids > Bid Submission > CY 2024 – Manage Plans > Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

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

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

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

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

Notes:

- The above process to verify the accuracy of call center telephone numbers is separate from the Call Center Indicator activity that has already begun. You should have received communication from **CallCenterIndicators@hendall.com** in November 2023. The Call Center Indicators identify plan benefit package (PBP) phone numbers that are served by the same physical call center. This information is important as the Accuracy and Accessibility study is conducted at the call center level, with legal entities sharing results

of calls placed to a shared call center, with a limited exceptions. The Timeliness study is conducted at the phone number level. Results of calls placed to a shared phone number are shared by all legal entities utilizing that phone number, with limited exceptions. The Accuracy and Accessibility study indicators do not impact the Timeliness study. **Please be aware that while phone numbers must be kept current in HPMS, the Accuracy and Accessibility study indicators cannot be updated after the Call Center Indicator collection activity is completed.**

- Our regulations at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1) require the operation of a toll-free customer call center; MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.*** Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

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

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

  This information can be found in Chapter 1 of the CY2024 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2024 > View Documentation (under "Documentation" Section) > Bid Submission User manual for Contract Year 2024*).

Tips for Success/Best Practices

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

General:

- Provide basic services and information to individuals with disabilities, upon request.

- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio and data CDs, and in requested alternate languages) to individuals with disabilities upon request.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot program what options they should select for each plan. We train them to listen for options such as "current members," "pharmacy," or an option for those "interested in learning more about enrolling" for prospective calls, for example. When you are setting up your IVR options, please

keep this in mind. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. You may experience more successful call outcomes if the representative offers a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, "You need to call another number" or answering "no" to the introductory question, "Are you the right person to answer questions about…." will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make the most reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plans, or at least transfer us to the correct party who can answer those questions.

HPMS Entries:

- Current, prospective, and TTY/relay services customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or Telecommunications Relay Service (TRS) telephone numbers. CMS extracts the values found in the toll-free *and* alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. If you have updates at any time during the year, please enter them into HPMS immediately, and notify CallCenterMonitoring@cms.hhs.gov. A delay in updating the telephone number(s) prior to the start of the study may result in unsuccessful calls attributed to your plan's performance. Calls of this nature cannot be negated.

Ability to Accept Calls:

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

- CMS' monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Generally speaking, CMS also notes longer hold times at the beginning of a week with improvement as the week progresses. Call centers should evaluate their own needs and consider increased staffing during busier times.

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

- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
    - Test every telephone number supported by the call center.
    - Pull the telephone numbers from HPMS and ensure they ring to the intended location.
    - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.

- Test with more than one caller at the same time.
- See TTY section below for specific TTY testing suggestions.

- CMS will occasionally solicit volunteers for abbreviated training periods prior to the beginning of an actual study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. If you are launching new technology in your call center, consider joining a pilot or interviewer training session to ensure your equipment is working as expected. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next pilot or interviewer training session.

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

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

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

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

- Train CSRs to answer the introductory question asked of them ("Are you the right person to answer questions about…?") When we call customer service lines, we ask a question

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

Interpreter Availability:

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

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

- Interpreters should:
  - Adhere to generally accepted interpreter ethics principles, including confidentiality.
  - Demonstrate proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation.
  - Interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

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

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

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

- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English, for both written and verbal communication. Record and maintain that information in a tracking system to be used in future beneficiary contacts.

- Monitor CSR calls to ensure that foreign-language calls are being handled according to the plan sponsor's policies and procedures.

- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.

- Ensure that CSRs are able to respond promptly to questions. Each accuracy question has a 7-minute timer.

TTY Functionality:

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

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

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

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

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

- Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

- **The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan.** If you use

a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller's area code. It is the plan's responsibility to ensure that calls from any area code can be received via their relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements of 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1). Review the 2024 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2024. Consider sharing the most recent *Medicare & You* with translator service provider.

- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.

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

    - When we ask our introductory question, ("Are you the right person to answer questions about…?"), it is always best for the CSR to respond "yes" or "no," meaning yes, the CSR is the correct person to answer questions about a specific plan's benefits, or no, the CSR is not the correct person to answer questions about the plan's benefits. The CSR should then offer a "warm transfer" to the caller so that he or she may speak to the appropriate person. If the CSR responds at this high level first, it will save time, especially if the caller needs to be transferred to another party. If the CSR spends a great deal of time trying to get more information from the caller, the timer may expire, resulting in an unsuccessful call in the plan's performance.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*). Originally published in 2000, an enhanced version of the *National CLAS Standards* was most recently updated by OMH in October 2018. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" and serves as the overarching goal for *National CLAS Standards'* implementation. One key area is Communication and Language Assistance, which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and

providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the *National CLAS Standards* and its guidance document, *The Blueprint*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH's free e-learning program, *The Guide to Providing Effective Communication and Language Assistance Services*. If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes/Frequently Asked Questions and Data Dictionaries for each study are stored in HPMS via links in the lower left corners of the Performance Metrics pages. Please refer to pages 2 and 3 above for the location of the studies' results. This same location is where you will find these reference materials.

If you have any questions about the 2024 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Do not use secure email when communicating with this resource. **CMS will not open a secure email message.** CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.

From: Colleen O"Neil
To: CMS CallCenterMonitoring; Cindy Oppel
Cc: Jenna Pinardo; Conor Duffy; Amy Heilman; Kimberlee Reid
Subject: RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Friday, September 27, 2024 3:17:54 PM
Attachments: image001.png

Thank you for your response.

Can you help us to understand whether CMS would consider modifying the Accuracy and Accessibility study so that the results could provide more reliable signaling for prospective members about interpreter availability? For example, we think that if a callback option was permitted, this would more accurately reflect the beneficiary experience in the real world, where calls do get disconnected. Is there a particular concern CMS has with permitting plans to call back the CMS tester within the initial 8 minute window? We appreciate any information you can provide about the design of the study, its oversight, and validation of its resulting data.

Thank you,

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Monday, September 16, 2024 2:38 PM
To: Cindy Oppel <coppel@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Good evening,

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

Calls C1800301, D0900533, and D1100955 will remain as is. Your plan is disputing these calls as your procedure is to obtain the phone number of the prospective member and then to call them back if there is a disconnection. However, CMS does not allow callbacks from the plan as all questions should be answered in a single call. The attached call log shows that for each of these calls the disconnect source was not CMS, see column O HangUpBy = Resp. CMS states in our annual memo, attached to this response, on page 2 that "CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study."

Thank you again for reaching out with your questions.

Very respectfully,

Steve

From: Cindy Oppel <coppel@humana.com>
Sent: Friday, September 13, 2024 2:36 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for three (3) calls which we contend are is not performance failures on our part. We respectfully request that CMS review the information provided for the identified calls and advise regarding potential changes in results data.

1. **Humana MAPD Part D**

Case ID: D1100955
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
3/14/2024	12:10:45 p:m	296.05	Unexpected Breakoff: Disconnected	CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan. CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.

-

2. **Humana MAPD Part D**

Case ID: D0900533
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				

Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
2/27/2024	04:16:11	296.01	Unexpected Breakoff: CSR hung up	CSR put me on hold for interpreter. Called person hung up while hold music played.

3. **CarePlus Part C**

Case ID: C1800301

Contract ID: H1019

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
04/29/2024	06:19:36	296.01	Unexpected Breakoff: CSR hung up	CSR placed me on hold for interpreter and a few min later the call go disconnected.

Humana Response: These three calls (Case IDs D1100955, D0900533, and C1800301) were identified as failing the Accuracy and Accessibility Study because the calls disconnected due to technical errors *while Humana's CSRs were actively connecting with an interpreter to join the call*. While Humana agrees that dropped calls pose risks to beneficiary access, CMS actively monitors call disconnect rates under a different arm of the Call Center Monitoring Program – the Timeliness Study. The purpose of the Accuracy and Accessibility Study, on the other hand, is to "determine (1) the availability of interpreters for individuals, (2) teletypewriter (TTY) functionality, and (3) the accuracy of plan information provided by customer service representatives (CSRs) in all languages." *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)*. And CMS isolates the results of this study in its Star Ratings reported under Measure C30 – "Foreign Language Interpreter and TTY Availability." CMS should focus its evaluation for purposes of Measure C30 based on the substantive requirements it is attempting to evaluate, and exclude calls for which callers experience technical difficulties, in order to avoid double counting technical call drop issues and preserve the integrity of the Star Ratings system as an indicator of plan performance on precise topics of importance to beneficiaries.

In the case of all three calls referenced above, Humana was unable to complete these calls due to technical limitations imposed by the CMS study that do not exist when Humana CSRs engage with actual Medicare beneficiaries. Specifically, Humana's standard calling system and process for prospective members allows for Humana to call a prospective member back in the event of a dropped call. However, it is Humana's understanding that CMS would not accept a call back attempt from the Humana CSR if the initial call was disconnected. Therefore, these calls terminated prior to the expiration of the eight-minute timeframe available under CMS rules for connecting a beneficiary with an appropriate interpreter.

CMS's Star Rating Technical Notes and CMS guidance on the 2024 Call Center Monitoring program both state that whether or not an interpreter is considered "available" for purposes of the Star Rating measure calculation is based on whether the beneficiary is connected with the interpreter and the CSR is able to answer questions about the plan *within eight minutes*. *See, e.g., CY 2024 Star Rating Technical Notes* ("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; *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)* ("The measure is considered completed when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter.")

If Humana's CSRs had the opportunity to reconnect with the CMS testers, these calls could have been successfully "completed" within the 8-minute timeframe for purposes of the Star Rating measure based upon our historically strong performance/high pass rates within the Interpreter availability component of this measure. As CMS itself has stated, "the data used for CMS's Star Ratings must be accurate and reliable." *CY 2024 Star Rating Technical Notes, p. 14*. The determination that Humana failed these calls has a negative impact on Humana's CY 2025 Measure C30 Star Rating, results in double-counting of Humana's call disconnect errors and distorts the information available to beneficiaries about Humana's accessibility for individuals that need interpreter and TTY services. Therefore, Humana is requesting that CMS exclude Case IDs D1100955, D0900533, and C1800301from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

Humana
500 W. Main St. | Louisville, KY 40202

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Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文(Chinese):注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

Kreyòl Ayisyen (Haitian Creole): ATANSION: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

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From: CMS CallCenterMonitoring
To: Colleen O"Neil; Cindy Oppel
Cc: Jenna Pinardo; Conor Duffy; Amy Heilman; Kimberlee Reid
Subject: RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study
Date: Monday, September 30, 2024 3:26:00 PM
Attachments: image001.png

Good afternoon,

The Accuracy and Accessibility study will not be adjusted.

Thank you,

Steve

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 27, 2024 4:16 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; Cindy Oppel <coppel@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Thank you for your response.

Can you help us to understand whether CMS would consider modifying the Accuracy and Accessibility study so that the results could provide more reliable signaling for prospective members about interpreter availability? For example, we think that if a callback option was permitted, this would more accurately reflect the beneficiary experience in the real world, where calls do get disconnected. Is there a particular concern CMS has with permitting plans to call back the CMS tester within the initial 8 minute window? We appreciate any information you can provide about the design of the study, its oversight, and validation of its resulting data.

Thank you,

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Sent: Monday, September 16, 2024 2:38 PM
To: Cindy Oppel <coppel@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: RE: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

Good evening,

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

Calls C1800301, D0900533, and D1100955 will remain as is. Your plan is disputing these calls as your procedure is to obtain the phone number of the prospective member and then to call them back if there is a disconnection. However, CMS does not allow callbacks from the plan as all questions should be answered in a single call. The attached call log shows that for each of these calls the disconnect source was not CMS, see column O HangUpBy = Resp. CMS states in our annual memo, attached to this response, on page 2 that "CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study."

Thank you again for reaching out with your questions.

Very respectfully,

Steve

From: Cindy Oppel <coppel@humana.com>
Sent: Friday, September 13, 2024 2:36 PM
To: CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: Humana Inquiry - 2024 Performance Metrics for the Accuracy and Accessibility Study

In response to the July 11, 2024 HPMS memo regarding availability of the 2024 Call Center Monitoring Performance Metrics for Accuracy and Accessibility Study, Humana is submitting supporting documentation, as applicable, for three (3) calls which we contend are is not performance failures on our part. We respectfully request that CMS review the information provided for the identified calls and advise regarding potential changes in results data.

1. **Humana MAPD Part D**

Case ID: D1100955
Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
3/14/2024	12:10:45 p:m	296.05	Unexpected Breakoff: Disconnected	CSR put me on hold to get an interpreter with music playing in the background when the line

				unexpectedly disconnected by the plan. CSR put me on hold to get an interpreter with music playing in the background when the line unexpectedly disconnected by the plan.

2. **Humana MAPD Part D**

Case ID: D0900533

Contract IDs: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H2944, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
2/27/2024	04:16:11	296.01	Unexpected Breakoff: CSR hung up	CSR put me on hold for interpreter. Called person hung up while hold music played.

3. **CarePlus Part C**

Case ID: C1800301

Contract ID: H1019

Case Details *(Column in raw data file provided by CMS)*				
Ts0_date *(W)*	Ts0_time *(X)*	ERC Code *(H)*	ERC Description	Finish Note *(K)*
04/29/2024	06:19:36	296.01	Unexpected Breakoff: CSR hung up	CSR placed me on hold for interpreter and a few min later the call go disconnected.

Humana Response: These three calls (Case IDs D1100955, D0900533, and C1800301) were identified as failing the Accuracy and Accessibility Study because the calls disconnected due to technical errors *while Humana's CSRs were actively connecting with an interpreter to join the call*. While Humana agrees that dropped calls pose risks to beneficiary access, CMS actively monitors call disconnect rates under a different arm of the Call Center Monitoring Program – the Timeliness Study. The purpose of the Accuracy and Accessibility Study, on the other hand, is to "determine (1) the availability of interpreters for individuals, (2) teletypewriter (TTY) functionality, and (3) the accuracy of plan information provided by customer service representatives (CSRs) in all languages." *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)*. And CMS isolates the results of this study in its Star Ratings reported under Measure C30 – "Foreign Language

Interpreter and TTY Availability." CMS should focus its evaluation for purposes of Measure C30 based on the substantive requirements it is attempting to evaluate, and exclude calls for which callers experience technical difficulties, in order to avoid double counting technical call drop issues and preserve the integrity of the Star Ratings system as an indicator of plan performance on precise topics of importance to beneficiaries.

In the case of all three calls referenced above, Humana was unable to complete these calls due to technical limitations imposed by the CMS study that do not exist when Humana CSRs engage with actual Medicare beneficiaries. Specifically, Humana's standard calling system and process for prospective members allows for Humana to call a prospective member back in the event of a dropped call. However, it is Humana's understanding that CMS would not accept a call back attempt from the Humana CSR if the initial call was disconnected. Therefore, these calls terminated prior to the expiration of the eight-minute timeframe available under CMS rules for connecting a beneficiary with an appropriate interpreter.

CMS's Star Rating Technical Notes and CMS guidance on the 2024 Call Center Monitoring program both state that whether or not an interpreter is considered "available" for purposes of the Star Rating measure calculation is based on whether the beneficiary is connected with the interpreter and the CSR is able to answer questions about the plan *within eight minutes*. *See, e.g., CY 2024 Star Rating Technical Notes* ("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; *CMS, "2024 Part C and Part D Call Center Monitoring" (Dec. 1, 2023)* ("The measure is considered completed when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter.")

If Humana's CSRs had the opportunity to reconnect with the CMS testers, these calls could have been successfully "completed" within the 8-minute timeframe for purposes of the Star Rating measure based upon our historically strong performance/high pass rates within the Interpreter availability component of this measure. As CMS itself has stated, "the data used for CMS's Star Ratings must be accurate and reliable." *CY 2024 Star Rating Technical Notes, p. 14*. The determination that Humana failed these calls has a negative impact on Humana's CY 2025 Measure C30 Star Rating, results in double-counting of Humana's call disconnect errors and distorts the information available to beneficiaries about Humana's accessibility for individuals that need interpreter and TTY services. Therefore, Humana is requesting that CMS exclude Case IDs D1100955, D0900533, and C1800301from the Call Center Monitoring report and the calculation of Humana's CY 2025 Star Ratings.

Thank you,

Cindy Oppel
Associate Director | Medicare Regulatory Compliance
Law, Risk & Compliance (LR&C)

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500 W. Main St. | Louisville, KY 40202

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F 502.508.7929
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 1, 2023

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

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

SUBJECT: 2024 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2024. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2024 call center information **no later than December 15, 2023**.

For 2024, CMS has contracted with Hendall Inc., and its subcontractor American Institutes for Research (AIR), to monitor the performance of plan sponsors' call centers with respect to the standards at 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1).

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk telephone lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5 percent or less.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the plan divided by the total number of calls made to the telephone number associated with the contract.

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

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2) teletypewriter (**TTY) functionality,** and (3) the **accuracy of plan information provided by**

customer service representatives (CSRs) in all languages. Languages tested in 2024 are unchanged from 2023 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2024.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. CMS considers a CSR unavailable if the caller is unable to communicate with the CSR through an interpreter. The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures.

2. TTY functionality is defined as the ability of a caller using a TTY device to communicate with someone and receive answers to questions at the plan's call center directly or via a relay operator. A call is considered connected when the caller reaches a TTY/relay operator. The measure is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via the TTY/relay operator (before beginning the first of three general Medicare or plan-specific accuracy questions) within seven minutes of the TTY/relay operator reaching the plan. CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR. The percent of completed TTY calls (the number of completed TTY calls out of all TTY calls) is used for Part C and D Star Ratings measures.

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

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

In the event that an organization believes that CMS may have miscalculated its call center results based on data posted in HPMS, it may bring the relevant information to CMS' attention and ask for a review of the results. **We advise organizations that they should ask for this review within 2 weeks if they do not want the data reflected in compliance actions, public reporting, or star ratings.** CMS may not be able to make adjustments if issues aren't brought to its attention within 2 weeks. **CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study.**

IMPORTANT ACTION: Verify 2024 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2024 Part C and/or Part D call center telephone numbers in HPMS by **December 15, 2023**. This includes current and prospective enrollee **toll-free** beneficiary call center telephone numbers**, toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis and updated in the monitoring contractor's automated dialing software. If any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately, pursuant to 42 C.F.R. §§ 422.504(f)(2)(vii) and 423.505(f)(2)(vii). It is important that all organizations always keep these telephone numbers up-to-date in HPMS. Organizations should notify CallCenterMonitoring@cms.hhs.gov after an update is made. **If an organization achieves poor results on the measures due to calls to an inaccurate telephone numbers, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is available in HPMS prior to the launch of the studies.** Use the paths outlined below to verify and/or update the telephone numbers.

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

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: > Plan Bids > Bid Submission > CY 2024 – Manage Plans > Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

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

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

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

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

Notes:

- The above process to verify the accuracy of call center telephone numbers is separate from the Call Center Indicator activity that has already begun. You should have received communication from **CallCenterIndicators@hendall.com** in November 2023. The Call Center Indicators identify plan benefit package (PBP) phone numbers that are served by the same physical call center. This information is important as the Accuracy and Accessibility study is conducted at the call center level, with legal entities sharing results

of calls placed to a shared call center, with a limited exceptions. The Timeliness study is conducted at the phone number level. Results of calls placed to a shared phone number are shared by all legal entities utilizing that phone number, with limited exceptions. The Accuracy and Accessibility study indicators do not impact the Timeliness study. **Please be aware that while phone numbers must be kept current in HPMS, the Accuracy and Accessibility study indicators cannot be updated after the Call Center Indicator collection activity is completed.**

- Our regulations at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1) require the operation of a toll-free customer call center; MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.*** Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

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

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

  This information can be found in Chapter 1 of the CY2024 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2024 > View Documentation (under "Documentation" Section) > Bid Submission User manual for Contract Year 2024*).

Tips for Success/Best Practices

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

General:

- Provide basic services and information to individuals with disabilities, upon request.

- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio and data CDs, and in requested alternate languages) to individuals with disabilities upon request.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot program what options they should select for each plan. We train them to listen for options such as "current members," "pharmacy," or an option for those "interested in learning more about enrolling" for prospective calls, for example. When you are setting up your IVR options, please

keep this in mind. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. You may experience more successful call outcomes if the representative offers a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, "You need to call another number" or answering "no" to the introductory question, "Are you the right person to answer questions about…." will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make the most reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plans, or at least transfer us to the correct party who can answer those questions.

HPMS Entries:

- Current, prospective, and TTY/relay services customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or Telecommunications Relay Service (TRS) telephone numbers. CMS extracts the values found in the toll-free *and* alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. If you have updates at any time during the year, please enter them into HPMS immediately, and notify CallCenterMonitoring@cms.hhs.gov. A delay in updating the telephone number(s) prior to the start of the study may result in unsuccessful calls attributed to your plan's performance. Calls of this nature cannot be negated.

Ability to Accept Calls:

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

- CMS' monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Generally speaking, CMS also notes longer hold times at the beginning of a week with improvement as the week progresses. Call centers should evaluate their own needs and consider increased staffing during busier times.

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

- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
    - Test every telephone number supported by the call center.
    - Pull the telephone numbers from HPMS and ensure they ring to the intended location.
    - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.

- Test with more than one caller at the same time.
- See TTY section below for specific TTY testing suggestions.

- CMS will occasionally solicit volunteers for abbreviated training periods prior to the beginning of an actual study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. If you are launching new technology in your call center, consider joining a pilot or interviewer training session to ensure your equipment is working as expected. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next pilot or interviewer training session.

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

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

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

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

- Train CSRs to answer the introductory question asked of them ("Are you the right person to answer questions about…?") When we call customer service lines, we ask a question

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

Interpreter Availability:

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

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

- Interpreters should:
  - Adhere to generally accepted interpreter ethics principles, including confidentiality.
  - Demonstrate proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation.
  - Interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

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

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

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

- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English, for both written and verbal communication. Record and maintain that information in a tracking system to be used in future beneficiary contacts.

- Monitor CSR calls to ensure that foreign-language calls are being handled according to the plan sponsor's policies and procedures.

- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.

- Ensure that CSRs are able to respond promptly to questions. Each accuracy question has a 7-minute timer.

TTY Functionality:

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

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

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

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

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

- Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

- **The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan.** If you use

a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller's area code. It is the plan's responsibility to ensure that calls from any area code can be received via their relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements of 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1). Review the 2024 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2024. Consider sharing the most recent *Medicare & You* with translator service provider.

- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.

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

    - When we ask our introductory question, ("Are you the right person to answer questions about…?"), it is always best for the CSR to respond "yes" or "no," meaning yes, the CSR is the correct person to answer questions about a specific plan's benefits, or no, the CSR is not the correct person to answer questions about the plan's benefits. The CSR should then offer a "warm transfer" to the caller so that he or she may speak to the appropriate person. If the CSR responds at this high level first, it will save time, especially if the caller needs to be transferred to another party. If the CSR spends a great deal of time trying to get more information from the caller, the timer may expire, resulting in an unsuccessful call in the plan's performance.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (*National CLAS Standards*). Originally published in 2000, an enhanced version of the *National CLAS Standards* was most recently updated by OMH in October 2018. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" and serves as the overarching goal for *National CLAS Standards'* implementation. One key area is Communication and Language Assistance, which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and

providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the *National CLAS Standards* and its guidance document, *The Blueprint*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH's free e-learning program, *The Guide to Providing Effective Communication and Language Assistance Services*. If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes/Frequently Asked Questions and Data Dictionaries for each study are stored in HPMS via links in the lower left corners of the Performance Metrics pages. Please refer to pages 2 and 3 above for the location of the studies' results. This same location is where you will find these reference materials.

If you have any questions about the 2024 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Do not use secure email when communicating with this resource. **CMS will not open a secure email message.** CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.

	A	B	C	D	E
1	*All calls originate from the Maryland region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan. The Raw Data depicts the time the call was placed from the Maryland Area. Be sure to adjust it according to your call center's time zone(s).				
2	**Column Label**	**Variable Name**	**Values**	**Description**	**Special Handling**
3	A	**contract_id**	{string}	Contract ID	
4	B	**cas_caseid**	{string}	Unique 8-digit Call ID: Type(1)+Week(2-3)+Sequ. Call Number(4-8): type = E (enrollee), P(pharmacy), C (Survey II C), D (Survey II D)	
5	C	**parent_organization_id**	{numeric}	Parent Organization ID Number	
6	D	**parent_organization_name**	{string}	Parent Organization Name	
7	E	**contract_name**	{string}	Contract Name	
8	F	**organization_type**	{string}	Organization type as listed in HPMS	
9	G	**CallCenterInd**	{string}	Call Center Indicator	
10	H	**ERC (Extended Result Code)**	261	Non-toll free number	
11	H	**ERC**	290.1	Partial interview - reached CSR/TTY/Interviewer but only partially answered accuracy questions: CSR Hung up	
12	H	**ERC**	290.2	Partial interview - reached CSR/TTY/Interviewer but only partially answered accuracy questions: Disconnected call	
13	H	**ERC**	290.3	Partial interview - reached CSR/TTY/Interviewer but only partially answered accuracy questions: OTHER (q_drop_reason)	
14	H	**ERC**	290.4	Partial interview - reached CSR/TTY/Interviewer - CSR would not answer questions because CSR did not have answers to plan-specific 'eligibility questions'	
15	H	**ERC**	290.5	Partial interview - reached CSR/TTY/Interviewer -CSR unable to transfer call to more knowledgeable CSR	
16	H	**ERC**	290.6	Partial interview - reached CSR/TTY/Interviewer - CSR does not recognize the plan	
17	H	**ERC**	290.7	Partial interview - CSR could not answer accuracy question in 7 minutes	
18	H	**ERC**	291	Phone not answered	
19	H	**ERC**	292	HOLD Q greater than 10 minute wait	
20	H	**ERC**	293.1	Plan Call Center Dropped Call - Center Closed during Required Hours of Operation	
21	H	**ERC**	293.2	Plan Call Center Dropped Call - Recording insists on SSN, member number, etc.	
22	H	**ERC**	293.3	Plan Call Center Dropped Call - Other Language only	
23	H	**ERC**	293.4	Plan Call Center Dropped Call - Other	
24	H	**ERC**	293.5	Plan Call Center Dropped Call - Disconnected	
25	H	**ERC**	293.6	Plan Call Center Dropped Call - Voicemail	
26	H	**ERC**	294.1	LEP: Timeout during wait for interpreter or prior to the interpreter answering the introductory question (more than 8 minutes)	
27	H	**ERC**	294.2	TTY: Timeout prior to the CSR answering the introductory question(more than 7 minutes)	
28	H	**ERC**	295	Completed Call: Answered all questions	
29	H	**ERC**	295.2	Completed Call: SNP Case	
30	H	**ERC**	296.01	Unexpected Breakoff: CSR hung up	
31	H	**ERC**	296.02	Unexpected Breakoff: CSR insists on member name, SSN, etc.	
32	H	**ERC**	296.03	Unexpected Breakoff: Call center responded in Other Language only	
33	H	**ERC**	296.04	Unexpected Breakoff: Other	
34	H	**ERC**	296.05	Unexpected Breakoff: Disconnected	
35	H	**ERC**	296.06	Unexpected Breakoff: Voice mail	
36	H	**ERC**	296.07	Unexpected Breakoff: CSR said to call back and gave other phone #	
37	H	**ERC**	296.08	Unexpected Breakoff: Call center will call back	
38	H	**ERC**	296.09	Unexpected Breakoff: CSR refused	
39	H	**ERC**	296.1	Unexpected Breakoff: Center Closed during Required Hours of Operation	
40	H	**ERC**	296.11	Unexpected Breakoff: CSR unable to answer question about Medicare	
41	H	**ERC**	296.12	TTY/TDD Operator Hung up	
42	H	**ERC**	296.13	TTY Service Not Available	
43	H	**ERC**	296.14	TTY: Told to Call Back, Given a Callback Number	
44	H	**ERC**	296.15	TTY: OTHER	
45	H	**ERC**	296.16	TTY Operator Cannot Answer Questions	
46	H	**ERC**	296.17	TTY Disconnected	
47	H	**ERC**	296.18	TTY: Voicemail	
48	H	**ERC**	296.2	TTY: Insists on Member Name, SSN, etc.	
49	H	**ERC**	296.21	TTY: Center Closed	
50	H	**ERC**	296.22	TTY: Call Center will Call Back	
51	H	**ERC**	296.3	TTY: Can connect to TTY operator but cannot connect to the plan	
52	H	**ERC**	297	Neither Call Center Contact Nor Ring No Answer - Other	
53	H	**ERC**	297.11	Neither Call Center Contact Nor Ring No Answer - Bad Phone	
54	H	**ERC**	297.12	Neither Call Center Contact Nor Ring No Answer - Busy	
55	H	**ERC**	297.13	Neither Call Center Contact Nor Ring No Answer - Dropped less than 6 rings	
56	H	**ERC**	297.14	Neither Call Center Contact Nor Ring No Answer - Not Targeted Plan Number	
57	H	**ERC**	297.2	Neither Call Center Contact Nor Ring No Answer - Technology Barrier (Fax modem computer)	
58	H	**ERC**	297.3	Neither Call Center Contact Nor Ring No Answer - Cannot Connect to TTY operator	
59	H	**ERC**	297.99	Neither Call Center Contact Nor Ring No Answer - Call Cannot Be Dialed From This Area	
60	H	**ERC**	298	IVR greater than 10 minute wait	
61	H	**ERC**	299.1	Interviewer left IVR - Center Closed during Required Hours of Operation	
62	H	**ERC**	299.2	Interviewer left IVR - Recording insists on SSN, member number, etc.	
63	H	**ERC**	299.3	Interviewer left IVR - Other Language only	
64	H	**ERC**	299.4	Interviewer left IVR - Other (reason_drop string)	
65	H	**ERC**	299.6	Interviewer left IVR - Voicemail	
66	I	**cas_casestatus**	261	Non-toll free number	
67	I	**cas_casestatus**	290	Partial Completed Call	
68	I	**cas_casestatus**	291	Phone not answered	

