IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

PLAINTIFF'S MOTION FOR EXPEDITED SUMMARY JUDGMENT

Plaintiff SCAN Health Plan ("SCAN") respectfully moves this Court for expedited summary judgment under Federal Rule of Civil Procedure 56. SCAN is entitled to summary judgment because the Centers for Medicare and Medicaid Services ("CMS") unlawfully determined SCAN's 2024 "Star Rating"—a measure of SCAN's health plan's quality and performance—in a manner that was arbitrary and capricious and contrary to law.

As explained in the accompanying memorandum of law, CMS's determination of SCAN's 2024 Star Rating—which CMS calculated as 3.5 stars out of a possible 5 stars—was unlawful for two, independent reasons. First, CMS disregarded its own binding regulations when it calculated the "cut points" that CMS applied to determine SCAN's Star Rating. Those "cut points" form the guideposts against which SCAN's performance is measured, as they serve as the dividing line between a Star Rating of 5, 4, 3, or fewer stars on each of CMS's quality measures. In order to provide health plans with predictability on the criteria by which their performance will be measured each year, CMS's regulations require CMS to apply a "guardrail" to prevent its cut points from changing by more than 5 percentage points from one year to the next. Here, however, CMS failed to apply its regulatory guardrail in determining the measure-specific cut points for the 2024 Star Ratings

that CMS applied to SCAN. This error caused SCAN's overall Star Rating to fall from 4 stars to 3.5 stars.

Second, CMS erroneously determined that SCAN failed to timely make available a foreign language interpreter on a secret-shopper test call on February 9, 2023. CMS's regulations require that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative . . . ." 42 C.F.R. § 422.111(h)(1)(iii). To enforce this regulation, CMS measures whether health plans in fact make available interpreters within 8 minutes. Here, it is undisputed that SCAN had an interpreter connected to the February 9, 2023 secret-shopper test call within 6 minutes and 35 seconds. However, CMS determined that SCAN had failed this test call because it took more than 8 minutes for CMS's secret shopper to state, and then repeat, her question in unusually slow, stumbling French, which the interpreter clearly struggled to understand. CMS's determination that SCAN failed this test call was in error: SCAN plainly had an interpreter "available" within 8 minutes, *i.e.*, connected to the call. And even if CMS's regulation permitted CMS to account for the time it takes a plan to make an interpreter "available" *and also* for the plan to answer a secret shopper's question, CMS's decision here to count the delays introduced by its own caller against SCAN's measure-specific Star Rating was arbitrary and capricious.

Absent either of these two errors, SCAN would have received an overall 2024 Star Rating of 4 stars, rather than 3.5 stars, and would have been eligible for approximately $250 million in funding from CMS's "quality bonus payment" program for the 2025 plan year. Instead, CMS unlawfully determined that SCAN should receive a 3.5-star Star Rating, which has already resulted in irreparable harm to SCAN, and will result in SCAN losing approximately $250 million in funding from quality bonus payments that SCAN would have otherwise been entitled to.

Relief is urgently needed from this Court before June 3, 2024: All health plans must submit bids to CMS by June 3, 2024 to participate in the 2025 Medicare Advantage program, and

SCAN's Star Rating determines how SCAN must bid under the law. In lieu of preliminary injunction proceedings, the parties have therefore stipulated to a schedule for expedited summary judgment in advance of that June 3, 2024 deadline, Dkt. 19, which the Court has entered, Dkt. 20.

For the reasons stated in SCAN's accompanying memorandum of law, the Court should grant summary judgment to SCAN, setting aside CMS's determination of SCAN's 3.5-star Star Rating. The Court should enjoin the Defendants from using CMS's unlawful 3.5-star 2024 Star Rating in determining SCAN's eligibility for quality bonus payments. And the Court should order the Defendants, prior to June 3, 2024, to recalculate SCAN's Star Rating in compliance with governing law by (i) applying the required 5 percentage point guardrail in determining SCAN's 2024 Star Rating, and (ii) excluding the February 9, 2023 secret-shopper call from CMS's determination of SCAN's Star Rating (or, alternatively, determining that SCAN "passed" ("completed") the challenged call), and to utilize that recalculated Star Rating for purposes of determining SCAN's eligibility for quality bonus payments.

Dated: March 8, 2024

Respectfully submitted,

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

TABLE OF CONTENTS

Page

INTRODUCTION 1

A. The Medicare Advantage Program 6

B. Star Ratings 8

C. CMS's Methodology For Calculating Star Ratings 10

D. CMS's "Guardrails" For Calculating Star Ratings 12

E. CMS's Removal Of Outlier Data 13

F. CMS Violated Its Own Regulation In Calculating SCAN's 2024 Star Rating 14

G. CMS Relied On A Flawed Secret Shopper Call To Reduce SCAN's 2024 Star Rating 16

H. CMS's Unlawful Conduct Has Caused—And Will Continue To Cause—SCAN Irreparable Harm 19

ARGUMENT 20

I. CMS Violated Its Regulation Governing The Calculation Of Star Ratings, Which Required CMS To Apply A 5 Percentage Point Guardrail 21

A. CMS Violated Its Regulation By Using A Simulation Of The 2023 Star Rating Cut Points To Determine SCAN's 2024 Star Rating 21

B. CMS's Simulation Also Violated Its Regulations By Deleting Tukey Outliers And Disregarding Its Guardrail Relative To The 2022 Star Ratings 24

C. CMS Cannot Excuse Its Violation Of Its Regulation By Relying On Uncodified Preambles Published In The Federal Register 28

II. CMS Improperly Determined That A Single Secret Shopper Call Should Lower SCAN's Star Rating From 4 Stars to 3.5 Stars 33

A. CMS's Determination That No Interpreter Was Available Within 8 Minutes On The February 9, 2023 Test Call Was Inconsistent With CMS's Own Regulation 34

B. CMS's Determination That No Interpreter Was Available Within 8 Minutes On The February 9, 2023 Test Call Was Also Arbitrary And Capricious 37

III. CMS's 2024 Star Rating Determination Should Be Set Aside, And, In Turn, Be Re-Determined In Accordance With Governing Law 43

CONCLUSION 45

TABLE OF AUTHORITIES

Page(s)

Cases

AT&T Corporation v. Federal Communications Commission,
970 F.3d 344 (D.C. Cir. 2020) 28, 29, 37

AvMed, Inc. v. Becerra,
No. CV 20-3385 (JDB), 2021 WL 2209406 (D.D.C. June 1, 2021) 2, 10

Bell Helicopter Textron, Inc. v. Airbus Helicopters,
78 F. Supp. 3d 253 (D.D.C. 2015) 44

Biden v. Texas,
142 S. Ct. 2528 (2022) 40

Dep't of Homeland Sec. v. Regents of the Univ. of Cal.,
140 S. Ct. 1891 (2020) 42

eBay Inc. v. MercExchange, L.L.C.,
547 U.S. 388 (2006) 43

Eco Tour Adventures, Inc. v. Zinke,
249 F. Supp. 3d 360 (D.D.C. 2017) 29

Fischbein v. Olson Research Grp., Inc.,
959 F.3d 559 (3rd Cir. 2020) 35

G.Y.J.P. v. Wolf,
No. 20-1511, 2020 WL 4192490 (D.D.C. July 21, 2020) 20

Hewitt v. Helms,
459 U.S. 460 (1983) 26

J&K Prods., LLC v. SBA,
589 F. Supp. 3d 95 (D.D.C. 2022) 20

League of Women Voters v. Newby,
838 F. 3d 1 (D.C. Cir. 2016) 44, 45

**Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*,
463 U.S. 29 (1983) 39, 40, 42

Nalco Co. v. EPA,
786 F. Supp. 2d 177 (D.D.C. 2011) 44

**Nat. Res. Def. Council v. Wheeler*,
955 F.3d 68 (D.C. Cir. 2020) 31, 32, 33

Nat'l Env't Dev. Ass'ns Clean Air Project v. EPA,
752 F.3d 999 (D.C. Cir. 2014) 28

Nat'l Min. Ass'n v. U.S. Army Corps of Engineers,
145 F.3d 1399 (D.C. Cir. 1998) 45

Niz-Chavez v. Garland,
593 U.S. 155 (2021) 42

Nken v. Holder,
556 U.S. 418 (2009) 45

O'Donnell Constr. Co. v. District of Columbia,
963 F.2d 420 (D.C. Cir. 1992) 44

Sandin v. Conner,
515 U.S. 472 (1995) 26

St. Francis Med. Ctr. v. Azar,
894 F.3d 290 (D.C. Cir. 2018) 29

Tex. Children's Hosp. v. Azar,
315 F. Supp. 3d 322 (D.D.C. 2018) 29

Tex. Children's Hosp. v. Burwell,
76 F. Supp. 3d 224 (D.D.C. 2014) 29

United States v. Soybel,
13 F.4th 584 (7th Cir. 2021) 35

Westar Energy, Inc. v. FERC,
473 F.3d 1239 (D.C. Cir. 2007) 41

Statutes

5 U.S.C.
§ 702 20
§ 706 ..... 20, 43

42 U.S.C.
§ 1395w-21 6
§ 1395w-22 ..... 6, 7, 8, 9
§ 1395w-23 ..... 7, 8, 9
§ 1395w-24 ..... 7, 8, 9

Regulations

42 C.F.R.
§ 422.111 ..... 4, 16, 34, 35, 36 37
§ 422.162 ..... *passim*
§ 422.166 ..... *passim*
§ 423.182 ..... *passim*
§ 423.186 ..... *passim*

Federal Register Notices

69 Fed. Reg. 46,866 (2004) 8

75 Fed. Reg. 71,190 (2010) 8

76 Fed. Reg. 21,432 (2011) 41

83 Fed. Reg. 16,440 (2018) ..... *passim*

84 Fed. Reg. 15,680 (2019) 2, 12, 28

84 Fed. Reg. 15,830 (2019) 12

85 Fed. Reg. 9,044 (2020) 28, 30

85 Fed. Reg. 19,230 (2020) 12

85 Fed. Reg. 33,796 (2020) 13

85 Fed. Reg. 33,833 (2020) ..... *passim*

86 Fed. Reg. 6,007 (2021) 35, 37

87 Fed. Reg. 27,704 (2022) 32

87 Fed. Reg. 79,452 (2022) 32

88 Fed. Reg. 22,120 (2023) 32

INTRODUCTION

This case concerns the Centers for Medicare and Medicaid Services's ("CMS") unlawful departure from its governing regulations for rating private Medicare health plans, resulting in a loss of approximately $250 million to Plaintiff SCAN Health Plan ("SCAN"). SCAN brings this action in order to enforce the plain language of CMS's binding regulations, and require CMS to recalculate SCAN's relevant quality rating in the manner required by law.

SCAN is a California nonprofit healthcare plan whose mission is to keep its over 280,000 members healthy and independent. Under the Social Security Act, seniors and other Medicare beneficiaries have the choice to enroll either in traditional Medicare or in a private Medicare Advantage plan, where the government contracts with independent health plans to provide Medicare benefits to participants. Each year, CMS issues and widely publicizes "Star Ratings"—ranging from 1 to 5 stars—purporting to provide a "true reflection of [each] plan's quality." 83 Fed. Reg. 16,440, 16,520 (2018). CMS uses Star Ratings to assist beneficiaries to discern between plans and choose higher-quality plans; and to financially penalize lower-rated plans. Among other things, CMS awards "quality bonus payments" to higher-rated plans, which they then use to lower premiums and cost sharing, and to provide supplemental benefits to members.

SCAN has long enjoyed exemplary Star Ratings, including a rating of 4.5 stars for each of the last six years. Private ratings organizations agree with that track record: In 2023, J.D. Power found that SCAN ranks highest in overall customer satisfaction among Medicare Advantage plans in California. And year after year, SCAN has been named to U.S. News's list of Best Medicare Advantage plans. But SCAN's consistently high Star Rating fell dramatically and unexpectedly from 4.5 stars to 3.5 stars in late 2023, because CMS departed from its own rules for determining Star Ratings in two distinct ways.

First, CMS disregarded its binding regulations governing how SCAN's Star Rating must be determined. While the regulations governing the calculation of a plan's Star Rating are complex—to put it mildly—they boil down to a simple and familiar concept: like many school grades, "Star Ratings are graded on a curve." *AvMed, Inc. v. Becerra*, No. CV 20-3385 (JDB), 2021 WL 2209406, at *5 (D.D.C. June 1, 2021). First, CMS collects dozens of "measures" concerning plan quality, such as member satisfaction with the plan, member complaints, and the percent of female plan members who had a mammogram in the past 2 years. CMS then ranks hundreds of plans based on how well they scored on each measure, and assigns "cut points" between 5 stars, 4 stars, 3 stars, etc. for each measure (like a professor might deem 90% an "A" and 80% a "B"). CMS then determines a plan's measure-specific Star Ratings (like a student's grades on quizzes and exams). Lastly, CMS determines an overall Star Rating for each plan by calculating a weighted average of all the plan's Star Ratings across all measures (like how quizzes and exams may be weighted in an overall course grade). 42 C.F.R. §§ 422.166(a), 423.186(a).

Although CMS updates its Star Ratings each year based on the performance of each plan compared to hundreds of other plans (*i.e.*, "on a curve"), CMS has recognized that health plans need predictability in how their Star Ratings will be determined, and thus, how the measure-specific cut points for each Star Rating level will be determined. Drastic changes in CMS's Star Rating evaluation criteria (*i.e.*, cut points) from year to year would sow chaos among plans, who need to organize their operations; among potential plan members, who are shopping for plans; and among existing members, whose benefits could be cut suddenly if a plan's Star Rating falls. CMS therefore issued a new regulation in 2019 to "increase the predictability of the cut points" of Star Ratings. 84 Fed. Reg. 15,680, 15,754 (2019). CMS created a "guardrail" of "5 percentage points" on how far each "cut point" can change "from 1 year to the next." *Id.* § 422.166(a)(2)(i);

id. § 423.186(a)(2)(i). So, for example, if 80% were the cut point between 4 stars and 5 stars on a measure one year, that cut point could change to 75% or 85% the next year, but no further.

CMS, however, disregarded its regulations and did *not* apply the 5 percentage point guardrail relative to the *actual* cut points for the prior year, *solely* for the 2024 Star Ratings. CMS ignored the actual cut points from the 2023 Star Ratings, and instead *simulated* the 2023 Star Ratings cut points using an entirely new methodology that CMS viewed as more desirable from a policy perspective. CMS did so despite its regulation unambiguously requiring CMS to ensure that its "cut points . . . do not increase or decrease more than the value of the [5 percentage point] cap from 1 year to the next." *Id.* § 422.166(a)(2)(i); *id.* § 423.186(a)(2)(i). CMS's one-year departure from its regulation allowed cut points for some measures to increase by 30%, 40%, or more from 2023 to 2024, rather than the 5 percentage points mandated by the regulatory guardrail. CMS's departure from its binding regulation in turn caused SCAN's overall Star Rating to fall from 4 stars, as it should have been, applying the guardrail regulation, to 3.5 stars.

That drop has already caused serious harm to SCAN's competitive position and its ability to retain members and win new members. And, absent urgent relief from this Court, it will make SCAN ineligible for approximately $250 million in funding from quality bonus payments for the year 2025, which will in turn reduce member benefits and increase member cost sharing. CMS violated its regulation by determining SCAN's 2024 Star Rating without using the required 5 percentage point guardrail, and that determination should be set aside.

CMS also made a second key error, which was likewise independently sufficient to knock SCAN's Star Rating down from 4 stars to 3.5 stars. One of CMS's Star Rating measures is that, per CMS, it should take 8 minutes or less for a plan's customer service agent to get a foreign language interpreter on a customer service phone call to interpret questions from a caller that

speaks a foreign language. To test this measure (known as "C30"), CMS hires "secret shoppers" to call plans' customer service lines posing as consumers and request an interpreter, to see how long it takes to get one on the line. Here, CMS concluded that a call placed on February 9, 2023 failed this 8-minute metric. This *one call* was independently sufficient to cause SCAN's Star Rating to fall to 3.5 stars, and for SCAN to lose nearly $250 million in funding from CMS.

But CMS evaluated the challenged secret shopper call contrary to its own regulation. CMS's regulation requires that "interpreters must *be available* for 80 percent of incoming calls requiring an interpreter *within 8 minutes of reaching the customer service representative* . . . ." 42 C.F.R. § 422.111(h)(1)(iii) (emphases added). That text has an unambiguous meaning: An interpreter needs to be on the phone line, in dialogue with the caller, within 8 minutes. Here, that criterion was met within 6 minutes and 35 seconds of the challenged call reaching the customer service agent. CMS still found that SCAN failed to make an interpreter timely available on this call. That determination was contrary to law. To be sure, CMS purports to have issued guidance that allows CMS to consider—on top of the time it takes to make an interpreter *available*—the additional time it takes for CMS's secret shopper to pose her question, clarify it as necessary, and obtain a response. But that guidance cannot overcome the regulation's text, which requires that an interpreter must be "available" within 8 minutes, *i.e.*, connected to the call. Contrary to CMS's decision, that regulatory requirement was met here.

And, even assuming (contrary to the governing regulation) that CMS may consider more than just the time it takes to connect a call to the interpreter, here, the secret shopper botched the February 9, 2023 call, repeatedly stumbling over her question, and speaking in slow, non-standard language that she had to repeat and clarify to be understood. These errors resulted in it taking over 8 minutes to answer her question. CMS's decision to count delays caused by its own

secret shopper against SCAN's Star Rating was arbitrary and capricious. The call recording speaks for itself—as do other secret shopper calls in which it took less than *half* the time to answer an intelligible question in a foreign language. CMS's choice to evaluate SCAN based on the luck of how well CMS's secret shopper could communicate in French (here, poorly) violated the Administrative Procedure Act's ("APA's") requirement of reasoned decisionmaking, as well as CMS's own commitment to evaluate Star Ratings based only on matters that are "under the control of the health or drug plan." 83 Fed. Reg. at 16,521, 16,560. CMS concedes that SCAN met the 8-minute mark in 95% of test calls (which would have been 97%, but-for CMS's botched test-call), so there was clearly no systemic issue on SCAN's side. Yet CMS has never provided any justification for determining that SCAN failed this secret shopper call based on how well and quickly CMS's own secret shopper could articulate and clarify her question.

Either CMS's "guardrail" error *or* its "secret shopper" error was each independently sufficient to cause SCAN's Star Rating to drop from 4 star to 3.5 stars. CMS's determination of SCAN's Star Rating should therefore be set aside on either or both of these two grounds.

Relief is urgently needed from this Court before June 3, 2024: All health plans must submit bids to CMS by June 3, 2024 to participate in the 2025 Medicare Advantage program, and SCAN's Star Rating determines *how* SCAN must bid under the law. In lieu of preliminary injunction proceedings, the parties therefore stipulated to a schedule for expedited summary judgment in advance of that June 3 deadline, Dkt. 19, which the Court has entered, Dkt. 20.

