IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

HUMANA INC., and AMERICANS FOR BENEFICIARY CHOICE, Plaintiffs, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; DOROTHY FINK, in her official capacity as Acting Secretary of Health and Human Services; and STEPHANIE CARLTON, in her official capacity as Acting Administrator of the Centers for Medicare & Medicaid Services, Defendants.	Civil Action No. 4:24-cv-01004-O

APPENDIX IN SUPPORT OF DEFENDANTS' CONSOLIDATED BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS, RESPONSETO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT, AND CROSS-MOTION FOR SUMMARY JUDGMENT

Contents

Respectfully submitted,

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CERTIFICATE OF SERVICE

On February 7, 2025, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all parties electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Andrea Hyatt
Andrea Hyatt
Assistant United States Attorney

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December 3, 2024

VIA EMAIL QBPAPPEALS@cms.hhs.gov

Ms. Vanessa Duran
Director, Medicare Drug Benefit and C & D Data Group
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850

RE: Appeal of Humana Quality Bonus Payment Determination

Dear Ms. Duran,

Pursuant to 42 C.F.R. § 422.260, Humana Inc. ("Humana") respectfully submits this request for reconsideration of the Centers for Medicare & Medicaid Services' ("CMS's") 2026 Quality Bonus Payment ("QBP") determination ("QBP Rating") for Humana's Medicare Advantage ("MA") – Prescription Drug ("MA-PD") Contracts H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H8145, H8908, R0110, R1532, R4182, R5361, R5826, and R7220 (the "Impacted Contracts").

The 2026 QBP Rating for each Impacted Contract is based on the Contract Year ("CY") 2025 Quality Star Ratings ("Star Ratings") assigned to that contract.[1] Because CMS made a calculation error and/or relied on inaccurate data in calculating Humana's Star Rating Measures C30 and D01 (Call Center – Foreign Language Interpreter and TTY Availability), the Star Ratings and QBP Ratings currently assigned to the Impacted Contracts are incorrect. Humana respectfully requests that CMS adjust the Star Ratings and reconsider the QBP Ratings assigned to the Impacted Contracts.

Humana has identified specific errors in connection with CMS's evaluation of test calls made to Humana as part of the CY 2025 Accuracy & Accessibility Study. CMS identified three calls placed to Humana customer service representatives as "incomplete." This determination reflected a calculation error on CMS's part, as described in more detail below.

Defs.' Exhibit A

[1] Memo from Vanessa Duran to Medicare Advantage Organizations, "2026 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances" (Nov. 15, 2024), at 1.

I. Disconnected Calls

During the CY 2025 Accuracy & Accessibility Study, CMS identified two calls (case IDs D1100955 and D0900533) placed to Humana customer service representatives as "incomplete" because the calls disconnected while Humana's service representatives were connecting with an interpreter to join the call. Humana's standard practice in the event of a dropped call is to call the individual back, but CMS has stated that it does not permit callbacks in its test environment. CMS has not adopted a no-callback rule by regulation; this is an unwritten practice. Both calls disconnected due to third-party internet connection interruptions outside of Humana's control, and not due to any failure on Humana's part.

When presented with the same set of facts by another plan sponsor—*i.e.*, a dropped call with no evidence that the plan sponsor was responsible for the call being dropped—CMS has previously excluded such calls from the Accuracy & Accessibility Study measurements rather than including them in the measure and rating them as "incomplete." Specifically, Elevance Health described CMS's determination in response to its 2023 Star Ratings challenge as follows: "Based on the evidence presented by Elevance and CMS, the CMS Reconsideration Official found that there was no evidence the call at issue failed due to actions by Elevance and should not have counted against Elevance."[2]

CMS is obligated to apply its Star Ratings methodology uniformly across similarly situated plan sponsors and according to regulation. Because there is no evidence that calls D0900533 or D1100955 failed due to actions by Humana, just as was the case with the Elevance dropped call, these calls should not have been treated as "incomplete" calls in the calculation of Star Rating Measure D01. And CMS may not apply a no-callback rule without promulgating it through notice-and-comment rulemaking. This represents a calculation error and/or reliance on incorrect data in CMS's Star Ratings evaluation.