	A	B	C	D	E
69	I	**cas_casestatus**	292	HOLD Q - greater than 10 minute wait	
70	I	**cas_casestatus**	293	Plan Call Center Dropped Call	
71	I	**cas_casestatus**	294	Timeout during wait for interpreter or prior to the CSR answering the introductory question	
72	I	**cas_casestatus**	295	Completed Call	
73	I	**cas_casestatus**	296	Unexpected Breakoff	
74	I	**cas_casestatus**	297	Neither Call Center Contact Nor Ring No Answer	
75	I	**cas_casestatus**	298	IVR - greater than 10 minute wait	
76	I	**cas_casestatus**	299	Interviewer left IVR	
77	I	**cas_casestatus**	601	Call timeout at the 1st accuracy question	
78	I	**cas_casestatus**	602	Call timeout at the 2nd accuracy question	
79	I	**cas_casestatus**	603	Call timeout at the 3nd accuracy question	
80	J	**ERC_Description**	{string}	ERC Description	
81	K	**finishnote**	{string}	Up to 250 characters, to capture interviewers' comments	
82	L	**Unprofessional_Behavior_Note**	{string}	Interviewer comments if there are any unprofessional behaviors.	
83	M	**Interpreter_Problem_Note**	{string}	Interviewer comments if there are any Interpreter Problems.	
84	N	**ctype**	3	Part D	
85	N	**ctype**	5	Part C	
86	O	**clanguage**	1	The call was placed in Native Language (English in most states, Spanish in Pueto Rico)	
87	O	**clanguage**	2	The call was placed in Spanish (English in Pueto Rico)	
88	O	**clanguage**	3	The call was placed in French.	
89	O	**clanguage**	4	The call was placed in Vietnamese.	
90	O	**clanguage**	5	The call was placed in Mandarin.	
91	O	**clanguage**	6	The call was placed in Cantonese.	
92	O	**clanguage**	7	The call was placed in Tagalog.	
93	O	**clanguage**	8	This was a TTY test call (English only).	
94	P	**quarter**	1	Quarter of Production = 1	
95	P	**quarter**	2	Quarter of Production = 2	
96	P	**quarter**	3	Quarter of Production = 3	
97	P	**quarter**	4	Quarter of Production = 4	
98	Q	**week**	{numeric}	week of production Calendar week (1 --> 52)	
99	R	**phone**	{string}	Phone number called, as listed in Health Plan Management System (HPMS)	
100	S	**Assigned_contractID**	{string}	Assigned Contract ID we called to ask accuracy questions/Results applied to contracts within shared call center	
101	T	**Assigned_PlanID**	{string}	Assigned Plan ID we called to ask accuracy questions/Results applied to contracts within shared call center	
102	U	**PLANNAME**	{string}	Assigned Plan name we called to ask accuracy questions, as it appeared on survey caller's computer screen	
103	V	**ORGNAME**	{string}	Organization name as it appeared on survey caller's computer screen	
104	W	**ts0_date**	{date}	TS0, Set after dial1 - begin call	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
105	X	**ts0_time***	{time}	TS0, Set after dial1 - begin call	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
106	Y	**ts1_date**	{date}	TS1, Set after answered = 4,5, or 6	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
107	Z	**ts1_time***	{time}	TS1, Set after answered = 4,5, or 6	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
108	AA	**ts2_date**	{date}	TS2, Set after answered = 1,2, or 3	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
109	AB	**ts2_time***	{time}	TS2, Set after answered = 1,2, or 3	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
110	AC	**ts3_date**	{date}	TS3, Set after answered = 1(start IVR)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
111	AD	**ts3_time***	{time}	TS3, Set after answered = 1(start IVR)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
112	AE	**ts4_date**	{date}	TS4, Set after answered = 3 or IVRResult = 1 (start HOLD Q)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
113	AF	**ts4_time***	{time}	TS4, Set after answered = 3 or IVRResult = 1 (start HOLD Q)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
114	AG	**ts5_date**	{date}	TS5, Set after answered = 2 or IVRResult = 2 or Hold = 1 (reach CSR)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
115	AH	**ts5_time***	{time}	TS5, Set after answered = 2 or IVRResult = 2 or Hold = 1 (reach CSR)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
116	AI	**ts6_date**	{date}	TS6, Set after IVRResult = 3 or Hold = 3 (call dropped)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
117	AJ	**ts6_time***	{time}	TS6, Set after IVRResult = 3 or Hold = 3 (call dropped)	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
118	AK	**ts7_date**	{date}	TS7, Set exiting the call	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
119	AL	**ts7_time***	{time}	TS7, Set exiting the call	*All calls originate from the Maryland Region in the Eastern Time Zone. Calls are scheduled based on the local service areas for each plan.
120	AM	**TTY_Phone**	{string}	TTY number dialed - If Relay operator is used (see column D for Unique number, or column BL for TTY type), this is the prospective customer service phone number our call surveyor provided to TTY Relay operator.	
121	AN	**IVR_TIME**	{numeric}	IVR time (600 seconds limit)	
122	AN	**IVR_TIME**	-1	Missing	
123	AO	**HOLD_TIME**	{numeric}	Hold time (600 seconds limit)	
124	AO	**HOLD_TIME**	-1	Missing	
125	AP	**LEP_HOLDTIME**	{numeric}	LEP hold time (480 seconds limit)	
126	AP	**LEP_HOLDTIME**	-1	Missing	

	A	B	C	D	E
127	AQ	**TTY_HOLDTIME**	{numeric}	TTY hold time (420 seconds limit)	
128	AQ	**TTY_HOLDTIME**	-1	Missing	
129	AR	**CASETYPEIndicator**	C	Part C question asked	
130	AR	**CASETYPEIndicator**	D	Part D question asked	
131	AR	**CASETYPEIndicator**	P	Pharmacy question asked	
132	AS	**MMP_Indicator**	1	Medicare-Medicaid Plan (MMP)	
133	AS	**MMP_Indicator**	0	Not MMP	
134	AT	**INDSNP**	1	Special Needs Plan (SNP)	
135	AT	**INDSNP**	{blank}	Not SNP	
136	AU	**resCallCount**	{numeric}	Number of attempts to place call	
137	AV	**dayofwk**	1	Monday	
138	AV	**dayofwk**	2	Tuesday	
139	AV	**dayofwk**	3	Wednesday	
140	AV	**dayofwk**	4	Thursday	
141	AV	**dayofwk**	5	Friday	
142	AV	**dayofwk**	6	Saturday	
143	AV	**dayofwk**	7	Sunday	
144	AW	**timeofday**	{numeric}	Time scheduled to call	
145	AX	**ZIPCODE**	{string}	ZIP code as it appeared on survey caller's computer screen	
146	AY	**COUNTY**	{string}	County as it appeared on survey caller's computer screen	
147	AZ	**STATE**	{string}	State as it appeared on survey caller's computer screen	
148	BA	**Question1****	1-20	First Question asked: Question 1-20 Part C Non-MMP	
149	BA	**Question1**	21-40	First Question asked: Question 1-20 Part D Non-MMP	
150	BA	**Question1**	41-60	First Question asked: Question 1-20 Part C MMP	
151	BA	**Question1**	61-80	First Question asked: Question 1-20 Part D MMP	
152	BB	**Question2**	1-20	Second Question asked: Question 1-20 Part C Non-MMP	
153	BB	**Question2**	21-40	Second Question asked: Question 1-20 Part D Non-MMP	
154	BB	**Question2**	41-60	Second Question asked: Question 1-20 Part C MMP	
155	BB	**Question2**	61-80	Second Question asked: Question 1-20 Part D MMP	
156	BC	**Question3**	1-20	Third Question asked: Question 1-20 Part C Non-MMP	
157	BC	**Question3**	21-40	Third Question asked: Question 1-20 Part D Non-MMP	
158	BC	**Question3**	41-60	Third Question asked: Question 1-20 Part C MMP	
159	BC	**Question3**	61-80	Third Question asked: Question 1-20 Part D MMP	
160	BD	**Answer1**	{string}	Correct answer for the first question	
161	BE	**Answer2**	{string}	Correct answer for the second question	
162	BF	**Answer3**	{string}	Correct answer for the Third question	
163	BG	**A1**	1	The first question result: Correct	
164	BG	**A1**	2	The first question result: Incorrect	
165	BG	**A1**	3	The first question result: Don't know	
166	BG	**A1**	4	The first question result: Call terminated	
167	BG	**A1**	90	The first question result: Timeout (did not answer accuracy question within 7 minutes)	
168	BH	**O_A1M1**	{string}	Comment if the first result is incorrect	
169	BI	**A2**	1	The second question result: Correct	
170	BI	**A2**	2	The second question result: Incorrect	
171	BI	**A2**	3	The second question result: Don't know	
172	BI	**A2**	4	The second question result: Call terminated	
173	BI	**A2**	90	The second question result: Timeout (did not answer accuracy question within 7 minutes)	
174	BJ	**O_A2M1**	{string}	Comment if the second result is incorrect	
175	BK	**A3**	1	The third question result: Correct	
176	BK	**A3**	2	The third question result: Incorrect	
177	BK	**A3**	3	The third question result: Don't know	
178	BK	**A3**	4	The third question result: Call terminated	
179	BK	**A3**	90	The third question result: Timeout (did not answer accuracyc question within 7 minutes)	
180	BL	**O_A3M1**	{string}	Comment if the third result is incorrect	
181	BM	**CCETIMEZONE**	AST	Time zone covered by the contract: Atlantic Time (7AM-7PM EST)	
182	BM	**CCETIMEZONE**	EST	Time zone covered by the contract: EST (8AM-8PM EST)	
183	BM	**CCETIMEZONE**	CST	Time zone covered by the contract: CST (9AM-9PM EST)	
184	BM	**CCETIMEZONE**	MST	Time zone covered by the contract: MST (10AM-10PM EST)	
185	BM	**CCETIMEZONE**	PST	Time zone covered by the contract: PST (11AM-11PM EST)	
186	BM	**CCETIMEZONE**	HST	Time zone covered by the contract: Hawaii (1PM-1AM EST)	
187	BM	**CCETIMEZONE**	HDT	Time zone covered by the contract: Hawaii DST (2PM-2AM EST)	
188	BM	**CCETIMEZONE**	AH	Time zone covered by the contract: AST-Hawaii (7AM-1AM EST)	
189	BM	**CCETIMEZONE**	EC	Time zone covered by the contract: EST-CST (8AM-9PM EST)	
190	BM	**CCETIMEZONE**	EM	Time zone covered by the contract: EST-MST (8AM-10PM EST)	
191	BM	**CCETIMEZONE**	EP	Time zone covered by the contract: EST-PST (8AM-11PM EST)	
192	BM	**CCETIMEZONE**	EH	Time zone covered by the contract: EST-Hawaii (8AM-1AM EST)	
193	BM	**CCETIMEZONE**	CM	Time zone covered by the contract: CST-M (9AM-10PM EST)	
194	BM	**CCETIMEZONE**	CP	Time zone covered by the contract: CST-P (9AM-11PM EST)	
195	BM	**CCETIMEZONE**	CH	Time zone covered by the contract: CST-Hawaii (9AM-1AM EST)	
196	BM	**CCETIMEZONE**	MP	Time zone covered by the contract: MST-P (10AM-11PM EST)	
197	BM	**CCETIMEZONE**	MH	Time zone covered by the contract: MST-Hawaii (10AM-1AM EST)	

	A	B	C	D	E
198	BM	**CCETIMEZONE**	PH	Time zone covered by the contract: PST-Hawaii (11AM-1AM EST)	
199	BM	**CCETIMEZONE**	DE	Time zone covered by the contract: EST-Hawaii DST (8AM-2AM EST)	
200	BM	**CCETIMEZONE**	DC	Time zone covered by the contract: CST-Hawaii DST (9AM-2AM EST)	
201	BM	**CCETIMEZONE**	DM	Time zone covered by the contract: MST-Hawaii DST (10AM-2AM EST)	
202	BM	**CCETIMEZONE**	DP	Time zone covered by the contract: PST-Hawaii DST (11AM-2AM EST)	
203	BM	**CCETIMEZONE**	99	Time zone covered by the contract: Pharmacy - no time zone restriction	
204	BN	**TTY_TYPE**	1	TTY Type: State Relay Service	
205	BN	**TTY_TYPE**	2	TTY Type: Direct TTY line	
206	BN	**TTY_TYPE**	3	TTY Type: National 711 Relay Service	
207	BN	**TTY_TYPE**	4	TTY Type: Don't know	
208	BN	**TTY_TYPE**	5	TTY Type: Could not connect with TTY relay operator	
209	BO	**ANSWERED**	01	Answered by IVR	
210	BO	**ANSWERED**	02	Answered by Live Person	
211	BO	**ANSWERED**	03	Placed Directly into Hold Queue	
212	BO	**ANSWERED**	04	Busy signal / "all circuits are busy"	
213	BO	**ANSWERED**	05	Did not connect to a plan / bad phone (specify)	
214	BO	**ANSWERED**	06	Ring, no answer after 6 rings	
215	BP	**IVR1**	{string}	1st IVR keypress option (Can be either number or text)	
216	BQ	**IVR2**	{string}	2nd IVR keypress option (Can be either number or text)	
217	BR	**IVR3**	{string}	3rd IVR keypress option (Can be either number or text)	
218	BS	**IVR4**	{string}	4th IVR keypress option (Can be either number or text)	
219	BT	**IVR5**	{string}	5th IVR keypress option (Can be either number or text)	
220	BU	**IVR6**	{string}	6th IVR keypress option (Can be either number or text)	
221	BV	**IVR7**	{string}	7th IVR keypress option (Can be either number or text)	
222	BW	**IVR8**	{string}	8th IVR keypress option (Can be either number or text)	
223	BX	**IVR9**	{string}	9th IVR keypress option (Can be either number or text)	
224	BY	**IVR10**	{string}	10th IVR keypress option (Can be either number or text)	
225	BZ	**IVRResult**	01	Sent to Hold Queue - ("one moment"; instructed to hold, wait, stay or remain on the line / hear music or advertisements)	
226	BZ	**IVRResult**	02	Got Live Person	
227	BZ	**IVRResult**	03	Call terminated	
228	BZ	**IVRResult**	04	Case do over	
229	BZ	**IVRResult**	90	TIMEOUT	
230	CA	**HOLD**	01	Live Person	
231	CA	**HOLD**	02	Sent to IVR	
232	CA	**HOLD**	03	Call terminated	
233	CA	**HOLD**	04	Case do over	
234	CA	**HOLD**	90	TIMEOUT	
235	CB	**LIVE**	01	Answer to Introductory Question: Yes	
236	CB	**LIVE**	02	Answer to Introductory Question: Anything Other than Yes	
237	CB	**LIVE**	03	Answer to Introductory Question: Case Do over	
238	CB	**LIVE**	90	Answer to Introductory Question: Timeout	
239	CC	**O_LIVE2M1*** **	{string}	Comment at Live Person (If sent back to IVR): Time spent would be reflected in LEP/TTY Holdtime	
240	CD	**O_LIVE2M2**	{string}	Comment at Live Person (If put on HOLD): Time spent would be reflected in LEP/TTY Holdtime	
241	CE	**O_LIVE2M3**	{string}	Comment at Live Person (If disconnected or other problems): Time spent would be reflected in LEP/TTY Holdtime	
242	CF	**EndScreen**	01	No unprofessional behavior	
243	CF	**EndScreen**	02	Unprofessional behavior	
244	CF	**EndScreen**	03	Case do over	
245	CG	**EndScreen2**	01	Was There unprofessional behavior: Yes	
246	CG	**EndScreen2**	02	Was There unprofessional behavior: No	
247	CH	**Unprofessional**	1	Is there any unprofessional behavior: Yes	
248	CI	**Interpret**	1	Are there any interpreter problems?: Yes	
249	CI	**Interpret**	2	Are there any interpreter problems?: No	
250	CJ	**linesttime**	{string}	Line start time (Start of operation time): for all time zone covered in service areas	
251	CK	**lineendtime**	{string}	Line end time (End of operation time): for all time zone covered in service areas	
252					
253					
254					
255					
256	**Number Identifier in raw data**	****Questions List**		**Question**	**Special Handling**
257	1	**C1_Premium**	{string}	**My mom, who lives in <COUNTY> county, does not get extra help and is not on Medicaid. What is the monthly consolidated premium for <PLANNAME>? If asked, you want the consolidated premium, which is the cost of the Part C and Part D (if offered) benefits combined.**	
258	2	**C2_Website**	{string}	**Is your privacy notice on your website? If CSR asks: you are referring to the Privacy Notice under the HIPAA Privacy Law. If CSR offers to mail it to you, you do not need to follow through. Just say, "Thank you, but I'll read it on the website."**	
259	3	**C3_Reduce**	{string}	**Will joining <PLANNAME> affect how much my mom pays for her Part B premium? If the CSR states yes but then states the amount reduced is $0, that is the same as saying, "no, joining the plan will not affect how much is paid for the Part B premium.**	
260	4	**C4_Emergency**	{string}	**If my mom goes to the emergency room, will the copayment be waived if she is admitted to the hospital within a certain amount of time? We are specifically asking if the copayment amount will be waived if admitted to the hospital, if there is a copayment. If a plan answers yes, the copayment is waived if admitted, they must tell you the correct number of hours or days within which the admission must occur for the waiver to happen. We do not want to know if the coinsurance amount will be waived if admitted to the hospital, which is or could be a separate matter.**	Exclude plans that do not charge a copayment.

	A	B	C	D	E
261	5	C5_NonNetwork	{string}	If my mom enrolls in <PLANNAME>, will she be covered if she goes to an out-of-network doctor for routine care? If asked, you are not asking how much it will cost to see an out-of-network physician. You are asking if the services of an out-of-network physician are covered by the plan. This question is not about cost.	Exclude HMO-POS and PFFS plan types from this question.
262	6	C6_STAR	{string}	What is the star rating for <PLANNAME>? If asked, you want to know only the overall star rating. The star rating is the score assigned by the Centers for Medicare & Medicaid Services. If the expected response is "plan too new to be measured" or "not enough data available" and the CSR offers a star rating to you, code this answer as incorrect.	
263	7	C7_ Referral	{string}	Is a referral required for an outpatient transfusion? If asked what you mean by "outpatient transfusion," you mean units of blood delivered in an outpatient setting. You may hear information regarding the need for prior authorization or medical necessity or cost-sharing data, but focus on whether or not a referral is required. If you are not clear if a Yes or No answer was given, follow up with "I am not clear as to what you are saying - is a referral required?"	Exclude PFFS organization types
264	8	C8_Smoking	{string}	My mom is a smoker and is trying to quit. Will <PLANNAME> provide counseling to help her quit smoking? Focus on whether or not the plan will provide counseling for smoking cessation. Do not focus on the number of counseling visits the plan will cover. All people with Medicare who use tobacco are covered.	
265	9	C9_Braille Handbook Access	{string}	My mom is blind; could she get a member handbook and provider directory in braille? If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Questions C9 and C20 are both about alternate access. Use dynamic programming to ensure only C9 OR C20 is used in any given call. In other words, C9 and C20 must not be scheduled for use during the same call.
266	10	C10_SkilledNursing	{string}	How many days does your plan cover for care at a Skilled Nursing Facility?{ Every plan is required to provide at least 100 days of coverage. See the answer below for the correct number of days for this plan, which can be up to an unlimited number of days.	
267	11	C11_FluShot	{string}	Does my mom have to pay for a flu shot received from an in-network provider?	
268	12	C12_Medigap	{string}	Can my mom use her Medicare supplement insurance to pay for Medicare Advantage plan's out-of-pocket costs, like co-pays? Medicare supplement insurance is also referred to as "Medigap."{/span}	
269	13	C13_Provider Participation	{string}	Will you let my mom know if her primary doctor leaves the plan?	
270	14	C14_Hearing Aids	{string}	Does your plan provide Hearing Aids as a supplemental benefit under Part C? Some plans may offer an optional package which may come with an additional premium for the beneficiary, but that is not the focus of this question. We simply want to know if they offer hearing aids as a supplemental benefit, so we only need a yes or no response to this. If they offer an optional package at additional cost to the beneficiary, the answer is still "yes," they provide hearing aids as a supplemental benefit. The CSR may also mention inner ear, outer ear, or over the ear aids, but we don't need those specifics for this question.	
271	15	C15_Cost	{string}	What is the in-network maximum out-of-pocket cost for <PLANNAME>?	Exclude PFFS plans because they do not have an in-network MOOP amount. Ask only local MA plans including HMOs, HMO-POS, local PPO, and regional PPOs plans.
272	16	C16_Original Medicare	{string}	If my mom enrolls in your plan, does she have the option to go back to original Medicare during next year's open enrollment period?	
273	17	C17_Vision	{string}	Does <PLANNAME> cover routine eye exams? If the CSR states that routine eye exams would be covered if the beneficiary purchases an additional package that may come with an additional premium, that is the same as saying yes, this plan covers routine eye exams. We don't need to capture the premium cost – just focus on would this plan cover a routine eye exam if any optional coverage was purchased.	
274	18	C18_Website 2	{string}	Do you have a summary of your plan benefits on your website?	
275	19	C19_ServiceArea	{string}	My mom lives in <COUNTY> county. Can she enroll in your plan? Interviewers have ZIP code informtion available for the plan in question in the event the CSR needs to confirm the ZIP code of the beneficiary because the service area includes only a portion of the county.	
276	20	C20_Member Handbook	{string}	Would my mom be able to get a member handbook and provider directory in large print? If the CSR states they must order the format to know if it's available, mark as incorrect and state why in text box beneath the incorrect response option.	Questions C9 and C20 are both about alternate access. Use dynamic programming to ensure only C9 OR C20 is used in any given call. In other words, C9 and C20 must not be scheduled for use during the same call.
277	21	D1_ Copaxone	{string}	Does <PART D PLAN NAME> cover brand name Copaxone 40mg/ml prefilled syringe? INTERVIEWER NOTE: Copaxone 40mg/ml prefilled syringe is a brand name product. You are specifically asking whether this brand name product in the specific strength is on the formulary. You do not want to know if the generic version of Copaxone 40mg/ml prefilled syringe is on formulary.	
278	22	D2_Krazati	{string}	Is Krazati a covered medication for <PART D PLAN NAME>? INTERVIEWER NOTE: If CSR states it is on the plan's formulary that is the same as saying it is a covered medication.	
279	23	D3_Viracept	{string}	Would my mom need prior authorization to get Viracept? INTERVIEWER NOTE: 100% of plans have this drug on their formularies. Prior authorization is never allowed. Exceptions will never be necessary. If a CSR indicates any of these things to you, attempt to clarify by stating, "I don't understand. Is prior authorization required or not?" If they answer that an exception is needed or the drug is not on the formulary, score the answer as incorrect and note the CSR's answer in the system.	
280	24	D4_Wegovy	{string}	Is Wegovy a covered medication for <PART D PLAN NAME>? INTERVIEWER NOTE:If CSR states it is on the plan's formulary, it is the same as saying it is a covered medication.	
281	25	D5_YF-VAX	{string}	My mom wants to get the YF-VAX vaccine. Is this covered by your plan? INTERVIEWER NOTE: If asked, YF-VAX is the name of one type of yellow fever vaccine. YF-VAX is a vaccine for yellow fever.	
282	26	D6_Utilization Management	{string}	My mom's doctor stated that she needs to take 2 tablets of her medication everyday but the pharmacy says there's a quantity limit of 1 tablet per day. Does that mean her doctor has to contact <PLAN NAME> before the plan will cover more than 1 tablet a day of her medication? INTERVIEWER NOTE: If asked what drug, respond with "I'm not asking about any particular drug. I just know that my mom ran into this in the past and I want to make sure I understand." If the CSR says your mom must meet certain clinical criteria or the drug must be medically necessary, that is the same as answering "Yes" to this question.	
283	27	D7_Walmart	{string}	My mom thinks it is cheaper to buy some of her prescriptions at Walmart and pay $4.00 for a generic drug instead of using her insurance. If she enrolls in your plan, does she have to show her plan card and buy her drugs through your plan or can she continue to pay for drugs on her own? She does not have to show her plan card. She can pay the $4.00 for her prescriptions. CSR may say that it is cheaper to use the plan or that if she does not use the plan her costs will not count toward her overall drug plan expense, but focus on whether or not the CSR says it is okay to pay out of pocket at Walmart.)	
284	28	D8_Transition Supply	{string}	If my mom joins your plan, and one of her medications is not covered by your plan, can she get a temporary supply of her medicine at the beginning of her enrollment in the plan? If CSR asks, this would be within the first 90 days.	
285	29	D9_BAE	{string}	Would a copy of a letter from the Social Security Administration showing that my mom receives Supplemental Security Income 'be acceptable evidence for low income subsidy?	Plans with a service area in Puerto Rico, US Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa will not be asked this question.
286	30	D10_Pharmacy Directory	{string}	Where can my mom get a list of <PLANNAME>'s network pharmacies? INTERVIEWER NOTE: Plans are required to post their Provider and Pharmacy Directory to their website. Telling you it is available on the website is a correct answer. If the CSR offers to send you a copy based upon your request, this is a correct answer. You do not need to follow through on the request to mail you a copy.	
287	31	D11_Audio Benefits Access	{string}	My mom is blind; can she get an audio version of your summary of benefits? Any audio format is acceptable (e.g., .mp3, .mp4, .wav, audio disk, cassette, or other). The critical issue to watch for is whether the CSR is willing to provide the information in an audio format. If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Ask either D11 or D18 during a single call. Please ensure that both questions are not asked during any single call.