The Court should grant summary judgment to SCAN, setting aside CMS's determination of SCAN's 3.5-star Star Rating. The Court should enjoin the Defendants from using CMS's unlawful 3.5-star Star Rating in determining SCAN's eligibility for quality bonus payments. And the Court should order the Defendants, prior to June 3, 2024, to recalculate SCAN's Star Rating

in compliance with governing law by (i) applying the required 5 percentage point guardrail in determining SCAN's 2024 Star Rating, and (ii) excluding the February 9, 2023 secret-shopper call from CMS's determination of SCAN's Star Rating (or, alternatively, determining that SCAN "passed" ("completed") the challenged call), and to utilize that recalculated Star Rating for purposes of determining SCAN's eligibility for quality bonus payments.[1]

BACKGROUND

A. The Medicare Advantage Program

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

Under the Act, beneficiaries enrolled under so-called "Original Medicare" (Medicare Parts A and B) receive benefits for covered medical services directly from the federal government. *See* 42 U.S.C. §§ 1395c–1395i-6; 42 U.S.C. §§ 1395j-1395w-6. Alternatively, Medicare beneficiaries may elect coverage under the "Medicare Advantage" program (Medicare Part C), which Congress created in 1997 with the goal of expanding availability of high-quality health plan options to Medicare beneficiaries, while also generating cost savings to the

[1] Also pending before this Court is a case filed by Elevance Health, Inc. and its affiliates raising a challenge to their 2024 Star Ratings. Am. Complaint, No. 23-3902 (D.D.C. Mar. 7, 2024), Dkt. 13. The cases share some overlapping legal issues—specifically, how CMS should apply its guardrail regulation. But the cases also raise differing legal issues, including SCAN's challenge to the French language call, and the asserted manner/bases that CMS departed from its regulations in calculating each party's respective Star Ratings. *See id.* Because the cases differ in terms of (i) the challenged agency action, (ii) the requested plaintiff-specific relief, (iii) the administrative records, and (iv) their factual basis, they do not appear to be related within the meaning of Local Rule 40.5. *See J&K Prods., LLC v. SBA*, 589 F. Supp. 3d 95, 98-99 (D.D.C. 2022) ("[C]ases are related when they involve common issues of fact—not common issues of law."); *G.Y.J.P. v. Wolf*, No. 20-1511, 2020 WL 4192490, at *2 (D.D.C. July 21, 2020) (same). But in an abundance of caution and for the Court's awareness, SCAN raises the Elevance matter to the Court's attention.

government. *See id*. § 1395w-21; Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275–327 (1997).

Under the Medicare Advantage program, CMS contracts with private Medicare Advantage plans, which provide Medicare-covered benefits. By law, these plans must include the same level of benefits offered by Original Medicare—although Medicare Advantage may also offer supplemental benefits (like optical or dental benefits). *See* 42 U.S.C. § 1395w-22. Medicare Advantage Plans therefore compete to encourage beneficiaries to select their plans by offering both high-quality care and supplemental benefits. *See id.* In addition, under Medicare Part D, enrollees in traditional Medicare or Medicare Advantage plans may also choose to enroll in optional Part D prescription drug benefits. *See generally* 42 U.S.C. § 1395w-101, *et seq*.[2]

To fund Medicare Advantage benefits, the government pays Medicare Advantage plans a pre-determined monthly sum for each plan enrollee. *See* 42 U.S.C. § 1395w-23. Each year, CMS establishes "benchmark" rates that are meant to represent what it would cost CMS to provide Medicare benefits to an average enrollee. *See id.* § 1395w-23(b)(1)(B). Plans then submit bids for the estimated cost for covering Medicare defined standard benefits to an average Medicare Advantage enrollee for the upcoming year. *See id.* § 1395w-23(a)(1)(B). If a plan bids below the benchmark, CMS returns a portion of the difference to the plan as a "rebate," which plans can use to fund improvements upon the Medicare defined standard benefit through reduced cost sharing, lower Part D premiums, and supplemental benefits not included in traditional Medicare. *See, e.g.*, *id.* §§ 1395w-23(a)(1)(E), 1395w-24(a)(6)(A). To determine the amount of such rebates, each plan submits a bid each June for the payment they seek from CMS for the

[2] All of SCAN's Medicare Advantage plans include Medicare Part D drug coverage.

coming year based on their projected revenues and costs. *See id*. § 1395w-24(a)(1)(A).[3]

B. Star Ratings

Under the Balanced Budget Act of 1997, each Medicare Advantage plan was required to "have arrangements . . . for an ongoing quality assurance program." 111 Stat. at 291 (codified at 42 U.S.C. § 1395w-22(e)(1) (1997)). Under that now-superseded statute, CMS had authority to regulate plans' quality assurance programs, and to both select and publicize the "quality and outcomes measures" that CMS "determine[d] to be appropriate." 42 U.S.C. § 1395w-22(e)(1), (e)(2)(A)(xii) (1997).

The Medicare Modernization Act of 2003 substantially amended (and largely erased) the original 1997 Balanced Budget Act provisions above, and added a new § 1395w-22(e)(3) entitled "Data," which remains effective today. Subparagraph (A)(i) requires each Medicare Advantage plan to "provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality." 42 U.S.C. § 1395w-22(e)(3)(A)(i). CMS has interpreted the amendments to mean that CMS could continue to collect the same data that were collected as of November 1, 2003. *See* 69 Fed. Reg. 46,866, 46,886 (2004).

CMS has published raw data about Medicare Advantage plan quality and performance since 1998. *See* 83 Fed. Reg. at 16,520. But in 2008, CMS began publishing annual Star Ratings, which provide a summary rating of 1 to 5 stars (including half-stars in-between) for each plan. *Id*. At first, the Star Ratings served two purposes: to provide beneficiaries with information on plan performance to consider when choosing a plan, and to help CMS identify low performing

[3] The bids submitted by Medicare Advantage plans require extensive supporting documentation, including information about the specific benefits and cost sharing that the plan will cover and a detailed financial breakdown of how the plan arrived at its bid amount, with the actuarial basis and support for the calculations. 42 U.S.C. § 1395w-24(a)(6)(A); 42 C.F.R. § 422.254(b)(5).

plans for compliance actions. *See, e.g.*, 75 Fed. Reg. 71,190, 71,219 (2010). In addition to prominently displaying Star Ratings in digital and print materials, CMS's online Plan Finder tool displays plans to beneficiaries in order of their Star Ratings (highest to lowest), with the purpose of steering beneficiaries to higher-rated plans. *See, e.g.*, 42 C.F.R. § 422.166(h).[4]

In 2010, Congress amended the Medicare Act, and added the concept of a "quality rating," *i.e.*, a Star Rating, into two different statutory payment formulas to award higher funding levels to highly rated Medicare Advantage plans. *See* Pub. L. No. 111-152, 124 Stat. 1029, 1043–46 (2010); 42 U.S.C. §§ 1395w-23(o), 1395w-24(b)(1)(C). The first formula, codified at 42 U.S.C. § 1395w-23(o)(1), (3)(A)(i), rewards Medicare Advantage plans rated "4 stars or higher" with an increased benchmark against which to bid. In essence, this results in a direct bonus paid to the plan on each enrolled plan beneficiary, because when a plan bids below its benchmark, CMS returns a portion of the savings (relative to the benchmark) to the plan as a "rebate." 42 U.S.C. § 1395w-23(o)(1), (3)(A)(i). The second formula, codified at 42 U.S.C. § 1395w-24(b)(1)(C) and known as "beneficiary rebates," gives higher-rated plans a larger portion of the difference between their bid and their benchmark back as a rebate. *See id.* § 1395w-24(b)(1)(C)(v). Under either formula, rebates are used to lower patient cost-sharing and Part D premiums, and fund supplemental benefits not offered in traditional Medicare, such as dental and vision benefits. *See, e.g.*, 85 Fed. Reg. 33,885, 33,885-56 (2020).

In sum: Star Ratings directly impact the ability of SCAN and other Medicare Advantage plans to receive vital and substantial quality bonus payments, which in turn allow them to provide high-quality care and benefits to their members, and to better compete in the marketplace.

[4] *See also*, CMS Medicare Plan Finder, *available at* https://www.medicare.gov/plancompare/.

C. CMS's Methodology For Calculating Star Ratings

Since 2018, CMS has prescribed regulations for determining Star Ratings in two separate sections: Regulations under Medicare Part C (Medicare Advantage), *see, e.g.*, 42 C.F.R. §§ 422.162, 422.166, and regulations under Medicare Part D (prescription drug coverage), *see, e.g.*, 42 C.F.R. §§ 423.182, 423.186. Although the Part C and Part D regulations governing Star Ratings are codified in two sections, the regulations under Part C and Part D are near-verbatim copies of one another, and provide for calculation of a single, unified Star Rating containing data collected both under Part C and Part D (for plans offering both sets of benefits). Under CMS's regulations, Star Ratings are based "on the type of data specified in section 1852(e) of the Act [42 U.S.C. § 1395w-22(e)(3)] and on CMS administrative data," including "[c]linical data, beneficiary experiences, changes in physical and mental health, benefit administration information and CMS administrative data." 42 C.F.R. § 422.162(c)(1); *see also* 42 C.F.R. § 423.182(c)(1) (similar provisions under Part D).

The calculation of Star Ratings boils down to a familiar concept: "Star Ratings are graded on a curve," *AvMed*, 2021 WL 2209406, at *5, like a professor that (1) grades an exam; (2) analyzes the percentage scores and decides where to place "cut points" between the students for an A, B, C, etc.; (3) converts each student's exam score to a letter grade; and (4) averages all exam letter grades that semester to determine a student's final grade. CMS has a similar process:

(1) Measure Scores: CMS first calculates the raw "measure score" for each of dozens of "measures," such as Breast Cancer Screening (the "percent of female plan members aged 52-74 who had a mammogram during the past 2 years"). *See* 83 Fed. Reg. at 16,537–546. A "measure score" is the plan's raw score on each measure—usually expressed as a percentage. *See* 42 C.F.R. § 422.162(a) ("Measure score means the numeric value of the measure . . . ."); *id.*

§ 422.166(a)(1), (a)(4); *id.* §§ 423.182(a), 423.186(a)(1), (a)(4) (parallel provisions under Part D). Each plan will receive dozens of these raw measure scores each year. *See id.*

(2) Determining Cut Points Between Star Ratings: Just like a professor who decides the cut point between an A, B, and C, for a given measure, CMS analyzes the measure scores of hundreds of plans and, as relevant here, uses statistical "clustering" to identify plans with similar "measure scores" and set "cut points" for the measure scores that serve as dividing lines between the Star Rating levels. *See* 42 C.F.R. § 422.166(a)(1), (a)(4) ("CMS will determine cut points for the assignment of a Star Rating for each numeric measure score by applying . . . a clustering . . . methodology"); *id.* § 423.186(a)(1), (a)(4) (same for Part D); *id.* § 422.166(a)(2) (describing clustering methodology used to generate cut points); *id.* § 423.186(a)(2) (same for Part D). Here is an example of how CMS defines cut points for the measure Breast Cancer Screening (the "percent of female plan members aged 52-74 who had a mammogram during the past 2 years"):

Star Rating:	1 Star	2 Star	3 Star	4 stars	5 stars
Measure Value:	Under 52%	≥ 52%	≥ 63%	≥ 71%	≥ 79%

(3) Conversion of Measure Scores to Measure Star Ratings: Using these cut points, CMS then converts a plan's raw measure score, for each measure, into a Star Rating between 1 and 5. *See* 42 C.F.R. § 422.166(a)(1), (a)(4) ("Measure scores are converted to a 5-star scale . . . with whole star increments for the cut points."); *id.* § 423.186(a)(1), (a)(4) (same for Part D). This is like converting an "85%" raw score on a school exam or quiz to the letter grade "B."

(4) Determining Overall Star Rating: After the first three steps, CMS will have, for each Medicare Advantage plan, dozens of Star Ratings for dozens of individual measures. *See id.* CMS determines a plan's overall Star Rating as a weighted average of all the plan's individual measure Star Ratings. *See* 42 C.F.R. § 422.166(c)(1), (d)(1) ("The overall rating for a [Medicare Advantage-Prescription Drug] contract will be calculated using a weighted mean of the Part C

and Part D measure-level Star Ratings."); *id.* § 423.186(c)(1), (d)(1) (same). This is similar to a professor taking a weighted average of homework grades (least weight), quiz grades (medium weight), and exam grades (heaviest weight) in calculating a student's final course grade.

D. CMS's "Guardrails" For Calculating Star Ratings

As discussed above, CMS updates its Star Rating cut points annually based on hundreds of plans' performance on CMS's measures. *See* 42 C.F.R. § 422.166(a)(1)-(2); *id.* § 423.186(a)(1)-(2). If the performance of the plans as a whole changes, the cut points change. *Id.* Understandably, this annual update generates uncertainty for Medicare Advantage plans because they cannot know in advance what raw measure scores will qualify for a high star rating, or for a low star rating.

In April 2019, CMS promulgated a regulation to reduce this unpredictability by providing that the Star Rating cut points could not change more than 5 percentage points from one year to the next. 84 Fed. Reg. 15,830, 15,842 (2019) (amending 42 C.F.R. § 422.166(a)(2)(i) and § 423.186)(a)(2)(i)). CMS adopted "a guardrail so that the measure-threshold-specific cut points for non-CAHPS[5] measures do not increase or decrease more than the value of the cap from 1 year to the next. The cap is equal to 5 percentage points . . . ." 42 C.F.R. § 422.166(a)(2)(i); *id.* § 423.186)(a)(2)(i) (same). CMS provided that its new guardrail rule would come into effect immediately. *Id.* § 422.166(a)(2)(i) (2019); *id.* § 423.186(a)(2)(i) (2019); *see also* 84 Fed. Reg. at 15,754. CMS explained that it adopted its guardrail regulation to provide "a degree of predictability," and "[c]ommenters overwhelmingly supported increasing the stability and predictability of cut points" by adopting these new guardrails. 84 Fed. Reg. at 15,754.

[5] Consumer Assessment of Healthcare Providers and Systems ("CAHPS") consist of patient surveys that "ask consumers and patients to evaluate the interpersonal aspects of health care." 42 C.F.R. § 422.162(a). Non-CAHPS measures, by contrast, derive data from sources other than CAHPS surveys. *See* Ex. 9 to Plumb Decl. at 2 (Healthcare Effectiveness Data and Information Set (HEDIS) - Healthy People 2030 | health.gov). Only non-CAHPS data are at issue in this case.

On April 6, 2020, CMS delayed the implementation of the guardrail rule by one year, due to the Covid-19 pandemic, to "begin[] with the 2023 Star Ratings" issued in October 2022 for the 2023 plan year. 85 Fed. Reg. 19,230, 19,274-75 (2020). CMS amended its regulation to reflect this one-year delay, now providing that CMS would apply its guardrails "[e]ffective for the [2023] Star Ratings issued in October 2022." *Id.*; *see also* 42 C.F.R. § 422.166(a)(2)(i); 42 C.F.R. § 423.186(a)(2)(i). (CMS issues its Star Ratings each year in October to govern plans during the *following* year, so in October 2023 CMS issued the "2024 Star Ratings.")

In October 2022, CMS issued the 2023 Star Ratings, which were the first Star Ratings in which CMS applied its guardrails. CMS thus determined that the 2023 Star Rating cut points could not change more than 5 percentage points relative to the 2022 Star Rating cut points. *See* Ex. 7 to Plumb Decl. at 10 (2023 Star Rating Technical Notes) ("Guardrails were added to the . . . clustering methodology that is used to set cut points . . . ."); *id.* at 148 ("Guardrails [were] applied").

E. CMS's Removal Of Outlier Data

On June 2, 2020, after CMS had already adopted its guardrail regulation (in April 2019) and delayed implementation by one year (in April 2020), CMS made a separate change to its Star Rating calculation methodology: CMS decided to remove "Tukey outer fence outliers" ("Tukey outliers") from measure scores, before using those measure scores to generate cut points between Star Ratings. 85 Fed. Reg. 33,796, 33,907-08 (2020). CMS implemented this change to begin with the "2024 Star Ratings" issued in October 2023, the ones at issue in this case. *Id.* at 33,836.

That "Tukey outliers" jargon reflects another concept familiar to students: When grading on a curve, a professor might choose to ignore the handful of extraordinary high and low performers (*e.g.*, those scoring a perfect 100% or a 15%), and set the cut point for an A, B, or C based on the typical students in the, say, 40% to 90% range. Here, too, CMS would simply ignore

extreme outlier measure scores in determining cut points: "Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering [to set cut points], Tukey outer fence outliers are removed." 42 C.F.R. § 422.166(a)(2)(i); *id.* § 423.186(a)(2)(i). After removing Tukey outliers, CMS engages in the same "clustering" process described above to determine "cut points" between Star Ratings. *Id.* CMS then applies a guardrail to prevent cut points from changing more than 5 percentage points from one year to the next. *Id.*

In sum: The new "Tukey outliers" process changes the "cut points" between Star Ratings, because CMS is ignoring part of its data—the outliers—and determining cut points without them.

F. CMS Violated Its Own Regulation In Calculating SCAN's 2024 Star Rating

When CMS implemented its new "Tukey outliers" methodology for the first time to determine the 2024 Star Ratings issued in October 2023—the Star Ratings at issue here—CMS violated its regulation by calculating the 2024 Star Rating cut points without applying the 5 percentage point guardrail, relative to the *actual* cut points from the 2023 Star Ratings.

CMS's new "Tukey outliers" methodology had a key effect when it was first applied: For many measures, the methodology resulted in massive shifts in cut points.[6] Here is an example, showing how CMS calculated cut points for the measure "D01"—which measures availability of interpreters on Part D drug-benefit customer service calls—in the 2023 Star Ratings (without the Tukey outlier method) and 2024 Star Ratings (when CMS applied the Tukey outlier method): [7]

Year	1 star	2 stars	3 stars	4 stars	5 stars
2023 Ratings (Without Tukey method)	Under 30%	≥ 30%	≥ 64%	≥ 80%	≥ 91%
2024 Ratings (With Tukey method)	Under 73%	≥ 73%	≥ 86%	≥ 96%	≥ 99%
Difference From 2023 to 2024 Ratings		43%	22%	16%	8%

[6] *Compare* Ex. 7 at 35-113 (2023 Star Ratings Technical Notes) (2023 Star Rating cut points) *with* Ex. 8 at 40-112 (2024 Star Ratings Technical Notes) (2024 Star Rating cut points).

[7] *See* Ex. 7 at 88 (2023 cut points); Ex. 8 at 88 (2024 cut points); Ex. 1 to Plumb Decl. at 7.

As the final row shows, CMS's adoption of the Tukey outlier method in the 2024 Star Ratings caused each cut point to increase far more than CMS's 5 percentage point guardrail, with cut points increasing between 8 percentage points (5 stars) and 43 percentage points (2 stars) relative to the 2023 Star Rating cut points set a year earlier. For example, as relevant to SCAN, its plan scored a 92% score on this measure ("D01"), which would have been a 4-star rating under application of the 5 percentage point guardrail, but was now a 3-star rating without the guardrail.[8]

In September 2023, CMS notified SCAN that its overall Star Rating had dropped from 4.5 stars to 3.5 stars. Plumb Decl. ¶ 33. SCAN was prepared for the possibility of receiving a 4-star rating consistent with recent changes in CMS's regulations, but was surprised to see a further drop from 4 stars to 3.5 stars. *Id.* ¶¶ 32-34. SCAN identified that this drop was caused by CMS's sudden change in cut points—disregarding the 5 percentage point guardrail relative to the prior year cut points. *Id*. SCAN immediately contacted CMS to alert it to the error, and requested that CMS recalculate SCAN's Star Rating in accordance with CMS's regulation. Ex. 1 at 5-7.