II. Silent Caller

CMS identified a third call (case ID C0701002) as "incomplete" because neither the Humana representative nor the CMS call surveyor spoke; each was silent throughout the entire duration of the call. After an extended period of silence with no communication, the call was disconnected. A federal district court recently evaluated an analytically identical set of facts presented by UnitedHealthcare and determined that CMS acted contrary to its own guidelines in determining that the call was "incomplete." Specifically, the court found that

> The problem for CMS here is that the test caller never asked the introductory question that's required to evaluate a call at this phase. Because the introductory question was not asked, Plaintiffs' call center did not fail to answer it. Thus, CMS acted inconsistently with its own guidelines by evaluating the call as "unsuccessful."[3]

As clearly articulated by the district court, CMS's own methodology does not permit it to treat call C0701002 as "incomplete." That is because the call never connected, and even if it did, the call surveyor did not follow the required steps to test call completion. In treating the call as incomplete, CMS made a calculation error and/or relied on incorrect data in calculating Humana's Star Ratings.

In addition, Humana understands that CMS recently revised Star Ratings for one or more plan sponsors based on the district court decision in the UnitedHealthcare case, but did not revise Star Ratings for all

[2] Amended Complaint (Dkt. 13) ¶ 4, *Elevance Health, Inc. v. Becerra*, 2024 WL 2880415 (D.D.C. June 7, 2024).
[3] *UnitedHealthcare Benefits of Texas, Inc. v. CMS*, 2024 WL 4870771, at *4 (E.D. Tex. Nov. 22, 2024).

similarly situated plans. CMS did not provide notice to all plan sponsors of these changes nor explain why CMS made changes in certain circumstances and not others. CMS is obligated to apply its Star Ratings methodology uniformly across similarly situated plan sponsors, and Humana respectfully requests that CMS reconsider its evaluation of call C0701002, which was erroneously identified as "incomplete."

Taken together, these errors resulted in a reduction in CY 2025 Star Ratings on Measures C30 and D01, impacting Humana's Overall Star Ratings, as well as Humana's 2026 QBP Ratings for the Impacted Contracts. Humana respectfully requests that CMS adjust the Star Ratings and reconsider the 2026 QBP Ratings assigned to the Impacted Contracts.

Sincerely,

Jane Susott

Vice President, Associate General Counsel

Attachment A

Request for Reconsideration

Note: The QBP administrative review process is a two-step process that includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. This first step affords an MA organization the opportunity to request a reconsideration of how its Star Rating, for the given measure in question, was calculated. This is not an opportunity for an MA organization to question how every measure was calculated. A request for reconsideration must be submitted by the date and time specified below in order to reserve the right to later request an informal hearing on the record.

Instructions: Use only the "Request for Reconsideration" form that can be found in HPMS. To download a copy of the form from HPMS, select Quality and Performance on the home page, then Performance Metrics. On the Performance Metrics page select Reports, Costs and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. Mark an "X" next to the measure(s) that the MA organization is questioning and requesting reconsideration. In the "Description of the Issue" specify any errors that the MA organization asserts CMS may have made in calculating the contract's QBP determination. Save the information, please include your contract number in the filename and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Reconsideration of QBP is made by completing the Excel version of this form downloaded from HPMS and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on December 3, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H0292
Contact First Name (your first name):	Jane
Contact Last Name (your last name):	Susott
Contact Title (your job title):	Vice President, Associate General Counsel
Contact Phone Number (your phone number, include extension if necessary):	502-235-1521
Contact email address (your email address):	jsusott@humana.com