	A	B	C	D	E
288	32	D12_TrOOP	{string}	My mom is moving, so she will need to change plans mid-year. If she selects your plan, will your plan be made aware of the payments that she made for her drugs while she was enrolled in her old plan? INTERVIEWER NOTE: The CSR may state she should check the Explanation of Benefits (EOB) she receives from the new plan just to make sure, but focus on the CSR's answer here. We are looking for a response that indicates yes, the TrOOP balance (payments she made for her drugs while enrolled in the old plan) will be communicated to the new plan.	
289	33	D13_Premium	{string}	My mom lives in <COUNTY> county. What is the monthly premium for <PLANNAME>? INTERVIEWER NOTE: If the CSR asks for additional information, the mother is not on Medicaid and does not receive ExtraHelp. You want the consolidated premium, which is the cost of the Part C and Part D (if offered) benefits combined.	Exclude plans that do not offer Part D drug coverage
290	34	D14_IRA	{string}	My mom's doctor says she needs to get the Shingrix vaccine. How much will she have to pay for the Shingrix vaccine? INTERVIEWER NOTE: Beginning January 1, 2023, Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) will be available with no deductible and no cost-sharing to Medicare beneficiaries with prescription drug coverage.	
291	35	D15_Privacy Notice	{string}	Where can my mom find the plan's privacy notice? INTERVIEWER NOTE: Plans are required to post their Privacy Notice on their website. Telling you it is available on the website is a correct answer. If the CSR offers to send you a copy based upon your request, this is a correct answer. You do not need to follow through on the request to mail you a copy.	
292	36	D16_MedTherapy	{string}	My mom heard that the plan has a Medication Therapy Management Program where she will be asked to make an appointment to talk to a pharmacist about her medicine. If she does not participate, will she still be able to enroll in the plan? NOTE: Even if the beneficiary does not participate in the Medication Therapy Management Program, the beneficiary can still enroll in the prescription drug plan.	Only the entities on this list with MTMPs should be asked this question. Exclude all other plans in our Part D universe file if they are not on this list.
293	37	D17 Representative	{string}	If my mom enrolls in your plan, do you have a form she can fill out to make me her representative? INTERVIEWER NOTE: Plans are required to post instructions on how to appoint a representative and a link to the downloadable version of the CMS Appointment of Representative Form on their website, because it is required content on the website. Telling you it is available on the website is a correct answer. If the CSR offers to send you a copy based upon your request, this is a correct answer. You do not need to follow through on the request to mail you a copy.	
294	38	D18_Braille Benefits Access	{string}	My mom is blind; can she get a braille version of your summary of benefits? If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Ask either D11 or D18 during a single call. Please ensure that both questions are not asked during any single call.
295	39	D19_D_Partial	{string}	Sometimes my mom's doctor wants her to try a new brand drug for a few days. If she gets less than a month's supply of the drug, does she have to pay a full month's copay? INTERVIEWER NOTE: The following answers are all acceptable. No, you will not pay the full month's copay for a brand drug; No, there is a reduced copay for this drug; No, there is pro-rated cost sharing for Part D drugs in this plan. Correct answer may include information about a daily cost-sharing rate. The rate will be based on the one-month copayment amount divided by the actual number of days entered for that one month supply for that specific tier.	
296	40	D20_STAR	{string}	What is the star rating for < PLANNAME >? INTERVIEWER NOTE: If asked, you want to know only the overall star rating. The star rating is the score assigned by the Centers for Medicare & Medicaid Services. If the expected response is "plan too new to be measured" or "not enough data available" and the CSR offers a star rating to you, code this answer as incorrect.	
297	41	MMP C1_Premium.	{string}	What is the monthly premium for <PLANNAME>? INTERVIEWER NOTE: There is no monthly premium for an MMP. If asked, you want the consolidated premium, which is the cost of the Part C and Part D (if offered) benefits combined.	
298	42	MMP C2_ Website	{string}	Is your privacy notice on your website? INTERVIEWER NOTE: If CSR asks, you are referring to the Privacy Notice under the HIPAA Privacy Law. If CSR offers to mail it to you, you do not need to follow through. Just say, "Thank you, but I'll read it on the website."	
299	43	MMP C3_Reduce	{string}	If my mom isn't on Medicaid, can she sign up for <PLANNAME>?	
300	44	MMP C4_Emergency	{string}	What's the most my mom would have to pay if she has to go to the emergency room?	
301	45	MMP C5_NonNetwork	{string}	Would my mom be covered if she goes to an out-of-network doctor during the continuity of care period?	
302	46	MMP C6_Cost Share	{string}	Will my mom have to pay for Medicare preventive services like diabetes screening or a yearly wellness visit?	
303	47	MMP C7_Chemo	{string}	How much would my mom have to pay for Chemotherapy?	
304	48	MMP C8_Renal	{string}	How much would my mom have to pay for dialysis? If the CSR asks whether they already have a disease that requires renal dialysis services, respond "no."	
305	49	MMP C9_Skilled Nursing	{string}	How much would my mom have to pay for Medicare skilled nursing facility services? INTERVIEWER NOTE: MMPs must offer all Medicare A and B benefits at $0 cost sharing. MMP enrollees pay $0 for care at a skilled nursing facility. We are not asking for any state-imposed Patient Pay amounts (Medicaid). Some states impose a "Patient Pay" amounts for nursing home care that is not technically considered cost sharing.	
306	50	MMP C10_FluShot	{string}	Would my mom have to pay for a flu shot?	
307	51	MMP C11_Provider Participation	{string}	Will you let my mom know if her primary care doctor leaves the plan?	
308	52	MMP C12_Specialist	{string}	For <PLANNAME>, will my mom need a referral to see a women's health specialist?	
309	53	MMP C13 Ambulance	{string}	What would my mom have to pay for an ambulance ride by ground transportation?	
310	54	MMP C14_Vision	{string}	Does <PLANNAME> cover routine eye exams? The plan might not have a routine eye exam benefit. If they do, it would be a supplemental or Medicaid-covered benefit, which for MMPs would be mandatory. There are no optional supplemental benefits for MMPs. The CSR does not need to specify that the benefit is supplemental.	
311	55	MMP C15_ServiceArea	{string}	My mom lives in <COUNTY> county. Can she enroll in your plan? ZIP code information for the plan in question is located in the header in the event the CSR needs to confirm the ZIP code of the beneficiary because the service area includes only a portion of the county.	
312	56	MMP C16_Expenses	{string}	Does your plan cover X-rays done at the hospital on an outpatient basis? X-rays are included among the outpatient diagnostic procedures, tests and lab services that all MMPs cover under Medicare Part B.	
313	57	MMP C17_Member Handbook	{string}	Would my mom be able to get a member handbook and provider directory in large print? If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Questions MMP C17 and MMP C20 are both about alternate forms of access. Ensure only MMP C17 OR MMP C20 is used in any given call. In other words, MMP C17 and MMP C20 must not be scheduled for use during the same call.
314	58	MMP C18_Plan Benefits	{string}	Do you have a summary of your plan benefits on your website?	
315	59	MMP C19_Equipment	{string}	My mom needs help getting around. Does your plan cover equipment like walkers and wheelchairs?	
316	60	MMP C20_Braille Handbook Access	{string}	My mom is blind; could she get a member handbook and provider directory in braille? If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Questions MMP C17 and MMP C20 are both about alternate forms of access. Ensure only MMP C17 OR MMP C20 is used in any given call. In other words, MMP C17 and MMP C20 must not be scheduled for use during the same call.
317	61	MMP D1_Copaxone	{string}	Does <MEDICARE-MEDICAID PLAN NAME> cover brand name Copaxone 40mg/ml prefilled syringe? INTERVIEWER NOTE: 40mg/ml prefilled syringe is a brand name product. You are specifically asking whether this brand name product in the specific strength is on the formulary. You do not want to know if the generic version of Copaxone 40mg/ml prefilled syringe is on the formulary.	
318	62	MMP D2_Krazati	{string}	Is Krazati a covered medication for <MEDICARE-MEDICAID PLAN NAME>? INTERVIEWER NOTE:If CSR states it is on the plan's formulary that is the same as saying it is a covered medication.	
319	63	MMP D3_Viracept	{string}	Would my mom need prior authorization to get Viracept? INTERVIEWER NOTE: 100% of plans have this drug on their formularies. Prior authorization is never allowed. Exceptions will never be necessary. If a CSR indicates any of these things to you, attempt to clarify by stating, "I don't understand. Is prior authorization required or not?" If they answer that an exception is needed or the drug is not on the formulary, score the answer as incorrect.	
320	64	MMP D4_Latisse	{string}	Is Latisse a covered medication for <MEDICARE-MEDICAID PLAN NAME>? INTERVIEWER NOTE: If CSR states it is on the plan's formulary, that is the same as saying it is a covered medication.	

	A	B	C	D	E
321	65	MMP D5_YF-VAX	{string}	My mom wants to get YF-VAX. Is this covered by <Medicare-Medicaid Plan Name>? INTERVIEWER NOTE: If asked, YF-VAX is the name of one type of yellow fever vaccine.	
322	66	MMP D6_Utilization Management	{string}	My mom's doctor stated that she needs to take 2 tablets of her medication everyday but the pharmacy says there's a quantity limit of 1 tablet per day. Does that mean her doctor has to contact <PLAN NAME> before the plan will cover more than 1 tablet a day of her medication? INTERVIEWER NOTE: If asked what drug, respond with "I'm not asking about any particular drug. I just know that my mom ran into this in the past and I want to make sure I understand." If the CSR says your mom must meet certain clinical criteria or the drug must be medically necessary, that is the same as answering "Yes" to this question.	
323	67	MMP D7_IRA	{string}	My mom's doctor says she needs to get the Arexvy vaccine. How much will she have to pay for the Arexvy vaccine? INTERVIEWER NOTE: Beginning January 1, 2023, Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) will be available with no deductible and no cost-sharing to Medicare beneficiaries with prescription drug coverage.	
324	68	MMP D8_90Days	{string}	If my mom joins your Medicare-Medicaid Plan, and one of her medications is not covered by your plan, can she get a temporary supply of her medicine at the beginning of her enrollment in the plan? NOTE: If CSR asks, this would be within the first 90 days.	
325	69	MMP D9_Deductible	{string}	What's the annual deductible for drugs covered by <PLANNAME>?	
326	70	MMP 10_Braille Benefits Access	{string}	My mom is blind; can she get a braille version of your summary of benefits? NOTE: If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Ensure that either MMP D10 or MMP D15 is asked during a single call. Both questions are about alternate access for beneficiaries with disabilities, so please ensure that both questions are not asked during any single call.
327	71	MMP D11_Premium	{string}	What's the monthly premium for <PLANNAME>? NOTE: If asked, you want the consolidated premium, which is the cost of the Part C and Part D (if offered) benefits combined.	
328	72	MMP D12_MedTherapy	{string}	My mom heard that the plan has a Medication Therapy Management Program where she will be asked to make an appointment to talk to a pharmacist about her medicine. If she does not participate, will she still be able to enroll in the plan? NOTE Even if the beneficiary does not participate in the Medication Therapy Management Program, the beneficiary can still enroll in the prescription drug plan.	Only the entities on this list with MTMPs should be asked this question. Exclude all other plans in our Part D universe file if they are not on this list.
329	73	MMP D13_D_PARTIAL	{string}	Sometimes my mom's doctor wants her to try a new brand drug for a few days. If she gets less than a month's supply of the drug, does she have to pay a full month's copay? INTERVIEWER NOTE: The following answers are all acceptable. No (you will not pay the full month's copay for a brand drug); No, there is a reduced no copay for this drug; No, there is pro-rated $0 cost sharing for Part D drugs in this plan. Correct answer may include information about a daily cost-sharing rate. The rate will be based on the one-month copayment amount divided by the actual number of days entered for that one month supply for that specific tier.	
330	74	MMP D14_Mail	{string}	Can my mom get her prescriptions by mail?	
331	75	MMP D15_Audio Benefits Access	{string}	My mom is blind; can she get an audio version of your summary of benefits? NOTE: Any audio format is acceptable (e.g., .mp3, .mp4, .wav, audio disk, cassette, or other). The critical issue to watch for is whether the CSR is willing to provide the information in an audio format. If the CSR states they must order the format to know if it's available, mark as incorrect and state why in the text box beneath the incorrect response option.	Ensure that either MMP D10 or MMP D15 is asked during a single call. Both questions are about alternate access for beneficiaries with disabilities, so please ensure that both questions are not asked during any single call.
332	76	MMP D16_Network Pharmacies	{string}	Where can my mom get a list of <PLANNAME> network pharmacies? NOTE: MMPs are required to post their directories to their websites. Telling you it is available on the website is a correct answer. If the CSR offers to send you a copy based upon your request, this is a correct answer. You do not need to follow through on the request to mail you a copy.	
333	77	MMP D17_Drug Coverage	{string}	Do you cover generic and brand name drugs?	
334	78	MMP D 18_Home Infusion	{string}	Do you have home infusion pharmacies in your network?	
335	79	MMP D19_Forumulary Exception	{string}	If a prescription drug my mom takes isn't on your List of Covered Drugs, can she ask for an exception? INTERVIEWER NOTE: If the CSR uses the word formulary, it is the same as a List of Covered Drugs.	
336	80	MMP D20_Translate	{string}	My mom speaks <LANG5PCT> and I'm trying to help her choose a health plan in <COUNTY> County. Is your formulary in that language?	Only ask this question of plans that are required to translate into foreign language per the 2019 language lookup dataset, and ask this question in English and TTY only. Do not ask this question in Spanish, French, Mandarin, Cantonese, Tagalog, or Vietnamese.
337					
338		***Once a call reaches a live person (CSR or TTY Operator), LEP/TTY_holdtime will begin, regardless of the call being sent back to the IVR or being placed on hold.			

AR. 000076

Medicare

Part C & D

Call Center Monitoring

Accuracy and Accessibility Study

Technical Notes

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Document Change Log

Previous Version	Description of Change	Revision Date
2008	Added purpose section, contact information, and expanded/clarified definitions	**05/15/2016**
2017	Revised call and measure outcomes and provided additional detail for performance metrics shown in HPMS for 2017, including unsuccessful calls.	**3/23/2017**
2019	Expanded sections for Purpose, Contact Information, and Understanding the Data. Added FAQs.	**06/30/2019**
2021	Revised language to match the Call Center Monitoring Memo, and expanded/clarified definitions	**07/20/2021**
2022	Revised based on 42 CFR 422.111(h) and 423.128(d)	**06/30/2022**
2024	Revised language around where calls originate. Minor format updates.	**06/05/2024**

Purpose

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

Background

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

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

This study is conducted at the call center indicator level by calling all toll-free prospective phone numbers for the Part C call center or the Part D call center. A simple random sample method is adopted for the Accuracy and Accessibility Study where no advance knowledge of call centers' Limited English Proficiency (LEP) and TTY services or customer service representative (CSR) performance is required. There are eight different survey modes: English, Spanish, French, Vietnamese, Mandarin, Cantonese, Tagalog, and TTY. (These modes are announced each year in the annual call center monitoring memo.) English is considered the native language we are testing for all states/territories except Puerto Rico, where Spanish is tested as the native language. For interpreter availability/LEP calls, the overall sample size is first determined at the unique phone line or call center level and the sample size for each mode is then allocated. Although TTY services utilize a separate set of phone numbers, TTY is defined as one of the survey modes and it is treated like one of the languages from the sample design perspective. Therefore, TTY calls are a subset of the total sample. Since there is no TTY call center information, TTY sample size is first built at the unique TTY phone number level. For state relay phone numbers and other TTY lines that cover a large number of contracts, the sample is selected at the TTY/ LEP call center level to get sufficient coverage for these lines.
The metrics and compliance outcomes are posted in the HPMS at the conclusion of the study. The raw data, which is available by download from HPMS, show which accuracy questions were "assigned" to plans for each case/call. Each call center is assigned a numerical call center indicator which is also shown in the raw data. All plan-level results are "rolled up"and reported out to you in HPMS by contract ID.

Results are displayed for all MAOs, MA-PDs, PDPs, and MMPs. Data were collected from contracts that cover U.S. territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only direct Contract

PFFS, National PACE (Programs for the All-Inclusive Care of the Elderly), MSA, employer contracts, and organizations that did not have a phone number accessible to survey callers. Contracts with *only* SNPs are excluded from the accuracy measure of the Accuracy and Accessibility Study. Any plan under marketing and enrollment sanction is excluded from the Accuracy and Accessibility Study until such sanction is released.

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

Contact Information

The Call Center Monitoring resource mailbox can assist you with all aspects of Call Center Monitoring, including questions or concerns related to this study. Please include the contract ID, phone number on which the call was received, and specific details such as the unique call ID found in the raw data or the date and time of the call along with your question/concern. **Please do not use secure email to communicate with us.** This project never shares personally identifiable information.

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

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

Performance Metrics Availability in HPMS

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

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

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

Understanding the Data: Call Outcomes Compared to Measure Outcomes

Call outcomes and measure outcomes may differ, meaning you may have a call listed in the raw data that reached a CSR, but one of the measures included in that call was not successful. To help you understand your raw data and your results, please think about the separate phases of each call as shown below:

Phase 1: Dial
Phase 2: Connect
Phase 3: Introductory Question (Interpreter Availability/LEP or TTY measure)
Phase 4: Accuracy Measure

In phase 1 *(dial)*, we download your toll-free and alternate toll-free (TTY) calling information fromHPMS. We program it, schedule it, and then dial it.

In phase 2 (*connect*), we determine if we can reach a live CSR at the plan who can assist us with our questions. Reasons for unsuccessful calls may include (1) wrong number listed in HPMS; (2) technology barrier preventing us from connecting (e.g., all circuits are busy; please check number and try again later); (3) prolonged wait times for a representative due to high call volumes at the plan; (4) center is closed at an inappropriate time; or (5) other reasons caused by the plan or the plan's phone carrier.

Whichever type of call was scheduled (TTY, interpreter availability/LEP, or native language call) will be scored as unsuccessful if we are not able to connect to a live CSR at the plan during that scheduled call or if the CSR cannot assist us with our questions or cannot forward our call to someone who can assist. (CMS provides you with a data dictionary in HPMS. The data

dictionary provides definitions for our numerical codes in the raw data. These codes explain the outcome for you.)

Once we connect to the plan, we wait in the IVR or hold queues until a CSR is available, with certain time limits. Timers allow 10 minutes each for wait times in both hold and IVR queues for non-TTY calls. If either timer expires before we reach a live CSR, the call is unsuccessful. Whichever type of call was scheduled (TTY, interpreter availability/LEP, or native language call) will be scored as unsuccessful if we are not able to reach a live CSR.

If we connect with a live CSR within the given time parameters, the call moves into phase 3 (*introductory question*) to ensure we are speaking with a representative in the correct department. If yes, the call is moves into phase 4 to ask the three accuracy questions.

- For native language the *call* is **connected** if we reach a live representative within the permitted time.
- The *interpreter availability/LEP measure* may have a connected, complete, or unsuccessful outcome. If we are testing interpreter availability, we place the call in a foreign language and wait for the CSR to bring an interpreter to the phone to assist the CSR in answering our introductory question. We permit eight minutes for the CSR to connect to an interpreter *and answer our introductory question*. An example of an introductory question is, "Are you the right person to answer questions about [Plan name's] health benefits?" The *call* is considered **connected** when the caller connects with the CSR. The *interpreter availability/LEP measure* is considered **completed** when the CSR, via an interpreter, provides an affirmative response to the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. Alternatively, if a CSR happens to speak the foreign language we are testing, and that representative is able to answer the questions without an interpreter's assistance, this too would count as a **completed** interpreter availability/LEP measure outcome. In order for the *interpreter availability/LEP* measure to be **complete**, there must be true communication, meaning the CSR must answer the introductory question and be able to converse in the foreign language we are testing with or without an interpreter's assistance. For non-SNP cases, we will then move to the accuracy measure by asking the first of three accuracy questions.
- The *TTY functionality measure* may have a connected, **complete,** or unsuccessful outcome. When we test TTY functionality, we contact the plan via TTY device either directly for in- house TTY devices or via a state or national relay operator's assistance when the plan opts to list 711 or a state relay operator's phone number in HPMS. If we can connect to a live CSR and they answer "yes" to the introductory question (e.g., "Are you the right person to answer questions about [Plan name's] health benefits?") within seven minutes,the *TTY functionality measure* is **completed**.
- For non-SNP cases, we will then move to the accuracy measure by asking the first of three accuracy questions.
- The final phase for non-SNP calls is the accuracy measure. Recall that SNPs are exempt from the accuracy measure, so for SNPs, this phase is skipped. Accuracy question outcomes are defined as either having been *answered correctly* or *answered incorrectly*. Accuracy questions *not answered* due to a timer expiring are not included in the

calculation of the percentage of accurately answered questions for this measure. For this reason, not answering before the seven-minute timer expires is neutral to the plan's performance.

If we are testing accuracy *in the native language*, we simply call the plan's toll-free prospective phone number and ask the CSR "Are you the right person to answer questions about…?" and wait to ensure we hear a "yes" response before we move on to the first accuracy question. English calls placed within the United States are given seven minutes to answer the introductory question. Spanish calls paced within Puerto Rico are likewise given seven minutes to answer the introductory question. (Please note that when we call plans in Puerto Rico, where Spanish is the native language, and we ask questions in English, this is considered an interpreter availability/LEP call and not a native language call, so CSRs would therefore be given eight minutes to answer the introductory question.)

For all non-SNP call types, we ask up to three plan-specific benefit questions or general Medicare questions. The contractor knows the correct answer it should receive, and their interviewer "scores" the answer received from the CSR against the expected response. In the raw data, you will see the question we asked, the expected response, and the scoring. If an incorrect answer was provided by a CSR, we record what the CSR stated during the call in the raw data. You may use the raw data to better understand your accuracy measure scores. You should also use the raw data and results from the study as a learning experience for your CSRs. CMS recommends that you review the raw data to see what questions were answered incorrectly, and then review the correct information with your staff members as a knowledge refresher opportunity.

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

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

- **Code 295** indicates the *call* was completed, meaning that the interpreter availability/LEP or TTYmeasure (phase 3) and the accuracy questions (phase 4) were completed.
- **Code 295.2 indicates an SNP call was completed,** meaning the interpreter availability/LEP or TTY measure (phase 3) was completed**.** (SNPs do not receive accuracy questions.)
- **Code 290.x** *(where x is filled in with a number)* indicates that interpreter availability/LEP or TTY measure (phase 3) was completed, and the accuracy measure (phase 4) was *partially* completed. This means we reached a live CSR and received a response to the introduction question, but a later measure was not able to be completed for some reason. For example, code 290.7 is defined in the data dictionary as "Partial interview - CSR could not answer accuracy question in seven minutes." This means the *call* was answered by a live person and the phase 3 measure (interpreter availability/LEP, TTY functionality, or native language call) was completed. We then moved on to the phase 4

component of the call – the accuracy measure - where a separateseven-minute timer is activated for each accuracy question. In this example, a code 290.7could mean that the CSR did not answer the first, second, or third accuracy question because a timer expired, or some other problem prevented that from happening. You can review the raw data for the individual call to determine if each question was answered and, if so, whether it answered accurately or inaccurately. The raw data also shows you if and when a timer expired for an accuracy question, meaning on the first, second, or third accuracy question. Please recall that any unanswered question has a neutral impact to the plan's performance and is not cause for concern.

Performance Metrics

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

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

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

All Calls - Percentage of Completed Calls out of All Calls – This metric shows the percentage of completed monitoring calls out of the total number of monitoring calls.

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

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

- Phone number was called but did not answer after six rings.
- Survey could not continue; Call Center disconnected call (including hanging up).
- Survey could not continue; Call Center responded in Spanish only.
- Survey could not continue; call dropped before it rang six times.
- Survey could not continue; line did not accept incoming calls.
- Survey could not continue; message stated that the target number cannot be dialed from surveyor's area code.
- Survey could not continue; phone line problems.
- Survey could not continue; reached a number that was NOT the targeted call center (due to incorrect phone number listed in HPMS).
- Survey could not continue; reached a system filtering inbound calls.

- Survey could not continue; reached Call Center voicemail.
- Survey could not continue; received a busy signal.
- Survey could not continue; technology barrier (e.g., received a computer modem/fax machine signal, beeper/pager number, etc.)
- Survey could not continue; received a message that an identification number was needed to continue.
- Survey could not continue; received a TYY device for the hearing impaired when calling via telephone.
- Survey could not continue; received message that the Call Center was closed.
- Survey could not continue; CSR refused to answer question.
- Survey could not continue; CSR insists on member name, SSN, ID etc. to continue.
- Survey could not continue; CSR tells our interviewer to call back.
- Survey could not continue: CSR unable to answer questions about Medicare/Medicaid.
- Surveyor navigated the IVR for 10 minutes and call reached time limit.
- Surveyor was in the HOLD queue for 10 minutes and then call reached limit.
- Surveyor cannot connect to TTY operator.
- Surveyor can connect to TTY operator but cannot connect to the plan.
- Survey could not continue for other reasons*.

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

- Disconnected number
- CSR Offers New Number to Call

Connected and Completed Calls by Language - The languages tested were: English, Spanish, French, Vietnamese, Mandarin, Cantonese, and Tagalog. HPMS displays the total number of monitoring calls, total number of connected calls, total number of completed calls,and percentage of completed calls out of all calls.

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

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

A call is considered **connected** when the caller reaches the CSR (phase2). A call is considered **complete** when establishing contact with an interpreter (or receiving assistance through a bilingual CSR), answering the introductory question (phase 3), and then beginning the first of three general Medicare or plan-specific accuracy questions (phase 4) within eight minutes of reaching a CSR. (For example, this means the introductory question was answered "yes" before moving on to the first accuracy question in the accuracy measure.) Interpreters must be able to communicate responses to the call surveyor in the callcenter's non-primary language (Spanish in Puerto Rico and English elsewhere) about the plan

sponsor's Medicare benefits.

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

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

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

Completed contact using a TTY device is defined as establishing contact with and confirming that the CSR can answer questions about the plan's Medicare Part C (or Part D) benefit within seven minutes. *Remember:* A call is considered connected for TTY cases when the caller reaches the plan.

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

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

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

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

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

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

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

Foreign Language Accuracy Result – This metric is the percentage of times that a Medicare

question was answered accurately out of the total number of Medicare questions answered, when those questions were asked in a foreign language.

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

Call Center Monitoring Definitions

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

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

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

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

Limited English Proficiency (LEP) – The acronym LEP is used in the performance metrics section of HPMS to indicate a call made to determine interpreter availability as part of the Accuracy and Accessibility Study.

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

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

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

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

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

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

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

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

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

TTY functionality is defined as the percent of the time a caller using a TTY device was able to communicate with someone who could answer questions either at the sponsor's call center or via relay operator. The calculation of this measure is the number of completed contacts with the CSR divided by the number of attempted contacts.
TTY Hold Time is a code used to capture the time waiting for the TTY operator. The TTY hold time is the time between reaching the plan, either via 711/state relay operator or connecting

directly to a live CSR, and the time when a live CSR confirms he or she can assist with questions about Medicare Part C or Part D benefits and the confirmation was received on the tester's TTY device. The time for waiting for the TTY operator (TTY_HOLD) is seven minutes.

HPMS Display Groupings

The Accuracy and Accessibility Study displays all cumulative results for the total study in any given year. Weekly and quarterly totals are not available.

Raw Data

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

Data Dictionary

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

Frequently Asked Questions

Accuracy and Accessibility Study

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

Answer: Calls are made to a number during the time it is supposed to be operable, which is at least 8:00 a.m. to 8:00 p.m. (according to the local time zones for the regions in which they operate) for beneficiary customer service lines. For example, if the same phone number serves plans in both New York and California, the number receives test calls from CMS from 8:00 a.m. in New York until 8:00 p.m. in California. The calls received in that interval are distributed evenly throughout the interval. Statistics for any given contract typically include all calls made to phone numbers associated with the contract.

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

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

Prior to the start of this study, CMS asked MA organizations and Part D sponsors to indicate if the prospective customer service phone numbers in HPMS routed to one or more *physical call centers* so that CMS could assign a call center indicator. *This was done in an effort to minimize the call volume to Part C and Part D prospective enrollee customer service call centers.*

Question: How are call center indicators assigned?

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

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

Below are some generalities about our contractor's process:

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

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

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

When a compliance office has indicated a physical call center is shared by SNP-only and non-SNP phone numbers, calls are distributed so that the SNP-only number receives at least one call a week. In this case, TTY calls are only made to non-SNP phone numbers. When a call center only uses SNP-only phone numbers, the call center can expect six calls per week, including TTY calls. We will not ask any accuracy questions for SNP plans, so the call is considered complete when an interpreter is available and answers "Yes" to our introductory question. In contrast, for non-SNP plans we will also ask accuracy questions. Consequently, SNPs which share phone numbers with non-SNPs can also share interpreter availability/LEP performance metrics with the non-SNP plan (but NOT vice versa.)

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

Question: Is there an average number of phone calls placed for the Accuracy and Accessibility Study?

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

In 2024, you could expect to receive, on average, 96 calls ***to each call center indicator***. This total comes from an average of 6 calls each week. Those 6 calls were comprised of 1 TTY test

call, 2 native language calls, and 3 foreign language calls. In 2024, we placed *approximately* 96 calls to your Part C Call Center Indicator, and approximately 96 calls to your Part D Call Center Indicator, if you were a sponsor offering Part D services.

The contractor will review the information each year to determine how many calls should be placed for that year's study.

Recall that the Accuracy and Accessibility Study is conducted at the *call center* level, not the phone number level like the Timeliness Study. Our monitoring calls include the native language (Spanish in Puerto Rico; English elsewhere), TTY, and each of the six foreign languages that we test. Note that a call center indicator could have many phone lines (e.g., 35 phone lines in 2024) and each call will be to a different phone number when there is more than one number for a call center indicator. Another thing to note is that one phone line can be associated with multiple plans.

Interpreter Availability Measure

Question: When do you release the languages for testing?

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

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

Answer: For our Accuracy and Accessibility Study, when testing interpreter availability, there are separate timers for many functions. There is one for time spent in the IVR and a separate timer for the hold queue, and there is still another timer for time waiting for the interpreter to join. Once the call is answered, our interviewer identifies if he or she encountered an IVR or a live person (sometimes a call center is set up so that a live customer service representative answers the phone rather than the IVR options). Other things our interviewer could experience are whether there was a ring but no answer or some kind of auto-dialer failure. The majority of the time they encounter an IVR. Time spent in the IVR is captured in "IVR_Time" in our raw data. For all non-TTY calls, when the interviewer encounters an IVR, the plan has 10 minutes before the test call will time out if no CSR comes to the phone. If a timer expires, the call ends and the interviewer records information to capture the call failure so it will appear in the raw data. If a live CSR *does* come to the phone before those 10 minutes expire, our interviewer then selects "Live Operator" on their screen so that the raw data will capture the time when this

occurred. The second timer is what we call the "LEP_Hold" screen if we are testing interpreter availability, with LEP meaning "limited English proficiency." This is an 8-minute timer. The interpreter should connect with the CSR and assist with answering yes to our introductory question before the 8-minute LEP Hold timer goes off; if not, the call ends due to the timer failure, and this is an unsuccessful call counted toward the interpreter availability measure.