CMS rejected SCAN's request. *Id.* at 4-5. CMS responded that, in its preamble to its June 2020 Final Rule adopting its new regulation providing for the use of the Tukey outlier deletion method starting with the 2024 Star Ratings, CMS had stated that "in the first year of implementing this [Tukey] process, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years." Ex. 1 at 4-6 (citing 85 Fed. Reg. 33,833 (2020)). CMS took the position that

[8] Ex. 5 to Plumb Decl. at 5 (92% score). Because the cut point for a 4-star rating was $\geq$ 80% in the 2023 Star Ratings, application of a 5 percentage point guardrail relative to the 2023 Star Ratings would mean that the 2024 Star Rating cut point for a 4-star rating would have been $\geq$85%. 42 C.F.R. § 423.186(a)(2)(i). As another example of this same problem, a plan that achieved an 85% score would have received 4 stars on measure D01 in 2023, but would have received only 2 stars on measure D01 in 2024 despite having the exact same 85% measure score.

this meant that CMS could calculate *simulated* 2023 Star Rating cut points using the Tukey outlier deletion method (a method that had not yet been in effect when CMS *actually* calculated the 2023 Star Ratings a year earlier). *Id.* CMS stated that the simulated, "rerun 2023 Star Ratings cut points serve as the basis for the guardrails for the 2024 Star Ratings." *Id*. In other words, CMS asserted that the 5 percentage point guardrail for the 2024 Star Rating cut points should be applied *not* relative to the *actual* 2023 Star Rating cut points, but to *simulated* 2023 Star Rating cut points recalculated using the Tukey outlier method (which was not in effect at that time). *Id.*

CMS's departure from its 5 percentage point guardrail created catastrophic consequences for SCAN. Had CMS applied the guardrail in its regulation, SCAN would have received a Star Rating of 4 stars, and been eligible for approximately $250 million in funding from quality bonus payments. Plumb Decl. ¶¶ 34, 41-45, 55-58. As it stands, SCAN has already suffered serious harm to enrollment in its plans since CMS publicized its erroneous 3.5-star Star Rating, and faces imminent, catastrophic financial harm if this flawed Star Rating is allowed to stand. *Id.* ¶¶ 55-66.

G. CMS Relied On A Flawed Secret Shopper Call To Reduce SCAN's 2024 Star Rating

Besides failing to apply its required guardrail, CMS also improperly determined SCAN's 2024 Star Rating using an erroneous "C30" "Call Center—Foreign Language Interpreter and TTY Availability" measure. For this measure, CMS hires secret shoppers (auditors) to pose as consumers and call each plan's customer service line. Ex. 8 at 85 (2024 Star Rating Technical Notes). CMS tests this measure C30 to determine whether Medicare Advantage plans comply with CMS's regulation at 42 C.F.R. §§ 422.111(h)(1)(iii), which requires that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative . . . ." 42 C.F.R. § 422.111(h)(1)(iii).

On February 9, 2023, a CMS secret shopper posing as a French-speaking consumer called

SCAN's customer service line. Ex. 3 to Plumb Decl. at 15 (Technical Report to Reconsideration Decision) ("Reconsideration Decision"). During this call, SCAN's customer service representative connected the secret shopper with a French interpreter within 6 minutes and 35 seconds of the caller first reaching the representative. *Id.* at 19. So, an interpreter was "available" within 8 minutes, as CMS's regulation requires. 42 C.F.R. § 422.111(h)(1)(iii). Yet, in determining SCAN's score for the C30 measure, CMS asserted that more was required of SCAN, namely, that the C30 measure is only "completed" (*i.e.*, passed) "when the caller confirms that the CSR [customer service representative] is *able to answer questions* about plan benefits via an interpreter . . . within eight minutes." Ex. 3 at 17 (emphasis added).

As a result, CMS determined that the February 9, 2023 call had failed. *Id.* Even though the secret shopper confirmed an interpreter was on the line at 6:35, the secret shopper wasted most of the remaining time repeating her question in slow, difficult to understand language:

6:35: Interpreter: French Interpreter, everything you say will remain secret and confidential. How can I help you?

6:41: SCAN Customer Service Representative: Yes, thank you. I have someone on the line who speaks French. Please go ahead.

6:49: Interpreter: [In French] Hello. My name is Bernard, I am your French interpreter. Everything you say is going to be private and confidential.

7:01: Secret Shopper: [In French] Yes, good evening. So I have . . . I have a question.

7:05: Interpreter: [In French] Good evening.

7:07: [In French] Uh . . . are you the per-- . . . are you the right person to answer questions about the medical benefits of . . . uh . . . Village Health, H-M-O . . . P-O-S . . .C . . .-S-N-P?"

7:34: [In French] Interpreter: Excuse me ma'am. I missed that. The medical benefits of this village. Can you repeat it, please?

7:43: [In French] Secret Shopper: Yes, that's the name of the plan. It's Village Health, then H-M-O . . . P-O-S . . . C- . . .-S-N-P?

8:11: Interpreter: [in English] Are you the right person to answer questions about the plan Village Health, H-M-O P-O-S C-S-N-P?

8:26: [in English] Agent: Yes of course. How may I assist you?

8:31: [in French] Interpreter: Yes of course. What can I do for you?

Ex. 4 to Plumb Decl. at 17 (recording at 8:19); *id.* at 19-20 (transcript). CMS identified this call as outside the required 8-minute timeframe because of additional time needed to clarify the caller's poorly phrased and confusing inquiry. Ex. 3 at 18-19. Most significantly, the secret shopper spoke in an unusually slow manner, introducing pauses and interruptions that disrupted the shopper's own questions as they were asked. Ex. 4 at 17 (recording at 8:31); *id.* at 20 (transcript). Indeed, the secret shopper spent over 25 seconds asking a single question. *Id.* at 17, 20. These delays and interruptions forced the interpreter to ask the shopper to repeat the question, adding an unnecessary 34-second delay, of which 21 seconds were the caller repeating the name of the plan a second time. *Id.* On top of that, the secret shopper used an ambiguous French term—which has multiple and confusing English meanings—to refer to "medical benefits." *Id.*[9]

Thus, while SCAN had an interpreter available within 6 minutes and 35 seconds, and resolved the secret shopper's question in under 8 minutes (excluding the required time for the secret shopper to clarify and repeat her question), CMS determined the call was outside the 8-minute time limit because additional time was required to clarify the secret shopper's confusing

[9] The term "les avantages medicaux" can mean either "medical benefits" or "medical advantages."

inquiry. Nor was this secret shopper's lack of clarity anything like other secret shoppers: Another secret shopper called SCAN to pose exactly the same question in French, and took just 18 seconds to state the question (not over 25 seconds), and 41 seconds from start to finish to state the question, have it interpreted, and have it answered (not 86 seconds). *Compare* Ex. 4 at 17 (February 9, 2023 recording at 8:31) *with id.* at 29 (March 24, 2023 recording at 3:53). The only difference between the two calls was the manner of speech of CMS's secret shopper. *Id.* CMS nonetheless included the February 9, 2023 secret shopper's call as a data point in SCAN's Star Rating for measure C30, triggering a reduction of that measure from 5 to 4 stars. Ex. 4 at 13 (request for hearing). That, in turn, triggered a reduction in SCAN's overall Star Rating from 4 to 3.5 stars. *Id*. Without including that call in CMS's analysis (or, by counting it as a "pass," rather than a "fail"), SCAN's overall Star Rating would have been 4 stars. *Id*.

On November 10, 2023, SCAN submitted a Request for Reconsideration of CMS's determination of SCAN's Star Rating measure C30. Ex. 2 to Plumb Decl. On February 22, 2024, CMS rejected SCAN's Request. Ex. 3 at 7, 19-20. Although CMS did not dispute the secret shopper's delays caused the call to exceed 8 minutes, CMS found that because the shopper had been on hold for 6 minutes 35 seconds, any delay beyond that point caused by her was irrelevant. *Id.* at 19 ("SCAN call center wasted the first six and a half minutes waiting for an interpreter.").

On February 29, 2024, SCAN submitted a request for an informal hearing, requesting that CMS overturn its determination that the February 9, 2023 call had failed to meet its "available within 8 minutes" standard for measure C30. Ex. 4 at 7-8, 13.

H. CMS's Unlawful Conduct Has Caused—And Will Continue To Cause—SCAN Irreparable Harm

CMS's fundamentally flawed 3.5-star Star Rating has caused, and will continue to cause, irreparable harm to SCAN. Plumb Decl. ¶¶ 55-66. SCAN's Star Rating is a critical factor in

determining CMS's payments to SCAN, and directly impacts benefits and related services that SCAN is able to offer. *Id.*; 42 U.S.C. § 1395w–23(o).

On June 3, 2024, SCAN will submit a bid to CMS for renewal of its Medicare Advantage contract, outlining the services it commits to provide Medicare beneficiaries in the 2025 plan year. Plumb Decl. ¶ 12. This bid, together with SCAN's 2024 Star Ratings, determines the funding SCAN will receive from quality bonus payments. *Id.* ¶¶ 20-21; *supra* at 8-9. By reducing SCAN's 2024 Star Rating to 3.5 stars, CMS has rendered SCAN ineligible for approximately $250 million in funding from quality bonus payments. Plumb Decl. ¶¶ 57-58. This loss will severely impair SCAN's ability to provide existing, much less enhanced services to its members. *Id.* ¶ 60. And because CMS's 3.5-star Star Rating erroneously signals to beneficiaries that SCAN's plan quality has dropped markedly, and is inferior to the quality of its competitors' plans, CMS's rating has already irreparably harmed SCAN's competitive position, reputation, and goodwill, and undermined its ability to gain and retain members. *Id.* ¶¶ 61-66.

Faced with the impending June 3, 2024 deadline for submitting bids to CMS, SCAN filed its Complaint on December 29, 2023. Dkt. 1. After discussions with Defendants' counsel about how to organize the case efficiently and avoid the need for preliminary injunction proceedings, on February 23, 2024, SCAN and Defendants agreed to a stipulated briefing schedule for expedited summary judgment, with the goal of resolving the parties' dispute prior to SCAN's June 3, 2024 bid deadline. Dkts. 19-20.

ARGUMENT

A court "shall . . . hold unlawful and set aside agency action . . . found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. §§ 706(2)(A), (2)(C); *see also* 5 U.S.C. § 702. CMS's determination of SCAN's 2024 Star Rating

is all of these, and SCAN is therefore entitled to summary judgment.

I. CMS Violated Its Regulation Governing The Calculation Of Star Ratings, Which Required CMS To Apply A 5 Percentage Point Guardrail

CMS disregarded its binding regulations governing the determination of SCAN's 2024 Star Rating. Here, CMS improperly determined SCAN's 2024 Star Rating by using cut points that CMS developed based (in part) on *simulated* 2023 Star Rating measure cut points, rather than the *actual* 2023 Star Rating measure cut points, as its regulations required. And even if CMS was allowed to run a simulation of the 2023 Star Rating cut points (it was not), in generating the simulated 2023 Star Rating cut points, CMS did not apply *any guardrail* at all to limit changes in the simulated 2023 Star Rating cut points relative to the 2022 Star Rating cut points. CMS's refusal to apply the required guardrail erroneously reduced SCAN's Star Rating to 3.5 stars.

A. *CMS Violated Its Regulation By Using A Simulation Of The 2023 Star Rating Cut Points To Determine SCAN's 2024 Star Rating*

CMS's regulations in 42 C.F.R. § 422.166(a)(1)-(2) and § 423.186(a)(1)-(2) required CMS to calculate SCAN's 2024 Star Rating by applying a 5 percentage point guardrail to limit changes in the 2024 Star Rating cut points relative to the *actual* cut points that CMS determined in calculating its 2023 Star Ratings a year earlier. CMS failed to do so here.

Initially, it is undisputed by all parties, including CMS, that CMS's regulations required CMS to calculate SCAN's 2024 Star Rating by applying a 5 percentage point guardrail to limit the 2024 Star Rating cut points *relative to some other dataset*. The only question is: Is the dataset that sets the baseline for the 5 percentage point guardrail on the 2024 Star Rating cut points (i) the *actual* 2023 Star Rating cut points (as SCAN argues), or (ii) *simulated* 2023 Star Rating cut points (as CMS argues). Here, the plain text of the regulations compels the former calculation.

Tellingly, CMS did not dispute in the record below that CMS's regulations required CMS to apply a 5 percentage point guardrail to the prior year's *actual* cut points in determining the

2024 Star Rating cut points. *See* Ex. 1 at 2-6. No wonder: CMS did exactly that one year earlier. Specifically, when CMS applied its 5 percentage point guardrail regulation for the first time in October 2022, CMS determined cut points for the 2023 Star Ratings by applying a 5 percentage point guardrail based on the *actual* cut points from the 2022 Star Ratings. *See* Ex. 7 at 18 (2023 Star Rating Technical Notes) ("[E]ach 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 . . . ."); *id.* at 148 (applying "5 percentage point" guardrail to the "prior year's cut point").

CMS's determination back then adhered to its unambiguous regulations. *See* 42 C.F.R. § 422.166(a)(2); *id.* § 423.186(a)(2). CMS's regulations provide that, each year, CMS "will determine cut points for the assignment of a Star Rating for each numeric measure score by applying [] a clustering . . . methodology." *Id.* § 422.166(a)(1); *see also* 42 C.F.R. § 422.162(a), (a)(2)(i) (CMS determines "four cut points" using "clustering"); *id.* § 423.186(a)(1); *id.* § 422.166(a), (a)(2)(i) (same). Once these cut points are calculated, CMS then imposes a guardrail on how far the cut points can move relative to the prior year's actual cut points:

> Effective for the Star Ratings issued in October 2022 and subsequent years, CMS will add a guardrail so that the *measure-threshold-specific cut points* for non–CAHPS measures do not increase or decrease more than the value of the cap *from 1 year to the next*. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap).

42 C.F.R. § 422.162(a)(2) (emphases added); *see also* 42 C.F.R. § 423.186(a)(2) (same for Part D). The regulations thus require CMS to ensure that "the measure-threshold-specific cut points" do not change "more than the value of the [5 percentage points] cap" "from 1 year to the next," and do not provide for use of simulated cut points. *See id.*

CMS's regulations further provide that this "guardrail" is determined based on a 5 percentage point "absolute percentage cap," which CMS has defined as "a cap applied to non–

CAHPS measures that are on a 0 to 100 scale that restricts movement of the current year's measure-threshold-specific cut point to no more than the stated percentage as *compared to the prior year's cut point*." *Id.* § 422.162(a) (emphasis added); *see also id.* § 423.186(a) (same). And CMS defines a "guardrail" as "a bidirectional cap that restricts both upward and downward movement of a measure-threshold-specific cut point for the current year's measure-level Star Ratings as compared to *the prior year's measure-threshold-specific cut point*." *Id.* § 422.162(a) (emphasis added); *id.* § 423.182(a) (same). Taking a belt-and-suspenders approach, CMS has defined this "cap" or "cut point cap" as "a restriction on the change in the amount of movement a measure-threshold-specific cut point can make as compared to the prior year's measure-threshold-specific cut point." *Id.*

Taken together, CMS's regulations required CMS to determine its 5 percentage point guardrail for the 2024 Star Rating cut points using the actual 2023 Star Ratings cut points, not simulated cut points. But CMS nonetheless determined the 2024 Star Ratings cut points by applying a 5 percentage point guardrail based on *simulated* 2023 Star Rating cut points, which differed from the actual cut points used in the 2023 Star Ratings. *See* Ex. 1 at 2-6; Ex. 8 at 159 (2024 Star Rating Technical Notes) ("For the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun . . . These rerun 2023 Star Ratings cut points serve as the basis for applying the guardrails for the 2024 Star Ratings.").

This alone should be sufficient to resolve this case: CMS needed to determine its guardrail for the permissible change in the 2024 Star Rating cut points based on a 5 percentage point change compared to the *actual* 2023 Star Rating cut points. Had CMS simply done so, SCAN's overall Star Rating would not have fallen to 3.5 stars; rather, it would have been 4 stars. Plumb Decl. ¶¶ 34, 41-45. That should be dispositive. But, as detailed below, even if CMS was allowed to rely on simulated 2023 Star Rating cut points, the design of CMS's simulation had additional, and

outcome determinative, problems of its own.

B. *CMS's Simulation Also Violated Its Regulations By Deleting Tukey Outliers And Disregarding Its Guardrail Relative To The 2022 Star Ratings*

Setting aside that CMS's use of a simulation of the 2023 Star Rating cut points alone violated CMS's regulation, CMS made two further departures from its binding regulations in how it designed its simulation of the 2023 Star Rating cut points. These departures caused CMS's 2024 Star Rating cut points to change dramatically relative to the 2023 Star Rating cut points.

1. *CMS's simulated 2023 Star Rating measure score data removed Tukey outliers without regulatory authority*

CMS's first departure from its regulations is that, in its simulation of the 2023 Star Rating cut points, CMS removed Tukey outliers from the 2023 Star Rating measure score data. Ex. 8 to Plumb Decl. at 159 (2024 Star Rating Technical Notes) ("the 2023 Star Ratings cut points were rerun including . . . Tukey outlier deletion . . . .").

As explained above, CMS's choice to apply Tukey outlier deletion in its simulation of the 2023 cut points had the effect of *discarding* vast amounts of data that CMS *had used* to determine the *actual* 2023 Star Ratings a year earlier. CMS's application of the Tukey outlier deletion method thus caused the simulated 2023 Star Rating cut points to drastically depart from the actual 2023 Star Rating cut points.[10] (Much like a professor calculating the curve for a class by ignoring the extreme high- and low-performers would change the grade cut points.) But CMS had not removed Tukey outliers in determining the *actual* 2023 Star Rating cut points in 2022, because CMS's regulation provided that "*Effective for the [2024] Star Ratings issued in October 2023 and subsequent years* . . . Tukey outer fence outliers are removed." 42 C.F.R.

[10] *Compare* Ex. 8 at 159-60, Table K-7, K-8 (2024 Star Ratings Technical Notes) (simulated 2023 Star Rating cut points) *with* Ex. 7 at 35-113 (2023 Star Ratings Technical Notes) (actual 2023 Star Rating cut points).

§§ 422.166(a)(2)(i), 423.186(a)(2)(i) (emphasis added). So CMS's simulation of the 2023 Star Rating cut points improperly removed Tukey outliers one year before its regulations permitted.

2. *In calculating its simulated 2023 Star Rating cut points, CMS failed to apply guardrails relative to the 2022 Star Rating cut points*

The wild swings in CMS's simulated 2023 Star Rating cut points caused by the deletion of Tukey outliers could have been limited, if CMS had simply applied its 5 percentage point guardrail *when it generated its simulation*. Instead, in its simulation of the 2023 Star Rating cut points, CMS *entirely disregarded* the guardrail that was supposed to restrict how far the 2023 Star Rating cut points could move, relative to the 2022 Star Rating cut points. Ex. 8 at 159 (2024 Star Rating Technical Notes).

As CMS explained, "For the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun including mean resampling, Tukey outlier deletion *and no guardrails*." *Id.* (emphasis added). This caused the simulated 2023 Star Rating cut points to drastically depart from the actual 2022 Star Rating cut points that were supposed to set a guardrail on how far the 2023 Star Rating cut points could change from 2022.[11] By contrast, CMS *had applied* a 5 percentage point guardrail, relative to the 2022 Star Rating cut points, in determining the *actual* 2023 Star Rating cut points a year earlier, because CMS's regulation provided that "Effective for the [2023] Star Ratings issued in October 2022 and subsequent years, *CMS will add a guardrail* so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next." 42 C.F.R. §§ 422.166(a)(2)(i), 423.186(a)(2)(i) (emphasis added). So CMS's simulation again

[11] *Compare id.* at 159-60, Table K-7, K-8 (2024 Star Ratings Technical Notes) (simulated 2023 Star Rating cut points) *with* Ex. 6 at 36-90 (2022 Star Ratings Technical Notes) (actual 2022 Star Rating cut points).

violated the plain language of its regulations, by applying no guardrails in a year when CMS's regulations required that "CMS will add a guardrail." *Id.*; *see also Hewitt v. Helms*, 459 U.S. 460, 471 (1983) ("Will," "shall," and "must" have an "unmistakably mandatory character."), *overturned in part on unrelated grounds, Sandin v. Conner*, 515 U.S. 472, 482 (1995).

3. *CMS's errors designing the simulated 2023 Star Rating cut points caused a drastic shift in the 2024 Star Rating cut points, which goes against the plain text and purpose of the guardrails regulation*

Taken together, in CMS's simulation, (i) the removal of Tukey outliers from the simulated 2023 Star Rating measure score data—absent any regulatory authorization—and (ii) the removal of guardrails relative to the 2022 Star Rating cut points—again, absent any regulatory authorization—caused CMS's simulated 2023 Star Rating cut points to change dramatically from the actual 2023 Star Rating cut points. *Supra* at 24-26. As detailed below, these wild swings in CMS's cut points caused SCAN's overall Star Rating to plummet from 4.5 stars to 3.5 stars in just one year. As a result, SCAN's Star Rating no longer provided a "true reflection of the plan's quality" based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. at 16,521.