Overall Rating	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01-Breast Cancer Screening	HEDIS		Not Appealable	
C02-Colorectal Cancer Screening	HEDIS		Not Appealable	
C03-Annual Flu Vaccine	CAHPS		Not Appealable	
C04-Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05-Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06-Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07-Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08-Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09-Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10-Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C11-Controlling Blood Pressure	HEDIS		Not Appealable	
C12-Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17-Transitions of Care	HEDIS		Not Appealable	
C18-Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS		Not Appealable	
C19-Getting Needed Care	CAHPS		Not Appealable	
C20-Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
C23-Rating of Health Plan	CAHPS		Not Appealable	
C24-Care Coordination	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM			
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ratings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center	X	X	Please see the attached correspondence for a more detailed description of Humana's reconsideration request. Humana has determined that CMS made a calculation error and/or relied on inaccurate data in calculating Humana's Star Rating Measure C30, which resulted in an error in the calculation of its QBP Ratings. Specifically, CMS identified a call (case ID C0701002) placed to a Humana customer service representative as "incomplete" because neither the Humana representative nor the CMS call surveyor spoke; each was silent throughout the entire duration of the call. After an extended period of silence with no communication, the call was disconnected. A federal district court recently evaluated an analytically identical situation and determined that CMS acted contrary to its own guidelines in determining that such a call was "incomplete." CMS is obligated to apply its Star Ratings methodology uniformly across similarly situated plan sponsors and according to regulation. Call C0701002 should not have been treated as an incomplete call in the calculation of Star Rating Measure C30. This represents a calculation error and/or reliance on incorrect data in CMS's Star Ratings evaluation, resulting in an error in the calculation of Humana's QBP Ratings. Humana respectfully requests that CMS reconsider its QBP determination.

Part D Measures	Data Source	Request for Reconsideration		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01-Call Center – Foreign Language Interpreter and TTY Availability	Call Center	X	X	Please see the attached correspondence for a more detailed description of Humana's reconsideration request. Humana has determined that CMS made a calculation error and/or relied on inaccurate data in calculating Humana's Star Rating Measure D01, which resulted in an error in the calculation of its QBP Ratings. Specifically, CMS identified two calls (case IDs D1100955 and D0900533) placed to Humana customer service representatives as "incomplete" because the calls disconnected due to internet connection interruptions outside of Humana's control, and not due to any failure on Humana's part. When presented with the same set of facts by another plan sponsor, CMS excluded dropped calls from the Star Rating measurement, rather than treating them as "incomplete." CMS is obligated to apply its Star Ratings methodology uniformly across similarly situated plan sponsors and according to regulation. These calls should not have been treated as "incomplete" calls in the calculation of Star Rating Measure D01. This represents a calculation error and/or reliance on incorrect data in CMS's Star Ratings evaluation, resulting in an error in the calculation of Humana's QBP Ratings. Humana respectfully requests that CMS reconsider its QBP determination.
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03-Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Rating of Drug Plan	CAHPS		Not Appealable	
D06-Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07-MPF Price Accuracy	PDE, MPF Pricing		Not Appealable	
D08-Medication Adherence for Diabetes Medications	PDE		Not Appealable	
D09-Medication Adherence for Hypertension (RAS antagonists)	PDE		Not Appealable	
D10-Medication Adherence for Cholesterol (Statins)	PDE		Not Appealable	
D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)

Technical Report for Humana – H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H8145, H8908, R0110, R1532, R4182, R5361, R5826, and R7220

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Defs.'
Exhibit B

Factual Background

Regulations Governing the 2025 Part C and D Star Ratings

The Centers for Medicare & Medicaid Services (CMS) develops and publicly posts a 5-star rating system for Medicare Advantage (MA)/Part C and Part D plans as part of its responsibility to disseminate comparative information, including information about quality, to beneficiaries under sections 1851(d) and 1860D–1(c) of the Social Security Act ("the Act") and based on the collection of different types of quality data under section 1852(e) of the Act. The Part C and Part D Star Ratings system is used to determine quality bonus payment (QBP) ratings for MA plans under section 1853(o) of the Act and the amount of MA beneficiary rebates under section 1854(b) of the Act. The methodology for the Star Ratings system for the MA and Part D programs is codified at 42 CFR §§ 422.160 through 422.166 and 423.180 through 423.186, respectively, and we have specified the measures used in setting Star Ratings through rulemaking. Each year before the Star Ratings are released, CMS offers two Star Ratings plan preview periods during which time contracts may review their measure-level numeric scores and associated Star Ratings and raise issues or ask questions.