The introductory question we ask is "Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?" We determine the question based upon which number we dialed - the Part C prospective beneficiary line or their Part D prospective beneficiary line. If the CSR, with assistance via the interpreter, is able to respond "yes," we move on to the first of three accuracy questions. If we hear "yes" before the timer expires and move to the first accuracy question, this is a complete interpreter availability measure outcome.

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

Question: Regarding the rule about connecting an interpreter within eight minutes, can no single transaction be longer than eight minutes, or is this an average?

Answer: No single transaction can take longer than eight minutes. If it takes longer than eight minutes for the CSR to bring the interpreter onto the line to answer our introductory question, the timer will expire, and the call will end. This results in an unsuccessful outcome. For the interpreter availability measure to be complete, the CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires.

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

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

Question: How is the interpreter availability performance established? Must the call be connected *and* complete? We believe this to mean:

- Caller reaches a live CSR
- CSR brings an interpreter on the line, and the interpreter relays a response to the question, "Are you the right person to answer questions about…?" and
- Caller begins to ask the first benefit question within eight minutes of reaching the CSR.

Answer: For interpreter availability, we measure both connected and completed statuses. We report both results to you in HPMS at the conclusion of the study.

To explain further, if we establish contact with your CSR while speaking in a foreign language, *the call* is connected. Then we ask an introductory question (for example, "Are you the right person to answer questions about [Plan name's] health benefits?" The CSR will then bring an interpreter to the phone to assist with answering that question. Answering the introductory question with the interpreter's assistance (or having a bilingual CSR answer the introductory question in the language being tested) within eight minutes determines the outcome of the *interpreter availability measure* (i.e., a caller was able to reach someone who could speak the caller's language and ask that person questions). Once the interpreter helps the CSR answer "yes" to this introductory question, if done within eight minutes and allowing us to move on to the first accuracy (benefit) question for non-SNP plans, we have determined that your *interpreter availability measure* is ***complete***. Once we know that a yes answer has been received, we stop measuring interpreter availability and begin measuring the accuracy component by moving on to the first of three accuracy (benefit) questions, each of which is given seven minutes to answer. So, the definition we provide of needing to move on to begin the first of three accuracy questions for a complete interpreter availability status simply shows that the introductory question has been answered and we've then moved on to the next separate measure, which is accuracy. In other words, your explanation above is a correct understanding of the interpreter availability measure.

The difference between a connected call outcome and a complete interpreter availability measure is reported for you. A number of things could cause a call to go awry and not permit the interpreter availability measure to complete. For example, sometimes the interpreter joins the call and the CSR then hangs up or gets disconnected. Sometimes the interpreter joins but then the interpreter gets disconnected. If this happens, they cannot actually answer the introductory question, so interpretation did not occur and the measure is not complete. In this scenario, a CSR could have a second interpreter join and answer the introductory question. As long as that happens within eight minutes, we could still have a complete outcome.

Question: Does the outcome of the three accuracy questions have any bearing on the interpreter availability component of the survey, or do these just pertain to the accuracy measure?

Answer: The accuracy questions only pertain to the accuracy measure. They have no bearing on the interpreter availability measure. We only count questions in our accuracy scores that were asked to and answered by the CSR. If our timer expires before the CSR can answer an accuracy question, the effect is neutral to the plan because unanswered accuracy questions are not counted in the numerator or the denominator for the accuracy measure. So, if a timer expires, the call will end but please know that this has a neutral effect on the plan's performance.

TTY Functionality

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

Answer: For the purpose of this study TTY can refer to either a machine (device) or IP software. Plans must provide TTY functionality, but CMS does not direct plans on how to handle the calls.

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

Answer: The TTY measure is conducted in English only. For plans with service areas

exclusively in Puerto Rico, please be aware that we do test TTY only in English for your plans as well.

Question: If the state or national (711) relay operator for TTY is not available or accidentally drops the call, is the outcome considered unsuccessful?

Answer: Yes, the outcome would be considered unsuccessful if the state or national relay operator is not available or accidentally drops the call.

The majority of contracts opt to use the relay operator via 711 in lieu of using in-house TTY equipment, so we want to share additional information about the monitoring experience when using a relay operator. Below is a narrative describing the process.

During the call, the 711-relay operator narrates what is happening via TTY for the contractor's interviewer as they move through the call. That way, we can capture what is happening and report those metrics for each contract. Below is a description of how it works, andinstances when a failure is or is not counted against the contract.

The interviewer uses TTY IP (Internet Protocol) to call 711. There is no ring limit for TTY calls to the relay operator.

If the call does not connect to the relay operator on the first attempt or they receive a busy signal, they may log out of the TTY program, restart if needed, and make a second attempt to connect via 711. If they cannot connect via 711 on the second attempt, they also have a toll-free number for the relay operator to be used in a third attempt. If the interviewer uses the toll-free option in lieu of 711, they are trained to leave a comment in the call notes. For example, they might include this note, "Call did not go through with 711 and used 1-800-xxx-xxxx instead." If, after a third attempt, theinterviewer is not able to connect with a TTY relay operator, the inability to connect is reported and this is counted against the contract. Codes for reporting a failure to connect via TTY are available. For example, we might see code 296.19 (TTY Could Not Connect to Relay Operator) in the raw data results. Rationale: We attempt to create an authentic experience of a Medicare beneficiary trying to receive assistance via a TTY device. Our policy is to report an unsuccessfulcall if, after three attempts, we cannot connect to the relay operator. The organization should use this feedback to evaluate its business policy for use of a relay operator in lieu of an in-house TTY device.

Once our interviewer connects using TTY IP with the relay operator at 711, we give 711 the plan's toll-free Part C or Part D prospective beneficiary customer service number to dial. There is no timer activated at this point. We ask the TTY operator to confirm the number he or she is dialing. Note: If the TTY operator dials the wrong number, the monitoring contractor opts to use its "do over" option available to try again. In this scenario, the invalidated call is not counted against the plan.

The operator will narrate what's happening by replying through the TTY software, e.g., he or shemay type "ringing."

When answered, the relay operator will relay the next options: "Thank you for calling The Example Health Plan. Please hold for next representative," or relay the IVR options available. At this point, the seven-minute TTY hold timer is initiated.

The interviewer navigates through the IVR via the relay operator by telling the operator to select X in the IVR choices, or to say "representative." If the relay operator relays information to the interviewer indicating that his or her call disconnected from the health plan when making the requested selection in the IVR, the disconnected call gets coded as such and this is counted in the results in the same manner that disconnected calls are counted for non-TTY calls.

If the relay operator indicates there has been an extended hold time and asks if we wish to call back later, the interviewer will state again, "No, please hold for a live CSR." The CMS interviewer will hold until a live CSR answers or the seven-minute TTY hold timer expires. According to the Federal Communications Commission's Telecommunications Relay Service Consumer Guide, the relay operator answering or placing a call must stay with the call for a minimum of 10 minutes to avoid disruptions to the user, and relay operators must answer 85 percent of all calls within 10 seconds. If a relay operator is unwilling to hold for the duration of our seven-minute timer waiting for a live representative to answer, the outcome is beyond CMS' control and an unsuccessful call will be attributed to the plan.

If the call successfully connects with a live CSR who can respond "yes" to the introductory question ("Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?") before the seven-minute TTY HOLD timer expires, the TTY measure is completed and the survey continues and each of the randomly generated three accuracy questions is asked. A time stamp is set on exiting the interviewer's screen so that the length of time to answer can be determined. The TTY_HOLD timer captures the time waiting for the live CSR to respond to the relay TTY operator. We then move to asking the first of three randomly generated accuracy questions. Each accuracy question has its own seven-minute timer.

If the relay operator stops responding via TTY before the introductory question is answered "yes" and relayed to us via TTY, this counts against the contract in the form of anunsuccessful TTY outcome. For example, our interviewer is communicating and types "GA" for "go ahead" to the relay operator on our TTY software and we receive no response in return. In this case, we remain on the line until the call times out. This is counted as unsuccessful in our test forTTY functionality because we have not had true communication in the process because we are still awaiting an answer to our introductory question. Our rationale behind this is that plans needsto know how members are affected when they attempt to contact their plan via a relay operator, especially if there are TTY functionality failures occurring during this process. We want plans to have this information so that they can make informed business decisions about processes that affect their membership.

Question: If the relay operator disconnected from the TTY test call or the caller is unable to understand operator messages, why would CMS attribute that unsuccessful result to the plan?

Answer: All organizations are free to decide if they want to use an in-house TTY device or TTY software to handle customer service calls from members or prospective members who have a hearing or speech impairment. When a plan opts to use a state or national relay service in lieu of using an in-house device, CMS considers the relay operator to be an agent of the plan. During our test calls, if *we* disconnect the line with the relay operator, we will not count the outcome of the call in the plan's performance. If the relay operator disconnects the call or refused to wait the

entire seven minutes in use for the TTY hold timer, CMS views this the same as if the plan had disconnected the call or hung up because CMS views the relay operator as an agent of the plan, by extension. If the plan disconnects from the call with the relay operator through which we are communicating, we also count the unsuccessful outcome of the TTY call in the plan's performance because the plan caused the disconnection to occur and thus the performance should reside with the plan. Please be aware that on our TTY calls, if the plan is disconnected, we will ask the relay operator if they know what happened, meaning we ask the relay operator if they know if the CSR hung up. Oftentimes, the relay operator will not know if the line was disconnected or the CSR hung up, but they are able to confirm for us that we still have an active line of communication open with the relay service and we are still able to communicate; therefore, our interviewer did not lose the connection with the relay operator. For this reason, if the plan or the relay service is the party that is no longer available on the call, the unsuccessful outcome is attributed to the plan.

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

Plan: This is a business decision for the plan to make and CMS cannot offer an opinion. Plans should weigh the pros and cons of using an in-house TTY system versus the national 711 relay service or their state relay number.

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

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

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

Answer: CMS, through its monitoring contractor, makes the following suggestions for testing in-house TTY devices or software:

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

settings on the carrier side that need to be adjusted.

- If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.

Accuracy Measure

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

Answer: No, the effect is neutral to the contract. During the Accuracy and Accessibility Study, CMS interviewers will ask up to three accuracy questions per monitoring call placed. Each question is allotted seven minutes to determine if the CSR is able to provide an accurate and timely response to questions based upon the approved bid submission submitted into HPMS by the plan, or to general Medicare accuracy questions. The percentage of accurate responses is calculated as the number of *questions answered accurately* divided by *the total number of answered questions* x 100. ***Note: If a CSR is unable to answer the question before the timer expires, the call ends. The effect of a timed-out call is neutral to the plan, meaning the question was not answered accurately or inaccurately and therefore is not counted in the equation since a response was not received in the allotted time.***

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

Answer: No. Each accuracy question has a seven-minute timer. If the first accuracy question is not answered before the seven-minute timer expires, the call ends. The second accuracy question will not be asked. Our interviewers make several calls to each plan so organizations should have sufficient opportunity to answer accuracy questions.

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

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

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

Answer: Two of the goals of the Accuracy and Accessibility Study, which is performed by testing interpreter availability, TTY functionality, and accuracy of the questions asked, is to determine if interpreters are available, and to determine the accuracy of responses given to prospective members. So, we would separate the interpreter availability component from this question, as it is a given that an interpreter is available in this scenario. In regard to the accuracy questions, an interpreter must be able to respond to questions accurately, so if the interpreter did not do that correctly, this must be attributed to the plan's performance. If the response to the question is not relayed correctly due to the failure of the language interpreter with whom the plan

contracted, we believe it is everyone's best interest to report that negative result back to the plan through the failure of the accuracy question being tested. Doing so helps inform the interpretation service's performance, and the plan can use that feedback for its future business decisions. We do not score or judge the interpreter's performance throughout the call – we are only looking for the correct response to the question. We would not hold the performance of the interpreter against the plan, generally speaking, so long as the response to the accuracy question is accurate. We are always happy to hear from any plan who believes a certain result may be unfair, and we are certainly willing to investigate issues that may arise, but in the instance described above, failure to respond accurately due to the failure of the interpreter is counted against the plan in the form of incorrect response to that the question being tested.

Please know that we also place calls in the native language, so your accuracy score is comprised of us asking questions in all modes – in English via TTY, in the native language (Spanish in Puerto Rico and English elsewhere), and via an interpreter when we test interpreter availability in six foreign languages.

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

Answer: If the answer is not provided before the seven-minute mark, yes, it would be considered to have "timed out". It might help if I describe the timers to answer your question. The Limited English Proficiency (LEP) hold timer is used when waiting for an interpreter to assist the CSR with the introductory question (an eight-minute timer), the TTY HOLD timer is used when connecting via a TTY device (a seven-minute timer), and each of the three accuracy questions utilize a seven-minute timer. The interviewer has a screen that has a timer on it that counts up to 420 seconds (seven minutes x 60 seconds) or 480 second (eight minutes x 60 seconds). When that timer goes off, the interviewer does not have the ability to change the outcome of the call ending, so the answer is yes, if someone was halfway through the answer, the result would be the same as if they had not begun to answer -- the timer goes off and there is no longer an opportunity to accept the response from the CSR.

If we are determining interpreter availability, if we have not received a yes response to the introductory question before the timer goes off, that is counted as an unsuccessful interpreter availability measure.

When we have moved to the accuracy questions, if a timer goes off, that has a neutral effect on the plans, meaning we have already had a completed call for the interpreter availability component or TTY functionality score, so that would count in a good way for the plan if that portion of the test is over. If the timer goes off during the accuracy questions, this does not negatively impact the plan because it has a neutral effect. At that stage we are determining the accuracy of the answer only. If the timer goes off before an answer was provided, we show a "time out" in the raw data. The call will end, but the result of the timer going off during an accuracy question is simply that the question was not answered. This is not counted as unsuccessful or inaccurate, in other words.

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

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

CMS emphasizes that CSRs will be assisted if they are trained on plan-specific questions (For example, "What is my copay or coinsurance for a certain service?" and "Is a certain drug on the formulary?"). It may also help if CSRs are familiar with information in the latest version of *Medicare & You*, which is available here at the following link: https://www.medicare.gov/medicare-and-you/medicare-and-you.html

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

Answer: SNPs are exempt from the accuracy measure, so we do not ask accuracy questions. The main purpose of the Accuracy and Accessibility Study is to determine if a plan is capable of bringing an interpreter to the phone to assist, and to test if the plan can communicatewith a "prospective enrollee beneficiary" (CMS' contractor in this case) via TTY device. It is theresults of these two measures from which the Part C and Part D Star Ratings are derived. When we call in a foreign language or via TTY device, the "main focus" of the study is underway so we can determine if the plan was able to communicate with the caller. We ask the introductory question as a means of determining if the interpreter can join the line, in other words, or the CSR can communicate via TTY device or with the 711 relay service. Because contracts with *only SNPs* are excluded from the accuracy measure (which is not part of the Star Ratings), we have no need to ask any more questions.

Calls placed in English that ask only our introductory question are used for the Timeliness Study, where we are measuring the average hold time and disconnect rates, but they are also placed during the Accuracy and Accessibility Study. To add some historical perspective on the issue of contracts with only SNPs versus those contracts with both non-SNPs and SNPs, in years past we did not include contracts with only SNPs in our Accuracy and Accessibility Study. Those contracts asked CMS to include them so that they were a part of the data collection for Star Ratings purposes, so we added SNP-only contracts back into this study to satisfy the collection of information for Star Ratings. Because contracts with only SNPs are excluded from the accuracy questions, the introductory question is all that we ask.

We test English language calls across all studies as a first step to confirming that sponsor call center representatives are accessible and can be reached in a timely manner. Then, in addition to English language calls we test for interpreter availability and TTY service during the Accuracy and Accessibility Study for the reasons stated above. Statistically, if we did not test English during the Accuracy and Accessibility Study, we would need to make significantly more interpreter and TTY calls, thus increasing the burden on call centers to obtain information that is part of the English language subset. English is a baseline measurement and although we do not take compliance actions, we do use and analyze the data.

Accuracy and Accessibility Study Raw Data

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

Answer: The raw data is available to you in HPMS under the performance metrics sections. This is new functionality we added to make your experience a little easier. Previously you would have requested the raw data from the Call Center Monitoring mailbox; now you can download it yourself.

For the Accuracy and Accessibility Study, you can find detailed results for your contract in HPMS by following the paths below:

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

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

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

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

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

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

Answer: When downloading your raw data from HPMS, you should also see a link to a data dictionary for each study just to the left of the raw data link. Please be aware that the Timeliness

Study (current enrollees) uses one dictionary, while the Accuracy and Accessibility Study (prospective enrollees) uses a different dictionary. If you ever need these, simply download from HPMS at the same time you download the raw data.

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

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

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

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

Answer: You are correct that this study is conducted at the call center level, unlike the Timeliness Study which is conducted at the phone number level. First, the study is based at the call center level, so we first refer to what the compliance officer told us before the study in our response for call center indicators. To explain, we ask the Compliance Officer to tell us which lines route into separate and distinct physical call centers. So, please understand that your response to that inquiry determines how many call centers are used when testing. However, there

are other considerations that will result in variation of results when applied at the contract level. For example, SNPs are not asked the accuracy questions. Non-SNPs *are* asked accuracy questions. Results are rolled up to the contract level. So, if you have a contract with ONLY SNPs, the contract will not have accuracy results. If you have multiple contracts using the same call center indicator where some contracts are SNP-only and some are a mixture of SNP and non-SNP, you will not see uniform results for the accuracy measure.

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

General Questions

Question: Who do I contact if I have questions?

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

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

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

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

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

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

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

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

Answer: CMS' duplicate raw data lists the disposition codes from the calls we make in our call center monitoring studies (see data dictionaries that explain those codes for each study). Code 297.12 is one of the codes we use when we are unable to connect to a plan. This code is used for situations like receiving a message of "all circuits are busy" or a fast-busy signal. Our contractor has a system in place that requires their survey callers to make a second attempt *for any disposition where we cannot connect to the plan*, such as 297.12. The system will not allow the caller to record the information of "Neither Call Center Contact nor Ring/No Answer" unless a second attempt has been made to connect to the plan. Only one outcome is counted "against" the plan, but two attempts are made for every call in this scenario. The call outcome is included in the performance metrics and duplicated raw data so that the compliance officer can see the outcome of those two attempted calls/1 unsuccessful call disposition for a contract. We pass along that data so the compliance officer can understand how a beneficiary would have been impacted by the inability to connect to the plan on the same date and time.

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

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

Answer: In a situation like the one above, it is best for you to send the specific details of your question to CallCenterMonitoring@cms.hhs.gov. We will research the issue with our contractor. Things to consider are: (1) the timeliness study is based upon the phone number. The Accuracy and Accessibility Study is conducted at the *call center level.* All share results *at the contract level* but (1) One or more contracts might have been under sanction during the Accuracy and Accessibility Study and therefore would have been excluded. (2) The plan sponsor might have

changed the phone number in HPMS at some point during the study. Our contractor tracks this and can tell us when the change was made. (3) Some functions of studies do not apply to all situations. For example, contracts with *only* SNPs are excluded from the accuracy measure in the Accuracy and Accessibility Study. (4) Contracts under one parent organization may vary, especially based upon their service areas. For example, one contract may serve only the Eastern Time Zone while another contract may serve Eastern and Central Time Zones. This would mean that each could be called the same number of hours (from 8:00 am to 8:00 pm in their local service areas), but those times would be different and thus the results applicable to a certain contract may be different. (5) The compliance officer may have told us that the phone numbers route to physically distinct call centers for the Accuracy and Accessibility Study.

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

Answer: Please send the specifics of your inquiry to CallCenterMonitoring@cms.hhs.gov. We will be happy to research the Compliance Activity Module and our records to determine when the letter was issued to the compliance officer. Perhaps the email notification went to a spam or junk folder? The party questioning this, could also check the HPMS performance metrics sectionto determine if the non-compliant values match what is in the letter. Aside from that, we can offer the compliance officer the suggestion that he or she determine:

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

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

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

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

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

The explanation for this is our contractor schedules calls during a certain block of time. The

interviewers work through the calls scheduled one at a time. If the interviewer falls behind on their schedule due to earlier calls having longer-than-expected wait times or other issues, the auto dialer pulls up the call and dials it, and occasionally this inadvertently happens after the scheduled block of time. Please know that we do have a quality assurance process on the "back end" of the study that reviews the service areas, expected hours of operation, and times calls were placed. If any call was placed later than expected hours of operation for your call center, the call is removed from your performance metrics and the duplicated raw data we provide to you before we share the results with you. We attempt to catch them all, but if we missed one, please let us know.

We try to minimize this from happening so that we do not take up your customer service representatives' time and resources – or our resources -- but it does occasionally happen. We are implementing a way to move these calls that are scheduled but not yet placed to the following day to avoid this problem. If you ever have questions about this, be sure to let us know at CallCenterMonitoring@cms.hhs.gov. We will be happy to research the call and confirm that it gets invalidated in your results.

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

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

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

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

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

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

Answer: If you can, please convert the software to .mp3 or .wav format and put it in a compressed zip file format to email to CMS. To compress the file, highlight the file, right click with your mouse, and choose "send to a compressed file." Once compressed, please email it to CallCenterMonitoring@cms.hhs.gov along with the contract ID, the phone number on which the call was received, the date and time of the call, and the details of your request. CMS uses VLC software for recording playback. This software can read several formats including 3GP, ASF, AVI, DVR-MS, FLV, Matroska (MKV), MIDI, QuickTime File Format, MP4, Ogg, OGM, WAV, MPEG-2 (ES, PS, TS, PVA, MP3), AIFF, Raw audio, Raw DV, MXF, VOB, RM, DVD-Video, VCD, SVCD, CD Audio, DVB.

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

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

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

CMS does not have a written best practice to share, ideally sponsors should have an alternate call center to which calls could be directed. One example used by several sponsors is an auto forward to the pharmacy technical assistance call center for issues relating to prescription drugs, pharmacy billing questions, etc. To be clear, there is no specific requirement for this, and it is only offered as an example. That said, hypothetically, the calls as described *would be* non-compliant and scored as unsuccessful attempts if our test calls reach a message asking the party to call back, due to the requirement that call centers must be open during required hours of operation. This is true even if the closure was self-reported. Again, hypothetically, inappropriate call center closures may result in compliance action. Your plan to alert CMS in such an unexpected event is a good one. CMS suggests that MAOs, MA-PDs, PDPs, and MMPs self-disclose any call center closures – whether related to declarations of emergency or not -- to the assigned CMS Regional Office Account Manager. Adding CallCenterMonitoring@cms.hhs.gov as a cc would be helpful to us. Since 2006, CMS has consistently advised Part D sponsors and MAOs to report voluntarily to CMS any instances of program non-compliance that they discover on their own. As CMS staff have stated in numerous presentations to industry, we look more favorably on instances of non-compliance when it is self-reported rather than through other means, such as beneficiary complaints, complaints from competing contractors, audits, or our own data analysis. That is, CMS believes that self-reporting can be seen as evidence of an effective compliance program, indicating that while some non-compliance has occurred, the Part D sponsor or MAO has capable management and oversight in place exercising effective control over the organization.

Question: How was compliance determined for the 2024 Accuracy and Accessibility Study?

Answer: Interpreter Availability was tested to determine if the services were compliant with 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii), which require interpreters to be available for 80 percent of incoming calls requiring an interpreter within 8 minutes. TTY functionality was tested to determine if services were complaint with 42 C.F.R. §§ 422.111(h)(1)(iv) and 423.128(d)(1)(iv), which require 80 percent of incoming calls requiring TTY services to be connected to a TTY operator within 7 minutes. Accuracy was tested to determine if the services were compliant with 42 C.F.R. §§ 422.2262(a)(1)(i) and 423.2262(a)(1)(i), which requires MA organizations and Part D sponsors not to provide information that is inaccurate or misleading.

For 2024, we determined the accuracy compliance threshold to be 90 percent. MA organizations and Part D sponsors with accuracy results below 90 percent are outliers and per 42 C.F.R. §§ 422.504(m)(1)(ii) and 423.505(n)(1)(ii), CMS may determine that an MA Organization or Part D sponsor is out of compliance when its performance in fulfilling requirements represents an outlier relative to the performance of other organizations.

From:	CMS PartC&DStarRatings
To:	Darin Bruce
Cc:	CMS PartC&DStarRatings; CMS PartC&DStarRatings
Subject:	RE: Part C and D Star Ratings: Members Choosing to Leave the Plan Detail Data Available for Review
Date:	Monday, July 22, 2024 12:17:00 PM
Attachments:	2025_SR_Voluntary_Disenrollment_Detail_File_Layout.pdf image001.png

Hello,

The disenrollment detail data has been transferred to your organization. It includes an indicator field to mark if the member was excluded in the final data or not. The file can be found in the GENTRAN / Connect:Direct / TIBCO / Mainframe File Transfer (MFT) mailbox your organization uses for transferring enrollment/disenrollment data with CMS.

Please note that the data files were created on a PC as a tab delimited file and uploaded to the CMS mainframe to begin their journey. In the process, they were converted from ASCII to EBCDIC. The files may need to be converted back to ASCII when they are downloaded.

The transferred file contains all of the members that were included in the starting numerator data. We then processed the data to exclude members which met the exclusion criteria for the measure. Excluded members have a reason code greater than zero. Members with a reason code of zero were not excluded and will be counted in the final numerator that will be used in the 2025 Star Ratings.

The file layout of the detail files is attached. The summary-level disenrollment data are available for contracts to review in HPMS. To assess the summary-level disenrollment select: “Quality and Performance,” then “Performance Metrics,” then “Reports,” “Star Ratings and Display Measures,” then “Star Ratings” for Report Type, “2025” for Report Period, and “Measure Detail – Disenrollment” for Sub-Report.

We have created and transferred the extracts for the contracts requested.

The naming convention of the files transferred is:
P#EFT.OY.RXXXXX.DEN.DETAIL.DYYMMDD.THHMMSSS
Where:
XXXXX is replaced by the contract number that the data is for
YYMMDD is replaced by the year, month and date the file was sent
HHMMSSS is replaced by the hour, minute and second the file was sent

Sincerely,
The Part C and D Star Ratings Team

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: CMS PartC&DStarRatings
Sent: Thursday, July 18, 2024 7:03 AM
To: Darin Bruce <dbruce@humana.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Part C and D Star Ratings: Members Choosing to Leave the Plan Detail Data Available for Review

Confirming receipt.

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: Darin Bruce <dbruce@humana.com>
Sent: Wednesday, July 17, 2024 8:54 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Part C and D Star Ratings: Members Choosing to Leave the Plan Detail Data Available for Review

To Whom It May Concern:

I am the person who retrieves our files from CMS.
We are ready to receive the Disenrollment Detail files.
We use Connect:Direct to receive our files.
Please see attachment for our list of 46 contracts.
Please let me know if you need anything else.

Thanks!

From: HPMS <hpms@cms.hhs.gov>
Sent: Wednesday, July 17, 2024 6:16 PM
To: Darin Bruce <dbruce@humana.com>
Subject: Part C and D Star Ratings: Members Choosing to Leave the Plan Detail Data Available for Review

The beneficiary-level disenrollment detail data mentioned in the April 11, 2024, HPMS memo entitled "Information to Review Data Used for Medicare Part C and D Star Ratings and Display Measures" are now available for distribution to contracts to review prior to the first plan preview.

The information transmitted is intended only for the person or entity to which it is addressed
and may contain CONFIDENTIAL material. If you receive this material/information in error,
please contact the sender and delete or destroy the material/information.