For example, CMS modified the actual 2023 Star Rating cut points for measure D01 (the Medicare Part D interpreter availability measure), as follows, in its simulation of 2023 Star Rating cut points:

Year	1 star	2 stars	3 stars	4 stars	5 stars
2023 (Actual Cut Points)[12]	Under 30%	≥ 30%	≥ 64%	≥ 80%	≥ 91%
2023 (Simulated Cut Points)[13]	Under 68%	≥ 68%	≥ 81%	≥ 91%	≥ 97%
Difference (Actual v. Simulation)		38%	23%	11%	6%

[12] Ex. 7 at 88 (2023 Star Ratings Technical Notes).

[13] Ex. 8 at 160 (2024 Star Ratings Technical Notes).

As detailed above, this simulation matters because CMS used these simulated 2023 Star Ratings as the basis to apply a 5 percentage point guardrail to the 2024 Star Rating cut points. *Supra* at 21-23. That is, CMS decided the 2024 Star Ratings could not vary more than 5 percentage points relative to the *simulated* 2023 Star Rating cut points. Ex. 8 at 159 (2024 Star Rating Technical Notes) ("[t]hese rerun 2023 Star Ratings cut points serve as the basis for applying the guardrails for the 2024 Star Ratings . . ."). This allowed CMS's 2024 Star Rating cut points to balloon upward, relative to the *actual* 2023 Star Rating cut points; for example, on measure D01:

	1 star	2 stars	3 stars	4 stars	5 stars
1. 2023 (Actual Cut Points)[14]	Under 30%	≥ 30%	≥ 64%	≥ 80%	≥ 91%
2. 2023 (Simulated Cut Points)[15]	Under 68%	≥ 68%	≥ 81%	≥ 91%	≥ 97%
3. 2024 (CMS's Cut Points)[16]	Under 73%	≥ 73%	≥ 86%	≥ 96%	≥ 99%
4. 2024 (Corrected Cut Points)	Under 35%	≥ 35%	≥ 69%	≥ 85%	≥ 96%
5. Change from CMS's 2024 Cut Points to Corrected 2024 Cut Points	38%	38%	17%	11%	3%

As this table illustrates, applying the 5 percentage point guardrail to the *actual* 2023 Star Rating cut points (row 1) would have produced only limited changes in the 2024 Star Rating cut points (row 4). But instead, CMS re-ran *simulated* 2023 Star Rating cut points (row 2), and used those *simulated* cut points to find that the 2024 Star Rating cut points had not changed in excess of the 5 percentage point guardrail, relative to the *simulated* 2023 Star Rating cut points (row 3).

Because CMS's simulation of the 2023 Star Ratings departed from its regulations in multiple ways, CMS determined cut points for the 2024 Star Ratings that changed by far more than 5 percentage points from CMS's *actual* 2023 Star Rating cut points, in violation of 42 C.F.R. §§ 422.166(a)(2)(i), 423.186(a)(2)(i). These massive changes in cut points, in one year's time,

[14] Ex. 7 at 88 (2023 Star Ratings Technical Notes).

[15] Ex. 8 at 160 (2024 Star Ratings Technical Notes).

[16] Ex. 8 at 88 (2024 Star Ratings Technical Notes).

defeated the very "predictability of the cut points" from one year to the next that CMS had emphasized in adopting its guardrails in the first place. 84 Fed. Reg. 15,680, 15,754 (2019).

C. *CMS Cannot Excuse Its Violation Of Its Regulation By Relying On Uncodified Preambles Published In The Federal Register*

When SCAN challenged CMS's application of the unlawful 2024 Star Rating cut points to SCAN, CMS did not rely on its regulation to justify its decision, but rather pointed to Federal Register preambles that, in CMS's view, control. Ex. 1 at 2-6. To be sure, those preambles provide that, to implement the Tukey outlier deletion method in the first year, "the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years." 85 Fed. Reg. 33,833, 33,835 (2020); 85 Fed. Reg. 9,044 (2020) (same); *see also* Ex. 1 at 2-6 (citing these preambles). CMS claimed that these preambles authorized it to use simulated 2023 Star Rating cut points as the basis for its 2024 Star Rating guardrails. Ex. 1 at 2-6. That is simply wrong.

1. *CMS's codified regulations in the Federal Register control over CMS's uncodified Federal Register Preambles*

It is black letter law that an agency's action is contrary to law and "arbitrary and capricious if the agency fails to 'comply with its own regulations.'" *Nat'l Env't Dev. Ass'ns Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014) ("an agency is bound by its own regulations"). And where, as here, an agency purports to promulgate a Federal Register preamble that contradicts its unambiguous regulation, the regulation controls over the preamble.

For example, in *AT&T Corporation v. Federal Communications Commission*, the D.C. Circuit rejected the agency's view that "its explanatory statements, published in the Federal Register, should be treated as part of the binding regulation." 970 F.3d 344, 350 (D.C. Cir. 2020). That is because "the 'real dividing point' between the portions of a final rule with and without legal force is designation for 'publication in the Code of Federal Regulations.'" *Id*. Thus,

"where, as here, there is a discrepancy between the preamble and the Code, it is the codified provisions that control." *Id.* at 351. "For example, if a preamble purports to establish the regulatory treatment of [a specific issue] but the regulations as published in the Code do not, then the preamble statement is a nullity." *Id.* The D.C. Circuit's decision in *AT&T Corporation* dictates the result here: It was the "codified provisions" in 42 C.F.R. § 422.166(a)(2)(i) and 42 C.F.R. § 423.186(a)(2)(i) "that control" CMS's obligations here, not CMS's "preamble." *See id.*

Case after case reaffirms the D.C. Circuit's holding. As this Court has previously explained, while the "preamble to a . . . rule may be used to help inform the proper interpretation of an ambiguous text," a Federal Register "preamble cannot, however, be used to contradict the text of the . . . rule at issue." *Tex. Children's Hosp. v. Azar*, 315 F. Supp. 3d 322, 334 (D.D.C. 2018). Accordingly, "[a]n agency interpretation that conflicts with an unambiguous regulation is substantively invalid." *Eco Tour Adventures, Inc. v. Zinke*, 249 F. Supp. 3d 360, 372 (D.D.C. 2017). Thus, where, as here, the "actual regulatory text included a step-by-step guide" for a given calculation by an agency, that text controls instead of the preamble; and to the extent that the regulation "is contradicted by the Rule's Preamble, the [regulation's] definition controls." *Tex. Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224, 237 (D.D.C. 2014) ("A preamble does not create law; that is what a regulation's text is for."). In sum: Where an agency's "regulation itself is clear, [a court] need not evaluate . . . the preamble, which itself lacks the force and effect of law." *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 297 (D.C. Cir. 2018).

That well-established law explains *why*, when CMS has chosen to make one-year *ad hoc* adjustments to its rules for calculating Star Ratings in the past, it has consistently published those one-year adjustments in the Code of Federal Regulations. *See, e.g.*, 42 C.F.R. § 422.166(f)(1)(i) (stating rules to apply "For the 2022 Star Ratings only"); *id.* § 422.166(i)(11) (same); *id.*

§ 422.166(i)(12) (providing "Special rules for the 2023 Star Ratings only"); *id.* § 422.166(j) (stating "Special rules for 2021 and 2022 Star Ratings only"). Indeed, the very regulation in dispute here reflects such a one-year ad-hoc adjustment, as CMS delayed its new guardrail rule by one year due to the COVID-19 pandemic, to become "[e]ffective for the Star Ratings issued in October 2022," not in October 2021 as CMS initially planned. 42 C.F.R. § 422.166(a)(2)(i); 42 C.F.R. § 423.186(a)(2)(i). CMS knows full well that it needs to codify regulations in the Code of Federal Register for them to have the force and effect of law: it just chose not to do so here.

2. *CMS's uncodified Federal Register Preambles cannot vary CMS's codified regulation for two, additional reasons specific to this case*

On top of these settled legal principles, CMS's reliance on uncodified Federal Register preambles is also unavailing for two, more specific reasons particular to this case.

The first is that CMS's preambles provided no notice whatsoever, much less opportunity for notice and comment, that CMS would simulate the 2023 Star Rating cut points with "no guardrails" relative to the 2022 Star Ratings, as it did here. *Supra* at 28; Ex. 8 at 159 (2024 Star Rating Technical Notes) ("the 2023 Star Ratings cut points were rerun including . . . no guardrails"). Instead, CMS stated that "the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years." 85 Fed. Reg. at 33,833; *see also* 85 Fed. Reg. at 9,044 (similar statement in the proposed rule). Far from CMS providing notice that "no guardrails" would apply, CMS's preamble literally stated that "guardrails would be applied" in order to provide "consistency between the years." 85 Fed. Reg. at 33,835.

Without notice of CMS's *actual* "no guardrails" proposal, SCAN and other plans were deprived of the opportunity to comment on CMS's proposal to run a simulation removing guardrails (since applying guardrails would have greatly limited the impact of removing Tukey

outliers in CMS's simulation). *See, e.g.*, *Nat. Res. Def. Council v. Wheeler*, 955 F.3d 68, 83–84 (D.C. Cir. 2020) (modifying "pre-existing legal obligations" requires "notice-and-comment").

Notably, this "no guardrails" error is independently sufficient to grant SCAN relief, even if the Court were to conclude that CMS's Federal Register preamble controls over its regulation. That is, even if CMS were correct (it is not) that the Federal Register preambles control over CMS's regulations and allowed CMS to run a simulation of the 2023 Star Ratings using the Tukey outlier deletion method, CMS's Federal Register preambles *never mentioned the removal of guardrails*. 85 Fed. Reg. at 33,835. To the contrary, the regulation stated that "CMS will add a guardrail," 42 C.F.R. § 422.166(a)(2)(i), 42 C.F.R. § 423.186(a)(2)(i), and the preamble likewise stated that "guardrails would be applied." 85 Fed. Reg. at 33,835. CMS's adoption of "no guardrails" relative to the 2022 Star Rating cut points to generate its simulation of the 2023 Star Rating cut points caused SCAN's Star Rating to decline from 4 stars from 3.5 stars, even assuming CMS could permissibly act contrary to its regulation by stating in the Federal Register that it would run a simulation using Tukey outlier deletion.[17]

Second, CMS overlooks the actual history of the preambles it relies on, which CMS itself

[17] CMS's "no guardrails" error was sufficient to lower SCAN's 2024 Star Rating from 4 stars to 3.5 stars, based on CMS's measure C08, "Osteoporosis Management in Women who had a Fracture." For the 2024 Star Ratings, CMS set a cut point of 55% on measure C08 to earn a 4-star Star Rating, using its simulation of the 2023 Star Ratings with "no guardrails." Ex. 8 at 159 (2024 Star Ratings Technical Notes) (measure C08 2023 cut point simulation); *id.* at 51-52, 155 (measure C08 2024 cut point). But if CMS had restricted its simulation of the 2023 Star Rating cut points with guardrails relative to the actual 2022 Star Rating cut points, the simulated 2023 cut point for a 4-star Star Rating on measure C08 would have been 55% (not 60%), and the 2024 Star Rating cut point for 4 stars for measure C08 would have been 50% (not 55%). *Id.*; Ex. 6 at 44 (2022 Star Ratings Technical Notes) (measure C08 2022 cut points). Thus, if CMS had applied guardrails relative to the 2022 Star Ratings, as it was supposed to, SCAN's 2024 Star Rating for measure C08 would have been 4-stars, and, more importantly, its overall Star Rating would have been 4 stars. *Id.*; Ex. 8 at 155 (measure C08 2024 cut points prior to application of guardrails); Ex. 5 at 3 (reflecting 53% score for measure C08); Plumb Decl. ¶¶ 44-45.

overturned in May 2022. After issuing its June 2020 preamble stating that CMS would now adopt "Tukey outer fence outlier deletion" and that, in the "first year of implementing this process" "the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion," 85 Fed. Reg. at 33,833, CMS *removed its Tukey outlier deletion method* from its regulation in May 2022. 87 Fed. Reg. 27,704, 27,895 (2022) (revising § 422.166(a)(2)(i) to remove the Tukey outlier methodology); *id*. at 27,900 (revising § 423.186(a)(2)(i) to remove the Tukey outlier methodology); 42 C.F.R. § 422.166(a)(2)(i) (2022) (deleting the Tukey outlier methodology from regulation); 42 C.F.R. § 423.186(a)(2)(i) (2022) (same). Of course, the new Tukey outlier deletion methodology was the entire *reason* CMS had stated in its June 2020 preamble that it would need to "rerun" a simulation of the 2023 Star Ratings to include the new Tukey outlier methodology in the first year in which the new methodology was adopted (*i.e.*, the 2024 Star Ratings). 85 Fed. Reg. at 33,835. That is, it would make no sense to run a simulation using a new Tukey outlier methodology that CMS had just deleted from its regulation. *Id.*

To be sure, a year later in April 2023, CMS added the Tukey outlier deletion text back into its regulations, claiming that the text had been "inadvertently removed from the codified regulation text" by mistake. 88 Fed. Reg. 22,120, 22,295 (2023). But in proposing to revive in 2023 the text that CMS had deleted from its regulation in 2022, CMS never proposed to *also* revive any specialized procedure to introduce the Tukey outlier deletion in the first year it was implemented by running a simulation. *See generally* 87 Fed. Reg. 79,452, 79,635 (2022) (Proposed Rule). CMS provided no opportunity to comment on any alleged intention to resuscitate its 2020 simulation preamble concerning "rerunning" simulated cut points: CMS only proposed to resuscitate its regulatory text *alone* through a "technical amendment to fix this codification error." *Id.*; *see also Nat. Res. Def. Council*, 955 F.3d at 83–84. So CMS's 2020

preamble allegedly providing for a simulation of the 2023 cut points had no further force and effect, once CMS vacated the very regulation that formed the entire basis for that preamble. *See Nat. Res. Def. Council*, 955 F.3d at 83 (an "interpretive rule" "derive[s] a proposition from an existing document" like a "regulation," rather than the interpretive rule "creating legal effects").

In sum, CMS's determination of SCAN's 2024 Star Ratings using a *simulation* of the 2023 Star Rating cut points, without applying *any guardrail* relative to the 2022 Star Rating cut points, was arbitrary and capricious and contrary to law for all the reasons identified above, and should be set aside.

II. CMS Improperly Determined That A Single Secret Shopper Call Should Lower SCAN's Star Rating From 4 Stars to 3.5 Stars

If the Court resolves SCAN's first claim in its favor, there is no need to proceed further: The first claim alone would result in a favorable recalculation of SCAN's 2024 Star Rating as 4 stars, providing SCAN complete relief.[18] But SCAN's second claim likewise provides a complete and independent basis for relief: CMS improperly determined that SCAN had failed the "C30" "Call Center—Foreign Language Interpreter and TTY Availability" measure on a February 9, 2023 secret shopper call. The call failed because it took more than 8 minutes for the caller to state her question in French, repeat and clarify the question, and receive an answer.

But there are two problems with CMS's position. First, CMS flouted its regulation, which requires only that an interpreter be "available" within 8 minutes, *i.e.*, connected to the call. Here, the secret shopper was indisputably connected to the interpreter within 6 minutes 35 seconds. CMS violated its regulation by *also* requiring the caller to state, repeat, and have her inquiry

[18] More specifically, if SCAN were to prevail on its first claim, it would result in SCAN obtaining an overall 4-star Star Rating. If SCAN were to then *also* prevail on its second claim, it would not result in a further increase from 4 stars to 4.5 stars.

answered within an 8-minute time limit, well after the interpreter was "available." Second, CMS acted arbitrarily and capriciously when it found that it was proper for CMS to count against SCAN the extensive delay caused by CMS's own secret shopper—a delay quite unlike other secret shopper calls SCAN received—in determining that this call failed CMS's measure C30.

Excluding the February 9, 2023 secret shopper call from measure C30 (or correcting the call from a "fail" to a "pass") would result in measure C30 increasing from 4 stars to 5 stars, and raise SCAN's overall Star Rating to 4 stars. CMS should be required to do just that here.

A. *CMS's Determination That No Interpreter Was Available Within 8 Minutes On The February 9, 2023 Test Call Was Inconsistent With CMS's Own Regulation*

CMS violated its own regulation when it found that no interpreter was available within 8 minutes of reaching a customer service agent on the February 9, 2023 secret shopper call. Instead, CMS improperly required not only that the interpreter be available, but also that CMS's caller had her question posed, repeated, and answered within the 8-minutes timeframe.

CMS explained in its Reconsideration Decision below that "CMS monitors plan sponsors' Part C and Part D call centers to ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h) . . . for providing timely and accurate information." Ex. 3 at 14. Under its measure C30, "Interpreter Availability was tested to determine if the services were compliant with 42 C.F.R. §§ 422.111(h)(1)(iii) . . . which require[s] interpreters to be available for 80 percent of incoming calls requiring an interpreter within 8 minutes." *Id.* at 68 (CMS Call Center Monitoring Accuracy and Accessibility Study Technical Notes).

The governing regulation, 42 C.F.R. § 422.111(h)(1), requires that Medicare Advantage plans must "provide[] interpreters" and that "*interpreters must be available* for 80 percent of incoming calls requiring an interpreter *within 8 minutes of reaching the customer service representative* . . . ." 42 C.F.R. § 422.111(h)(1)(iii) (emphases added).

But here, an interpreter was "available . . . within 8 minutes of reaching the customer service representative" on the challenged February 9, 2023 call: The interpreter introduced himself at 6:35, reaffirmed to the caller, in French, that her questions would be secret and confidential at 6:49 (an ethical standard that CMS requires), received the caller's question beginning at 7:01, asked the caller to clarify part of the name of her requested health plan at 7:34, and the caller began repeating herself to facilitate the interpretation at 7:43. *Supra* at 17.

The interpreter was surely "available" at 6:35, under the unambiguous meaning of the term: "Available" simply means an interpreter is "present or ready for immediate use." Available, Merriam-Webster Dictionary (2024); *see also United States v. Soybel*, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"); *Fischbein v. Olson Research Grp., Inc*., 959 F.3d 559, 566 (3rd Cir. 2020) (same). "Available" in the temporal sense of "available . . . within 8 minutes" thus is defined by the *potentiality* of a future activity, not the *completion* of that activity, like a restaurant table or a rental car being "available" at a specified time. *See, e.g.*, *Soybel*, 13 F.4th at 595 ("available" means "readiness for . . . immediate use"). Here, the interpreter was not just "present" or "ready" for immediate use at 6:35, he was *already providing interpretation services*. Ex. 3 at 19 (Reconsideration Decision); Ex. 4 at 20 (transcript).

CMS adopted this very interpretation of the word "available" when it promulgated this regulation. CMS explained that it was "finalizing § 422.111(h)(1)(iii)(B). . . to reflect the current compliance standard we used evaluating interpreter availability—80 percent of calls *being connected to an interpreter* within 8 minutes." 86 Fed. Reg. 6,007, 6,007 (2021) (emphasis added); *see also id.* at 6,008 (finalizing CMS's proposed rule that "an interpreter *must be connected to an interpreter* within the proposed 8 minutes . . . ." (emphasis added)). CMS explained that the reason it was codifying the new regulation was to "provid[e] plans clear

standards under which to operate their customer service call centers." *Id.*

So under the unambiguous meaning of CMS's governing regulation, SCAN had an interpreter "available" within 8 minutes, *i.e.*, "connected" within 8 minutes. CMS's contrary determination that an interpreter was unavailable within 8 minutes on the February 9, 2023 secret shopper call rested not on CMS's governing regulation, but on guidance documents that purport to tack on additional requirements, beyond the regulatory requirement to have an interpreter "available" within 8 minutes. As CMS stated in its Reconsideration Decision:

> Before CMS launched the 2023 study, it first reached out to plans via the annual Call Center Monitoring HPMS memo [Health Plan Management System] released on December 1, 2022. Within this memo CMS provided several key points of information, including *the definition of interpreter availability*. The memo notes, "*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."