Call Center Monitoring

CMS monitors plan sponsors' Part C and Part D call centers to ensure compliance with regulatory requirements, found at 42 CFR §§ 422.111(h) and 423.128(d), for providing timely and accurate information. The purpose is to measure plans' call center accessibility and to determine if the information provided to current and prospective members is accurate.

There are two call center measures included in the Part C and D Star Ratings program – one measure focuses on Part C and the other on Part D. The measures capture Teletypewriter (TTY) Functionality[1] and Accessibility of Foreign Language Interpretation[2] when prospective members call the health and drug plan, respectively. Defined in a December 1, 2023, Health Plan Management System (HPMS) memo titled "2024 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies", (see Appendix A), and in the Medicare 2025 Part C & D Star Ratings Technical Notes[3], these measures examine the number of completed contacts with an interpreter and via TTY divided by the number of attempted contacts. To determine compliance with these requirements, CMS places outbound calls to plans' call centers. During these calls, CMS's contracted surveyor starts and stops timers to record hold times, measures time for customer service representatives (CSRs) to respond to questions, and measures time to make interpreters available to the prospective member. Completed contact with an interpreter is when the CSR, via an interpreter, provides an affirmative response to the introductory question (e.g., "Are you the right person to answer questions about [Plan name's] health (measure C30) or drug (measure D01) benefits?") within eight minutes. Completed contact with a TTY service is when the call surveyor can connect to a live CSR and the CSR answers "yes" to the introductory question (e.g., "Are you the right person to

[1] 42 CFR §§ 422.111(h(1)(iv) and 423.128(d)(1)(v)
[2] 42 CFR §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii)
[3] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf

answer questions about [Plan name's] health (measure C30) or drug (measure D01) benefits?") within seven minutes.

Contract's Description of the Issue: Call Center - Foreign Language Interpreter and TTY Availability (C30 and D01)

The following contracts under parent organization Humana Inc. appeal two calls for measure D01 and one call for measure C30: H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H8145, H8908, R0110, R1532, R4182, R5361, R5826, and R7220 (hereinafter "Humana").

For measure D01 Humana states that CMS erred when it identified two calls (case IDs D1100955 and D0900533) placed to Humana CSRs as unsuccessful because the calls disconnected while Humana's CSRs were connecting with an interpreter to join the call. Humana makes two arguments in support of its request to exclude these calls from the numerator for measure D01.

First, Humana states that their standard practice in the event of a dropped call is to call the individual back, but CMS does not permit callbacks in its test environment. Humana states that CMS must have its "no-callback rule" in regulation and not as an "unwritten practice."

Next Humana states that both calls disconnected due to third-party internet connection interruptions outside of Humana's control, and not due to any failure on Humana's part. In support of excluding the calls based on this argument, Humana states that CMS has not applied its Star Ratings methodology uniformly across similarly situated plan sponsors. This is based on a 2024 Star Ratings challenge by Elevance Health, in which a CMS reconsideration official excluded a dropped call as a result of Elevance's request for reconsideration. Humana refers to a district court filing in *Elevance Health, Inc. v. Becerra*, No. 23-3902 (RDM), 2024 WL 2880415 (D.D.C. June 7, 2024), in which Elevance described the reconsideration official's finding as follows: "Based on the evidence presented by Elevance and CMS, the CMS Reconsideration Official found that there was no evidence the call at issue failed due to actions by Elevance and should not have counted against Elevance."

For measure C30, Humana states that CMS erred when it identified one call (case ID C0701002) as unsuccessful because neither the Humana representative nor the CMS caller spoke; each was silent throughout the duration of the call and after an extended period the call disconnected. In support of their position, Humana points to a district court decision involving a different plan sponsor and a different test call, UnitedHealthcare Benefits of Texas, Inc. v. Centers for Medicare & Medicaid Services, No. 6:24-cv-357-JDK, 2024 WL 4870771 (N.D. Tex. Nov. 22, 2024), in which the court found that "[t]he problem for CMS here is that the test caller never asked the introductory question that's required to evaluate a call at this phase. Because the introductory question was not asked, Plaintiff's call center did not fail to answer it. Thus, CMS acted inconsistently with its own guidelines by evaluating the call as

'unsuccessful.'"