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disability, sex, marital status, gender, sexual orientation, gender identity, or religion.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文(Chinese):注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

Kreyòl Ayisyen (Haitian Creole): ATANSION: Si w pale Kreyòl Ayisyen, gen sèvis èd

pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

2025 Star Ratings Contract Voluntary Disenrollment Detail File Layout (Measurement year 1/1/2023 – 12/31/2023)

Field Name	Field Description	Comments
Demographic Data		
hicn	RRB / HICN	RRB will display if available; otherwise this defaults to HICN.
Mbi	Beneficiary Medicare Beneficiary Identifier	Medicare Beneficiary Identifier
Previous Contract Data		
prev_plan	Previous Contract Number	The data in these fields refer to the contract from which the beneficiary has voluntarily disenrolled, i.e. the contract they are leaving.
prev_pbp	Previous Plan ID	
prev_enrdt	Previous Contract Enrollment Date	
prev_disndt	Previous Contract Disenrollment Date	
prev_drsn	Previous Contract Disenrollment Reason Code	
Previous Part D Plan Data (if available)		
prevd_stdt	Previous Part D Start Date	If the contract the beneficiary is leaving has part D, these fields will be populated; otherwise, zeros in NUM fields and Nulls in CHAR fields.
prevd_endt	Previous Part D End Date	
prevd_drsn	Previous Part D Disenrollment Reason Code	
New Contract and Plan Data (2 occurrences - Part D listed first if available)		
new1_plan	New Contract Number (occurrence 1)	These fields contain information about the contract or contracts that the beneficiary enrolled in directly after his or her voluntary disenrollment from the contract listed in the "Previous Contract Data" section. There are 2 occurrences for this because the beneficiary could disenroll from an MAPD and go into 2 contracts: 1 with MA and 1 as a stand-alone PDP. In cases where the beneficiary has part D, the part D contract data will be listed in the first occurrence. When no data is available for one or both of the occurrences, the system will put zeros in NUM fields and BLANK or spaces in CHAR fields.
new1_enrdt	New Contract Enrollment Date (occurrence 1)	
new1_pbp	New Plan ID (occurrence 1)	
new1_stdt	New Plan Start Date (occurrence 1)	
new2_plan	New Contract Number (occurrence 2)	
new2_enrdt	New Contract Enrollment Date (occurrence 2)	
new2_pbp	New Plan ID (occurrence 2)	
new2_stdt	New Plan Start Date (occurrence 2)	
Exclusion Codes		
reason	Reason for exclusion from final Voluntary Disenrollment Measure	0 = Included in final voluntary disenrollment numerator data 1 = Dropped, member in LIS reassignment (premium increase) contact file 2 = Dropped, member in PDP Contract Service Area Reduction/Termination contact file 3 = Dropped, member in MA Contract Service Area Reduction/Termination contact file 4 = Dropped, member has new contract enrollment type code of J and new plan 1 or 2 is a MMP 5 = Dropped, member in MMP passive enrollment file 6 = Dropped, member enrolled in employer group plan benefit package 7 = Dropped, member passively enrolled into Point of Sale contract X0001 8 = Dropped, member in PBP granted a special enrollment exception file 9 = Dropped, member in a PBP that terminated A = Dropped, member affected by PBP service area reduction, no PBPs left within contract that the member eligible to enroll into B = Dropped, member of 1876 Cost contract transitioned to replacement MA contract (H contract) C = Dropped, Members that 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 D = Dropped, member disenrolled from terminating MMP at end of measurement year

Case 4:24-cv-01004-O Document 19 Filed 11/21/24 Page 113 of 468 PageID 228

AR. 000113

From: CMS PartC&DStarRatings
To: Darin Bruce
Cc: CMS PartC&DStarRatings
Subject: RE: Part C and D Star Ratings: Members Choosing to Leave the Plan Detail Data Available for Review
Date: Tuesday, July 23, 2024 8:50:00 AM
Attachments: image001.png

Hello,

All 4 files for H5216 have been resent this morning. Please refer to todays date stamp (240723) and time (07:51) for reference.

Sincerely,
Part C and D Star Ratings Team

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, July 22, 2024 4:09 PM
To: Darin Bruce <dbruce@humana.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Part C and D Star Ratings: Members Choosing to Leave the Plan Detail Data Available for Review

Hello,

Thank you for letting us know. Confirming receipt.

Sincerely,

Part C and D Star Ratings Team

From: Darin Bruce <dbruce@humana.com>
Sent: Monday, July 22, 2024 10:05 AM

From:	CMS PartC&DStarRatings
To:	Stefanie Oyarzun
Cc:	Tiffany Gay; Sleth Ibanez; CMS PartC&DStarRatings
Subject:	RE: H1019-CarePlus Members Choosing to Leave the Plan Data Request
Date:	Tuesday, July 23, 2024 7:17:34 AM
Attachments:	2025_SR_Voluntary_Disenrollment_Detail_File_Layout.pdf image001.png

Hello,

The disenrollment detail data has been transferred to your organization. It includes an indicator field to mark if the member was excluded in the final data or not. The file can be found in the GENTRAN / Connect:Direct / TIBCO / Mainframe File Transfer (MFT) mailbox your organization uses for transferring enrollment/disenrollment data with CMS.

Please note that the data files were created on a PC as a tab delimited file and uploaded to the CMS mainframe to begin their journey. In the process, they were converted from ASCII to EBCDIC. The files may need to be converted back to ASCII when they are downloaded.

The transferred file contains all of the members that were included in the starting numerator data. We then processed the data to exclude members which met the exclusion criteria for the measure. Excluded members have a reason code greater than zero. Members with a reason code of zero were not excluded and will be counted in the final numerator that will be used in the 2025 Star Ratings.

The file layout of the detail files is attached. The summary-level disenrollment data are available for contracts to review in HPMS. To assess the summary-level disenrollment select: “Quality and Performance,” then “Performance Metrics,” then “Reports,” “Star Ratings and Display Measures,” then “Star Ratings” for Report Type, “2025” for Report Period, and “Measure Detail – Disenrollment” for Sub-Report.

We have created and transferred the extracts for the contracts requested.

The naming convention of the files transferred is:
P#EFT.OY.RXXXXX.DEN.DETAIL.DYYMMDD.THHMMSSS
Where:
XXXXX is replaced by the contract number that the data is for
YYMMDD is replaced by the year, month and date the file was sent
HHMMSSS is replaced by the hour, minute and second the file was sent

Sincerely,
The Part C and D Star Ratings Team

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)

PartCandDStarRatings@cms.hhs.gov

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From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, July 22, 2024 5:32 PM
To: Stefanie Oyarzun <spodhajser@humana.com>
Cc: Tiffany Gay <tgay@careplus-hp.com>; Sleth Ibanez <sibanez@careplus-hp.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: H1019-CarePlus Members Choosing to Leave the Plan Data Request

Hello,

Confirming receipt.

Sincerely,

Part C and D Star Ratings Team

From: Stefanie Oyarzun <spodhajser@humana.com>
Sent: Monday, July 22, 2024 9:20 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Tiffany Gay <tgay@careplus-hp.com>; Sleth Ibanez <sibanez@careplus-hp.com>
Subject: H1019-CarePlus Members Choosing to Leave the Plan Data Request

Good afternoon,

We are ready to receive the data related to “Members choosing to leave the plan” for the following contract:

H1019

Please let us know if you need any additional information.

Stefanie Oyarzun
Compliance Lead | Regulatory Compliance- Medicare

Law, Risk & Compliance (LR&C)
C: 305-833-0386

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and may contain CONFIDENTIAL material. If you receive this material/information in error,
please contact the sender and delete or destroy the material/information.

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2025 Star Ratings Contract Voluntary Disenrollment Detail File Layout (Measurement year 1/1/2023 – 12/31/2023)

Field Name	Field Description	Comments
Demographic Data		
hicn	RRB / HICN	RRB will display if available; otherwise this defaults to HICN.
Mbi	Beneficiary Medicare Beneficiary Identifier	Medicare Beneficiary Identifier
Previous Contract Data		
prev_plan	Previous Contract Number	The data in these fields refer to the contract from which the beneficiary has voluntarily disenrolled, i.e. the contract they are leaving.
prev_pbp	Previous Plan ID	
prev_enrdt	Previous Contract Enrollment Date	
prev_disndt	Previous Contract Disenrollment Date	
prev_drsn	Previous Contract Disenrollment Reason Code	
Previous Part D Plan Data (if available)		
prevd_stdt	Previous Part D Start Date	If the contract the beneficiary is leaving has part D, these fields will be populated; otherwise, zeros in NUM fields and Nulls in CHAR fields.
prevd_endt	Previous Part D End Date	
prevd_drsn	Previous Part D Disenrollment Reason Code	
New Contract and Plan Data (2 occurrences - Part D listed first if available)		
new1_plan	New Contract Number (occurrence 1)	These fields contain information about the contract or contracts that the beneficiary enrolled in directly after his or her voluntary disenrollment from the contract listed in the "Previous Contract Data" section. There are 2 occurrences for this because the beneficiary could disenroll from an MAPD and go into 2 contracts: 1 with MA and 1 as a stand-alone PDP. In cases where the beneficiary has part D, the part D contract data will be listed in the first occurrence. When no data is available for one or both of the occurrences, the system will put zeros in NUM fields and BLANK or spaces in CHAR fields.
new1_enrdt	New Contract Enrollment Date (occurrence 1)	
new1_pbp	New Plan ID (occurrence 1)	
new1_stdt	New Plan Start Date (occurrence 1)	
new2_plan	New Contract Number (occurrence 2)	
new2_enrdt	New Contract Enrollment Date (occurrence 2)	
new2_pbp	New Plan ID (occurrence 2)	
new2_stdt	New Plan Start Date (occurrence 2)	
Exclusion Codes		
reason	Reason for exclusion from final Voluntary Disenrollment Measure	0 = Included in final voluntary disenrollment numerator data 1 = Dropped, member in LIS reassignment (premium increase) contact file 2 = Dropped, member in PDP Contract Service Area Reduction/Termination contact file 3 = Dropped, member in MA Contract Service Area Reduction/Termination contact file 4 = Dropped, member has new contract enrollment type code of J and new plan 1 or 2 is a MMP 5 = Dropped, member in MMP passive enrollment file 6 = Dropped, member enrolled in employer group plan benefit package 7 = Dropped, member passively enrolled into Point of Sale contract X0001 8 = Dropped, member in PBP granted a special enrollment exception file 9 = Dropped, member in a PBP that terminated A = Dropped, member affected by PBP service area reduction, no PBPs left within contract that the member eligible to enroll into B = Dropped, member of 1876 Cost contract transitioned to replacement MA contract (H contract) C = Dropped, Members that 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 D = Dropped, member disenrolled from terminating MMP at end of measurement year

Case 4:24-cv-01004-O Document 19 Filed 11/21/24 Page 119 of 468 PageID 234

AR. 000119

From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Amy Heilman; Dillon Nicole; Jenna Pinardo; Conor Duffy; Kimberlee Reid; CMS PartC&DStarRatings
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings
Date: Thursday, August 8, 2024 3:30:37 PM

We are currently focused on the plan preview so once we have a little time we plan to update. Hopefully, it is fairly soon.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, August 8, 2024 4:07 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

Thank you for your quick response.

Can you provide any additional detail on when we can expect to receive the updated 2024 Star Ratings Technical Notes and Attachment C with updated national Star averages?

Thank you,
Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, August 8, 2024 2:37 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

We anticipate updating the 2024 Star Ratings Technical Notes and will include updated numbers with that update.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, August 8, 2024 2:30 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: Plan Preview #1 - Updated national averages for 2025 ratings

Good Afternoon,

Given the clarifying language on treatment for 2025 Star rating cut points in the Medicare 2025 Part C & D Star Ratings Technical Notes, can CMS share or publish updated 2025 measure-level national Star averages given the 2025 recalculated ratings, and as typically provided in Attachment C of the corresponding year technical notes?

Regards,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; Kimberlee Reid; CMS PartC&DStarRatings
Subject: RE: PP1 - Disenrollment Files
Date: Monday, August 12, 2024 6:27:44 AM
Attachments: 2025_SR_Voluntary_Disenrollment_Detail_File_Layout.pdf
image001.png
image002.png
image003.png
image004.png
image005.png

Hi Colleen,

The disenrollment detail data has been transferred to your organization. It includes an indicator field to mark if the member was excluded in the final data or not. The file can be found in the GENTRAN / Connect:Direct / TIBCO / Mainframe File Transfer (MFT) mailbox your organization uses for transferring enrollment/disenrollment data with CMS.

Please note that the data files were created on a PC as a tab delimited file and uploaded to the CMS mainframe to begin their journey. In the process, they were converted from ASCII to EBCDIC. The files may need to be converted back to ASCII when they are downloaded.

The transferred file contains all of the members that were included in the starting numerator data. We then processed the data to exclude members which met the exclusion criteria for the measure. Excluded members have a reason code greater than zero. Members with a reason code of zero were not excluded and will be counted in the final numerator that will be used in the 2025 Star Ratings.

The file layout of the detail files is attached. The summary-level disenrollment data are available for contracts to review in HPMS. To assess the summary-level disenrollment select: “Quality and Performance,” then “Performance Metrics,” then “Reports,” “Star Ratings and Display Measures,” then “Star Ratings” for Report Type, “2025” for Report Period, and “Measure Detail – Disenrollment” for Sub-Report.

We have created and transferred the extracts for the contracts requested.

The naming convention of the files transferred is:
P#EFT.OY.RXXXXX.DEN.DETAIL.DYYMMDD.THHMMSSS
Where:
XXXXX is replaced by the contract number that the data is for
YYMMDD is replaced by the year, month and date the file was sent
HHMMSSS is replaced by the hour, minute and second the file was sent

Thank you and regards,

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)

PartCandDStarRatings@cms.hhs.gov

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From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, August 12, 2024 7:13 AM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - Disenrollment Files

Confirming receipt.

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 7:12 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>

Subject: PP1 - Disenrollment Files

Good Morning,

The workbook of disenrollment data received in July for H5216 does not match the Plan Preview 1 disenrollment data for the Members Choosing to Leave the Plan measure. To enable Humana to fully validate PP1 MCLP rates given the year 2 impact of previously consolidated contracts, can CMS please provide detailed disenrollment files for contracts H9070 and H8087?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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2025 Star Ratings Contract Voluntary Disenrollment Detail File Layout (Measurement year 1/1/2023 – 12/31/2023)

Field Name	Field Description	Comments
Demographic Data		
hicn	RRB / HICN	RRB will display if available; otherwise this defaults to HICN.
Mbi	Beneficiary Medicare Beneficiary Identifier	Medicare Beneficiary Identifier
Previous Contract Data		
prev_plan	Previous Contract Number	The data in these fields refer to the contract from which the beneficiary has voluntarily disenrolled, i.e. the contract they are leaving.
prev_pbp	Previous Plan ID	
prev_enrdt	Previous Contract Enrollment Date	
prev_disndt	Previous Contract Disenrollment Date	
prev_drsn	Previous Contract Disenrollment Reason Code	
Previous Part D Plan Data (if available)		
prevd_stdt	Previous Part D Start Date	If the contract the beneficiary is leaving has part D, these fields will be populated; otherwise, zeros in NUM fields and Nulls in CHAR fields.
prevd_endt	Previous Part D End Date	
prevd_drsn	Previous Part D Disenrollment Reason Code	
New Contract and Plan Data (2 occurrences - Part D listed first if available)		
new1_plan	New Contract Number (occurrence 1)	These fields contain information about the contract or contracts that the beneficiary enrolled in directly after his or her voluntary disenrollment from the contract listed in the "Previous Contract Data" section. There are 2 occurrences for this because the beneficiary could disenroll from an MAPD and go into 2 contracts: 1 with MA and 1 as a stand-alone PDP. In cases where the beneficiary has part D, the part D contract data will be listed in the first occurrence. When no data is available for one or both of the occurrences, the system will put zeros in NUM fields and BLANK or spaces in CHAR fields.
new1_enrdt	New Contract Enrollment Date (occurrence 1)	
new1_pbp	New Plan ID (occurrence 1)	
new1_stdt	New Plan Start Date (occurrence 1)	
new2_plan	New Contract Number (occurrence 2)	
new2_enrdt	New Contract Enrollment Date (occurrence 2)	
new2_pbp	New Plan ID (occurrence 2)	
new2_stdt	New Plan Start Date (occurrence 2)	
Exclusion Codes		
reason	Reason for exclusion from final Voluntary Disenrollment Measure	0 = Included in final voluntary disenrollment numerator data 1 = Dropped, member in LIS reassignment (premium increase) contact file 2 = Dropped, member in PDP Contract Service Area Reduction/Termination contact file 3 = Dropped, member in MA Contract Service Area Reduction/Termination contact file 4 = Dropped, member has new contract enrollment type code of J and new plan 1 or 2 is a MMP 5 = Dropped, member in MMP passive enrollment file 6 = Dropped, member enrolled in employer group plan benefit package 7 = Dropped, member passively enrolled into Point of Sale contract X0001 8 = Dropped, member in PBP granted a special enrollment exception file 9 = Dropped, member in a PBP that terminated A = Dropped, member affected by PBP service area reduction, no PBPs left within contract that the member eligible to enroll into B = Dropped, member of 1876 Cost contract transitioned to replacement MA contract (H contract) C = Dropped, Members that 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 D = Dropped, member disenrolled from terminating MMP at end of measurement year

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AR. 000129

From:	CMS MP-CAHPS
To:	Colleen O"Neil
Cc:	Jenna Pinardo; Conor Duffy; Dillon Nicole; Kimberlee Reid; Amy Heilman; CMS PartC&DStarRatings
Subject:	RE: PP1 - CAHPS thresholds
Date:	Wednesday, August 14, 2024 12:39:34 PM
Attachments:	MCAHPS_BaseGroupCutpoints.xlsx Humana_CaseMix_MeansTest_Reports.zip image001.png image002.png image003.png image004.png

Dear Colleen O'Neil,

When calculating the 15th, 30th, 60th, and 80th percentiles that serve as thresholds for the base groups for a given measure, all contract scores, including contracts consumed in a consolidation, are included if the score is based on at least 11 survey responses. To assign a contract's score to a base group, the contract's score is rounded to the nearest integer and compared to the base group thresholds that are also rounded to the nearest integer.

You compared changes in the percentile values to the national mean. The changes of percentiles from one year to the next will often be similar to the change in the mean but aren't necessarily the same. Furthermore, changes of one point in the rounded thresholds may correspond to unrounded changes of less than one point or more than one point. See the attached file "MCAHPS_BaseGroupCutpoints.xlsx," which provides more precise base group threshold values for both the current (sheet "2024_Cutpoints") and prior (sheet "2023_Cutpoints") year. For example, looking at the Getting Needed Care base group thresholds, the 15th percentile (threshold for base group 2) increased from 76.457392 to 76.982869, which translates to an increase in rounded percentiles from 76 to 77, and the 60th percentile (threshold for base group 4) increased from 81.453754 to 81.576171, which translates to an increase in rounded percentiles from 81 to 82.

See the attached zip file "Humana_CaseMix_MeansTest_Reports.zip", which includes a means and tests report and case-mix report for each of Humana's contracts. The means and tests report provides additional statistics used to calculate the Star Rating for each applicable measure. The case-mix report includes a worksheet for every item or composite that receives a Star Rating. For further information about analysis of MA & PDP CAHPS Reported Measures, please visit the 'Scoring and Star Ratings' section on the MA & PDP CAHPS website at Scoring and Star Ratings (ma-pdpcahps.org).

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole

<DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>

Subject: PP1 - CAHPS thresholds

Good Afternoon,

1. Can CMS please define the threshold setting methodology for CAHPS, specifically, if consumed contracts (consolidated and/or otherwise terminated contracts as of 1/1/2025 are included in the percentile calculations?

2. After reviewing BY 2026 CAHPS ratings, we have identified data points that appear to contradict each other, preventing us from fully validating CAHPS rates and application of thresholds.

    - For example, the "Getting Needed Care" measure thresholds increased without demonstrating a commensurate increase in industry improvement. Upward movement across 2-star, 3-star, and 4-star thresholds would seem to suggest significant industry improvement on the measure. However, the reported national average for Getting Needed Care only increased by 0.24 points from 80.62 in BY 2025 to 80.86 in BY 2026, contradicting the degree of threshold movement.

Getting Needed Care threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	76%	77%	+ 1%
3 Star	78%	79%	+ 1%
4 Star	81%	82%	+ 1%

    - Additionally, related to the "Getting Needed Prescription Drugs" measure, the only threshold movement was at the 3-star threshold which fell by 1 point. However, given the national average for this measure was 90.37 for BY 2025 and 89.68 for BY 2026 – a decline of 0.69 points and almost 3x the magnitude of the Getting Needed Care measure increase, we would have expected commensurate decreases in thresholds.

Getting Needed Prescription Drugs (MAPD) threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	87%	87%	--
3 Star	89%	88%	- 1%
4 Star	90%	90%	--
5 Star	91%	91%	--

Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Jenna Pinardo; Conor Duffy; Amy Heilman; Kimberlee Reid; CMS PartC&DStarRatings
Subject: RE: PP1 Question - H0473 SNP Care Management
Date: Wednesday, August 14, 2024 6:31:10 PM
Attachments: image001.png
image002.png
image003.png
image004.png

The Star Ratings are based on what the contract is going to offer in the coming year so it is correctly noted on Medicare Plan Finder as specified at §422.162(B)(i). For example, contracts that will offer SNPs in 2025 should have SNP measures included in their 2025 Star Ratings as long as the contract was operational during the 2023 measurement year and offered SNP plans. The Star Ratings are calculated at the contract level so if at least one plan benefit package will be a SNP, the SNP measures are included in the calculation of the Star Ratings for all plans under the contract. We added an additional clarification in Technical Notes this year, but this is how the Star Ratings have always been calculated. The first bullet is related to how the measure is calculated, but the second bullet is related to which measures are included in the calculation of the overall and summary ratings.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, August 14, 2024 2:54 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: PP1 Question - H0473 SNP Care Management

Good Afternoon,

We noticed potentially conflicting guidance in the technical notes regarding the treatment of SNP measures when the underlying PBP is being discontinued for the applicable Stars Rating Year. Based on established guidance in previous technical notes and this year's technical notes on page 47 (referenced below in bullet 1), we expected data for the H0473 "Special Needs Plan (SNP) Care Management" measure to be included because the SNP PBP will be offered for the entirety of calendar year 2024. However new guidance in this year's technical notes on page 13 (referenced below in bullet 2) appears to conflict with the language in bullet 1.

1. "The Part C Reporting Requirements data are summed into a contract-level rate after excluding PBP's that do not map to any PBP offered by the contract in the calendar year for which the Reporting Requirements data underwent data validation" [p47]

2. "If a contract offered a SNP PBP in the 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" [p13]

Can CMS confirm that H0473 should receive a measure-level rate and star for the SNP Care Management Measure for SRY25?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Conor Duffy; Jenna Pinardo; Kimberlee Reid; Amy Heilman; CMS PartC&DStarRatings
Subject: RE: PP1 Question - H5216 Members Choosing to Leave the Plan
Date: Thursday, August 15, 2024 11:43:35 AM
Attachments: image001.png
image002.png
image003.png
image004.png

Hello,

We updated the Members Choosing to Leave the Plan rate for H5216 to 17% as shown below. This will be updated in HPMS for the second plan preview.

Contract ID	Members Choosing to Leave the Plan Rate (Before Consolidation)	July 2023 Enrollment
H5216	17.180864	2,320,533
H8087	14.827883	65,403
H9070	18.78562	22,996
Enrollment weighted average final rate for H5216	17.1323	
Rounded Enrollment weighted average final rate for H5216	17%	

Thank you,
Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 3:47 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 Question - H5216 Members Choosing to Leave the Plan

We can provide updates.

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, August 14, 2024 3:42 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid

<kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: RE: PP1 Question - H5216 Members Choosing to Leave the Plan

Thank you for your timely response.

Once CMS makes the correction, can you please confirm the final rate will reflect 17%?

Best,
Colleen O'Neil

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 3:00 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 Question - H5216 Members Choosing to Leave the Plan

Thank you for your email. We do see an issue and are working to correct.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, August 14, 2024 2:50 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 Question - H5216 Members Choosing to Leave the Plan

Good Afternoon,

Thank you for providing the previously requested disenrollment detail for H8087 and H9070. Upon review of the detail, the Members Choosing to Leave the Plan rate numerators for contracts H8087 and H9070 appear to include members who remained on their plans through consolidation into the H5216 contract.

Contract change due to contract consolidation is not voluntary on the member's part and therefore does not reflect a member's choice to leave a plan. Counting movement such as this in the numerator would be contrary to the clearly stated intent and exclusion criteria of the measure.

Can CMS confirm that 1) members who remain with their plan through a contract consolidation are excluded from the final numerator as they involuntarily left their contract due to circumstances beyond their control and 2) H5216's MCTLP rounded rate is 17% and not 20%?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From:	CMS PartC&DStarRatings
To:	Colleen O"Neil
Cc:	Jenna Pinardo; Conor Duffy; Amy Heilman; Kimberlee Reid; Dillon Nicole; CMS PartC&DStarRatings
Subject:	RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings
Date:	Thursday, September 5, 2024 5:46:54 PM
Attachments:	Humana.zip image001.png

Hello,

Please see attached.

Sincerely,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, September 5, 2024 11:31 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>
Subject: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Dear Sir/Madam:

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In addition, the Technical Notes PDF contains several tables that would be beneficial to receive in a spreadsheet to consume, particularly Performance Summary Thresholds, Measure Star Cut Points, and CAI Detail. Is it possible for CMS to share a supplemental file with this information in Excel or CSV format?

Humana Contract List

H0028, H0292, H0336, H0473, H0783, H1019, H1036, H1468, H1951, H2029, H2237, H2463, H2486, H2944, H3533, H4007, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7617, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315, S2874, S5552, S5884

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Jenna Pinardo; Conor Duffy; Amy Heilman; Kimberlee Reid; Dillon Nicole; CMS PartC&DStarRatings
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings
Date: Friday, September 6, 2024 9:32:05 AM
Attachments: image001.png
image002.png

We have looked further into this. This contract is a second year consolidation and the improvement workbooks will not populate in these situations so please use the information available in HPMS.

Thank you and regards,

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Friday, September 6, 2024 10:24 AM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

We are looking at why the workbook is not populating for this particular contract. Let us know if you see this issue for any other contracts.

Thanks you and regards,

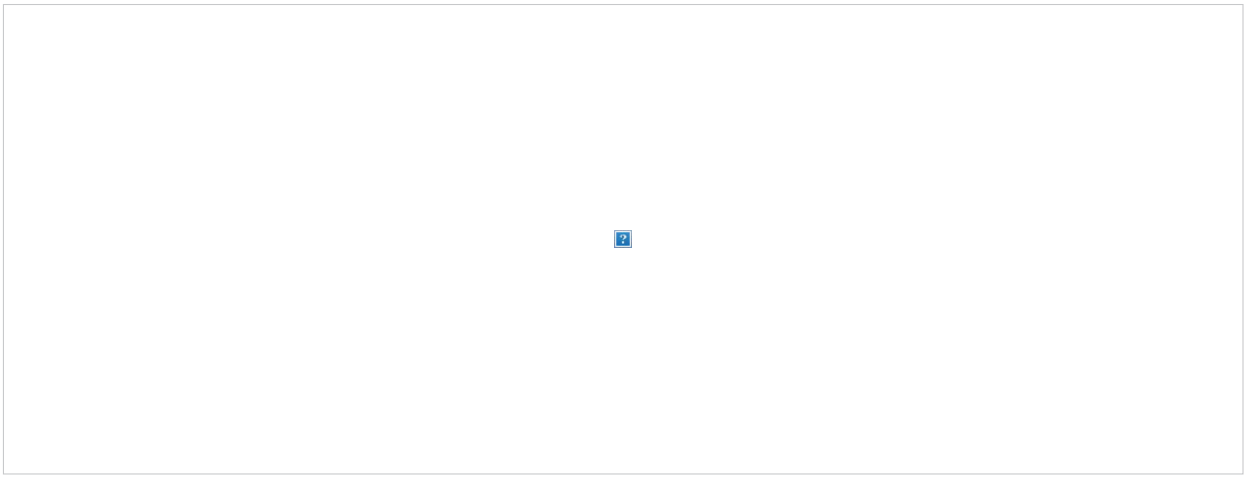
Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 6, 2024 10:07 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Thank you.

In our review, we noticed the H5216 improvement workbook did not include denominators for most measures (see image below). In order to validate the improvement for this contract, the denominators are a necessity. Can CMS please send us the full H5216 improvement workbook, including all measure denominators?

Best,
Colleen O'Neil



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Sent: Thursday, September 5, 2024 6:47 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
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From: Colleen O'Neil <coneil1@humana.com>
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To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>

Subject: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

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Best,

Colleen O’Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej

pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

From:	CMS PartC&DStarRatings
To:	Colleen O"Neil
Cc:	Amy Heilman; Dillon Nicole; Jenna Pinardo; Conor Duffy; Kimberlee Reid; CMS PartC&DStarRatings
Subject:	RE: Updated national averages for 2024 ratings
Date:	Tuesday, September 10, 2024 1:02:24 PM
Attachments:	image005.png image006.png image007.png image008.png image009.png

This has been updated on the website.

Thank you and regards,

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: Colleen O'Neil <coneil1@humana.com>
Sent: Tuesday, September 10, 2024 10:37 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Updated national averages for 2024 ratings

Thank you for your response.

Upon review, the data appears unchanged from the values shared last fall in Tables C-1 and C-2 of the 2024 Part C & D Star Ratings Technical Notes. Given the recalculated thresholds, we would expect there to be some change in the industry measure star national averages.