Ex. 3 at 17 (Reconsideration Decision) (emphases added); *see also id.* at 23 (2023 Call Center Monitoring Guidance) (same). So, in CMS's current view, the interpreter must not only be *available*, but also complete the interpretative task of (i) receiving a secret shopper's question, (ii) clarifying any ambiguities the secret shopper's question, (iii) interpreting it into English, (iv) receiving a response from the customer service agent, and (v) interpreting that response into a foreign language, all within 8 minutes. *Id*. Thus, in CMS's view, SCAN was evaluated not based on an "*interpreter*" being "*available* . . . within 8 minutes," as required by its regulation, 42 C.F.R. § 422.111(h)(1)(iii)(B) (emphases added), but rather, when the "caller confirms that *the CSR [customer service representative] is able to answer questions* about plan benefits via an interpreter . . . within eight minutes." Ex. 3 at 17 (Reconsideration Decision) (emphasis added).

But once again, where there is a conflict between CMS's published regulations and its sub-regulatory guidance, CMS's published regulations must control. *AT&T Corp.*, 970 F.3d at 350; *supra* at 28-29 (collecting authority). Here, the legal requirement that CMS subjected to notice and comment was that "interpreters must be available . . . within 8 minutes of reaching the customer service representative . . . ." 42 C.F.R. § 422.111(h)(1)(iii). CMS told commenters that this meant a caller must be "connected to an interpreter within 8 minutes." 86 Fed. Reg. at 6,007-08. SCAN fulfilled that requirement on the February 9, 2023 test call, when the interpreter connected and began engaging in interactive dialogue with the secret shopper at the 6 minutes and 35 seconds mark. Ex. 3 at 19 (Reconsideration Decision); Ex. 4 at 20 (transcript).

CMS therefore violated its own regulation in determining that SCAN's interpreter was unavailable within 8 minutes on the February 9, 2023 secret shopper call.

B. *CMS's Determination That No Interpreter Was Available Within 8 Minutes On The February 9, 2023 Test Call Was Also Arbitrary And Capricious*

Apart from being contrary to law, CMS's determination of measure C30 for the challenged February 9, 2023 call was also arbitrary and capricious. SCAN's receipt of $250 million in funding from quality bonus payments—and the breadth of benefits that SCAN's over 280,000 members will receive in plan year 2025—hinged solely on one failed call and the happenstance of how clearly, quickly, and effectively a CMS *third-party contractor* was able to state her question and clarify herself in French (here, poorly). CMS does not dispute that these entirely extrinsic factors caused the test call to fail. Remarkably, CMS's decision embraces these as *appropriate* factors in its determination. CMS's decision was entirely arbitrary and capricious.

SCAN identified to CMS that it took CMS's secret shopper on the February 9, 2023 test call an unusually long 1 minute and 30 seconds to pose her question, then for her to clarify, repeat, and have it answered, which included a series of lengthy, unnatural pauses and repetitions

that made her question unintelligible to the interpreter:

> **7:01:** Secret Shopper: [In French] Yes, good evening. So I have . . . I have a question.
>
> **7:05:** Interpreter: [In French] Good evening.
>
> **7:07:** [In French] Uh . . . are you the per-- . . . are you the right person to answer questions about the medical benefits of . . . uh . . . Village Health, H-M-O . . . P-O-S . . .C . . .-S-N-P?"
>
> **7:34:** [In French] Interpreter: Excuse me ma'am. I missed that. The medical benefits of this village. Can you repeat it, please?
>
> **7:43:** [In French] Secret Shopper: Yes, that's the name of the plan. It's Village Health, then H-M-O . . . P-O-S . . . C- . . .-S-N-P?

Ex. 4 at 17 (recording at 8:31); *id.* at 20 (transcript). The call recording tells the story here: The secret shopper was noticeably struggling to state her question, and the interpreter plainly was unable to understand her slow, stumbling, effectuated language. *Id.* at 17, 20. This caused significant and unnecessary delay to answering her question. *Id.* By contrast, on a second call on March 24, 2023, it took another secret shopper just 41 seconds to clearly state the *identical* question in French and have it answered, 45 seconds less than the February 9, 2023 call. Ex. 2 at 5 (reconsideration request); Ex. 4 at 15 (hearing request); *id.* at 29 (March 24, 2023 call recording at 3:53). So SCAN *is* able to respond to a clear question in under a minute, well within CMS's purported 8-minute policy. Ex. 2 at 5, Ex. 4 at 15, 29. The difference between the two calls is the added time it took the first caller to repeat her question in slow, halting French.

Tellingly, CMS's Reconsideration Decision *did not dispute* that CMS's secret shopper had introduced roughly 45 seconds of delay, or that *SCAN's call would have met CMS's reinterpreted 8-minute requirement without that lengthy delay*. Instead, CMS stated it was *appropriate* to count any delays caused by the secret shopper against SCAN's Star Rating:

> Each person has a unique style of communication and to expect that each person will speak in the exact same way is not realistic. This applies to both the CMS callers and an individual Medicare beneficiary from the general public who is calling. The purpose of these test calls is to replicate the experience prospective members would have if they called the plan's toll-free number. How prospective members ask a question will differ from call to call.

Ex. 3 at 18 (Reconsideration Decision). Thus, in justifying the disparate outcomes on the February 9 and March 24 calls, CMS took the position that "CMS asked the same question on both calls, and any differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." *Id.* at 19.

This dismissive approach is fraught with many problems. First and foremost, it violates CMS's own guidance for the Star Ratings program, which requires CMS to evaluate plans "fairly and equally" based only on matters that are "under the control of the health or drug plan" to provide a "a true reflection of the plan's quality." 83 Fed. Reg. at 16,521, 16,560. The difference in the quality of speech of CMS's *secret shopper* has nothing to do with "the plan's quality." *Id.*

CMS claimed in its Reconsideration Decision that "CMS callers are trained to ask questions in a conversational way"—but the highly effectuated way the CMS caller asked the question with the long pauses and repetitions was not conversational. *Supra* at 38. Even more fundamentally, CMS has never provided any justification for why SCAN should be penalized to the tune of hundreds of millions of dollars based on "differences in the way they [the questions] were stated [by] the individual caller," as an appropriate criterion for "what CMS is testing." *Id.* In CMS's view, a call that is connected at 7:10 could still pass if the secret shopper spoke clearly and intelligibly, while a call connected a minute earlier could still fail if clarification and repetition were needed. CMS's failure to account for the delays introduced by its own caller was arbitrary and capricious, as CMS "failed to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

CMS claimed that it was not required to analyze the extensive delays caused by its contracted secret shopper in the "final seconds on a call," because the "SCAN call center wasted the first six and a half minutes [*sic*] [actually, 6:35] waiting for an interpreter." Ex. 3 at 19. CMS's explanation for its decision does not bear scrutiny.

To begin, CMS misses the point: The question is, could SCAN have responded to a clearly stated question within the remaining 1 minute 25 seconds *after* the interpreter was connected to the call? The answer is clearly "yes": That time is more than adequate time to respond to a caller speaking intelligibly, as demonstrated by a separate March 24, 2023 secret shopper call, where it took only 41 seconds for the secret shopper to state the same question clearly in French and have it answered immediately. *See supra* at 38-39. By completely ignoring that SCAN was capable of responding to a clear question in the allocated time, CMS again "failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43.

CMS also reasoned that "SCAN chose their interpreter service and, therefore, is responsible for the performance of the interpreter service" in taking 6 minutes 35 seconds to join the call. Ex. 3 at 19 (Reconsideration Decision). Not only is CMS's explanation wrong for all the reasons discussed above, it actually resolves the case *against* CMS: It is CMS that "chose" their secret shopper contractor, and following CMS's logic, it is CMS, not SCAN, that is "responsible" for the contractor's performance, since CMS hired them. *Id.*; *see also* Ex. 3 at 22 (CMS noting its selection of its preferred contractor). CMS has never justified why SCAN would be responsible for both the performance of its own contractor *and also CMS's contractor*. *See Biden v. Texas*, 142 S. Ct. 2528, 2543 (2022) (agency decision must be "reasonable and reasonably explained"). Nor does CMS's rationale of looking only to the amount of hold time bear scrutiny, given that CMS has never even analyzed the magnitude of real-world hold times

required to utilize the third-party interpretation services that are necessary to comply with CMS's interpretation-related mandates. 76 Fed. Reg. 21,432, 21,502, 21,547 (2011).

Notably, CMS's flat refusal to account for its contractor's performance after a 6 minute 35 second hold time is also inconsistent with CMS's guidance for its call monitoring program. Among other things, CMS's guidance states that CMS *does* take into account and excuses delays caused even by plans' *interpreters*, which, per CMS, a plan supposedly controls. In guidance CMS promulgated in 2016, CMS took the position that if an interpreter's deficient performance "successfully interpreting" undermined a plan's ability to respond to questions, CMS would *not* "count [that] against you." Ex. 10 to Plumb Decl. at 4 (available at CMS, "2016 Call Center Monitoring Questions and Answers," www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting). According to CMS, "we do have mechanisms where if you have the recorded conversation we can listen to it to see if there is a problem [with the interpreter] . . . . *If it is due to the failure strictly of the interpreter, I wouldn't hold that against you.*" *Id.* CMS takes the same approach to TTY (teletypewriter) calls (a service for the hearing impaired) that also are evaluated under measure C30, explaining that if anything "goes awry" with the "Call Center Monitoring contractor," "it does not count against you" and CMS would not "hold you accountable for anything that is not your fault." *Id.* at 3.

It therefore defies reason that CMS never justified its failure to account for the delay caused by its secret shopper on the February 9, 2023 call, in the same manner that CMS otherwise does throughout its call center monitoring program, and in evaluating measure C30 specifically. CMS therefore arbitrarily failed to treat "like cases alike." *Westar Energy, Inc. v. FERC*, 473 F.3d 1239, 1241 (D.C. Cir. 2007). Indeed, CMS could have simply taken the *same* approach here as it does throughout the rest of its call monitoring program, excusing any delay introduced

by the caller (or, for that matter, the interpreter). CMS's failure to consider that less-harsh alternative meant CMS failed to consider, as it must, an obvious "alternative[]" "within the ambit of the existing [policy]," *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020), and ignored an "important aspect of the problem." *State Farm*, 463 U.S. at 43.

Here is the core problem: CMS determined that even a single failed test call is enough to knock down a plan from a 5 Star Rating for measure C30 to a 4 Star Rating for measure C30, resulting in a $250 million loss to SCAN. Plumb Decl. ¶¶ 48-49. Measure C30 requires nearly a 100% pass rate to reach 5 stars.[19] Given the overwhelming economic consequences of just a single call, CMS must satisfy all of the requirements of reasoned decisionmaking: "If men must turn square corners when they deal with the government, it cannot be too much to expect the government to turn square corners when it deals with them." *Niz-Chavez v. Garland*, 593 U.S. 155, 172 (2021). CMS has never offered any explanation of why, with hundreds of millions of dollars on the line, it is remotely justified or rational for CMS to measure SCAN's quality based on factors that undisputedly were outside of its control. *See State Farm*, 463 U.S. at 43.

For all the foregoing reasons, CMS's determination that no interpreter was available within 8 minutes of the secret shopper reaching a customer service agent on February 9, 2023 was both contrary to law and arbitrary and capricious. CMS's determination should be set aside, and CMS should disregard the February 9, 2023 call in its 2024 Star Rating determination (or, alternatively, measure C30 should be corrected to reflect that SCAN passed this call).

[19] Under the Medicare Part C interpreter measure (measure C30), CMS requires a 97% pass rate, which means that more than 2 failed calls will disqualify a plan from a 5-star rating for that measure. *See* Ex. 8 at 86 (2024 Star Ratings Technical Notes).

III. CMS's 2024 Star Rating Determination Should Be Set Aside, And, In Turn, Be Re-Determined In Accordance With Governing Law

Because CMS's determination of SCAN's 3.5-star Star Rating was arbitrary and capricious and contrary to law, it must be set aside. 5 U.S.C. § 706(2)(A).

Beyond this default remedy under the APA, the Court should exercise its equitable power to enjoin the Defendants from using CMS's unlawful 3.5-star Star Rating in determining SCAN's eligibility for quality bonus payments. And the Court should order the Defendants, before June 3, 2024, to recalculate SCAN's Star Rating in compliance with 42 C.F.R. §§ 422.111(h), 422.166(a), 423.186(a), by (i) applying the 5 percentage point guardrail required by CMS's regulation, and (ii) excluding the February 9, 2023 secret-shopper call from CMS's determination of SCAN's Star Rating (or coding that call as a "pass"). Indeed, the Defendants stipulated to a briefing schedule allowing for a decision before the June 3, 2024 deadline for Medicare Advantage bids for the year 2025, to leave time to implement such remedies, if necessary. *See* Dkts. 19-20.

All equitable factors governing the grant of an injunction favor that relief here: SCAN has shown that "(1) it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction." *eBay Inc. v. MercExchange, L.L.C.*, 547 U.S. 388, 391 (2006).

SCAN has suffered, and will continue to suffer, irreparable harm absent injunctive relief from this Court. By erroneously reducing SCAN's 2024 Star Rating to 3.5 stars, CMS has rendered SCAN ineligible for quality bonus payments in the 2025 plan year, which will deprive SCAN of approximately $250 million in funding that would otherwise be used to provide more robust benefits and lower cost sharing and premiums to its members. Plumb Decl. ¶¶ 56-60, 66.

The fact that SCAN "has little hope of obtaining 'adequate compensatory or other corrective relief at a later date' if the injunction does not issue . . . weighs heavily in favor of granting the injunction." *O'Donnell Constr. Co. v. District of Columbia*, 963 F.2d 420, 428 (D.C. Cir. 1992). Here, SCAN cannot be compensated by the government for its losses caused by the erroneous Star Rating, because CMS possesses sovereign immunity. *See, e.g., Nalco Co. v. EPA*, 786 F. Supp. 2d 177, 188 (D.D.C. 2011) ("Where a plaintiff 'cannot recover damages from the defendant due to the defendant's sovereign immunity . . . any loss of income . . . is irreparable per se.'").

SCAN also has suffered, and will continue to suffer absent an injunction, severe harm to its competitive position, reputation, and goodwill. *See, e.g.*, *Bell Helicopter Textron, Inc. v. Airbus Helicopters*, 78 F. Supp. 3d 253, 274-75 (D.D.C. 2015) (finding "risk of future reputational harm, lost sales, and lost customers" irreparable). CMS has already widely publicized this 3.5-star Star Rating since October 2023. Plumb Decl. ¶¶ 19, 40. As a result, SCAN's plan appears less attractive to beneficiaries, which has contributed to a lower-than-expected enrollment since October 2023. *Id.* ¶ 62. These harms will accelerate and compound if CMS does not correct SCAN's 2024 Star Rating, as CMS's Star Rating will continue to cause beneficiaries to erroneously believe that SCAN offers an inferior product. *Id.* ¶¶ 62-66. Absent relief, beneficiaries will also switch to competitors' plans, because the loss of $250 million in funding will require SCAN to significantly cut supplemental benefits; increase member cost sharing; and reduce reimbursements to providers (potentially damaging SCAN's provider network). *Id.*; *see also League of Women Voters v. Newby*, 838 F. 3d 1, 9 (D.C. Cir. 2016) (finding irreparable harm when agency action "ma[de] it more difficult for [organizations] to accomplish their primary mission"). Such reputational, competitive, and operational harms will be time consuming and costly for SCAN to attempt to remediate, and it will not be possible for SCAN to fully remediate

these harms once they occur. Plumb Decl. ¶¶ 62-66. For example, once beneficiaries transition from SCAN to a 4-star or 4.5-star plan (or choose such a plan in lieu of SCAN in the first place), it is unlikely they will undertake the burden to transition back to SCAN, even if SCAN were to later return to a 4 or 4.5-star Star Rating. *Id*.

As to the second factor, here, the potential remedies available at law are inadequate to compensate for the foregoing injuries. In light of CMS's sovereign immunity, SCAN will be unable to recover against the government for its lost revenue, much less for the reputational, competitive, and operational harms identified above. *See, e.g.*, *Nat'l Min. Ass'n v. U.S. Army Corps of Engineers*, 145 F.3d 1399, 1408–09 (D.C. Cir. 1998) (finding no adequate remedy at law given there was no suggestion that the government had "waived its sovereign immunity").

The balance of equities and the public interest collapse with the government as the Defendants, and also favor injunctive relief. *Nken v. Holder*, 556 U.S. 418, 435 (2009). As detailed above, CMS's decision will inflict serious harm on SCAN members and potential members who will see a diminution in their benefits and increases in cost sharing absent an injunction. Plumb Decl. ¶¶ 60, 66. Moreover, "[t]here is generally no public interest in the perpetuation of unlawful agency action." *League of Women Voters*, 838 F.3d at 12. "To the contrary, there is a substantial public interest 'in having governmental agencies abide by the federal laws that govern their existence and operations.'" *Id*.

For these reasons, the equitable factors favor the award of injunctive relief.

CONCLUSION

For the foregoing reasons, this Court should grant SCAN expedited summary judgment; set aside CMS's determination of SCAN's 3.5-star Star Rating; and order CMS to redetermine SCAN's Star Rating before June 3, 2024.

Dated: March 8, 2024

Respectfully submitted,

/s/ Andrew D. Prins

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CERTIFICATE OF SERVICE

I hereby certify that I have electronically filed the foregoing with the Clerk of the Court using CM/ECF system which will send notification of such filing on all counsel of record on March 8, 2024.

Dated: March 8, 2024

Respectfully submitted,

/s/ Andrew D. Prins
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

DECLARATION OF MICHAEL PLUMB IN SUPPORT OF PLAINTIFF'S MOTION FOR EXPEDITED SUMMARY JUDGMENT

I, Michael Plumb, declare as follows:

1. I submit this declaration in support of SCAN Health Plan's ("SCAN's") Motion for Expedited Summary Judgment. This Declaration is based upon my personal knowledge and review of relevant documents. I am fully familiar with the facts and circumstances set forth herein. If called as a witness, I could and would testify competently thereto.

Background

2. I am the Chief Financial Officer of SCAN. I have held this position since November 2020.

3. I have worked in the healthcare industry for over 30 years and have extensive experience with commercial and Medicare Advantage health plans.

4. In my role as Chief Financial Officer of SCAN, I am responsible for all of the organization's financial operations, including financial planning and analysis, actuarial functions, and accounting. I am also familiar with the Centers for Medicare and Medicaid Services ("CMS")

Medicare Part C and D programs, Medicare Advantage bidding process, CMS's Star Ratings (including the calculation thereof), and CMS's Quality Bonus Payment program. Additionally, I am familiar with the impact of SCAN's Star Ratings on its business and members.

SCAN Health Plan

5. SCAN is a not-for-profit organization that offers Medicare Advantage plans for people aged 65 and older or otherwise eligible for Medicare.

6. SCAN's mission is to keep seniors healthy and independent.

7. SCAN offers the second largest not-for-profit Medicare Advantage plan in California, serving more than 280,000 members in California as of the end of 2023.

8. SCAN also operates health plans serving Medicare beneficiaries in Arizona, Nevada, New Mexico, and Texas.

9. Unlike other Medicare Advantage plan organizations that also offer separate commercial plans, SCAN's sole business line is its Medicare Advantage plans. SCAN does not offer commercial health insurance plans.

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

The Medicare Advantage Bidding System

11. Each year, CMS establishes a county-specific "benchmark," which is meant to be consistent with what it would cost CMS to provide Medicare defined standard benefits to an average Medicare enrollee.