For the reasons above, Humana requests that case IDs D1100955 and D0900533 be excluded from measure D01, and that case ID C0701002 be excluded from measure C30.

CMS's Response: Call Center – Foreign Language Interpreter and TTY Availability (C30 and D01)

CMS disagrees with Humana's claims that CMS erred when it identified two calls (case IDs D1100955 and D0900533) as unsuccessful because of a no call back policy that is not in regulation, and because the disconnect was not initiated by Humana.

First, measure D01 is defined in the Medicare 2025 Part C & D Star Ratings Technical Notes[4] as "Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan." The Star Ratings call center measures are not focused on disconnect rates but rather focus on whether a prospective member can call a plan and reach a CSR within a defined period of time for foreign language and TTY calls. Thus, disconnected calls are included in the denominator for measure D01 because a prospective member whose call is disconnected was unable to call the plan and reach a CSR within the defined period of time, or at all, in that call. CMS does not have a policy that would prohibit Humana from calling members and prospective members back if a call disconnects; however, this is not allowed in the CMS test environment because the measure is intended to capture whether the prospective member can call a plan and reach a CSR in a timely manner.

Second, Humana's two dropped calls are distinguishable from the call described by Elevance in a filing in *Elevance Health, Inc. v. Becerra*, No. 23-3902 (RDM), 2024 WL 2880415 (D.D.C. June 7, 2024). The Elevance call was not at issue in the district court litigation because it was resolved in favor of Elevance during the administrative review process by a CMS reconsideration official. The Elevance call dropped after the caller connected with a TTY operator through the nationwide 711 service, but before the TTY operator dialed the number for Elevance's customer service call center. The caller noted that they "connected with TTY operator and provide the number to call then waited and the TTY window dialer closed. The dialer window closed before TTY operator dialed the plan." The reconsideration official "[did] not find that CMS has demonstrated that the reason for this closure could be associated with the 711 relay service. With no clearly identified failure by Elevance's selected service, I cannot attribute the failure to Elevance." See Appendix B. Notably, Elevance could not have produced call logs or audio recordings to establish the cause of the disconnect because the call disconnected before the TTY relay operator reached the plan's customer service call center. Although CMS holds plans responsible for calls that go through a TTY relay operator, in that particular scenario CMS could not show that it did not cause the disconnect.

[4] https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf. (See pg. 80)

The facts here are distinctly different from those of the Elevance TTY call. First, Humana does not challenge a TTY call that dropped before the relay operator dialed Elevance's customer service call center. Instead, it challenges a foreign language call, in which the CMS caller connected to Humana's customer service call center before the call disconnected. Second, the CMS call logs provided to Humana on September 16, 2024, show that CMS did not initiate the disconnect (see Appendix C).[5] Third, Humana has full access to the necessary information to determine whether it initiated the disconnect, including its own call logs, which it failed to provide to CMS. Humana has provided no information to confirm that it did not initiate the disconnect that occurred after CMS reached its customer service call center. This call does not warrant the same treatment as the call at issue in the Elevance reconsideration decision.

For measure C30, CMS disagrees with Humana's claim that CMS erred when it identified case ID C0701002 as unsuccessful. That call is distinguishable from the one at issue in the district court decision cited by Humana, UnitedHealthcare Benefits of Texas, Inc. v. Centers for Medicare & Medicaid Services, No. 6:24-cv-357-JDK, 2024 WL 4870771 (N.D. Tex. Nov. 22, 2024). In the disputed United call, United provided a recording in which there was a brief sound that might have been the voice of a CSR, and the caller said hello once and then remained silent, thinking they were in a hold queue. There were no other words spoken during the call and the United representative hung up once the eight-minute threshold for making an interpreter available under 42 CFR § 422.111(h)(1)(iii)(B) had passed. It was under these facts that the court found that the caller should have asked the introductory question, after which the CSR should have connected to an interpreter. Here, Humana provides no call recordings, there is no indication that there may have been a live person speaking at any point, and the call unexpectedly disconnected after only six minutes and two seconds. This is not a scenario in which voices were heard on the call and the plan representative disconnected after eight minutes when the introductory question was not asked. This call does not warrant the same treatment as the United call relied upon by Humana.