Can CMS please review the 2024 Star Rating national averages to confirm they are based on the recalculated thresholds?“

Best,
Colleen O'Neil

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, September 9, 2024 3:15 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Updated national averages for 2024 ratings

Please see the star rating averages posted here -- https://www.cms.gov/files/document/updated-2024-star-ratings-cutpoints-and-star-averages.xlsx.

Thank you and regards,

Part C and D Star Ratings

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, September 5, 2024 7:21 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Updated national averages for 2024 ratings

Confirming receipt.

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, September 5, 2024 7:13 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Updated national averages for 2024 ratings

Good Evening,

Given the release of Plan Preview 2 for 2025 Star Ratings earlier this evening, can you please provide the updated 2024 Star measure-level national star rating averages? While the numeric rates would not have changed with the recalculated thresholds, the national average ratings would have.

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, August 26, 2024 6:03 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

Since we are working on the 2025 Star Ratings, we do not have timing yet. The numeric scores though would not have been updated for the 2024 Star Ratings.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 26, 2024 2:55 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

Good Afternoon,

Can CMS provide any additional timing details for the release of the updated 2024 Star Ratings Technical Notes?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

Living our Values

Caring Curious Committed

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, August 8, 2024 4:31 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

We are currently focused on the plan preview so once we have a little time we plan to update. Hopefully, it is fairly soon.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, August 8, 2024 4:07 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

Thank you for your quick response.

Can you provide any additional detail on when we can expect to receive the updated 2024 Star Ratings Technical Notes and Attachment C with updated national Star averages?

Thank you,
Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, August 8, 2024 2:37 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #1 - Updated national averages for 2025 ratings

We anticipate updating the 2024 Star Ratings Technical Notes and will include updated numbers with that update.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, August 8, 2024 2:30 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: Plan Preview #1 - Updated national averages for 2025 ratings

Good Afternoon,

Given the clarifying language on treatment for 2025 Star rating cut points in the Medicare 2025 Part C & D Star Ratings Technical Notes, can CMS share or publish updated 2025 measure-level national Star averages given the 2025 recalculated ratings, and as typically provided in Attachment C of the corresponding year technical notes?

Regards,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文(Chinese):注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

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Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

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From: CMS MP-CAHPS
To: Colleen O"Neil
Cc: Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; CMS PartC&DStarRatings; Kimberlee Reid
Subject: RE: PP1 - CAHPS thresholds
Date: Thursday, September 12, 2024 9:20:59 AM
Attachments: Humana_Consolidation_Scores_2024.xlsx
image001.png
image002.png
image003.png
image004.png
image005.png

Good morning,
Please see the attached file "Humana_Consolidation_Scores_2024.xlsx." Note that pre-consolidation scores are suppressed if the number of responses is below 11 or if the score was calculated with very low interunit reliability.

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, September 11, 2024 4:29 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good Afternoon,

We are continuing our work to validate the threshold calculation for the Rating of the Health Plan measure, but are unable to confirm the inclusion of Humana consumed contracts, as we do not have measure data for those plans. Can CMS please provide the pre-consolidation measure rates to 6 digits for Humana consumed and surviving contracts, similar to the detail in the attached document which CMS provided last year for our previous H5216/H8087/H9070 consolidation?

Consumed Contract	Surviving Contract
R0865	R0110
R0923	R0110
R1390	R0110
R3392	R0110
R3887	R0110
R5495	R0110
R7315	R0110
H7621	H5619

S2874 S5884

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Monday, September 9, 2024 10:54 AM
To: Colleen O'Neil <coneil1@humana.com>; Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
All available sample data are posted in HPMS. We provide sample data for one of each type of measure needed to replicate cut points. These data allow contracts to ensure they are able to replicate CMS's cut point methodology. All other CAHPS measures use the same cut point methodology (Relative Distribution and Significance Testing) as the Rating of Health Plan measure.

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, September 9, 2024 10:01 AM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Thank you for the detail provided for the Rating of the Health Plan measure.

To further support our efforts to validate Star ratings, we request the same information for the other CAHPS measures listed below.

- Annual Flu Vaccine
- Getting Needed Care
- Getting Appointments and Care Quickly

- Customer Service
- Rating of Health Care Quality
- Care Coordination
- Rating of Drug Plan
- Getting Needed Prescription Drugs

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Friday, September 6, 2024 9:20 AM
To: Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Consistent with sample measure data that has been made available in HPMS for other measures (e.g. C01), CMS has uploaded a file called "C23_Sample_Data.xlsx", which provides de-identified scores, rounded to 6 decimal places, for the Rating of Health Plan measure for all contracts with more than 10 valid responses to the survey item. These scores are used to calculate the 15th, 30th, 60th, and 80th percentiles that serve as the base group cut points. This file does not identify Humana contract scores, but that information has been provided in the contract-specific means and tests reports that were provided in a prior response to this inquiry.

Thank you,
MA & PDP CAHPS Survey Team

From: Kimberlee Reid <kreid1@humana.com>
Sent: Friday, August 30, 2024 5:08 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole

<DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon, MA & PDP CAHPS Survey Team,

Thank you for the additional information provided. Humana continues to work to validate the reported CAHPS results.

In an effort to complete this ask, we would highlight our previous request for deidentified unrounded industry rates for all contracts that reported. In this file, we would also ask that the Humana contract rates be identified.

Thank you,

Kimberlee Reid
Program Delivery Lead | Governance, Risk, Compliance & Communcations
Health Quality and Stars

Humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 1:39 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Dear Colleen O'Neil,

When calculating the 15th, 30th, 60th, and 80th percentiles that serve as thresholds for the base groups for a given measure, all contract scores, including contracts consumed in a consolidation, are included if the score is based on at least 11 survey responses. To assign a contract's score to a base group, the contract's score is rounded to the nearest integer and compared to the base group thresholds that are also rounded to the nearest integer.

You compared changes in the percentile values to the national mean. The changes of percentiles from one year to the next will often be similar to the change in the mean but aren't necessarily the same. Furthermore, changes of one point in the rounded thresholds may

correspond to unrounded changes of less than one point or more than one point. See the attached file "MCAHPS_BaseGroupCutpoints.xlsx," which provides more precise base group threshold values for both the current (sheet "2024_Cutpoints") and prior (sheet "2023_Cutpoints") year. For example, looking at the Getting Needed Care base group thresholds, the 15th percentile (threshold for base group 2) increased from 76.457392 to 76.982869, which translates to an increase in rounded percentiles from 76 to 77, and the 60th percentile (threshold for base group 4) increased from 81.453754 to 81.576171, which translates to an increase in rounded percentiles from 81 to 82.

See the attached zip file "Humana_CaseMix_MeansTest_Reports.zip", which includes a means and tests report and case-mix report for each of Humana's contracts. The means and tests report provides additional statistics used to calculate the Star Rating for each applicable measure. The case-mix report includes a worksheet for every item or composite that receives a Star Rating. For further information about analysis of MA & PDP CAHPS Reported Measures, please visit the 'Scoring and Star Ratings' section on the MA & PDP CAHPS website at Scoring and Star Ratings (ma-pdpcahps.org).

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 - CAHPS thresholds

Good Afternoon,

1. Can CMS please define the threshold setting methodology for CAHPS, specifically, if consumed contracts (consolidated and/or otherwise terminated contracts as of 1/1/2025 are included in the percentile calculations?

2. After reviewing BY 2026 CAHPS ratings, we have identified data points that appear to contradict each other, preventing us from fully validating CAHPS rates and application of thresholds.
    - For example, the "Getting Needed Care" measure thresholds increased without demonstrating a commensurate increase in industry improvement. Upward movement across 2-star, 3-star, and 4-star thresholds would seem to suggest significant industry improvement on the measure. However, the reported national average for Getting Needed Care only increased by 0.24 points from 80.62 in BY 2025 to 80.86 in BY 2026, contradicting the degree of threshold movement.

Getting Needed Care threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	76%	77%	+ 1%
3 Star	78%	79%	+ 1%
4 Star	81%	82%	+ 1%

- Additionally, related to the "Getting Needed Prescription Drugs" measure, the only threshold movement was at the 3-star threshold which fell by 1 point. However, given the national average for this measure was 90.37 for BY 2025 and 89.68 for BY 2026 – a decline of 0.69 points and almost 3x the magnitude of the Getting Needed Care measure increase, we would have expected commensurate decreases in thresholds.

Getting Needed Prescription Drugs (MAPD) threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	87%	87%	--
3 Star	89%	88%	- 1%
4 Star	90%	90%	--
5 Star	91%	91%	--

Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Jenna Pinardo; Conor Duffy; Amy Heilman; Kimberlee Reid; Dillon Nicole; CMS PartC&DStarRatings
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings
Date: Thursday, September 12, 2024 9:58:08 AM
Attachments: Improvement Data for H5216 Consolidation.xlsx
image001.png
image002.png
image003.png

Good morning,

Please see the attached Excel file which contains the data used to calculate the improvement measure for H5216 based on the contract being a second year consolidation.

Thank you,

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, September 9, 2024 1:08 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Confirming receipt.

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

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From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, September 9, 2024 10:23 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Good Morning,

In the measure star workbook (from HPMS) and overall rating calculation workbook (for H5216), we observed H5216 received a Part C Improvement rating of 3 star and a Part D Improvement rating of 2 star but do not have the individual rates to be able to validate the measure ratings.

Can CMS please provide the measure level data CMS used to calculate the H5216 Part C Improvement rate and the H5216 Part D Improvement rate?

Best,
Colleen O'Neil

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Friday, September 6, 2024 10:32 AM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

We have looked further into this. This contract is a second year consolidation and the improvement workbooks will not populate in these situations so please use the information available in HPMS.

Thank you and regards,

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Friday, September 6, 2024 10:24 AM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

We are looking at why the workbook is not populating for this particular contract. Let us know if you see this issue for any other contracts.

Thanks you and regards,

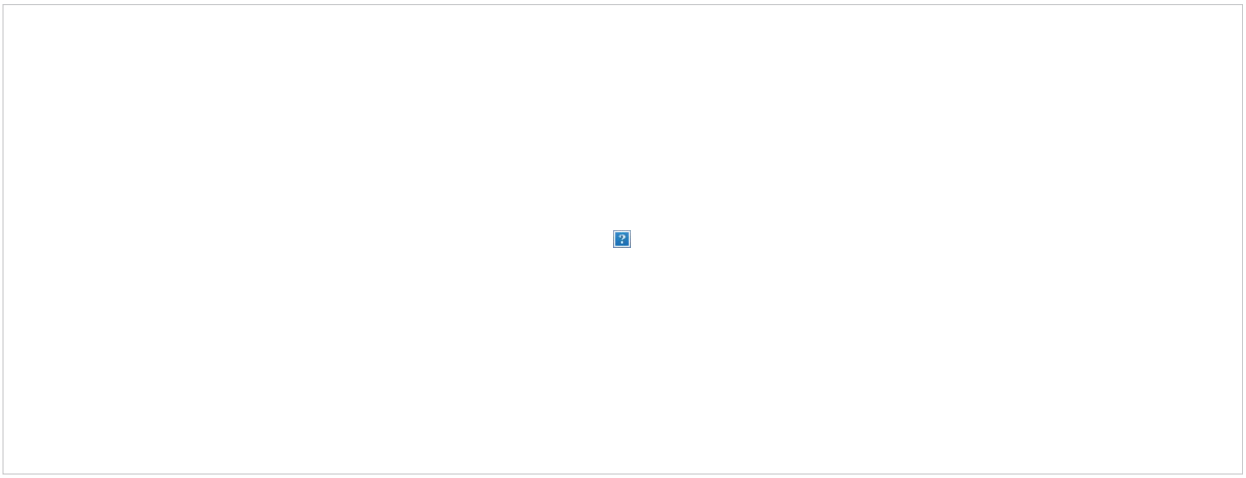
Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 6, 2024 10:07 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Thank you.

In our review, we noticed the H5216 improvement workbook did not include denominators for most measures (see image below). In order to validate the improvement for this contract, the denominators are a necessity. Can CMS please send us the full H5216 improvement workbook, including all measure denominators?

Best,
Colleen O'Neil



From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, September 5, 2024 6:47 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Hello,

Please see attached.

Sincerely,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, September 5, 2024 11:31 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; Dillon Nicole <DNicole@humana.com>
Subject: Plan Preview #2 – All Humana Contracts: Excel Workbooks Supporting Rates and Ratings

Dear Sir/Madam:

In years past, we have requested and received Excel workbooks for each contract which outlined details used to support rates and Star Ratings for the Part C and Part D Improvement Measures. These workbooks proved invaluable for our data validation efforts for Plan Preview Period 2. The "Improvement Details – Part C" and "Improvement Details – Part D" pages in HPMS do not seem to contain the same information. We believe these are the emulation workbooks, which may be titled "H5216_2025_SR_Calculations_2024_09_XX.xlsx" and "H5216_2024_IM_Calcs_2024_09_XX.xlsx". Can you please send the workbooks for **all the contracts listed below** to support our review? (H5216 used for example purposes only).

In addition, the Technical Notes PDF contains several tables that would be beneficial to receive in a spreadsheet to consume, particularly Performance Summary Thresholds, Measure Star Cut Points, and CAI Detail. Is it possible for CMS to share a supplemental file with this information in Excel or CSV format?

Humana Contract List

H0028, H0292, H0336, H0473, H0783, H1019, H1036, H1468, H1951, H2029, H2237, H2463, H2486, H2944, H3533, H4007, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H7617, H7621, H8145, H8908, R0110, R0865, R0923, R1390, R1532, R3392, R3887, R4182, R4845, R5361, R5495, R5826, R7220, R7315, S2874, S5552, S5884

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Colleen O"Neil
Cc: Jenna Pinardo; Dillon Nicole; Conor Duffy; Amy Heilman; Kimberlee Reid; CMS PartC&DStarRatings
Subject: RE: PP2: Humana Request for HEDIS/CMS additional threshold transparency
Date: Friday, September 13, 2024 11:34:19 AM
Attachments: image001.png

All available sample data are posted in HPMS. We provide sample data for one of each type of measure needed to replicate cut points. These data allow contracts to ensure they are able to replicate CMS's cut point methodology. The same programming is used for the four measures listed below as is used for the Breast Cancer Screening and the MTM Program Completion Rate for CMR measures, respectively. Even when the national average does not change, changes in the distribution of scores across contracts does impact the cut points.

Thank you and regards,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 13, 2024 11:57 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Dillon Nicole <DNicole@humana.com>; Conor Duffy <CDuffy5@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: PP2: Humana Request for HEDIS/CMS additional threshold transparency

Good Afternoon,

> To further support our efforts to validate Star ratings, can CMS please provide the de-identified industry data and unrounded cutpoint rates for the below measures? Humana believes that additional transparency into industry data is a critical part of the plan validation process, particularly for mature measures with stable national averages experiencing threshold movement and measures requiring actual or near perfection to achieve 5 stars.
>
> - Medication Reconciliation Post Discharge
> - Diabetes Care – Blood Sugar Controlled
> - Special Needs Plan (SNP) Care
> - Medicare Plan Finder: Price Accuracy

Best,

Colleen O'Neil (she/her)

Stars Improvement Principal

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please contact the sender and delete or destroy the material/information.

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From:	CMS PartC&DStarRatings
To:	Colleen O"Neil; CMS MP-CAHPS; Kimberlee Reid
Cc:	Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; CMS PartC&DStarRatings
Subject:	RE: PP1 - CAHPS thresholds
Date:	Friday, September 13, 2024 2:55:20 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png

As codified at §§ 422.166(i)(9) and 423.186(i)
(7) the rule for excluding the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance Area at the time of the disaster only applies to non-CAHPS measures.

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 13, 2024 3:34 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Good Afternoon,

> Humana has identified that CMS has included contracts impacted by the 60% disaster adjustment in the threshold setting process for the CAHPS measure category. To maintain consistency with the removal of disaster impacted contracts from all other measure categories, and to align with the CMS stated objective of disasters not impacting Star ratings, Humana requests that CMS remove disaster impacted contracts and re-calculate CAHPS thresholds.

Thank you,

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Friday, September 6, 2024 9:20 AM
To: Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Consistent with sample measure data that has been made available in HPMS for other measures (e.g. C01), CMS has uploaded a file called "C23_Sample_Data.xlsx", which provides de-identified scores, rounded to 6 decimal places, for the Rating of Health Plan measure for all contracts with more than 10 valid responses to the survey item. These scores are used to calculate the 15th, 30th, 60th, and 80th percentiles that serve as the base group cut points. This file does not identify Humana contract scores, but that information has been provided in the contract-specific means and tests reports that were provided in a prior response to this inquiry.

Thank you,
MA & PDP CAHPS Survey Team

From: Kimberlee Reid <kreid1@humana.com>
Sent: Friday, August 30, 2024 5:08 PM

To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon, MA & PDP CAHPS Survey Team,

Thank you for the additional information provided. Humana continues to work to validate the reported CAHPS results.

In an effort to complete this ask, we would highlight our previous request for deidentified unrounded industry rates for all contracts that reported. In this file, we would also ask that the Humana contract rates be identified.

Thank you,

Kimberlee Reid
Program Delivery Lead | Governance, Risk, Compliance & Communcations
Health Quality and Stars

Humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 1:39 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Dear Colleen O'Neil,

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You compared changes in the percentile values to the national mean. The changes of percentiles from one year to the next will often be similar to the change in the mean but aren't necessarily the same. Furthermore, changes of one point in the rounded thresholds may correspond to unrounded changes of less than one point or more than one point. See the attached file "MCAHPS_BaseGroupCutpoints.xlsx," which provides more precise base group threshold values for both the current (sheet "2024_Cutpoints") and prior (sheet "2023_Cutpoints") year. For example, looking at the Getting Needed Care base group thresholds, the 15th percentile (threshold for base group 2) increased from 76.457392 to 76.982869, which translates to an increase in rounded percentiles from 76 to 77, and the 60th percentile (threshold for base group 4) increased from 81.453754 to 81.576171, which translates to an increase in rounded percentiles from 81 to 82.

See the attached zip file "Humana_CaseMix_MeansTest_Reports.zip", which includes a means and tests report and case-mix report for each of Humana's contracts. The means and tests report provides additional statistics used to calculate the Star Rating for each applicable measure. The case-mix report includes a worksheet for every item or composite that receives a Star Rating. For further information about analysis of MA & PDP CAHPS Reported Measures,

please visit the 'Scoring and Star Ratings' section on the MA & PDP CAHPS website at Scoring and Star Ratings (ma-pdpcahps.org).

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 - CAHPS thresholds

Good Afternoon,

1. Can CMS please define the threshold setting methodology for CAHPS, specifically, if consumed contracts (consolidated and/or otherwise terminated contracts as of 1/1/2025 are included in the percentile calculations?

2. After reviewing BY 2026 CAHPS ratings, we have identified data points that appear to contradict each other, preventing us from fully validating CAHPS rates and application of thresholds.

   - For example, the "Getting Needed Care" measure thresholds increased without demonstrating a commensurate increase in industry improvement. Upward movement across 2-star, 3-star, and 4-star thresholds would seem to suggest significant industry improvement on the measure. However, the reported national average for Getting Needed Care only increased by 0.24 points from 80.62 in BY 2025 to 80.86 in BY 2026, contradicting the degree of threshold movement.

Getting Needed Care threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	76%	77%	+ 1%
3 Star	78%	79%	+ 1%
4 Star	81%	82%	+ 1%

   - Additionally, related to the "Getting Needed Prescription Drugs" measure, the only threshold movement was at the 3-star threshold which fell by 1 point. However, given the national average for this measure was 90.37 for BY 2025 and 89.68 for BY 2026 – a decline of 0.69 points and almost 3x the magnitude of the Getting Needed Care measure increase, we would have expected commensurate decreases in thresholds.

Getting Needed Prescription Drugs (MAPD) threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	87%	87%	--
3 Star	89%	88%	- 1%
4 Star	90%	90%	--
5 Star	91%	91%	--

   Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301

Coneil1@humana.com

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From:	CMS MP-CAHPS
To:	Colleen O"Neil
Cc:	Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; CMS PartC&DStarRatings; Kimberlee Reid
Subject:	RE: PP1 - CAHPS thresholds
Date:	Monday, September 16, 2024 11:49:14 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png

Good afternoon,

It is CMS policy that plans should not receive any identifiable MA & PDP CAHPS survey data.

The purpose of Questions 1 and 2 on the survey is not to ascertain eligibility, but rather to orient the plan member to the plan that is the focus of the survey in order to improve data quality.

Accordingly, the CAHPS Health Plan Survey has always contained an item which names the plan and asks the respondent to confirm recognition (Q1), and an item to capture plan name for responding members who do not recognize the name printed on the survey (Q2). In CAHPS development, AHRQ found that the name provided in Q2 was often associated with the plan named in Q1 and identified an informal or colloquial name used by the plan member. In adopting the CAHPS Health Plan Survey for MA & PDP CAHPS, CMS has implemented AHRQ's tested approach for plan identification.

To aid recognition of the plan, CMS provides survey vendors with each contract's plan marketing name as indicated in HPMS for printing on the MA & PDP CAHPS Survey. CMS recognizes that the marketing name may or may not match the name on the plan member's enrollment card, or the colloquial name used by the member in their interactions with plan staff and health care providers. To aid recognition, plans may provide their survey vendors one or more additional names that members may recognize for printing on the survey. We note that Humana did so for the 42 Medicare Advantage contracts fielding the 2024 survey.

For the 2024 survey, fewer than 1% of the members contributing to the Humana CAHPS data used in scoring indicated that they did not recognize the plan names printed on the survey (less than the average for all other MA contracts), indicating a high rate of recognition for the plan. The less than 1% who did not recognize the plan name were also verified eligible plan members and were included in scoring like other eligible plan members.

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, September 11, 2024 5:04 PM

To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

MA-PDP CAHPS Team,

Humana kindly request that CMS reconsider our request for support in validating the reported CAHPS scores. This information is important to Humana so that we can validate the threshold calculations for all measures, that the sampling methodology was accurate, exclusions were applied correctly, and measure-level calculations were performed correctly.

> For example, vendor reported data shows a significant number of members (454) who report not being covered by the Humana plan in the prior year, as cited on the survey Question 1. Humana requests member level information to perform this validation to ensure reported scores do not include members who were not eligible for a CAHPS survey because they terminated from their Humana plan or:
>
> 1. Were not a Humana member
> 2. Did not have 6 months of continuous enrollment
> 3. Were institutionalized
> 4. Were ineligible for other reasons
>
> To perform this validation Humana needs the member level details that are included in the sample file provided to our vendor.
>
> Humana therefore requests full access to this information needed to validate eligibility of enrollees to perform scoring calculations internally. This information will be isolated from other data sets and will be solely and specifically used to validate reported Stars results.

Thank you for your attention to this request.

Colleen O'Neil (she/her)
Stars Improvement Principal

From: Colleen O'Neil
Sent: Monday, September 9, 2024 10:01 AM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Thank you for the detail provided for the Rating of the Health Plan measure.

To further support our efforts to validate Star ratings, we request the same information for the other CAHPS measures listed below.

- Annual Flu Vaccine
- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Care Coordination
- Rating of Drug Plan
- Getting Needed Prescription Drugs

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Friday, September 6, 2024 9:20 AM
To: Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

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To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon, MA & PDP CAHPS Survey Team,

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In an effort to complete this ask, we would highlight our previous request for deidentified unrounded industry rates for all contracts that reported. In this file, we would also ask that the Humana contract rates be identified.

Thank you,

Kimberlee Reid
Program Delivery Lead | Governance, Risk, Compliance & Communcations
Health Quality and Stars

Humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 1:39 PM
To: Colleen O'Neil <coneil1@humana.com>
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Subject: RE: PP1 - CAHPS thresholds

Dear Colleen O'Neil,

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Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 - CAHPS thresholds

Good Afternoon,

1. Can CMS please define the threshold setting methodology for CAHPS, specifically, if consumed contracts (consolidated and/or otherwise terminated contracts as of 1/1/2025 are included in the percentile calculations?

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- For example, the "Getting Needed Care" measure thresholds increased without demonstrating a commensurate increase in industry improvement. Upward movement across 2-star, 3-star, and 4-star thresholds would seem to suggest significant industry improvement on the measure. However, the reported national average for Getting Needed Care only increased by 0.24 points from 80.62 in BY 2025 to 80.86 in BY 2026, contradicting the degree of threshold movement.

Getting Needed Care threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	76%	77%	+ 1%
3 Star	78%	79%	+ 1%
4 Star	81%	82%	+ 1%

- Additionally, related to the "Getting Needed Prescription Drugs" measure, the only threshold movement was at the 3-star threshold which fell by 1 point. However, given the national average for this measure was 90.37 for BY 2025 and 89.68 for BY 2026 – a decline of 0.69 points and almost 3x the magnitude of the Getting Needed Care measure increase, we would have expected commensurate decreases in thresholds.

Getting Needed Prescription Drugs (MAPD) threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	87%	87%	--
3 Star	89%	88%	- 1%
4 Star	90%	90%	--
5 Star	91%	91%	--

Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS PartC&DStarRatings
To: Amy Heilman
Cc: Jenna Pinardo; Dillon Nicole; Conor Duffy; Colleen O"Neil; Kimberlee Reid; CMS PartC&DStarRatings
Subject: RE: Plan Preview 2 - Validation Adequacy
Date: Tuesday, September 17, 2024 1:33:03 PM

CMS has been responding to emails received from contracts during the second plan preview as quickly as possible, including to more than a dozen emails from Humana. The plan previews provide an opportunity for plans to review their data for each measure before they are published on Medicare Plan Finder. Well before the preview periods begin each year, various datasets and reports are available for sponsors to review their underlying measure data that are the basis for the Part C and D Star Ratings. After the previews CMS needs time to investigate and process any necessary updates before publication, so the preview periods cannot be extended further and still allow for publication in time for open enrollment.

The Star Ratings calculations are not performed in a black box, and they are thoroughly validated internally and externally before publication. CMS provides extensive resources for plans to validate their data, including detailed technical notes, contract-specific worksheets that emulate the Star Ratings methodology, and sample data for each type of measure needed to replicate cut points. As we've explained, changes in the distribution of scores across contracts each year impact the cut points. This does not indicate data inaccuracies. For CAHPS we previously explained that scores that are calculated with very low interunit reliability for a given measure are included in both the calculation of base group cut points and the national mean used in significance testing. Further, the rule for excluding the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance Area at the time of the disaster does not apply to CAHPS measures. Again these are not calculation errors.

CMS has in no way limited Humana's ability to evaluate any suspected errors or to validate its stars performance, and other contracts have successfully validated their data and our calculations. We do not believe that additional member-level details for all contracts are needed to successfully validate scores. Using the sample data provided in HPMS for the four measures, contracts are able to validate each of the cut point methodologies. For example if the cut points can be replicated for the Breast Cancer Screening measure, then this validates the cut points for all Part C measures on the 0-100 scale where mean resampling and clustering are used to assign cut points as the same programming is used by CMS for all of these measures.

We appreciate your continued commitment to ensure the success of the Medicare Advantage and Prescription Drug programs.

From: Amy Heilman <aheilman@humana.com>
Sent: Friday, September 13, 2024 4:31 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Dillon Nicole <DNicole@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: Plan Preview 2 - Validation Adequacy

Part C and D Star Ratings Team,

Thank you in advance for your attention to this important communication. Humana has sent several emails over the course of the Star Ratings plan preview ("PP") 2 period to this team and other CMS teams involved in the Stars program (collectively, "CMS"), asking for additional information related to Humana's 2025 Star Rating performance and threshold calculations. In many cases, CMS has not provided the requested data, making it impossible for Humana to fully assess suspected errors in CMS's Star Rating calculations for certain measures. CMS also has not articulated any reasonable bases for failing to provide the necessary data. With PP2 closing later today, Humana has significant concerns about the reliability of the Star Rating data and calculations underlying its ratings and objects to the finalization of its Star Ratings without CMS providing this data. In order to assist CMS in responding to our requests and to highlight the collective significance of the outstanding requests, we have attached each prior unfulfilled request to this email. We respectfully reiterate and expand on those requests below.