12. In June of each year, SCAN must submit a bid to CMS that represents SCAN's estimated cost for covering Medicare defined standard benefits to an average Medicare Advantage enrollee in each county for the upcoming year. This year, all bids must be submitted by June 3, 2024 for the 2025 plan year.

13. These bids require extensive supporting documentation, including information about the benefits and cost sharing that the plan will cover and a detailed financial breakdown of how the plan arrived at its bid amount, with the actuarial basis and support for the calculations.

14. If SCAN's bid is below CMS's benchmark, then CMS pays a portion of the difference between CMS's benchmark and SCAN's bid as a "rebate" to SCAN, which can be used to fund improvements to the Medicare defined standard benefits.

CMS's Star Ratings Program

15. Each year, CMS publishes "Star Ratings," from 1 to 5 stars (including half-stars in between) that purport to represent the quality of healthcare and drug services provided by Medicare Advantage Plans and Medicare Part D Prescription Drug Plans. (All of SCAN's plans include both Medicare Advantage (Part C) medical coverage and Medicare Part D drug coverage.)

16. At a high level, CMS evaluates various "measures" of plan quality, and then converts those measures into a measure-specific Star Rating—between 1 and 5 stars—for each measure, based on the plan's performance on that measure relative to other Medicare Advantage plans across the country. The dividing line between each measure-specific Star Rating level is known as a "cut point," and CMS updates the "cut points" between measure-specific Star Ratings from year to year.

17. CMS then takes a weighted average of a plan's measure-specific Star Ratings, with some measures receiving greater weight than others, to arrive at the plan's overall Star Rating.

18. In April 2019, CMS promulgated regulations requiring CMS to set a guardrail to restrict the change in cut points for each measure-specific Star Rating from one year to the next by no more than 5 percentage points. *See* 42 C.F.R. § 422.166(a)(2)(i); 42 C.F.R. § 423.186(a)(2)(i).

19. CMS publishes Star Ratings on its website and in print material, and also lists plans on its online Medicare Plan Finder tool in order of highest to lowest Star Ratings, to help beneficiaries make informed enrollment decisions and steer them toward higher-rated plans.

20. Additionally, Star Ratings can affect the amount of payments that a Medicare Advantage plan receives based on CMS's "Quality Bonus Payments" paid to plans with a rating of 4 stars or higher, and by varying the determination of the "rebate" amount based on a plan's Star Rating.

21. The "Quality Bonus Payment" provided by CMS to Medicare Advantage plans with a Star Rating of at least 4 stars is applied as a 5% increase to the CMS benchmark rates.

22. Medicare Advantage plans are generally required to utilize the CMS "rebate" payments to improve upon the Medicare defined standard benefit through reduced beneficiary cost sharing, lower Part D member premiums, and supplemental benefits not included in traditional Medicare, such as dental, vision, and medical transportation benefits.

SCAN's Star Ratings

23. Based on its high-quality care and services, SCAN has historically received top-tier overall Star Ratings, including a Star Rating of 4.5 stars for the last six years, from 2018 to 2023.

24. Private organizations agree with CMS: In 2023, JD Power found that SCAN ranks highest in overall customer satisfaction among Medicare Advantage plans in California.

25. And year after year, SCAN has been named to U.S. News's list of Best Medicare Advantage Companies.

26. As a result of its exemplary overall Star Ratings, SCAN has in recent years qualified for Quality Bonus Payments, which have added roughly $250 million per year to the CMS benchmarks.

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

28. Moreover, SCAN's exemplary overall Star Ratings have historically contributed to SCAN's ability to attract and retain members—averaging more than 50,000 new members a year.

29. That is because Star Ratings represent a clear signal to beneficiaries of the quality of SCAN's services.

30. And, as described above, a Star Rating of 4 stars or higher provides SCAN additional payments that allow SCAN to offer additional services as part of its plan and lower premiums and cost sharing. As such, SCAN's exemplary Star Rating is critical to SCAN's ability to maintain its existing operations and compete in the marketplace for members.

31. As explained above, SCAN's annual bids for the Medicare Advantage program must detail the specific benefits and cost sharing that each plan will cover. Because SCAN's Star Rating influences these factors under the Medicare Advantage program's rules, SCAN's Star Ratings, and payments obtained as a result of those Star Ratings, determine the manner in which SCAN is required by law to bid its plans into the Medicare Advantage program.

CMS Reduces SCAN's 2024 Star Rating

32. In advance of the release of 2024 Star Ratings, SCAN was prepared for the possibility of a 4-star Star Rating in light of recent changes in CMS's regulations that govern the

calculation of Star Ratings, and notwithstanding SCAN's consistent plan quality year-over-year.

33. In September 2023, CMS informed SCAN of CMS's determination of SCAN's overall Star Rating. CMS determined a 2024 Star Rating of 3.5 stars for SCAN—a significant drop from 4.5 stars in the previous six years.

34. Shortly after CMS notified SCAN that its overall Star Rating had fallen from 4.5 stars to 3.5 stars in just one year, SCAN assessed that the drop from 4 stars to 3.5 stars was caused by CMS's updated measure-specific cut points, several of which had changed by more than 5 percent compared to the cut points from the prior year.

35. SCAN immediately contacted CMS on September 8, 2023 to alert CMS to its error in failing to apply the regulatory 5 percentage point guardrail in determining the cut points used to determine SCAN's measure-specific Star Ratings and overall Star Rating, and requested that CMS correct the error.

36. On September 8, 2023, CMS responded and stated that the "2023 Star Ratings cut points were rerun" and the "rerun 2023 Star Ratings cut points serve as the basis for the guardrails for the 2024 Star Ratings." Attached as **Exhibit 1** is a true and correct copy of the email exchange between SCAN and CMS dated between September 8, 2023 and September 22, 2023 entitled "Guardrail Question on CY2024 Star Rating 2nd Preview."

37. On September 11, 2023, SCAN responded to CMS and again requested that CMS recalculate SCAN's Star Rating based on the required 5 percentage point guardrail. CMS responded on September 11, 2023 and rejected SCAN's request, reiterating that CMS had run a simulation of the 2023 Star Rating cut points in generating the 2024 Star Rating cut points.

38. SCAN also contacted Cheri Rice, Deputy Director of the Center for Medicare at CMS on September 11, 2023 regarding the erroneous cut points and requested that CMS

redetermine SCAN's Star Rating.

39. On September 22, 2023, CMS contacted SCAN, stating that CMS would not alter its determination of SCAN's Star Rating because, "for the first year that Tukey outlier deletion is implemented (2024 Star Ratings), [CMS] will rerun the prior year's thresholds."

40. CMS made public the 2024 Star Ratings, including SCAN's erroneous 3.5-star Star Rating, on October 13, 2023.

CMS's Simulation Caused Drastic Changes In The 2024 Star Rating Cut Points

41. As described above, CMS's communications affirmed that, in determining the 2024 cut points, CMS used simulated, or "re-run", 2023 Star Ratings cut points to determine the 5 percentage point guardrail that would apply to the 2024 Star Ratings cut points, rather than using the actual cut points from the 2023 Star Ratings. As a result, CMS's use of a simulation resulted in drastic changes in the 2024 Star Rating measure-specific cut points.

42. For example, the changes in the 2024 Star Ratings cut points for measure D01 ("Call Center—Foreign Language Interpreter and TTY Availability") vastly exceeded the 5 percentage point guardrail relative to the 2023 Star Ratings cut points. SCAN scored 92% on this measure in the 2024 Star Ratings. Had CMS applied its 5 percentage point guardrail relative to the actual 2023 Star Rating cut points, SCAN would have received a measure-specific Star Rating of 4 Stars, and an overall Star Rating of 4 Stars, as depicted in the table below:

Year	1 star	2 stars	3 stars	4 stars	5 stars
2023 Ratings (Actual)	Under 30%	≥ 30%	≥ 64%	≥ 80%	≥ 91%
2024 Ratings (Actual)	Under 73%	≥ 73%	≥ 86%	≥ 96%	≥ 99%
2024 Ratings (If 5 Percentage Point Guardrail Applied Relative to Actual 2023 Ratings)	Under 35%	≥ 35%	≥ 69%	≥ 85%	≥ 96%

43. But because CMS instead applied its 5 percentage point guardrail relative to *simulated* 2023 Star Ratings cut points, SCAN received a measure-specific Star Rating for measure

D01 of 3 stars instead of 4 stars, and that one difference was enough to cause SCAN's overall Star Rating to drop from 4 stars to 3.5 stars.

44. The 2024 Star Rating measure-specific cut points for measure C08 ("Osteoporosis Management in Women who had a Fracture") also did not impose the 5 percentage point guardrail relative to the prior-year's cut points. SCAN scored 53% on this measure C08 in the 2024 Star Ratings. Had CMS applied its 5 percentage point guardrail relative to the actual 2023 Star Rating cut points (or if CMS had simply applied its 5 percentage point guardrail relative to the 2022 Star Rating cut points in generating its simulation of the 2023 Star Rating cut points), SCAN would have received a measure-specific Star Rating for measure C08 of 4 Stars instead of 3 stars, and an overall Star Rating of 4 Stars, as depicted in the table below:

Year	1 star	2 stars	3 stars	4 stars	5 stars
2023 Ratings (Actual)	Under 32%	≥ 32%	≥ 45%	≥ 55%	≥ 73%
2024 Ratings (Actual)	Under 29%	≥ 29%	≥ 42%	≥ 55%	≥ 71%
2024 Ratings (If 5 Percentage Point Guardrail Applied Relative to Actual 2023 or 2022 Ratings)	Under 28%	≥ 28%	≥ 40%	≥ 50%	≥ 68%

45. But due to CMS's use of a simulation to "re-run" the 2023 C08 measure-specific cut points and apply the guardrails to those "re-run" cut points, SCAN received a measure-specific Star Rating of 3 Stars, and an overall Star Rating of 3.5 Stars.

SCAN Challenged CMS's Erroneous Determination of Measure C30

46. SCAN also raised to CMS another problem with its calculation of SCAN's overall Star Rating: CMS's reliance on incorrect data to determine SCAN's measure-specific Star Rating for measure C30 ("Call Center—Foreign Language Interpreter and TTY Availability").

47. For this measure, CMS hires secret shoppers to pose as consumers, call each Medicare Advantage plan's customer service line, ask for an interpreter, and evaluate whether an interpreter was available within 8 minutes of reaching the customer service representative.

48. In assessing SCAN's 2024 measure-specific Star Rating for C30, CMS determined that SCAN failed to meet the 8-minute requirement for one secret shopper call placed on February 9, 2023, resulting in SCAN's measure-specific Star Rating on measure C30 declining from 5 stars to 4 stars, and SCAN's overall Star Rating declining to 3.5 stars, based solely on this call.

49. Had this February 9, 2023 call not been included in SCAN's measure-specific Star Rating for measure C30 (or, if the call had been corrected from "fail" to "pass"), SCAN would have achieved a measure-specific Star Rating on measure C30 of 5 stars, and SCAN's overall Star Rating would have been 4 stars.

50. CMS identified this February 9, 2023 call as outside of CMS's 8-minute requirement because the secret shopper's unclear manner of speech required the French interpreter to ask the secret shopper to clarify and repeat her question. Absent the delay caused by CMS's secret shopper, SCAN would have met CMS's purported 8-minute requirement.

51. On November 10, 2023, SCAN submitted a Request for Reconsideration of CMS's determination of SCAN's Star Rating for measure C30, pursuant to an internal appeal process made available by CMS for certain limited purposes. Attached as **Exhibit 2** is a true and correct copy of SCAN's Request for Reconsideration, dated November 10, 2023, and attachments thereto.

52. On February 22, 2024, CMS denied SCAN's Request for Reconsideration. Attached as **Exhibit 3** is a true and correct copy of the letter decision from CMS denying SCAN's Request for Reconsideration dated February 22, 2024, and attachments thereto.

53. On February 29, 2024, SCAN submitted a request for an informal hearing under 42 C.F.R. § 422.260(c)(2) to correct CMS's determination of SCAN's Star Rating for measure C30. Attached as **Exhibit 4** is a true and correct copy of the SCAN's Request for Informal Hearing dated February 29, 2024, and attachments thereto.

54. In its request for an informal hearing, SCAN asked that CMS reevaluate its denial of SCAN's Request for Reconsideration and overturn its determination that the February 9, 2023 secret shopper call failed to satisfy CMS's purported available-within-8-minutes requirement.

CMS's Star Rating for SCAN Has Irreparably Harmed SCAN and Will Continue to Cause Irreparable Financial and Reputational Harm

55. CMS's reduction of SCAN's 2024 Star Rating from 4.5 stars to 3.5 stars has had catastrophic consequences for SCAN: It has created a grave threat to SCAN's finances and has seriously harmed SCAN's reputation and competitive position in the marketplace.

56. As noted above, SCAN has received a Star Rating of 4.5 for six straight years, and the additional funding associated with the 4.5-star Star Rating would account for roughly $300 million being added to SCAN's benchmarks based on current membership.

57. SCAN estimates that if it had received a 2024 Star Rating of 4 stars, SCAN would be eligible for approximately $250 million of additional benchmark funding for the 2025 plan year related to the Quality Bonus Payment.

58. But because CMS reduced SCAN's 2024 Star Ratings to 3.5 stars, SCAN is not eligible for the Quality Bonus Payments applicable to plans rated 4 stars or higher in 2025.

59. Because SCAN's sole business line is its Medicare Advantage plans, the loss of these Quality Bonus Payments cannot be offset by other lines of business, and thus will be devastating to SCAN's operations and threatens SCAN's ability to provide existing, much less enhanced, benefits and services to members in 2025.

60. The loss of $250 million in CMS funding will mean that SCAN must significantly cut supplemental benefits, increase member cost sharing, and reduce reimbursements to healthcare providers, causing them a significant hardship, which could destabilize the provider network and potentially result in fewer network provider options for members.

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

62. The CMS determination and publication of the 3.5-star Star Rating has made SCAN's plan appear less attractive compared to competitor plans for prospective members who are shopping for a Medicare Advantage plan, thus contributing to a lower than expected level of sales during the recent Medicare Advantage Annual Enrollment Period (AEP), which ran from October 15, 2023 through December 7, 2023. It also makes existing members more likely to disenroll from SCAN to switch to another plan with a Star Rating of 4 stars or higher.

63. Once SCAN's members switch to other Medicare Advantage plans, it is very difficult for SCAN to win back those members. Medicare Advantage plans are generally "sticky" in the sense that it takes time and effort for members to reevaluate and switch plans. Having expended the time and effort to change from SCAN to a higher-rated plan, it is unlikely that a member will expend the effort to move back to SCAN in the future, even if SCAN were to later revert to a Star Rating of 4 or 4.5 stars. Changing plans can also sometimes require a beneficiary to change healthcare providers, which is another barrier to members switching back to SCAN.

64. As a result, even if SCAN were to later return to a 4 or 4.5-star Star Rating, it is highly unlikely that SCAN's former members will expend the time and undertake the burden of transitioning back to SCAN.

65. This harm to SCAN's reputation and enrollment will only compound, as CMS's flawed Star Rating will continue to cause beneficiaries to erroneously believe that SCAN's plans are lower in quality relative to its competitors' plans due to SCAN's 3.5-star Star Rating.

66. To make matters worse, unless CMS corrects its 2024 Star Rating prior to the 2025 plan year, members will also continue to switch to competitors' Medicare Advantage plans

because the loss of $250 million in Quality Bonus Payments means that SCAN must reduce its supplemental benefits and increase cost sharing—further driving away members.

Exhibits in Support of Motion for Summary Judgment

67. Attached as **Exhibit 5** is a true and correct copy of an excerpt of CMS's public database reflecting CMS's determination of SCAN's 3.5-star Star Rating and SCAN's performance on the individual measures for the 2024 Star Ratings, in the form obtained from https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

68. Attached as **Exhibit 6** is a true and correct copy of CMS's Medicare 2022 Part C and D Star Ratings Technical Notes dated October 3, 2021.

69. Attached as **Exhibit 7** is a true and correct copy of CMS's Medicare 2023 Part C and D Star Ratings Technical Notes dated January 19, 2023.

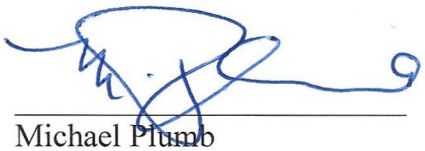
70. Attached as **Exhibit 8** is a true and correct copy of CMS's Medicare 2024 Part C and D Star Ratings Technical Notes dated December 13, 2023.

71. Attached as **Exhibit 9** is a true and correct copy of a public U.S. Department of Health and Human Services webpage entitled "Healthcare Effectiveness Data and Information Set (HEDIS) – Healthy People 2030 | health.gov" in the form obtained from https://health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/healthcare-effectiveness-data-and-information-set-hedis.

72. Attached as **Exhibit 10** is a true and correct copy of a CMS guidance document entitled "2016 Call Center Monitoring Questions and Answers" in the form obtained from www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting.

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

Executed at Long Beach on the 8th day of March, 2024.



Michael Plumb
Chief Financial Officer, SCAN Health Plan

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Case No. 1:23-cv-3910-CJN

INDEX OF EXHIBITS

Plaintiff SCAN Health Plan respectfully submits the following Index of Exhibits.

Exhibit	Description
1	Email exchange between SCAN and CMS entitled "Guardrail Question on CY2024 Start Rating 2nd Preview" (September 22, 2023)
2	SCAN Request for Reconsideration (November 10, 2023)
3	CMS Reconsideration Decision (February 22, 2024)
4	SCAN Request for Informal Hearing (February 29, 2024)
5	2024 Star Ratings Data Tables - H5425 (October 13, 2023)
6	CMS Medicare 2022 Part C & D Star Ratings Technical Notes (October 4, 2021)
7	CMS Medicare 2023 Part C & D Star ratings Technical Notes (January 19, 2023)
8	CMS Medicare 2024 Part C & D Star ratings Technical Notes (December 13, 2023)
9	Healthcare Effectiveness Data and Information Set (HEDIS)
10	2016 Call Center Monitoring Questions and Answers (February 3, 2016)

EXHIBIT 1

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Friday, September 22, 2023 6:21 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>; Moon Leung <MLeung@scanhealthplan.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Guardrail Question on CY2024 Star Rating 2nd Preview

We know a meeting is being set up with Cheri. In the meantime, here is additional background about cut points. As we stated in the CY 2021 NPRM (85 FR 9044) and final rule (CMS–4190–F) (85 FR 33833, 33835), for the first year that Tukey outlier deletion is implemented (2024 Star Ratings), we will rerun the prior year's thresholds using mean resampling and Tukey outlier deletion so that guardrails will be applied consistently between years. This is an intrinsic part of the Tukey outlier deletion rule and the rule satisfied the requirements in the Administrative Procedure Act for notice and comment rulemaking. CMS was clear in this rulemaking that in the first year of implementing this process the prior year's thresholds will be rerun.

Best regards,

Part C and D Star Ratings Team

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, September 11, 2023 9:13 PM
To: Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>; Moon Leung <MLeung@scanhealthplan.com>
Subject: Guardrail Question on CY2024 Star Rating 2nd Preview

Cheri,

Hope you are well and that you had a nice summer. We wanted to reach out to you regarding the exchange (see below) that we've had with the CMS Stars Mailbox with respect to the application of the guardrails to the 2024 cut rates for non-CAHPS Star measures. In response to our inquiry, the CMS Stars Mailbox explained that "**rerun** 2023 star rating cut points serve as the basis for the guardrails for the 2024 Star Ratings." This is concerning to us because it is not consistent with Section 422.166(a)(2)(i).

§ 422.166 Calculation of Star Ratings.

(a) Measure Star Ratings —

(1) Cut points. CMS will determine cut points for the assignment of a Star Rating for each numeric measure score by applying either a clustering or a relative distribution and significance testing methodology. For the Part D measures, CMS will determine MA–PD and PDP cut points separately.