Conclusion

CMS finds no evidence that we incorrectly scored case IDs D1100955, D0900533, and C0701002 for the Humana contracts H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H8145, H8908, R0110, R1532, R4182, R5361, R5826, and R7220. CMS consistently and appropriately administered the call center study, and calls were properly placed and scored accordingly. As such none of the Star Ratings should be adjusted for these contracts. Humana's Star Ratings measures C30 and D01 and the overall ratings (QBP ratings) should remain unchanged for these contracts.

[5] See column O HangUpBy = Resp, which means the disconnect source was not CMS.

Appendices

Appendix A – "2024 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies" HPMS memo dated December 1, 2023

Appendix B – QBP Decision Letter Elevance Health

Appendix C – CMS Call Logs

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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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CENTER FOR MEDICARE

February 22, 2024

Reconsideration Determination for H2593

Dear Ms. Turano,

Elevance Health's contract H2593 requested an administrative reconsideration of its 2025 Quality Bonus Payment (QBP) determination. The request was based on the 2024 Star Ratings for the Overall Rating and Call Center – Foreign Language Interpreter and TTY Availability (D01) measure. I reviewed the QBP determination, the evidence and findings upon which the initial determination was based, and the additional information your organization submitted. As a result of my review, CMS will update the QBP rating for H2593 to 3 stars. **This reconsideration decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided in this reconsideration decision notice.**

With respect to call number C1201004, I have no decision to make because H2593 already has a 5 Star Rating for C30, the measure into which this specific call factors. There is no possible change to this Star Rating, so I have no decision to render. With respect to call number D2000386, I have determined that the call should be removed from the results. In this call, "the chat window closed unexpectedly while waiting on the live screen." I do not find that CMS has demonstrated that the reason for this closure could be associated with the 711 relay service. With no clearly identified failure by Elevance's selected service, I cannot attribute the failure to Elevance. This would then make the score for D01 a 100% success rate, which merits a 5 Star Rating on D01. This decision renders the issue of cut points for D01 moot and I render no decision on that issue.

The administrative review process is a two-step process that includes a request for reconsideration and a request for an informal hearing on the record. This notice of the contract's reconsideration determination concludes the first step of the administrative review process. If your organization is dissatisfied with this reconsideration decision, the contract may request an informal hearing on the record to be conducted by a hearing officer designated by CMS.

The informal hearing request must pertain only to the measures and values in question that precipitated the request for reconsideration, in this case 2024 Star Ratings for the Overall Rating and Call Center – Foreign Language Interpreter and TTY Availability (D01) measure. The request must include a statement that describes the error(s) the contract asserts CMS made in its QBP determination and how correction of those errors could result in the

organization's qualification for a higher QBP. In making the request your organization must provide clear and convincing evidence that this reconsideration determination is incorrect. The burden is on the MA organization to prove an error was made in the calculation of its QBP. The hearing officer's decision will be final and binding on both the MA organization and CMS.

In the event that the hearing officer finds that your organization's QBP determination was incorrect, CMS will be obligated to recalculate the organization's QBP status based on that finding. The recalculation could cause your organization's QBP to become higher *or lower*. In some instances, the recalculation of the measures may not cause the Star Rating to rise above the cut off for the higher QBP Star Rating.