CMS has itself established the abbreviated one-week timeframe for the PP2 period, which arguably puts plan sponsors on their heels in identifying potential data inaccuracies and calculation errors across a substantial trove of internal and external data underlying over 40 Star Rating measures. But as CMS has stated, "During this second plan preview, CMS expects Part C and D sponsors to again closely review their posted data for each measure, as well as their preliminary Star Rating assignments. Sponsors should *immediately* alert CMS of any suspected data issues or errors during the plan preview in order to allow sufficient time to investigate and process any necessary data corrections." Humana has upheld its obligation to quickly and rigorously evaluate the data provided by CMS and has in fact identified numerous suspected errors. In requesting data to definitively confirm the existence of those errors (or conversely, the validity of the calculations), however, Humana has been met with resistance from the agency, and CMS has failed to provide the necessary data for Humana to complete its review. As a result, aspects of the Star Ratings calculations are essentially being performed in a black box, without external validation by an independent third party or plan sponsors. There are several reasons we believe additional transparency is necessary. Humana's PP2 results are such that a single error made in calculating the performance or thresholds of any one measure could have tremendous impact on overall Star Ratings. And due to the complexity and volume of data required to perform these calculations, errors are inevitable. In 2015, for example, Humana reported concerns related to CAHPS sampling methodology that led CMS to issue industry-wide corrections to 2016 Star Ratings. Last year, multiple plans identified errors in CMS's application of Tukey outlier deletion and guardrails, which, after litigation, prompted CMS to re-issue 2024 Star Ratings. And earlier this year, during PP1, Humana identified an error related to treatment of members in consolidated contracts for the Members Choosing to Leave The Plan measure, which CMS acknowledged and corrected.

Our concern that additional errors exist is well-founded. For many measures that are normally very stable, we have noticed threshold movement inconsistent with average industry performance and historical trends, including but not limited to: the 2-star threshold for the MPF Price Accuracy measure (D07) in Star Rating year 2025 being equal to the 5-star threshold in Star Rating year 2023; the 4 and 5-star thresholds for the Medication Reconciliation Post-discharge measure (C14) increasing by 5 percentage points after barely moving at all in the past three rating years; and all threshold levels for the Diabetes Care – Blood Sugar Controlled measure (C10) increasing at much higher rates than industry performance over the past two rating years. We have also noticed an unusually high number of 5-star thresholds at 99 and 100 percent. We are concerned that calculation errors could be driving these irregularities. This is just the second year that CMS has applied the Tukey outlier deletion methodology, which could be influencing threshold movement inappropriately. Moreover, in developing CAHPS

thresholds, we believe CMS failed to exclude both statistically unreliable measure scores and measure scores from disaster-impacted contracts. Again, these and other potential errors are explained more fully in the attached communications.

We think it is arbitrary and capricious that CMS would attempt to limit Humana's ability to further evaluate these suspected errors and/or validate its Stars performance. CMS imposes strict data integrity standards on plans that can lead to a Star Rating of zero when such standards are not satisfied, as per 42 CFR 422.164(g). Plans should be given a reasonable opportunity to ensure that CMS likewise is using accurate data and methodologies.

Accordingly, we reiterate our prior requests set forth in the attached communications and have the following additional requests:

1. Due to suspected errors in threshold calculations across a wide variety of measures, and the importance of those thresholds to all plan sponsors' reported quality performance, **Humana requests** all data necessary, including member level detail, to validate performance and threshold calculations for all measure thresholds. This request could be satisfied by having CMS provide the data to an independent third party for external validation of the agency's calculations to be shared with plans.

2. In light of the continued identification of suspected errors in Star Ratings data and calculations by Humana and CMS's unwillingness to provide the information necessary for validating suspected errors during the timeframe specifically identified by CMS as the opportunity for such validation, **Humana requests** that CMS establish a process for Humana and other plan sponsors to validate Star Ratings data in a more deliberate and reasonable manner that is reflective of the substantial volume and complexity of this data. The current timeframes for reviewing the data and engaging in back and forth with CMS are inadequate to fully validate these ratings, which are critical for communicating plan quality to members and determining plan payment. As the Medicare Advantage program continues to mature, improving transparency and data integrity in this manner is a rational next step in improving the program. Confidence in the accuracy of the Star Ratings program is paramount to the success of the Medicare Advantage program and consistent with the government's goals of a transparent and reliable quality rating system. Humana looks forward to working with CMS to achieve these goals.

Best regards,
Amy

Amy Heilman
Associate Vice President | Stars Improvement
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From: Mike Hoak
To: Newsom, Mark (CMS/CM)
Cc: Duran, Vanessa (CMS/CM)
Subject: Re: Humana Meeting Request
Date: Friday, September 27, 2024 6:45:04 PM

Sorry about this. I didn't have line of sight into those emails. I can assure you that in our meeting we only intend to focus on the question we sent this morning and broader issues around data transparency. The team will not be covering the material from those other emails.

From: Newsom, Mark (CMS/CM) <mark.newsom@cms.hhs.gov>
Sent: Friday, September 27, 2024 5:36:36 PM
To: Mike Hoak <mhoak@humana.com>
Cc: Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>
Subject: Re: Humana Meeting Request

Mike,

We are getting a shotgun approach set of emails from your Stars team that you are not copied on. It's creating a bit of confusion about what we are planning to talk about for the meeting. In order to have the right people in the meeting we need to be pencils down and comprehensive on the set of issues.

Mark

Mark A. Newsom | Deputy Group Director, Medicare Drug Benefit and C & D Data Group (MDBG) | Phone: 667-290-8554 | Mobile: 571-643-5024 | mark.newsom@cms.hhs.gov

From: Mike Hoak mhoak@humana.com
Sent: Friday, September 27, 2024 9:11 AM
To: Duran, Vanessa (CMS/CM) Vanessa.Duran@cms.hhs.gov; Newsom, Mark (CMS/CM) mark.newsom@cms.hhs.gov
Subject: Re: Humana Meeting Request

We have one technical question we wanted to discuss with the team on Monday. For CAHPS measures, the MA & PDP CAHPS Survey Team confirmed that CMS uses scores with low interunit reliability in the calculation of thresholds and national averages. However, the same scores are suppressed from public reporting and are not included in the calculation of summary and overall Star ratings. We would like to better understand why CMS uses this data in calculating thresholds and national averages but not calculating

contract Star ratings.

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From:	CMS PartC&DStarRatings
To:	Colleen O"Neil; CMS MP-CAHPS
Cc:	Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; Kimberlee Reid; CMS PartC&DStarRatings
Subject:	RE: PP1 - CAHPS thresholds
Date:	Wednesday, October 2, 2024 11:28:07 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png

RAND, the MA and PDP CAHPS contractor, verified using CMS enrollment information that the 454 individuals were enrolled as of July 2023 and continuously enrolled at the time the sample was pulled in January 2024. These are enrollees that Humana has been paid to provide services for.

On page 50 of the MA & PDP CAHPS Quality Assurance Protocols & Technical Specifications V14.1 (https://www.ma-pdpcahps.org/globalassets/ma-pdp/quality-assurance/2024-qapts-v14.0/ma-pdp-cahps-qapts-v14.1-final2.pdf), we state:

"Sampling procedures are designed so that participating contracts cannot identify enrollees selected to participate in the survey. Survey vendors are expected to maintain the confidentiality of enrollees and may not provide contracts/plans with the names of enrollees selected for the survey or any other enrollee information that could be used to identify an individual sampled enrollee (either directly or indirectly)."

Through all of the survey materials, we promise beneficiaries confidentiality. We have found across our surveys that beneficiaries are concerned about retribution and promising confidentiality helps alleviate these concerns.

Plans are often referred to by many names. Some beneficiaries even though they are in an MA plan consider themselves enrolled in Medicare or have another name they use to refer to their plan. These first two questions on the CAHPS survey are just used to orient the respondent. All of the respondents filling out the survey were continuously enrolled in Humana for at least 6 months.

Thank you,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 27, 2024 4:11 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>

Subject: RE: PP1 - CAHPS thresholds

Thank you for your response.

Can you please confirm that CMS or a third party (and if so, which third party) validated that all 454 individuals who responded to the survey but reported not being covered by the Humana plan in the prior year were both enrolled in the Humana plan at the time of the survey *and* had been continuously enrolled for at least a six month period? In addition, can you elaborate on CMS's concerns with sharing data with Humana to allow it to validate the accuracy of these eligibility and continuous enrollment checks? This is enrollment data about Humana's own members and would not be tied to any data regarding the survey responses.

Finally, can you share CMS's perspective on why it is appropriate to include survey data from individuals who are not aware of the plan they are enrolled in? Given the wide variety of reasons a beneficiary may be unaware of this information, we do not believe the survey responses provided by those individuals are a reliable indicator of the plan's performance.

Thank you for your attention to this important matter.

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Monday, September 16, 2024 12:49 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon,

It is CMS policy that plans should not receive any identifiable MA & PDP CAHPS survey data.

The purpose of Questions 1 and 2 on the survey is not to ascertain eligibility, but rather to orient the plan member to the plan that is the focus of the survey in order to improve data quality.

Accordingly, the CAHPS Health Plan Survey has always contained an item which names the plan and asks the respondent to confirm recognition (Q1), and an item to capture plan name for responding members who do not recognize the name printed on the survey (Q2). In CAHPS

development, AHRQ found that the name provided in Q2 was often associated with the plan named in Q1 and identified an informal or colloquial name used by the plan member. In adopting the CAHPS Health Plan Survey for MA & PDP CAHPS, CMS has implemented AHRQ's tested approach for plan identification.

To aid recognition of the plan, CMS provides survey vendors with each contract's plan marketing name as indicated in HPMS for printing on the MA & PDP CAHPS Survey. CMS recognizes that the marketing name may or may not match the name on the plan member's enrollment card, or the colloquial name used by the member in their interactions with plan staff and health care providers. To aid recognition, plans may provide their survey vendors one or more additional names that members may recognize for printing on the survey. We note that Humana did so for the 42 Medicare Advantage contracts fielding the 2024 survey.

For the 2024 survey, fewer than 1% of the members contributing to the Humana CAHPS data used in scoring indicated that they did not recognize the plan names printed on the survey (less than the average for all other MA contracts), indicating a high rate of recognition for the plan. The less than 1% who did not recognize the plan name were also verified eligible plan members and were included in scoring like other eligible plan members.

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, September 11, 2024 5:04 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

MA-PDP CAHPS Team,

Humana kindly request that CMS reconsider our request for support in validating the reported CAHPS scores. This information is important to Humana so that we can validate the threshold calculations for all measures, that the sampling methodology was accurate, exclusions were applied correctly, and measure-level calculations were performed correctly.

> For example, vendor reported data shows a significant number of members (454) who report not being covered by the Humana plan in the prior year, as cited on the survey Question 1. Humana requests member level information to perform this validation to ensure reported scores do not include members who were not eligible for a CAHPS survey because they terminated from their Humana plan or:
>
> 1. Were not a Humana member
> 2. Did not have 6 months of continuous enrollment

3. Were institutionalized
4. Were ineligible for other reasons

To perform this validation Humana needs the member level details that are included in the sample file provided to our vendor.

Humana therefore requests full access to this information needed to validate eligibility of enrollees to perform scoring calculations internally. This information will be isolated from other data sets and will be solely and specifically used to validate reported Stars results.

Thank you for your attention to this request.

Colleen O'Neil (she/her)
Stars Improvement Principal

From: Colleen O'Neil
Sent: Monday, September 9, 2024 10:01 AM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Thank you for the detail provided for the Rating of the Health Plan measure.

To further support our efforts to validate Star ratings, we request the same information for the other CAHPS measures listed below.

- Annual Flu Vaccine
- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Care Coordination
- Rating of Drug Plan
- Getting Needed Prescription Drugs

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Friday, September 6, 2024 9:20 AM
To: Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Consistent with sample measure data that has been made available in HPMS for other measures (e.g. C01), CMS has uploaded a file called "C23_Sample_Data.xlsx", which provides de-identified scores, rounded to 6 decimal places, for the Rating of Health Plan measure for all contracts with more than 10 valid responses to the survey item. These scores are used to calculate the 15th, 30th, 60th, and 80th percentiles that serve as the base group cut points. This file does not identify Humana contract scores, but that information has been provided in the contract-specific means and tests reports that were provided in a prior response to this inquiry.

Thank you,
MA & PDP CAHPS Survey Team

From: Kimberlee Reid <kreid1@humana.com>
Sent: Friday, August 30, 2024 5:08 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon, MA & PDP CAHPS Survey Team,

Thank you for the additional information provided. Humana continues to work to validate the reported CAHPS results.

In an effort to complete this ask, we would highlight our previous request for deidentified unrounded industry rates for all contracts that reported. In this file, we would also ask that the Humana contract rates be identified.

Thank you,

Kimberlee Reid
Program Delivery Lead | Governance, Risk, Compliance & Communcations
Health Quality and Stars

Humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 1:39 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Dear Colleen O'Neil,

When calculating the 15th, 30th, 60th, and 80th percentiles that serve as thresholds for the base groups for a given measure, all contract scores, including contracts consumed in a consolidation, are included if the score is based on at least 11 survey responses. To assign a contract's score to a base group, the contract's score is rounded to the nearest integer and compared to the base group thresholds that are also rounded to the nearest integer.

You compared changes in the percentile values to the national mean. The changes of percentiles from one year to the next will often be similar to the change in the mean but aren't necessarily the same. Furthermore, changes of one point in the rounded thresholds may correspond to unrounded changes of less than one point or more than one point. See the attached file "MCAHPS_BaseGroupCutpoints.xlsx," which provides more precise base group threshold values for both the current (sheet "2024_Cutpoints") and prior (sheet "2023_Cutpoints") year. For example, looking at the Getting Needed Care base group thresholds, the 15th percentile (threshold for base group 2) increased from 76.457392 to 76.982869, which translates to an increase in rounded percentiles from 76 to 77, and the 60th percentile (threshold for base group 4) increased from 81.453754 to 81.576171, which translates to an increase in rounded percentiles from 81 to 82.

See the attached zip file "Humana_CaseMix_MeansTest_Reports.zip", which includes a means and tests report and case-mix report for each of Humana's contracts. The means and tests report provides additional statistics used to calculate the Star Rating for each applicable measure. The case-mix report includes a worksheet for every item or composite that receives

a Star Rating. For further information about analysis of MA & PDP CAHPS Reported Measures, please visit the 'Scoring and Star Ratings' section on the MA & PDP CAHPS website at Scoring and Star Ratings (ma-pdpcahps.org).

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 - CAHPS thresholds

Good Afternoon,

1. Can CMS please define the threshold setting methodology for CAHPS, specifically, if consumed contracts (consolidated and/or otherwise terminated contracts as of 1/1/2025 are included in the percentile calculations?

2. After reviewing BY 2026 CAHPS ratings, we have identified data points that appear to contradict each other, preventing us from fully validating CAHPS rates and application of thresholds.

   - For example, the "Getting Needed Care" measure thresholds increased without demonstrating a commensurate increase in industry improvement. Upward movement across 2-star, 3-star, and 4-star thresholds would seem to suggest significant industry improvement on the measure. However, the reported national average for Getting Needed Care only increased by 0.24 points from 80.62 in BY 2025 to 80.86 in BY 2026, contradicting the degree of threshold movement.

Getting Needed Care threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	76%	77%	+ 1%
3 Star	78%	79%	+ 1%
4 Star	81%	82%	+ 1%

   - Additionally, related to the "Getting Needed Prescription Drugs" measure, the only threshold movement was at the 3-star threshold which fell by 1 point. However, given the national average for this measure was 90.37 for BY 2025 and 89.68 for BY 2026 – a decline of 0.69 points and almost 3x the magnitude of the Getting Needed Care measure increase, we would have expected commensurate decreases in thresholds.

Getting Needed Prescription Drugs (MAPD) threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change

2 Star	87%	87%	--
3 Star	89%	88%	- 1%
4 Star	90%	90%	--
5 Star	91%	91%	--

Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From:	CMS PartC&DStarRatings
To:	Colleen O"Neil
Cc:	Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; Kimberlee Reid; CMS hos; CMS PartC&DStarRatings
Subject:	RE: PP2: Humana Request for HOS de-identified unrounded rates for threshold validation
Date:	Wednesday, October 2, 2024 11:35:22 AM
Attachments:	image001.png

Baseline data are not provided to plans prior to follow-up so plans do not target these enrollees for interventions. Plan should be making sure they provide appropriate care to all of their enrollees.

Thank you,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 27, 2024 4:19 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS hos <hos@cms.hhs.gov>
Subject: RE: PP2: Humana Request for HOS de-identified unrounded rates for threshold validation

Thank you for your response.

Can you help us to understand the potential harm to the "integrity of the sample" that may be caused by sharing this data with Humana? It is genuinely unclear to us what harm could potentially result from the disclosure of Humana's own data to Humana. In order to have a thoughtful conversation around this topic, it will be helpful for us to have as much information as possible about CMS's concerns associated with Star Ratings data transparency.

Thank you,

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, September 16, 2024 7:40 AM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS hos <hos@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP2: Humana Request for HOS de-identified unrounded rates for threshold validation

To protect the integrity of the sample, CMS is unable to provide access to Baseline data until Follow-Up data collection is complete. For additional information about your plan's HEDIS HOS results, including numerators, denominators, and percentages calculated by NCQA, please see your plan's *HEDIS HOS Report.*

NCQA does not provide measure data by round, but rather calculates results using data collected from the combined Baseline and Follow-Up data collected in a single measurement year. Industry rates can be downloaded from HPMS. The threshold calculations follow the exact same programming as for Breast Cancer Screening. Sample data for Breast Cancer Screening is available in HPMS.

Thank you,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 13, 2024 12:43 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: PP2: Humana Request for HOS de-identified unrounded rates for threshold validation

Good Afternoon,

Humana has determined that information needed to validate the accuracy of the reported Health Outcomes Survey (HOS) Star rating measures is not available to health plans. Humana therefore requests full access to Humana plan data required to validate the measure performance calculations and de-identified unrounded industry rates to validate the threshold calculations for Star measures derived from the HOS.

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

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Kreyòl Ayisyen (Haitian Creole): ATANSION: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

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From:	CMS PartC&DStarRatings
To:	Colleen O"Neil
Cc:	Conor Duffy; Jenna Pinardo; Kimberlee Reid; Amy Heilman; Dillon Nicole; Cindy Oppel; CMS PartC&DStarRatings
Subject:	RE: PP2: Request for additional TTY/FL cutpoint data
Date:	Wednesday, October 2, 2024 11:37:19 AM
Attachments:	image001.png

It is not clear why this would be needed since the same programming used for the sample measures provided in HPMS is used to produce other cut points. The programming is not updated for each measure. If Humana has identified any potential issues with validating the cut point calculations please let us know.

Thank you,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 27, 2024 4:17 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Cindy Oppel <coppel@humana.com>
Subject: RE: PP2: Request for additional TTY/FL cutpoint data

Part C and D Star Ratings Team,

Thank you for your response. We appreciate that the sample data helps us to understand CMS's cut point *methodology*, but Humana is seeking the ability to actually validate that the cut point *calculations* are correct, which is only possible if CMS provides the actual underlying data and unrounded cut points. If CMS has a specific concern with providing the underlying data and unrounded cut points, it would be helpful for you to share that with us so that we can better understand CMS's perspective and work with you to resolve this issue.

Thank you,

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 10, 2024 4:34 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Cindy Oppel <coppel@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Subject: RE: PP2: Request for additional TTY/FL cutpoint data

Hello,

All available sample data are posted in HPMS. We provide sample data for one of each type of measure needed to replicate cut points. These data allow contracts to ensure they are able to replicate CMS's cut point methodology. The same programming is used for the Part C and D call center measures as is used for the Breast Cancer Screening and the MTM Program Completion Rate for CMR measures, respectively.

Sincerely,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Tuesday, September 10, 2024 8:57 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Conor Duffy <CDuffy5@humana.com>; Jenna Pinardo <jpinardo@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; Dillon Nicole <DNicole@humana.com>; Cindy Oppel <coppel@humana.com>
Subject: PP2: Request for additional TTY/FL cutpoint data

Good Afternoon,

To further support our efforts to validate Star ratings, can CMS please provide the de-identified industry data and unrounded cutpoint rates for the below measures? Humana believes that additional transparency into industry data will help all MAOs understand CMS's expectations and make us more successful in achieving those goals.

- Part C Interpreter and TTY Functionality
- Part D Interpreter and TTY Functionality

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

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Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

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From: CMS PartC&DStarRatings
To: Amy Heilman
Cc: Jenna Pinardo; Dillon Nicole; Conor Duffy; Colleen O"Neil; Kimberlee Reid; CMS PartC&DStarRatings
Subject: RE: Plan Preview 2 - Validation Adequacy
Date: Wednesday, October 2, 2024 11:38:13 AM

There is a rigorous quality assurance process for Star Ratings that includes validations of data and code by many analysts at CMS and at the contract organizations supporting the calculation of the Star Ratings. All programs are coded by multiple analysts independently and sometimes in different statistical programs to support the validation of the data runs. Prior to the plan previews, the team conducts a number of test runs to ensure any changes in the methodology for the year are tested for accuracy. There are validation steps throughout each process of producing the Star Ratings. This process is reinforced by plans themselves via the plan preview periods. Historically we have found that generally minor errors are identified and corrected thanks to the interaction with plans during the preview period. This is the purpose of the preview periods.

CMS releases extensive information for Star Ratings validation consistent with the law and regulations. We have to balance that desire for transparency with opposing concerns around protecting plan proprietary information and beneficiary protected health information, for example. With that in mind we have released extensive information for each contract prior to public release of the Star Ratings including: HPMS preview files and technical notes, Star Ratings calculators, improvement measure calculators, CAHPS case-mix files, CAHPS means test files which provide additional statistics used to calculate the Star Rating for each applicable measure, and patient-level disenrollment information.

Thank you,

Part C and D Star Ratings Team

From: Amy Heilman <aheilman@humana.com>
Sent: Friday, September 27, 2024 4:14 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Dillon Nicole <DNicole@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: Plan Preview 2 - Validation Adequacy

Part C and D Star Ratings Team,

Thank you for your response. Humana is seeking to validate not only that the data CMS has about Humana is correct, but that Humana's assigned Star Ratings are correct. This requires not only validating Humana's performance, but also CMS's evaluation of the entire data set and calculation of the cut points against which Humana's performance has been measured. This is of critical importance to Humana in light of the potential reduction in the Star Rating for Humana's largest MA plan in CY 2025. Validating the Ratings themselves is only possible if Humana receives both its own data as well as the industry data (which would not contain plan or beneficiary identifiable data) and the unrounded cut points. If CMS has a specific concern with providing this data, it would be helpful for you to share that with us so that we can better understand CMS's perspective and work with you to resolve this issue.

As you know, CMS has made calculation errors in the past. In fact, Humana identifies Star Rating calculation errors almost every year during the PP1 and PP2 periods. Due to the complexity of the Star

Ratings framework, CMS also sometimes makes judgment calls about the ways in which it will treat certain data for purposes of cut point determinations or other calculations. Against this backdrop, it is reasonable for Humana to request access to the data to confirm that CMS's methodology was applied accurately, particularly given the significant impact each measure has on Humana's overall rating for CY 2025 and payments for CY 2026. We are seeking more than just data about Humana's performance, which only enables us to validate that CMS has accurately identified where Humana's performance stands in comparison to CMS's calculated cut points. Rather, we are concerned about the overall validity of the cut point calculations and therefore are also seeking to validate that CMS has calculated the cut points correctly. Validating the cut points requires access to a broader data set, but importantly, does not require access to any plan or beneficiary identifiable data. We are not aware of any data privacy, security, or public policy reason that this data should not be shared with plans for validation.

You have stated that the Star Ratings calculations are thoroughly vetted both internally and externally before publication. We would ask you to please share information about both the internal and external validation process, including who has conducted the external validation. Humana was not aware of a third party data validation step for Star Ratings calculations. If this exists, that information may be helpful to us in understanding CMS's process for ensuring the reliability of the Star Ratings.

Our sincere hope is to obtain the data we need to validate our Star Ratings through informal dialogue and cooperation with the agency, so that any inaccuracies that are identified can be corrected as quickly as possible to avoid beneficiary confusion during AEP. If we are not able to obtain the data through this channel, we will seek the information through a Freedom of Information Act (FOIA) request, which provides CMS with a statutorily-mandated period of time to respond and provide the requested data and can be enforceable in court. We do not believe the requested data qualifies for withholding under the statutory exceptions to FOIA. Furthermore, we think it is arbitrary and capricious that CMS would attempt to limit Humana's ability to validate its Stars performance.

Again, we genuinely seek to understand CMS's concerns with sharing the requested data so that we can fully appreciate any legitimate risks or consequences associated with the enhanced transparency. We would like to sit down directly with CMS to discuss these issues as soon as possible.

Thank you for your attention to this important matter.

Best regards,
Amy

Amy Heilman
Associate Vice President | Stars Improvement
O: 502-580-5062

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 17, 2024 2:33 PM
To: Amy Heilman <aheilman@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Dillon Nicole <DNicole@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview 2 - Validation Adequacy

CMS has been responding to emails received from contracts during the second plan preview as quickly as possible, including to more than a dozen emails from Humana. The plan previews provide an opportunity for plans to review their data for each measure before they are published on Medicare Plan Finder. Well before the preview periods begin each year, various datasets and reports are available for sponsors to review their underlying measure data that are the basis for the Part C and D Star Ratings. After the previews CMS needs time to investigate and process any necessary updates before publication, so the preview periods cannot be extended further and still allow for publication in time for open enrollment.

The Star Ratings calculations are not performed in a black box, and they are thoroughly validated internally and externally before publication. CMS provides extensive resources for plans to validate their data, including detailed technical notes, contract-specific worksheets that emulate the Star Ratings methodology, and sample data for each type of measure needed to replicate cut points. As we've explained, changes in the distribution of scores across contracts each year impact the cut points. This does not indicate data inaccuracies. For CAHPS we previously explained that scores that are calculated with very low interunit reliability for a given measure are included in both the calculation of base group cut points and the national mean used in significance testing. Further, the rule for excluding the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance Area at the time of the disaster does not apply to CAHPS measures. Again these are not calculation errors.

CMS has in no way limited Humana's ability to evaluate any suspected errors or to validate its stars performance, and other contracts have successfully validated their data and our calculations. We do not believe that additional member-level details for all contracts are needed to successfully validate scores. Using the sample data provided in HPMS for the four measures, contracts are able to validate each of the cut point methodologies. For example if the cut points can be replicated for the Breast Cancer Screening measure, then this validates the cut points for all Part C measures on the 0-100 scale where mean resampling and clustering are used to assign cut points as the same programming is used by CMS for all of these measures.

We appreciate your continued commitment to ensure the success of the Medicare Advantage and Prescription Drug programs.

From: Amy Heilman <aheilman@humana.com>
Sent: Friday, September 13, 2024 4:31 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Dillon Nicole <DNicole@humana.com>; Conor Duffy <CDuffy5@humana.com>; Colleen O'Neil <coneil1@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: Plan Preview 2 - Validation Adequacy

Part C and D Star Ratings Team,

Thank you in advance for your attention to this important communication. Humana has sent several emails over the course of the Star Ratings plan preview ("PP") 2 period to this team and other CMS teams involved in the Stars program (collectively, "CMS"), asking for additional information related to

Humana's 2025 Star Rating performance and threshold calculations. In many cases, CMS has not provided the requested data, making it impossible for Humana to fully assess suspected errors in CMS's Star Rating calculations for certain measures. CMS also has not articulated any reasonable bases for failing to provide the necessary data. With PP2 closing later today, Humana has significant concerns about the reliability of the Star Rating data and calculations underlying its ratings and objects to the finalization of its Star Ratings without CMS providing this data. In order to assist CMS in responding to our requests and to highlight the collective significance of the outstanding requests, we have attached each prior unfulfilled request to this email. We respectfully reiterate and expand on those requests below.

CMS has itself established the abbreviated one-week timeframe for the PP2 period, which arguably puts plan sponsors on their heels in identifying potential data inaccuracies and calculation errors across a substantial trove of internal and external data underlying over 40 Star Rating measures. But as CMS has stated, "During this second plan preview, CMS expects Part C and D sponsors to again closely review their posted data for each measure, as well as their preliminary Star Rating assignments. Sponsors should *immediately* alert CMS of any suspected data issues or errors during the plan preview in order to allow sufficient time to investigate and process any necessary data corrections." Humana has upheld its obligation to quickly and rigorously evaluate the data provided by CMS and has in fact identified numerous suspected errors. In requesting data to definitively confirm the existence of those errors (or conversely, the validity of the calculations), however, Humana has been met with resistance from the agency, and CMS has failed to provide the necessary data for Humana to complete its review. As a result, aspects of the Star Ratings calculations are essentially being performed in a black box, without external validation by an independent third party or plan sponsors. There are several reasons we believe additional transparency is necessary. Humana's PP2 results are such that a single error made in calculating the performance or thresholds of any one measure could have tremendous impact on overall Star Ratings. And due to the complexity and volume of data required to perform these calculations, errors are inevitable. In 2015, for example, Humana reported concerns related to CAHPS sampling methodology that led CMS to issue industry-wide corrections to 2016 Star Ratings. Last year, multiple plans identified errors in CMS's application of Tukey outlier deletion and guardrails, which, after litigation, prompted CMS to re-issue 2024 Star Ratings. And earlier this year, during PP1, Humana identified an error related to treatment of members in consolidated contracts for the Members Choosing to Leave The Plan measure, which CMS acknowledged and corrected.