(2) Clustering algorithm for all measures except CAHPS measures.

(i) The method maximizes differences across the star categories and minimizes the differences within star categories using mean resampling with the hierarchal clustering of the current year's data. Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed. Effective for the Star Ratings issued in October 2022 and subsequent years, CMS will add a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap). New measures that have been in the Part C and D Star Rating program for 3 years or less use the hierarchal clustering methodology with mean resampling with no guardrail for the first 3 years in the program.

The language highlighted in yellow ensures that the cut points for non-CAHPS measures do not increase from year to year by more than the 5 percent cap, given that the very purpose of the guardrails is to provide stability and predictability for plans. The statute does not provide for the re-calculation of the prior year cut points for purposes of the application of the guardrails.

The Final Rule, as well as prior year Fact Sheets, define guardrails as "bi-directional caps that restrict upward and downward movement of a measure's cut points for the current year's measure-level Star Ratings compared to the prior year's measure-threshold specific cut points." This again states the comparison points are current year and prior year measure specific cut points.

There are non-CAHPS star measures such as D01 where the proposed 2024 cut points increase far in excess of 5 percentage points "from 1 year to the next." The 4 star cut points for measure D01 are proposed to change massively from ">=80% to <91%" in 2023 to ">=96% to <99%." Those proposed cut points are not consistent with the language in the final rule with respect to application of guardrails to year over year changes.

We would be happy to jump on a call to discuss this further, but hopefully the references above to the specific language in the Final Rule identifies the need for a revision of the extreme cut point changes proposed in the 2nd preview.

Michael Plumb
Chief Financial Officer
SCAN Group & SCAN Health Plan

Renée Delphin-Rodriguez (she/her/hers)
Chief Legal Officer & General Counsel
SCAN Group & SCAN Health Plan

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, September 11, 2023 10:56 AM

To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Guardrail Question on CY2024 Star Rating 2nd Preview

Hi Michael,

We are calculating cut points consistently with what we stated in the rule for the first year Tukey outlier deletion is applied. For example, in the proposed rule at 85 FR 9044 it said: "We request commenter feedback on Tukey outer fence outlier deletion as an additional step prior to hierarchal clustering. In the first year that this would be implemented, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years."

As another example at 85 FR 33833 in the final rule, "We requested comments on our proposal to use Tukey outer fence outlier deletion as an additional step prior to hierarchal clustering. We explained that under our proposal in the first year of implementing this process, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years."

As noted earlier, for the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun including Tukey outlier deletion and no guardrails. These rerun 2023 Star Ratings cut points serve as the basis for the guardrails for the 2024 Star Ratings.

Since the 2023 Star Ratings cut points were rerun to apply Tukey outlier deletion, you cannot apply the bi-directional guardrails to the 2023 Star Ratings cut points published in the Medicare 2023 Part C & D Star Ratings Technical Notes.

As an example, for D01 (Call Center – Foreign Language Interpreter and TTY Availability) measure for MA-PDs, the rerun 2023 Star Ratings cut points are as follows:

1 star cut point:	< 68%
2 star cut point:	>= 68% to < 81%
3 star cut point:	>=81% to < 91%
4 star cut point:	>=91% to <97%
5 star cut point:	>= 97%

The bi-directional guardrails are applied to the above cut points.

The final 2024 Star Ratings cut points for D01 are as follows:

1 star cut point:	< 73 %
2 star cut point:	>= 73 % to < 86 %
3 star cut point:	>= 86 % to < 96 %
4 star cut point:	>= 96 % to < 99 %
5 star cut point:	>= 99 %

Please note that guardrails were applied for this measure to the 1, 2 and 3 star cut points.

We plan to add a table to the 2024 Part C & D Star Ratings Technical Notes with the 2023 Star Ratings cut points that were rerun with Tukey outlier deletion and mean resampling.

Best Regards,
Joy

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, September 11, 2023 1:07 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>
Subject: RE: Guardrail Question on CY2024 Star Rating 2nd Preview

Thank you for your prompt response. However, we are following up because it does not seem to us that your response in the email below is consistent with what is actually included in the final rule.

We've combed through the attached final rule (CMS-4201-F) as well as the actual Federal Register for the references to the use of the cut point guardrails.

Page 671 of the attached final rule includes the following section that describes the Calculation of Star Ratings:

§ 422.166 Calculation of Star Ratings.
(a) * * *
(2) * * *
(i) The method maximizes differences across the star categories and minimizes the differences within star categories using mean resampling with the hierarchal clustering of the current year's data. Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed. Effective for the Star Ratings issued in October 2022 and subsequent years, CMS will add a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap). New measures that have been in the Part C and D Star Rating program for 3 years or less use the hierarchal clustering methodology with mean resampling with no guardrail for the first 3 years in the program.
* *

The portion highlighted in yellow specifies that "CMS will add a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next." That clearly states that the guardrails are meant to ensure that the cut points for non-CAHPS measures do not increase from year to year by more than the 5 percent cap. That is not consistent with the assertion in the e-mail response below that "rerun 2023 star rating cut points serve as the basis for the guardrails for the 2024 Star Ratings." There is no reference that we can find in the final rule that references the recalculation of the prior years cut points for purposes of the application of the guardrails.

The Final Rule, as well as prior year Fact Sheets, define guardrails as "bi-directional caps that restrict upward and downward movement of a measure's cut points for the current year's measure-level Star Ratings compared to the prior year's measure-threshold specific cut points." This again states the comparison points are current year and prior year measure specific cut points.

As we referenced in our original e-mail below, there are non-CAHPS star measures such as D01 where the proposed 2024 cut points increase far in excess of 5 percentage points "from 1 year to the next." (4 star cut points for measure D01 are proposed to change from ">=80% to <91%" in 2023 to ">=96% to <99%.") Those proposed cut points are not consistent with the language in the final rule, so it seems it would be appropriate to modify those cut points.

Michael Plumb
CFO, SCAN Health Plan

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Friday, September 08, 2023 10:37 AM
To: Moon Leung <MLeung@scanhealthplan.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Guardrail Question on CY2024 Star Rating 2nd Preview

Hi Moon,

When we proposed and finalized Tukey outlier deletion in the 2021 final rule (CMS–4190–F), we described that in the first year of adding Tukey outlier deletion, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years. For the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun including mean resampling, Tukey outlier deletion and no guardrails. These rerun 2023 Star Ratings cut points serve as the basis for the guardrails for the 2024 Star Ratings.

Best Regards,
Joy

From: Moon Leung <MLeung@scanhealthplan.com>
Sent: Friday, September 8, 2023 1:38 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: Guardrail Question on CY2024 Star Rating 2nd Preview

Hi CMS Star Team,

After reviewing the cut points for CY2024 and CY2023, it appears that the Guardrail rule was not applied to some Non-CAHPS Star measure cut points. Here are two examples:

Measure #	Measure	Source	WG	Year	Wgt	1 Star	2 Star	3 Star	4 Star	5 Star
C11	Diabetes Care – Blood Sugar Controlled	HEDIS	CM	2023	3	< 59%	≥ 59% to < 62%	≥ 62% to < 75%	≥ 75% to < 89%	≥ 89%
				2024	3	< 58%	≥ 58% to < 72%	≥ 72% to < 80%	≥ 80% to < 87%	≥ 87%
						2024 vs 2023	19%	10%	5%	4%

Measure #	Measure	Source	WG	Year	Wgt	1 Star	2 Star	3 Star	4 Star	5 Star
D01	Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan	Call Center	AD	2023	4	< 30%	≥ 30% to < 64%	≥ 64% to < 80%	≥ 80% to < 91%	≥ 91%
				2024	4	< 73%	≥ 73% to < 86%	≥ 86% to < 96%	≥ 96% to < 99%	≥ 99%
						2024 vs 2023	43%	22%	16%	8%

Can you respond to us regarding this potential error, or explain why the guardrails published in the final rule were not applied to the cut points?

Thanks very much for your help in advance.

Moon

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EXHIBIT 2

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: QBPAPPEALS@cms.hhs.gov
Cc: Moon Leung; Ginette Hawkins; Renee Delphin-Rodriguez
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)
Attachments: Request_For_Reconsideration_Form_2025 - SCAN Health Plan H5425.xlsm; C1201277_03242023.WAV; Attachment 1. Additional Details To Support QBP Reconsideration v3.docx; Attachment 1. Additional Details To Support QBP Reconsideration.docx

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Request_For_Reconsideration_Form_2025 SCAN Health Plan H5425.xlsm

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 November 17, 2023. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.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		Not Appealable	
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			

Attachment A

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

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			
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)

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "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." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

Additional Note
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

Slip Sheet for C1201277_03242023.WAV

Audio File Cannot Be Filed Electronically Pursuant to Local Civil Rule 5.4(e)

Attachment 1. Additional Details To Support QBP Reconsideration v3.docx

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

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EXHIBIT 3

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Thursday, February 22, 2024 3:57 PM
To: Michael Plumb
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)
Attachments: Scan_CMS Response.zip; Attachment B-Informal Hearing_Form_2025_2.xlsm; QBP Decision Letter SCAN Health Plan H5425.pdf

WARNING: This email originated outside of SCAN [United States].
DO NOT provide your username, password, or any other personal information in response to this or any other email.
SCAN WILL NEVER ask you for your username or password via email.
DO NOT CLICK on links or attachments unless you know the sender and are expecting the content.
REPORT phishing emails using the "Report Phish" button in your Outlook toolbar or by forwarding to the IT Security Team.

Attached please see information related to your Request for Reconsideration.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 12:44 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Great – thank you. I guess it was an issue with having multiple attachments in one e-mail. Thanks for confirming.

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 9:34 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thank you. Confirming receipt. Yes, it plays now.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 12:31 PM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Also strange – maybe there was an issue when attaching multiple files to the original email. I have attached the WAV file again here. Will it play for you this time?

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 8:52 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Thank you Michael! This works now. I was able to open the excel file and the word files. The WAV file opens but nothing is playing for us.

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Monday, November 13, 2023 11:36 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

That's strange – we downloaded it from the HPMS website. Thank you for letting us know. I have attached it again, please let me know if you continue to have a problem opening the excel spreadsheet.

Were you able to open the additional files attached to our e-mail (Microsoft Word file and .WAV file)?

From: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Sent: Monday, November 13, 2023 5:07 AM
To: Michael Plumb <MPlumb@scanhealthplan.com>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: RE: QBP Reconsideration Form for SCAN Health Plan (H5425)

Hi Michael,

We are unable to open the excel spreadsheet. Can you please resend?

QBP Appeals Team

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

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QBP Decision Letter SCAN Health Plan H5425.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CENTER FOR MEDICARE

February 22, 2024

Reconsideration Determination for H5425

Dear Mr. Plumb,

SCAN Health Plan's contract H5425 requested an administrative reconsideration of its 2025 Quality Bonus Payment (QBP) determination. The request was based on the 2024 Star Ratings for the measure: Call Center – Foreign Language Interpreter and TTY Availability (C30). 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 not change the QBP rating for H5425. **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.**

The reason for my decision is outlined in Attachment A, "Technical Report for SCAN Health Plan H5425." Attachment A explains how the measure and values in question were calculated and provides specific information about this contract's 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 2024 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 our regulations and as discussed in Attachment A, "[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 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 measure and values in question that precipitated the request for reconsideration, in this case the measure: Call Center – Foreign Language Interpreter and TTY Availability (C30). 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 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 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 A: Technical Report for SCAN Health Plan H5425
Attachment B: Request for an Informal Hearing

Attachment B-Informal Hearing_Form_2025_2.pdf

Attachment B - Request for Informal Hearing

Note: The QBP administrative review process is a two-step process which includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Bo h steps are conducted at the contract level. The burden is on the MA organization to prove that the reconsideration decision was incorrect.

Instructions: Use only the "Request for Informal Hearing" form provided with the reconsideration decision. One form must be submitted for each contract for which reconsideration is requested. Complete he identifiable information including all contact information. Please enable Macros in this form. Mark an "X" next to the measure(s) that is the basis for the Request for Informal Hearing. Do not mark any measures for which you did not request a reconsidera ion. Please attach full documentation that supports your request for an informal hearing on he record. Save the information, 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 Informal Hearing is made by completing this form and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5 00 p.m. EST on February 29, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	
Contact First Name (your first name):	
Contact Last Name (your last name):	
Contact Title (your job title):	
Contact Phone Number (your phone number, include extension if necessary):	
Contact email address (your email address):	

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 Ra ing	Star Ra ings		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 he Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconcilia ion Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Sta in 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 wi h 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 he Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ra ings		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			

Attachment A

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			
D02-Complaints about he 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 Ra ings		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 Medica ions	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-Sta in Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	
Additional Comments (Please provide any addi ional information relevant to your request)				

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The ime required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Bal imore, Maryland 21244-1850.

Technical Report for SCAN Health Plan H5425.pdf

Technical Report for SCAN Health Plan H5425

Contents

Factual Background **2**
Regulations Governing the 2024 Part C and D Star Ratings 2
Call Center Monitoring 2
Contract's Description of the Issue: Call Center - Foreign Language Interpreter and TTY Availability (C30) **3**
CMS's Response: Call Center - Foreign Language Interpreter and TTY Availability (C30) **5**
Conclusion **7**
Appendices **8**

Factual Background

Regulations Governing the 2024 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 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 §§ 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.

Call Center Monitoring

CMS monitors plan sponsors' Part C and Part D call centers to ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h) and 423.128(d), for providing timely and accurate information. The purpose is to measure plans' call center accessibility for current members and prospective members and to determine if the information provided to prospective members is accurate. Performance for the Part C and Part D call center measures is based on the Part C & D Call Center Monitoring Accuracy and Accessibility Study conducted from approximately February through June 2023. CMS provided notice to MA organizations and Part D sponsors, via an HPMS memo dated December 1, 2022 ("2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies") (see Appendix A), that the study would be conducted. In conducting the study, the CMS contractor only uses the call center phone numbers (including TTY numbers) identified by the plan in HPMS for contacting the call center.

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, 2022, Health Plan Management System (HPMS) memo titled "2023 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies" (see Appendix A), and in the Medicare 2024 Part C and 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, time for customer service representatives (CSRs) to respond to questions, and time to bring

[1] 42 C.F.R. §§ 422.111(h(1)(iv) and 423.128(d)(1)(v)
[2] 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii)
[3] https://www.cms.gov/files/document/2024technotes20230929.pdf

interpreters into the call. 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 benefits?") within eight minutes, before being asked the three accuracy questions. Interpreters must be able to communicate responses in the non-primary language used by the call surveyor. 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 within seven minutes, before being asked three accuracy measure questions. There must be communication received back from the CSR or TTY relay operator in order to confirm that the TTY device is working properly, and a connection is made so that all parties can communicate.

The surveyor reports that a call is an "unsuccessful call" as defined by the survey methodology when the call terminates early or fails to connect without action by the surveyor or error on the surveyor end. Such calls are counted as unsuccessful calls when the plan's survey results are tabulated. On the other hand, if the call disconnects because of the surveyor's action, surveyor's error, or other failure on the surveyor's end, the surveyor does not report the call as an "unsuccessful call" and the call is not counted in the plan's survey results at all.

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

SCAN Health Plan (SCAN) claims that for the Part C call center measure C30, CMS used incorrect data in the calculation of the measure. They argue that one of the foreign language interpreter availability calls (C0600900) was incorrectly included in their results based on a technical issue associated with the non-standard way the CMS caller asked the standard question for their contract H5425.

SCAN states that for call C0600900, received on 2/9/2023, there was a technical issue caused by the CMS caller's deviation from protocol that caused the call to exceed the 8-minute threshold. They argue the CMS caller did not ask the question clearly, including a stumble at the start, and spoke unusually slowly and stated the plan name in a non-standard manner that the interpreter had trouble understanding. This included several pauses during the question that increased the time it took to ask the question. The total time taken to ask the question was 25 seconds, which they believe demonstrates how long the pauses were. SCAN states that the CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. They state it was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8-minute threshold.

For comparison purposes, SCAN references call C1201277 which was received on 3/24/2023. SCAN states that in call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact

same plan name as in call C0600900). The total time taken to ask the question in call C1201277 was just 17 seconds and did not result in the interpreter needing to have the question repeated to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

SCAN states that for call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, they argue were it not for the additional delay caused by the non-standard way the CMS caller asked the question in C0600900, that call would have passed and been counted as a successful call. Additionally, they state in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit.

SCAN states that time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the question to be repeated, should not be included in the evaluation of a specific call's success. Thus, they state that this call was incorrectly included as a failure in their performance data and should be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, they argue the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. They claim that CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for their performance on the C30 measure.

SCAN also states that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. They note that page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. Per SCAN, the caller asked, "are you the right person to answer questions about the medical advantages of [Plan name]." They argue when dealing with MA products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8-minute time limit. SCAN states where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8-minute threshold, it is not appropriate for CMS to penalize the MA plan.

In summary, SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars).

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

CMS disagrees with SCAN's argument that their rating for measure C30 is incorrect. CMS has utilized a contractor to place calls to MA organizations and Part D sponsor's customer service call centers since 2009. While the methodology has undergone minor changes over the years, successful calls have always been premised on reaching a live CSR who confirms they can answer questions about the plan's Medicare benefits within a specified period of time. This is true whether the caller speaks English as a first language, is using a TTY device, or speaks a language other than English. Prior to each calendar year's monitoring, CMS releases an annual HPMS memo (see Appendix A) that describes the call center monitoring studies for the coming year; provides instructions to ensure that current, prospective, and TTY customer service call center toll-free telephone numbers are entered in the appropriate locations in HPMS; and offers best practices.

Before CMS launched the 2023 study, it first reached out to plans via the annual Call Center Monitoring HPMS memo released on December 1, 2022. Within this memo CMS provided several key points of information, including the definition of interpreter availability. The memo notes, "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... 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."[4]

SCAN has argued that the result of call C0600900 (see Appendix B for raw data related to this call) was impacted due to how the CMS caller asked the question. They claim that a technical issue occurred due to the CMS caller deviating from the standard protocol. CMS asks the same question for each call and that question is "Are you the right person to answer questions about [Plan name's] health (or prescription drug) benefits?" (see Appendix C, page 17). SCAN believes that this question was asked in a non-standard way, which caused confusion for the translator. CMS disagrees with the assertion that the caller deviated from the standard protocol and provides the table below to show exactly what was said during the call.

1	Standard version of the question when asked in English	Are you the right person to answer questions about [Plan name's] health benefits?

[4] Appendix A, page 2.

2	Standard version of the question when asked in French	Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
3	Standard version of the question translated from French back to English	Are you the right person to answer questions about health benefits of [Plan name]?
4	Exactly what the interviewer actually asked in French	Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP?
5	Exactly what the interviewer actually asked translated to English	Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?
6	What SCAN claims the interviewer asked in French	Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de [Plan name]?
7	What SCAN claims the interviewer asked translated to English	Are you the right person to answer questions about the medical advantages of [Plan name]?

SCAN cites that it took 25 seconds for the CMS caller to ask the introductory question, which they believe shows how long the pauses were when combined with the spelling out of the plan name. SCAN believes that this was an unfairly long amount of time and that this is the reason for the call failing. The CMS callers are trained to ask the question in a conversational way, as we are assessing to see if any caller at a given point in time can receive assistance. In this instance the CMS caller asked the standard question and provided the needed information the first time. Each person has a unique style of communication and to expect that each person will speak in the exact same way is not realistic. This applies to both the CMS callers and an individual Medicare beneficiary from the general public who is calling. The purpose of these test calls is to replicate the experience prospective members would have if they called the plan's toll-free number. How prospective members ask a question will differ from call to call. SCAN has suggested that 25 seconds to ask the general question is too long, but CMS believes it is within an acceptable time frame for a conversation. (Further, 25 seconds is less than 1/16th of the available time of 8 minutes for SCAN to complete the call by providing a "yes" response to the introductory question via the interpreter.)