Pursuant to the MA organization's agreement with CMS, the deadline for providing written notice requesting an informal hearing under 42 C.F.R. § 422.260(c)(2) is five business days from the issuance of this reconsideration decision, not ten days. Request for an informal hearing on the record regarding the 2025 QBP determination is made by completing the Attachment, "Request for an Informal Hearing," and e-mailing the completed form and supporting documentation to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on February 29, 2024. A request for an informal hearing must be submitted by the date and time above or this reconsideration decision is final and binding.** Please ensure you receive confirmation from the mailbox that your request was received.

Any questions regarding this decision may be submitted to QBPAPPEALS@cms.hhs.gov.

Sincerely,

Jeff Grant, CMS Reconsideration Official
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight

Attachment: Request for an Informal Hearing

contract_ic	caseid	contract_n	organizatic	CallCenter	erc	cas_cases	ERC_Desc	finishnote	TimeCaseStarted	TimeCaseEnded
H1019	C1800301	CAREPLUS	Local CCP	186	296.01	296	Unexpecte	CSR place	4/29/2024 18:19:30	4/29/2024 18:25:05
H0028	D0900533	CHA HMO,	Local CCP	11	296.01	296	Unexpecte	CSR put m	2/27/2024 16:16:06	2/27/2024 16:21:55
H0028	D1100955	CHA HMO,	Local CCP	11	296.05	296	Unexpecte	CSR put m	3/14/2024 12:10:40	3/14/2024 12:15:51

CaseDurat	TimeCallM	callerhangup	HangUpBy	CallEnded	CallDurati	time_logst	date_logst	time_loger	date_loger	Unprofessi	Interpreter
5.6	29APR24:1	4/29/2024 18:23	Resp	4/29/2024 18:23:29	3.9	18:19:34	########	18:23:29	########		
5.8	27FEB24:1	2/27/2024 16:19	Resp	2/27/2024 16:19:45	3.6	16:16:10	########	16:19:45	########		
5.2	14MAR24:	3/14/2024 12:13	Resp	3/14/2024 12:13:45	3	12:10:45	########	12:13:45	########		

ctype	clanguage	quarter	week	phone	Assigned_(	Assigned_I	PLANNAMI	ORGNAME	ts0_date	ts0_time	ts1_date	ts1_time	ts2_date
5	2	2	18	1-800-794	H1019	132	CareSalute	CAREPLUS	########	18:19:36			########
3	2	1	9	1-800-833	R4182	3	HumanaCl	HUMANA II	########	16:16:11			########
3	7	1	11	1-800-833	H5525	17	HumanaCl	HUMANA E	########	12:10:45			########

ts2_time	ts3_date	ts3_time	ts4_date	ts4_time	ts5_date	ts5_time	ts6_date	ts6_time	ts7_date	ts7_time	TTY_Phone	IVR_TIME	HOLD_TIM
18:19:43	########	18:19:43	########	18:20:48	########	18:22:03			########	18:25:05		64	74
16:16:18	########	16:16:18	########	16:17:21	########	16:19:01			########	16:21:54		62	99
12:10:51	########	12:10:51	########	12:12:01	########	12:12:07			########	12:15:51		69	6

LEP_HOLD	TTY_HOLD	CASETYPE	MMP_Indic	INDSNP	resCallCou	dayofwk	timeofday	ZIPCODE	COUNTY	STATE	QUESTION	QUESTION	QUESTION
105		C	0		1	1	18	33841	Polk	Florida	6	12	8
53		D	0		1	2	16	77991	Jackson	Texas	31	35	27
107		D	0		1	4	12	15279	Allegheny	Pennsylvar	23	27	22

ANSWER1	ANSWER2	ANSWER3	A1	O_A1M1	A2	O_A2M1	A3	O_A3M1	CCETIMEZ	TTY_TYPE	ANSWEREI	IVR1	IVR2	
4	No	Yes							EST		1	9	1	
Yes	You can fir	She can pay for her drugs on her own.							CH		1	9	1	
No	She can pa	Yes							DC		1			

IVR3	IVR4	IVR5	IVR6	IVR7	IVR8	IVR9	IVR10	IVRResult	HOLD	LIVE	O_LIVE2M:	O_LIVE2M:	O_LIVE2M:
								1	1	2			
								1	1	2			
								1	1	2			