Our concern that additional errors exist is well-founded. For many measures that are normally very stable, we have noticed threshold movement inconsistent with average industry performance and historical trends, including but not limited to: the 2-star threshold for the MPF Price Accuracy measure (D07) in Star Rating year 2025 being equal to the 5-star threshold in Star Rating year 2023; the 4 and 5-star thresholds for the Medication Reconciliation Post-discharge measure (C14) increasing by 5 percentage points after barely moving at all in the past three rating years; and all threshold levels for the Diabetes Care – Blood Sugar Controlled measure (C10) increasing at much higher rates than industry performance over the past two rating years. We have also noticed an unusually high number of 5-star thresholds at 99 and 100 percent. We are concerned that calculation errors could be driving these irregularities. This is just the second year that CMS has applied the Tukey outlier deletion methodology, which could be influencing threshold movement inappropriately. Moreover, in developing CAHPS thresholds, we believe CMS failed to exclude both statistically unreliable measure scores and measure scores from disaster-impacted contracts. Again, these and other potential errors are explained more fully in the attached communications.

We think it is arbitrary and capricious that CMS would attempt to limit Humana's ability to further evaluate these suspected errors and/or validate its Stars performance. CMS imposes strict data integrity standards on plans that can lead to a Star Rating of zero when such standards are not satisfied, as per 42 CFR 422.164(g). Plans should be given a reasonable opportunity to ensure that CMS likewise is using accurate data and methodologies.

Accordingly, we reiterate our prior requests set forth in the attached communications and have the following additional requests:

1. Due to suspected errors in threshold calculations across a wide variety of measures, and the importance of those thresholds to all plan sponsors' reported quality performance, **Humana requests** all data necessary, including member level detail, to validate performance and threshold calculations for all measure thresholds. This request could be satisfied by having CMS provide the data to an independent third party for external validation of the agency's calculations to be shared with plans.

2. In light of the continued identification of suspected errors in Star Ratings data and calculations by Humana and CMS's unwillingness to provide the information necessary for validating suspected errors during the timeframe specifically identified by CMS as the opportunity for such validation, **Humana requests** that CMS establish a process for Humana and other plan sponsors to validate Star Ratings data in a more deliberate and reasonable manner that is reflective of the substantial volume and complexity of this data. The current timeframes for reviewing the data and engaging in back and forth with CMS are inadequate to fully validate these ratings, which are critical for communicating plan quality to members and determining plan payment. As the Medicare Advantage program continues to mature, improving transparency and data integrity in this manner is a rational next step in improving the program. Confidence in the accuracy of the Star Ratings program is paramount to the success of the Medicare Advantage program and consistent with the government's goals of a transparent and reliable quality rating system. Humana looks forward to working with CMS to achieve these goals.

Best regards,
Amy

Amy Heilman
Associate Vice President | Stars Improvement
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From:	CMS PartC&DStarRatings
To:	Colleen O"Neil; CMS MP-CAHPS
Cc:	Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; Kimberlee Reid; CMS PartC&DStarRatings
Subject:	RE: PP1 - CAHPS thresholds
Date:	Wednesday, October 2, 2024 11:39:51 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png

Scores with very low interunit reliability for a given measure and contract are suppressed from public reporting and do not contribute to that contract's Star Ratings because due to low sample sizes and other factors they do not measure the contract's performance on that measure sufficiently precisely. To fully represent all performance and to maximize the precision of national averages and thresholds, CMS includes all eligible responses in calculating national averages and thresholds, including responses from contracts which, by themselves have very low interunit reliability. It should be noted that, given their small sample sizes, data from contracts with very low reliability have only a very small impact on national averages.

Following the call with Humana, where Humana representatives said they were concerned about Getting Needed Care and Customer Service, we calculated the difference in CAHPS measure-level Star Ratings taking out very low reliability scores even though we do not have this exclusion codified in the methodology for calculating CAHPS Star Ratings. We see no change in any of the Humana contracts for the measure-level Star Ratings for Getting Needed Care and Customer Service. In most cases the measure-level Star Ratings do not change when very low reliability scores are excluded from the national average and threshold calculations. When they do change, it results in the CAHPS measure-level stars going down since contracts with very low reliability scores tend to have lower scores so including the very low reliability scores slightly raises the mean and cut points when there is any impact.

Thank you,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 27, 2024 4:13 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Thank you for your response.

Can you help us to understand the thought process behind CMS including these unreliable scores in the process of setting thresholds and calculating the national average, when such unreliable scores are omitted from the calculation of particular contract-level scores? This is not a statistically valid methodology for handling low reliability data and could result in substantial distortions of the Star Ratings. Humana is unable to understand the significance of the impact on the thresholds without the underlying data, however.

Thank you for your attention to this important matter.

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Thursday, September 12, 2024 10:12 AM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Scores that are calculated with very low interunit reliability for a given measure are included in both the calculation of base group cut points and the national mean used in significance testing. However, these scores are suppressed from public reporting and are not included when determining a contract's Summary and Overall Star Ratings.

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, September 11, 2024 4:17 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good Afternoon,

With regards to the inclusion of valid responses, can CMS confirm that measure scores were excluded from threshold and national average calculations if the statistical reliability test resulted in

a “Very Low Reliability” designation?

Thank you,
Colleen O’Neil

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Friday, September 6, 2024 9:20 AM
To: Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Consistent with sample measure data that has been made available in HPMS for other measures (e.g. C01), CMS has uploaded a file called “C23_Sample_Data.xlsx”, which provides de-identified scores, rounded to 6 decimal places, for the Rating of Health Plan measure for all contracts with more than 10 valid responses to the survey item. These scores are used to calculate the 15th, 30th, 60th, and 80th percentiles that serve as the base group cut points. This file does not identify Humana contract scores, but that information has been provided in the contract-specific means and tests reports that were provided in a prior response to this inquiry.

Thank you,
MA & PDP CAHPS Survey Team

From: Kimberlee Reid <kreid1@humana.com>
Sent: Friday, August 30, 2024 5:08 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon, MA & PDP CAHPS Survey Team,

Thank you for the additional information provided. Humana continues to work to validate the reported CAHPS results.

In an effort to complete this ask, we would highlight our previous request for deidentified unrounded industry rates for all contracts that reported. In this file, we would also ask that the Humana contract rates be identified.

Thank you,

Kimberlee Reid
Program Delivery Lead | Governance, Risk, Compliance & Communcations
Health Quality and Stars

Humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 1:39 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Dear Colleen O'Neil,

When calculating the 15th, 30th, 60th, and 80th percentiles that serve as thresholds for the base groups for a given measure, all contract scores, including contracts consumed in a consolidation, are included if the score is based on at least 11 survey responses. To assign a contract's score to a base group, the contract's score is rounded to the nearest integer and compared to the base group thresholds that are also rounded to the nearest integer.

You compared changes in the percentile values to the national mean. The changes of percentiles from one year to the next will often be similar to the change in the mean but aren't necessarily the same. Furthermore, changes of one point in the rounded thresholds may correspond to unrounded changes of less than one point or more than one point. See the attached file "MCAHPS_BaseGroupCutpoints.xlsx," which provides more precise base group threshold values for both the current (sheet "2024_Cutpoints") and prior (sheet "2023_Cutpoints") year. For example, looking at the Getting Needed Care base group thresholds, the 15th percentile (threshold for base group 2) increased from 76.457392 to 76.982869, which translates to an increase in rounded percentiles from 76 to 77, and the 60th percentile (threshold for base group 4) increased from 81.453754 to 81.576171, which translates to an increase in rounded percentiles from 81 to 82.

See the attached zip file "Humana_CaseMix_MeansTest_Reports.zip", which includes a means and tests report and case-mix report for each of Humana's contracts. The means and tests report provides additional statistics used to calculate the Star Rating for each applicable measure. The case-mix report includes a worksheet for every item or composite that receives

a Star Rating. For further information about analysis of MA & PDP CAHPS Reported Measures, please visit the 'Scoring and Star Ratings' section on the MA & PDP CAHPS website at Scoring and Star Ratings (ma-pdpcahps.org).

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 - CAHPS thresholds

Good Afternoon,

1. Can CMS please define the threshold setting methodology for CAHPS, specifically, if consumed contracts (consolidated and/or otherwise terminated contracts as of 1/1/2025 are included in the percentile calculations?

2. After reviewing BY 2026 CAHPS ratings, we have identified data points that appear to contradict each other, preventing us from fully validating CAHPS rates and application of thresholds.
    - For example, the "Getting Needed Care" measure thresholds increased without demonstrating a commensurate increase in industry improvement. Upward movement across 2-star, 3-star, and 4-star thresholds would seem to suggest significant industry improvement on the measure. However, the reported national average for Getting Needed Care only increased by 0.24 points from 80.62 in BY 2025 to 80.86 in BY 2026, contradicting the degree of threshold movement.

Getting Needed Care threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change
2 Star	76%	77%	+ 1%
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4 Star	81%	82%	+ 1%

    - Additionally, related to the "Getting Needed Prescription Drugs" measure, the only threshold movement was at the 3-star threshold which fell by 1 point. However, given the national average for this measure was 90.37 for BY 2025 and 89.68 for BY 2026 – a decline of 0.69 points and almost 3x the magnitude of the Getting Needed Care measure increase, we would have expected commensurate decreases in thresholds.

Getting Needed Prescription Drugs (MAPD) threshold movement:

Star	BY 2025 Threshold	BY 2026 Threshold	Change

2 Star	87%	87%	--
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Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301
Coneil1@humana.com

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From: CMS MP-CAHPS
To: CMS PartC&DStarRatings; Colleen O"Neil
Cc: Jenna Pinardo; Conor Duffy; Dillon Nicole; Amy Heilman; Kimberlee Reid
Subject: RE: PP1 - CAHPS thresholds
Date: Friday, October 4, 2024 12:45:17 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png

Good afternoon,

Thank you for pointing out our typo. It should be -- When they do change, it results in the CAHPS measure-level stars going down since contracts with very low reliability scores tend to have lower scores so ~~including~~ excluding the very low reliability scores slightly raises the mean and cut points when there is any impact.

As previously stated, we have included the very low reliability scores to fully represent performance and to maximize precision of national averages and cut points. We can discuss the pros and cons of potentially considering a change in the future through rulemaking.

Regarding your request for data, we will update the CAHPS sample data in HPMS to indicate which scores are very low reliability.

Thank you,
MA & PDP CAHPS Survey Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, October 3, 2024 5:08 PM
To: Colleen O'Neil <coneil1@humana.com>; CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Confirming receipt.

From: Colleen O'Neil <coneil1@humana.com>
Sent: Thursday, October 3, 2024 4:43 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Part C and D Star Ratings Team –

Thank you for your response. We have a few questions.

First, you say that "contracts with very low reliability scores tend to have lower scores so *including* the very low reliability scores slightly *raises* the mean and cut points when there is any impact." Did you mean to say that *excluding* the very low reliability scores slightly raises the mean and cut points? This would make more sense if the low reliability scores tend to be lower.

While we appreciate your assurances that the more statistically valid approach generally would not have resulted in higher Star ratings for Humana or most plans, we would like the opportunity to independently validate this. And moreover, we are curious as to the thought process behind using this methodology in the first place. Wouldn't the inclusion of unreliable scores still be detrimental to accurate performance measurement overall? Is there something you think we are missing or not fully appreciating about the approach? Would CMS consider revising this approach? We know that CMS is committed in principle to the integrity of the Star Ratings program and are curious as to how this type of policy aligns with that goal.

As noted above, we would appreciate the opportunity to review and validate the data independently. Can you provide the data you used to calculate the CAHPS measure-level star ratings that excluded very low reliability scores? Specifically, we would ask that you provide the following (either directly to Humana or through posting on HPMS):

1. deidentified industry scores with each score flagged as either very low reliability or not,
2. national averages with very low reliability included,
3. national averages with very low reliability excluded, and
4. the contract enrollment for each score.

Thank you,
Colleen O'Neil

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, October 2, 2024 12:40 PM
To: Colleen O'Neil <coneil1@humana.com>; CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; Kimberlee Reid <kreid1@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: PP1 - CAHPS thresholds

Scores with very low interunit reliability for a given measure and contract are suppressed from public reporting and do not contribute to that contract's Star Ratings because due to low sample sizes and other factors they do not measure the contract's performance on that measure sufficiently precisely. To fully represent all performance and to maximize the precision of national averages and thresholds, CMS includes all eligible responses in calculating national averages and thresholds, including responses from contracts which, by themselves have very low interunit reliability. It should be noted that, given their small sample sizes, data from contracts with very low reliability have only a very small impact on national

averages.

Following the call with Humana, where Humana representatives said they were concerned about Getting Needed Care and Customer Service, we calculated the difference in CAHPS measure-level Star Ratings taking out very low reliability scores even though we do not have this exclusion codified in the methodology for calculating CAHPS Star Ratings. We see no change in any of the Humana contracts for the measure-level Star Ratings for Getting Needed Care and Customer Service. In most cases the measure-level Star Ratings do not change when very low reliability scores are excluded from the national average and threshold calculations. When they do change, it results in the CAHPS measure-level stars going down since contracts with very low reliability scores tend to have lower scores so including the very low reliability scores slightly raises the mean and cut points when there is any impact.

Thank you,

Part C and D Star Ratings Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Friday, September 27, 2024 4:13 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Thank you for your response.

Can you help us to understand the thought process behind CMS including these unreliable scores in the process of setting thresholds and calculating the national average, when such unreliable scores are omitted from the calculation of particular contract-level scores? This is not a statistically valid methodology for handling low reliability data and could result in substantial distortions of the Star Ratings. Humana is unable to understand the significance of the impact on the thresholds without the underlying data, however.

Thank you for your attention to this important matter.

Colleen O'Neil (she/her)
Stars Improvement Principal

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Thursday, September 12, 2024 10:12 AM

To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Scores that are calculated with very low interunit reliability for a given measure are included in both the calculation of base group cut points and the national mean used in significance testing. However, these scores are suppressed from public reporting and are not included when determining a contract's Summary and Overall Star Ratings.

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Wednesday, September 11, 2024 4:17 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Kimberlee Reid <kreid1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good Afternoon,

With regards to the inclusion of valid responses, can CMS confirm that measure scores were excluded from threshold and national average calculations if the statistical reliability test resulted in a "Very Low Reliability" designation?

Thank you,
Colleen O'Neil

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Friday, September 6, 2024 9:20 AM
To: Kimberlee Reid <kreid1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good morning,
Consistent with sample measure data that has been made available in HPMS for other measures (e.g. C01), CMS has uploaded a file called "C23_Sample_Data.xlsx", which provides de-identified scores, rounded to 6 decimal places, for the Rating of Health Plan measure for all

contracts with more than 10 valid responses to the survey item. These scores are used to calculate the 15th, 30th, 60th, and 80th percentiles that serve as the base group cut points. This file does not identify Humana contract scores, but that information has been provided in the contract-specific means and tests reports that were provided in a prior response to this inquiry.

Thank you,
MA & PDP CAHPS Survey Team

From: Kimberlee Reid <kreid1@humana.com>
Sent: Friday, August 30, 2024 5:08 PM
To: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Colleen O'Neil <coneil1@humana.com>
Subject: RE: PP1 - CAHPS thresholds

Good afternoon, MA & PDP CAHPS Survey Team,

Thank you for the additional information provided. Humana continues to work to validate the reported CAHPS results.

In an effort to complete this ask, we would highlight our previous request for deidentified unrounded industry rates for all contracts that reported. In this file, we would also ask that the Humana contract rates be identified.

Thank you,

Kimberlee Reid
Program Delivery Lead | Governance, Risk, Compliance & Communcations
Health Quality and Stars

Humana.com

From: CMS MP-CAHPS <MP-CAHPS@cms.hhs.gov>
Sent: Wednesday, August 14, 2024 1:39 PM
To: Colleen O'Neil <coneil1@humana.com>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>

Subject: RE: PP1 - CAHPS thresholds

Dear Colleen O'Neil,

When calculating the 15th, 30th, 60th, and 80th percentiles that serve as thresholds for the base groups for a given measure, all contract scores, including contracts consumed in a consolidation, are included if the score is based on at least 11 survey responses. To assign a contract's score to a base group, the contract's score is rounded to the nearest integer and compared to the base group thresholds that are also rounded to the nearest integer.

You compared changes in the percentile values to the national mean. The changes of percentiles from one year to the next will often be similar to the change in the mean but aren't necessarily the same. Furthermore, changes of one point in the rounded thresholds may correspond to unrounded changes of less than one point or more than one point. See the attached file "MCAHPS_BaseGroupCutpoints.xlsx," which provides more precise base group threshold values for both the current (sheet "2024_Cutpoints") and prior (sheet "2023_Cutpoints") year. For example, looking at the Getting Needed Care base group thresholds, the 15th percentile (threshold for base group 2) increased from 76.457392 to 76.982869, which translates to an increase in rounded percentiles from 76 to 77, and the 60th percentile (threshold for base group 4) increased from 81.453754 to 81.576171, which translates to an increase in rounded percentiles from 81 to 82.

See the attached zip file "Humana_CaseMix_MeansTest_Reports.zip", which includes a means and tests report and case-mix report for each of Humana's contracts. The means and tests report provides additional statistics used to calculate the Star Rating for each applicable measure. The case-mix report includes a worksheet for every item or composite that receives a Star Rating. For further information about analysis of MA & PDP CAHPS Reported Measures, please visit the 'Scoring and Star Ratings' section on the MA & PDP CAHPS website at Scoring and Star Ratings (ma-pdpcahps.org).

Thank you,
MA & PDP CAHPS Survey Team

From: Colleen O'Neil <coneil1@humana.com>
Sent: Monday, August 12, 2024 12:04 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Jenna Pinardo <jpinardo@humana.com>; Conor Duffy <CDuffy5@humana.com>; Dillon Nicole <DNicole@humana.com>; Kimberlee Reid <kreid1@humana.com>; Amy Heilman <aheilman@humana.com>
Subject: PP1 - CAHPS thresholds

Good Afternoon,

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Getting Needed Prescription Drugs (MAPD) threshold movement:

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Given the above, and consistent with sample measure industry data provided during Plan Preview 2, can CMS please provide de-identified industry contract unrounded rates and unrounded percentiles for 2024 and 2025 CAHPS measures to enable plans to fully validate CAHPS cut point calculations?

Best,

Colleen O'Neil (she/her)
Stars Improvement Principal

Louisville, KY
C 502 930 6301

Coneil1@humana.com

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To: Newsom, Mark (CMS/CM)
Cc: Duran, Vanessa (CMS/CM); Turco, Molly (CMS/CM)
Subject: RE: Follow-up from our 9/30 meeting
Date: Friday, October 4, 2024 3:53:31 PM
Attachments: image001.gif

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Mike Hoak
Vice President, Public Policy | Corporate Affairs

Mobile: (571) 466.6673
Email: mhoak@humana.com

From: Newsom, Mark (CMS/CM) <mark.newsom@cms.hhs.gov>
Sent: Thursday, October 3, 2024 8:25 AM
To: Mike Hoak <mhoak@humana.com>
Cc: Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>
Subject: Follow-up from our 9/30 meeting

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Mark A. Newsom | Deputy Group Director, Medicare Drug Benefit and C & D Data Group (MDBG) | Phone: 667-290-8554 | Mobile: 571-643-5024 | mark.newsom@cms.hhs.gov

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From: Turco, Molly (CMS/CM)
To: Duran, Vanessa (CMS/CM); Newsom, Mark (CMS/CM); Goldstein, Elizabeth (CMS/CM)
Subject: FW: follow up
Date: Monday, October 7, 2024 8:42:56 AM
Attachments: image001.png

From: Seshamani, Meena (CMS/OA) <Meena.Seshamani@cms.hhs.gov>
Sent: Monday, October 7, 2024 8:13 AM
To: mhoak@humana.com
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Thank you and we will be in touch.

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From: Newsom, Mark (CMS/CM)
To: Goldstein, Elizabeth (CMS/CM); Gaillot, Sarah (CMS/CM)
Subject: FW: Follow-up from our 9/30 meeting
Date: Monday, October 7, 2024 10:31:52 AM
Attachments: image001.gif
FW follow up.msg

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To: Mike Hoak <mhoak@humana.com>
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Mike,

Dr. Seshamani's email this morning reflects the agency's response to Humana's asks.

Mark

Mark A. Newsom | Deputy Group Director, Medicare Drug Benefit and C & D Data Group (MDBG) | Phone: 667-290-8554 | Mobile: 571-643-5024 | mark.newsom@cms.hhs.gov

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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

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Introduction

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

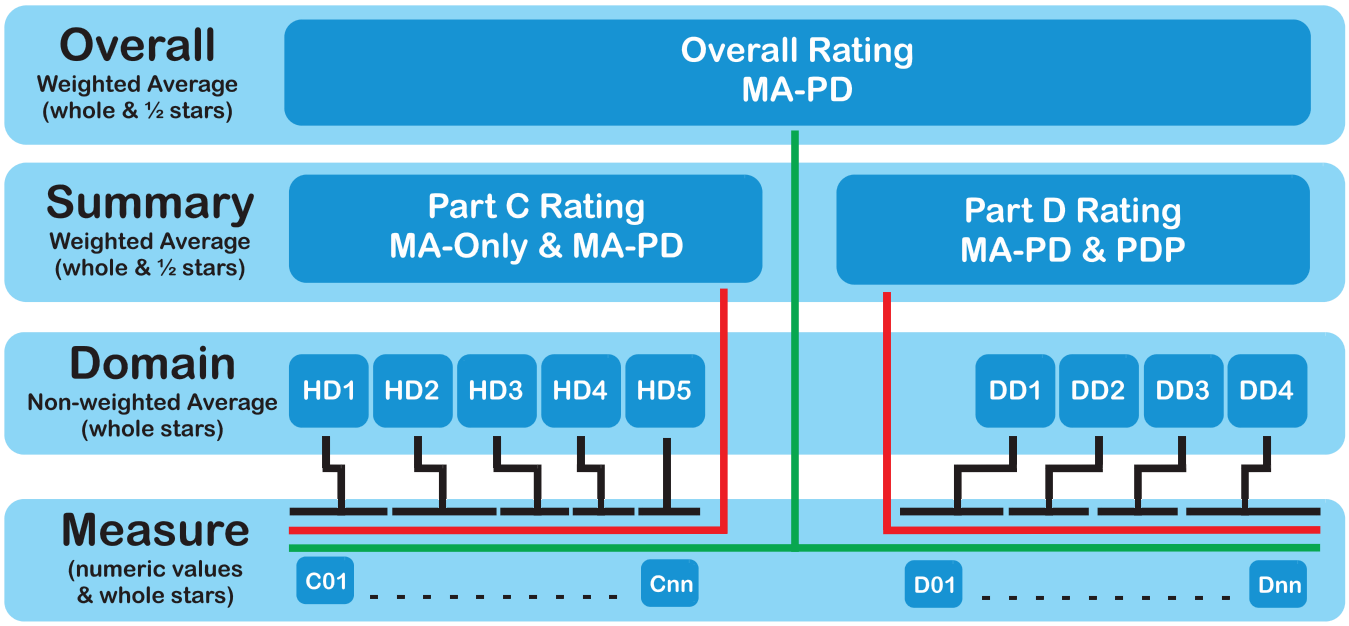
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 %

Domain: 2 - Managing Chronic (Long Term) Conditions

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C06 - Care for Older Adults – Medication Review

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C07 - Care for Older Adults – Pain Assessment

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

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

Reporting Requirements:

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

Cut Points:

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

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

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C09 - Diabetes Care – Eye Exam

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

Title	Description
	– Members who died any time during the measurement year. – Members receiving palliative care any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00203-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C10 - Diabetes Care – Blood Sugar Controlled

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00204-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C11 - Controlling Blood Pressure

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

Title	Description

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

- – • Members receiving palliative care during the measurement year.
- – • Members with a diagnosis of pregnancy

during the measurement year.

- – • Members in hospice or using hospice services any time during the measurement year.
- – • Members who died any time during the measurement year.

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcomes Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00167-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C12 - Reducing the Risk of Falling

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C13 - Improving Bladder Control

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

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

Title	Description

Reporting Requirements:

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

Cut Points:

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

Measure: C14 - Medication Reconciliation Post-Discharge

Title	Description

Label for Stars: The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge

Label for Data: The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge

Description: This shows the percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.

HEDIS Label: Medication Reconciliation Post-Discharge (MRP)

Measure Reference: NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 330

Metric: The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: Members in hospice or using hospice services any time during the measurement year.

Members who died any time during the measurement year.

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

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

Reporting Requirements:

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

Cut Points:

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

Measure: C15 - Plan All-Cause Readmissions

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

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

Title	Description

CMIT #: 00561-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description

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

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

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

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

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

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

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

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

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

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C17 - Transitions of Care

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00729-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

Domain: 3 - Member Experience with Health Plan

Measure: C19 - Getting Needed Care

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C20 - Getting Appointments and Care Quickly

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C21 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your health plan's customer service give you the

Title	Description
	information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00181-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C22 - Rating of Health Care Quality

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

Title	Description
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C23 - Rating of Health Plan

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C24 - Care Coordination

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

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

Measure: C25 - Complaints about the Health Plan

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C26 - Members Choosing to Leave the Plan

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C27 - Health Plan Quality Improvement

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

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

Reporting Requirements:

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

Cut Points:

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

Domain: 5 - Health Plan Customer Service

Measure: C28 - Plan Makes Timely Decisions about Appeals

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

Title	Description

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 4

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

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00562-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C29 - Reviewing Appeals Decisions

Title	Description

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

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

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

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

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MAOs, MA-PDs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to CallCenterMonitoring@cms.hhs.gov.
Data Time Frame:	02/2024 – 05/2024
General Trend:	Higher is better
Statistical Method:	Clustering

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

Reporting Requirements:

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

Cut Points:

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

Part D Domain and Measure Details

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

Domain: 1 - Drug Plan Customer Service

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

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

Title	Description
Weighting Value:	4
Major Disaster:	No adjustment for 2022 or 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00096-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

Measure: D02 - Complaints about the Drug Plan

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D03 - Members Choosing to Leave the Plan

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D04 - Drug Plan Quality Improvement

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

Title	Description
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

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

Cut Points:

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

Domain: 3 - Member Experience with the Drug Plan

Measure: D05 - Rating of Drug Plan

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

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

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: D06 - Getting Needed Prescription Drugs

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

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00294-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D08 - Medication Adherence for Diabetes Medications

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

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D10 - Medication Adherence for Cholesterol (Statins)

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: D11 - MTM Program Completion Rate for CMR

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

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

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

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

Title	Description

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Attachment A: CAHPS Case-Mix Adjustment

CAHPS Case-Mix Adjustment

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

For example, for the Part C measure "Rating of Health Plan," the model coefficient for "age 75-79" is 0.0511, 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

Attachment E: SNP Measure Scoring Methodologies

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):

$$OE(18+) = \left(\frac{\text{ObservedCount}(18+)}{\text{ExpectedCount}(18+)}\right)$$

And the national average of the (18+) Observed Rate:

$$\text{NatAvgObs}(18+) = \text{Average}\left(\left(\frac{\text{ObservedCount}(18+)_1}{\text{Denominator}(18+)_1}\right) + \ldots + \left(\frac{\text{ObservedCount}(18+)_n}{\text{Denominator}(18+)_n}\right)\right)$$

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

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{8+641}{214+4{,}792}\right) + \left(\frac{12+688}{225+4{,}761}\right) + \left(\frac{31+1{,}126}{573+8{,}629}\right) + \left(\frac{0+79}{12+533}\right)\right)$$

NatAvgObs = 0.135181

$$\text{OE Contract 1} = \left(\frac{8+641}{12+642}\right) = 0.992355$$

Final Rate Contract 1 = $0.992355 \times 0.135181 \times 100 = 13.41$
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.

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) Star Rating for contract *j* is estimated as:

$$\bar{x}_j = \frac{\sum_{i=1}^{n_j} w_{ij} x_{ij}}{\sum_{i=1}^{n_j} w_{ij}}$$

where n_j is the number of performance measures for which contract *j* is eligible; w_{ij} is the weight assigned to performance measure *i* for contract *j*; and x_{ij} is the measure star for performance measure *i* for contract *j*. The variance of the Star Ratings for each contract *j*, s_j^2, must also be computed in order to estimate the reward factor (r-Factor):

$$s_j^2 = \frac{n_j}{(n_j - 1)\left(\sum_{i=1}^{n_j} w_{ij}\right)} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j\right)^2\right]$$

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	

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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								

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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		

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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								

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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								

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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)															

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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

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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

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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”

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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	

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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.

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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

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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

Attachment R: Glossary of Terms

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.