EndScreen	EndScreen	Unprofessi	INTERPRET	linesttime	lineendtime
	2		2	8	20
	2		2	9	25
	2		2	9	26

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES 7500
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CENTER FOR MEDICARE

January 31, 2025

Reconsideration Determination for H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H8145, H8908, R0110, R1532, R4182, R5361, R5826, and R7220

Dear Ms. Susott,

Humana's contracts H0028, H0292, H0473, H0783, H1036, H1468, H1951, H2463, H2486, H3533, H4141, H4461, H4623, H5178, H5216, H5377, H5525, H5619, H5970, H6622, H7284, H8145, H8908, R0110, R1532, R4182, R5361, R5826, and R7220 requested an administrative reconsideration of their 2026 Quality Bonus Payment (QBP) determinations. The request was based on the 2025 Star Ratings for Call Center – Foreign Language Interpreter and TTY Availability (C30) and Call Center – Foreign Language Interpreter and TTY Availability (D01). I reviewed the QBP determinations, the evidence and findings upon which the initial determinations were based, and the additional information your organization submitted. As a result of my review, CMS will not change the QBP ratings for any of these contracts. **This reconsideration decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided in this reconsideration decision notice.**

I support the information provided in Attachment A, "Technical Report for Humana." Attachment A explains how the measures and values in question were calculated and provides specific information about these contracts' data. The methodology for the Medicare Advantage (MA) and Part D Star Ratings is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. The Medicare 2025 Part C & D Star Ratings Technical Notes, located at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html, also contain details about the methodology. Please note that, under CMS regulations, "[a]n administrative review cannot be requested for . . . the methodology for calculating the star ratings (including the calculation of the overall star ratings)" or "the set of measures included in the star rating system." 42 CFR 422.260(c)(3)(ii). The information in Attachment A may help your organization determine whether requesting an informal hearing would be beneficial.

The administrative review process is a two-step process that includes a request for reconsideration and a request for an informal hearing on the record. This notice of the contracts' reconsideration determination concludes the first step of the administrative review process. If your organization is dissatisfied with this reconsideration decision, your contract may request an informal hearing on the record to be conducted by a hearing officer designated by CMS. After the hearing officer's decision is issued by electronic mail to the MA organization, the hearing officer's decision is subject to review

Defs.'
Exhibit C

and modification by the CMS Administrator within 10 business days of issuance. If the Administrator does not review and issue a decision within 10 business days, the hearing officer's decision is final and binding.

The informal hearing request must pertain only to the measures and values in question that precipitated the request for reconsideration, in this case Call Center – Foreign Language Interpreter and TTY Availability (C30) and Call Center – Foreign Language Interpreter and TTY Availability (D01). The request must include a statement that describes the error(s) the contracts assert CMS made in their QBP determinations and how correction of those errors could result in the organization's qualification for higher QBPs. In making the request your organization must provide clear and convincing evidence that this reconsideration determination is incorrect. The burden is on the MA organization to prove an error was made in the calculation of its QBPs.

CMS will attempt to complete all informal hearings by early April. In the event that your organization's QBP determinations are found to be incorrect, CMS will be obligated to recalculate the organization's QBP statuses based on that finding. The recalculation could cause your organization's QBPs to become higher *or lower*. In some instances, the recalculation of the measures may not cause the Star Ratings to rise above the cut off for the higher QBP Star Ratings.

Request for an informal hearing on the record regarding the 2026 QBP determinations is made by completing Attachment B, "Request for an Informal Hearing," and e-mailing the completed form and supporting documentation to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on February 14, 2025. A request for an informal hearing must be submitted by the date and time above or this reconsideration decision is final and binding.** Please ensure you receive confirmation from the mailbox that your request was received.

Any questions regarding this decision may be submitted to QBPAPPEALS@cms.hhs.gov.

Sincerely,

John Pilotte, CMS Reconsideration Official
Director, Performance-Based Payment Policy Group

Attachment A: Technical Report for Humana
Attachment B: Request for an Informal Hearing