SCAN has stated that due to the interpreter needing the question to be restated, it added an unnecessary 34 seconds to the call, which is why it failed the 8-minute timer. SCAN's

argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with. SCAN chose their interpreter service and, therefore, is responsible for the performance of the interpreter service they have chosen. Had SCAN gotten an interpreter on the line only 34 seconds earlier (that is, in just under 6 minutes or *75% of the available time* to complete the call successfully on the measure), the call could have been completed successfully.

SCAN also brought up an additional French language call that they received where it took 17 seconds instead of 25 to ask the introductory question. For call C0600900 (the call being appealed) SCAN says that the time to get a translated response back was 86 seconds, or 45 seconds longer than the time it took for a different call C1201277, which SCAN characterizes as having no issue with the introductory question. CMS asked the same question on both calls, and any differences in the way they were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing (that is, how quickly a Medicare beneficiary can connect with a customer service representative to get information about the plan). With this argument, SCAN again has ignored the prolonged period that it took for the interpreter to join the call. SCAN's focus on the final seconds on a call disregards how the SCAN call center wasted the first six and a half minutes waiting for an interpreter. How SCAN elects to provide interpreters is within SCAN's control and SCAN is thus responsible for how well its chosen approach works.

SCAN has argued that a time delay caused by the CMS caller asking the introductory question in a non-standard way should not be held against the plan. CMS asks the same question on all calls. We use the same translation for each foreign language call that is placed. For the 2023 study, CMS placed 1,984 calls in French. Of those 1,761 were successful, meaning the interpreter was able to interpret a "yes" response back to the CMS caller within 8 minutes. That means that 88.76% of all French language calls were successful. Call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory question was asked. In addition, it should be noted that SCAN was called 13 times between Part C and Part D in French for the study, and they were successful on 11 of those calls. The only other French language call that was unsuccessful was disconnected by the plan.

Finally, SCAN stated that the translation itself could be a reason for the issue that occurred. CMS has not changed the French translation of this question for several years and there have not been other issues raised around the translation.

Conclusion

Permissible bases for requests for QBP reviews include a calculation error (miscalculation) or a data inaccuracy (incorrect data), not methodology codified in regulation. The regulation at 42 CFR § 422.260(c)(3)(ii) is clear on this. CMS consistently and appropriately administered the call center study, and calls were properly placed and scored accordingly. CMS finds no evidence that we incorrectly scored the questioned call for H5425; thus, the score for measure

C30 should not be adjusted. H5425's Star Rating for measure C30 and its QBP rating will remain unchanged.

Appendices

Appendix A – 2023 Part C and Part D Call Center Monitoring.pdf
Appendix B – Case C0600900 Raw Data.xlsx
Appendix C – Call Center Monitoring Accuracy and Accessibility Study Technical Notes 508 Technical Notes_2023_06.08.23_Final.pdf

Appendix A - 2023 Part C and Part D Call Center Monitoring.pdf

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, 2022

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: Amy Larrick Chavez-Valdez, Director
Medicare Drug Benefit and C & D Data Group

SUBJECT: 2023 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 2023. 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 2023 call center information **no later than December 16, 2022**.

For 2023, CMS has contracted with Insight Policy Research, 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 2023 are unchanged from 2022 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 2023.

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 2023 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2023 Part C and/or Part D call center telephone numbers in HPMS by **December 16, 2022**. 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 2023 – 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@insightpolicyresearch.com** in November 2022. 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 CY2023 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2023 > View Documentation (under "Documentation" Section) > Bid Submission User manual for Contract Year 2023*).

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. 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.** CMS generally calls from the Eastern time zone. 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 you are covering 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 current member customer service lines, we only 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.** Note that we only need to confirm we have reached a CSR who has authority to answer questions so we can measure the average hold time to reach a live CSR, but we do not ask any actual benefit-related questions when we call the *current member* customer service line or the pharmacy technical assistance help line.

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; and
  - 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 s/he has communicated his or her 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. Our test calls will generally be placed from the Eastern time zone 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 2023 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2023. 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 2023 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.

Appendix B - Case C0600900 Raw Data.xlsx

contrac	caseid	contract_name	organizatic	CallCe	erc	cas_c	ERC_Description	finishnote	TimeCaseStarted	TimeCaseEnded	CaseI	TimeCallMade	cal	HangU	CallEnded	CallDu	time_logs	date_logst
H0978	C0600900	SCAN HEALTH P	Local CCP	176	294.1	294	LEP: Timeout during wait for interpreter or prior to the interpreter answering the introductory question (more than 8 minutes)	Case timed out while waiting for Interpreter	2/9/2023 20:02:10	2/9/2023 20:12:55	10.8	09FEB23:20:02:15	Intvw	2/9/2023 20:12:46	10.5	20:02:15	2/9/2023	

time_loge	date_loger	Un	Inte	ctyp	cla	qu	week	phone	Assigne	Assi	PLANNAME	ORGNAME	ts0_date	ts0_time	ts1_	ts1	ts2_date	ts2_time	ts3_date	ts3_time	ts4_date	ts4_time	ts5_date	ts5_time	ts6_date
20:12:46	2/9/2023		5	3	1	6	1-877-916-1234	H5943	2		VillageHealth (HMO-POS C-SNP)	SCAN HEALTH PLAN	2/9/2023	20:02:15			2/9/2023	20:02:47	2/9/2023	20:02:47	2/9/2023	20:03:06	2/9/2023	20:03:45	2/9/2023

ts6_time	ts7_date	ts7_time	TTY	IVR_	HOLD	LEP_	TTY	CAS	MN	IND	res	day	tim	ZIPCOD	COUNTY	STATE	QU	QL	QUI	AN	AN:	ANS	A1	O_A	A2	O_/	A3	O_A	CCE	TTY	ANS	IVR1	IVR	IVR	IVR	IVR	IVR	IVR	IVR	IVR	IVR	IVR	HOI	LIVE	O_	O_L
20:11:45	2/9/2023	20:12:55	31	26	480	C	0	1	1	4	19	90051	Los Angeles	California	0	0	0														PST	1	FROM HOLD											1	1	90	

O_ End En Un INT line lineendtime

11 23

Appendix C – Call Center Monitoring Accuracy and Accessibility Study Technical Notes 508 Technical Notes_2023_06.08.23_Final.pdf

Medicare

Part C & D

Call Center Monitoring

Accuracy and Accessibility Study

Technical Notes

Table of Contents

DOCUMENT CHANGE LOG 2
PURPOSE 2
BACKGROUND 3
CONTACT INFORMATION 4
PERFORMANCE METRICS AVAILABILITY IN HPMS 5
UNDERSTANDING THE DATA: CALL OUTCOMES COMPARED TO MEASURE OUTCOMES 5
PERFORMANCE METRICS AS DISPLAYED IN HPMS 8
CALL CENTER MONITORING DEFINITIONS 12
HPMS DISPLAY GROUPINGS 15
RAW DATA 15
DATA DICTIONARY 15
FREQUENTLY ASKED QUESTIONS 16

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**

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*), which varies depending on the type of call being made. At this point, for foreign language calls, we also test interpreter availability/LEP and ask the introductory question. We then move to phase 4 for the accuracy measure where we ask up to three accuracy questions. For TTY calls, we test TTY functionality, ask the introductory question, and then move on to the fourth phase for the accuracy measure.

For native language calls, we ask our introductory question to ensure we are speaking with a representative in the correct department and then we move 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. **All monitoring calls are placed from the Columbia, Maryland area 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 2023, 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 2023, 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 2023) 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, 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. For the Accuracy and Accessibility Study, we call from the Eastern Time Zone. You'll need to adjust the time accordingly if your call center is located in another time zone. If the time zone is not a factor and the call was truly placed outside of 8:00 a.m. to 8:00 p.m. in your 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 2023 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 2023, we determined the accuracy compliance threshold to be 90 percent. MA organizations and Part D sponsors with accuracy results below 90 percent are outliers and per 42 C.F.R. §§ 422.504(m)(2) and 423.505(n)(2), CMS may determine that an MA Organization or Part D sponsor is out of compliance when its performance in fulfilling requirements represents an outlier relative to the performance of other organizations.

EXHIBIT 4

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Thursday, February 29, 2024 3:06 PM
To: CMS QBPAPPEALS
Cc: Renee Delphin-Rodriguez
Subject: RE: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)
Attachments: Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245 v2.xlsm

Just in case it is necessary for proper consideration of our informal hearing request, we have also attached here a second version (Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245 v2) that includes our justification on the "Additional Comments" section of the form, rather than just in an attached Microsoft Word document. We had to insert two additional rows since it did not fit in the one row in the original form.

Please confirm receipt.

From: Michael Plumb
Sent: Thursday, February 29, 2024 10:43 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Informal Hearing Request Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for an Informal Hearing for MAPD contract H5425. Please note that in addition to the Informal Hearing Request form (excel file), we have attached several additional documents:

- A Microsoft Word file that contains our reasoning for the request for the informal hearing, since it does not fit in the cell for "Additional Comments" in the Excel Form in row 69 [
- The email request for reconsideration submitted on November 9th, 2023, which included the following:
  - Excel based request for reconsideration form
  - A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).
  - An additional file (.wav format) that includes a recording of a call (#C1201277) that we referenced in our justification for reconsideration.
- An additional ZIP file that contains the ".wav" format recording of the call (#C0600900) that is the focus for our appeal.
- A certified translation of call #C0600900, the call we are appealing
- A certified translation of call #C1201277, a reference call that is included in our appeal justification

Please let us know if you have any questions, or if you have any issues opening any of the files given the size of this email. I know there was some difficulty previously opening the .wav file.

Also, to ensure CMS receipt of this request for an informal hearing, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: CMS QBPAPPEALS <QBPAPPEALS@cms.hhs.gov>
Cc: Moon Leung <MLeung@scanhealthplan.com>; Ginette Hawkins <GHawkins@scanhealthplan.com>; Renee Delphin-Rodriguez <r.delphin-rodriguez@scanhealthplan.com>
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Confidentiality Notice: This email may contain confidential information, some or all of which may be protected health information (PHI) as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or may otherwise be proprietary, privileged, confidential and/or exempt from disclosure under applicable law. This email is intended for the exclusive use of the individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner and is prohibited from using this information for purposes other than intended and prohibited from disclosing this information to any other party unless required to do so by law or regulation.

IMPORTANT WARNING: If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by return email or phone. Thank you for your prompt attention in this matter.

Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245 v2.xlsm

Attachment B - Request for Informal Hearing

Note: The QBP administrative review process is a two-step process which includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Bo h steps are conducted at the contract level. The burden is on the MA organization to prove that the reconsideration decision was incorrect.

Instructions: Use only the "Request for Informal Hearing" form provided with the reconsideration decision. One form must be submitted for each contract for which reconsideration is requested. Complete he identifiable information including all contact information. Please enable Macros in this form. Mark an "X" next to the measure(s) that is the basis for the Request for Informal Hearing. Do not mark any measures for which you did not request a reconsidera ion. Please attach full documentation that supports your request for an informal hearing on he record. Save the information, 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 Informal Hearing is made by completing this form and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5 00 p.m. EST on February 29, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.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 Ra ing	Star Ra ings		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 he Risk of Falling	HEDIS / HOS		Not Appealable	
C13-Improving Bladder Control	HEDIS / HOS		Not Appealable	
C14-Medication Reconcilia ion Post-Discharge	HEDIS		Not Appealable	
C15-Plan All-Cause Readmissions	HEDIS		Not Appealable	
C16-Sta in 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 wi h 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 he Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ra ings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			

Attachment A

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrec ly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

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			
D02-Complaints about he 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 Ra ings		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 Medica ions	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-Sta in Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

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

Request for Informal Hearing related to SCAN Health Plan H5245 for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23.

We incorporate by reference and renew each and every one of our prior objections stated in our Request for Reconsideration for Measure C30 (attached hereto) based on the incorrect data set used to calculate SCAN's Star Rating that included call #C0600900 received by SCAN Health on 2/9/23. As detailed in our prior Request for Reconsidera ion, for call C0600900, there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8 minute threshold: the CMS caller did not ask the question clearly, including mul iple stumbles, speaking unusually slowly, and stating he plan name in a non-standard manner such hat he interpreter had trouble understanding, requiring further clarification, and creating significant and unnecessary delay. Unfortunately, CMS's Reconsideration Decision ("Technical Report for SCAN Health Plan H5425") fails to meaningfully address the critical problems detailed in our Request for Reconsideration. We renew those same objections, as fur her detailed herein.

First: At Page 4 in the Reconsideration Decision, CMS states hat "SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars)." To be clear: We requested, and now request again, that the call be ei her counted as a successful ("completed") call OR excluded from the C30 Star Rating measure. Either approach would result in SCAN Health's measure Star Rating increasing from 4 to 5 stars, and its overall Star Rating increasing to 4 Stars. This would result in SCAN qualifying for a quality bonus payment, as CMS rewards Medicare Advantage plans rated "4 stars or higher" with a quality bonus payment. See, e.g., 42 U.S.C. § 1395w-23(o)(1), (3)(A)(i).

Second: SCAN previously argued that the result of the call C0600900 was impacted by how the caller asked the question, which was not consistent with CMS's standard protocol, causing confusion on the part of the interpreter; the caller's speech resulted in the question needing to be repeated, and hus led to the call exceeding the time limit. The Reconsideration Decision states that CMS "disagree[s] with [SCAN's] assertion that the caller deviated from the standard protocol," and includes a table (at 5-6) purporting to document he translation of the secret shopper's statements. Line 4 and 5 of the table include the following:

"4. Exac ly what the interviewer actually asked in French: Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP? 5. Exactly what the interviewer actually asked translated to English: Hello. Are you the right person to answer ques ions about health benefits of Village Health HMO POS D-SNP?"

But what is listed in line 4 of the table is not "exactly what the interviewer asked in French." CMS ignores the manner in which the question was delivered. SCAN outlined in its original request for reconsideration "exactly what the interviewer actually asked in French," with the secret shopper restarting the question and many long pauses, which caused the confusion for he interpreter and caused he need for the question to be repeated, which added over 34 seconds of time to the call and caused it to exceed the time limit. We encourage the reviewer to listen to the actual call to see why the description above does not appropriately represent the nature of the ques ion:

French: Bonjour. "Êtes-vous la per……..Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux…..de…uh….Village Heal h….. H-M-O……P-O-S…. C…..S-N-P?"

It took 25 seconds for the CMS caller to complete the question, because of the stumble, the need to start over, and the long pauses. The total elapsed ime for the CMS caller to say "HMO POS CSNP" was 11 seconds. CMS claims in its Reconsidera ion Decision that "CMS callers are trained to ask questions in a conversational way" – but the way the CMS caller asked the question with the long pauses was not conversational at all. Thus, the interpreter was confused by he caller's slow reading of the individual letters in the plan name, and it was not clear that the caller was speaking the name of he plan. After the interpreter asks for the latter part of the question to be repeated, the CMS caller even goes so far as to clarify hat it's the name of the plan ("the nom de plan") before she repeats it again. It is indisputable that he manner in which the question was asked caused confusion. Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line.

Attachment A

Third: In our Request for Reconsideration, we included a recording of ano her French call (C1201277 hat we received on 3/24/2023, attached hereto) where the exact same ques ion was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated. CMS claims in the denial justification that "CMS asked the same ques ion on both calls, and any difference in the way they were stated is down to the individual caller." But CMS also argues that "CMS callers are trained to ask the ques ion in a conversational way." The way in which he challenged CMS caller asked the question was non-standard and caused confusion for he interpreter that led to the delay that caused the call to exceed he time limit. The Reconsideration Decision fails to provide any non-arbitrary rationale for its disparate treatment of call C0600900 and C1201277, with CMS stating (at 7) hat any "differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." But that is exactly the point: CMS cannot provide any non-arbitrary justification for why SCAN Health should be penalized based on "differences in he way they [the questions] were stated [by] the individual caller." Indeed, CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS "wouldn't hold that against you" and would not "count against you." 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescrip ion-drug-coverage-contracting

Fourth: CMS's Reconsideration Decision also references that "SCAN's argument ignores the fact hat it took over six and a half minutes for he interpreter to join the call to begin with." This is not an accurate representa ion of SCAN's argument at all. SCAN fully understands that it took hat 6 minute and 35 seconds to get an interpreter on the line. SCAN would ask one simple question of the informal hearing reviewer:

Is 1 minute and 25 seconds enough time to complete the cycle of the CMS caller asking the standard question and getting the appropriate response from the customer service representative?

In its Reconsidera ion Decision, CMS ignores the fact that it is completely possible, and typical, to s ill have a successful call even in such a scenario, and CMS irrationally takes the position that if there is any hing else irregular or inappropriate about the call, that the cause of the call failure is solely attributable to the time it took to get the interpreter on the line. That is not a fair and reasonable posi ion – 1 minute and 25 seconds is more han enough time for the cycle to be completed when he standard question is asked clearly and appropriately. The reference call that we provided, C1201277, took 41 seconds to complete that cycle. The failed French call, C0600900, took 86 seconds to complete the cycle – 45 seconds longer than in call C1201277. Variations in individual callers should not result in it taking twice as much time to complete the cycle. This was not a normal variation in a conversational way of asking the standard question. 1 minute and 25 seconds is clearly sufficient to respond to a properly posed question, had the CMS caller posed one.

Fifth: In the Reconsideration Decision, CMS also includes 2023 statistics about the number of French calls to all plans, as well as to SCAN specifically, and claims that CMS asks the same question on all calls. That argument is not relevant to our reconsideration request - SCAN is not contending that CMS asks different questions on each call. SCAN is contending that the manner in which the CMS caller asked the question for the specific call in ques ion was non-standard, given the stumbling and the long pauses, and inconsistent wi h the secret shopper's clearer manner of speech on call C1201277. The manner in which the question was asked caused the confusion for the interpreter that led to the delay that caused he call to exceed the time limit.

CMS goes on to argue in its denial justifica ion that "call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory ques ion was asked." That argument is also not relevant to SCAN's argument presented in our reconsideration. We are not questioning all other French calls. We are simply contending that for call C0600900, the question was asked in a non-standard manner that caused confusion for the interpreter, which led to the delay that cause the call to exceed the time limit.

In summary: As stated in our Request for Reconsideration, for call C0600900, the CMS caller's phrasing of he question and the way it was asked, including the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. The non-standard manner the question was asked resulted in an additional 34 seconds of time given the need to repeat the question. Without that 34-second delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute ime limit, even wi h the amount of time it took to get the interpreter on the line. That is why the call should either be deemed a successful call, or at a minimum, excluded from the sample for his star measure.

Additionally: The Reconsideration Decision asserts (at 2) that measure C30 is used to "ensure compliance wi h regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." But the regulation upon which CMS relies states that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." Here, SCAN Health did have an interpreter "available" within 8 minutes of the caller reaching the customer service representative: The interpreter introduced himself at 6 minutes 35 seconds, and spent the remaining time in an interactive dialogue with he caller to interpret her question. "Available" simply means an interpreter is "present or ready for immediate use." Available, Meriam-Webster Dictionary (2024); see also United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"). That standard was clearly met here: The caller was "connected to an interpreter wi hin 8 minutes," i.e., at 6:35. 86 Fed. Reg. 6007, 6007-08 (2021). Here, there is an arbitrary misalignment between CMS's stated goal in its regulation (to ensure hat an interpreter is available, i e. connected, within 8 minutes) and the rationale for its Reconsideration Decision (requiring SCAN Health to complete answering a caller's question within 8 minutes).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The ime required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Bal imore, Maryland 21244-1850.

Attachment B-Informal Hearing_Form_2025 SCAN Health Plan H5245.xlsm

Attachment B - Request for Informal Hearing

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Due Date: A Request for Informal Hearing is made by completing this form and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5 00 p.m. EST on February 29, 2024. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Title (your job title):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.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 Ra ing	Star Ra ings		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	
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C17-Transitions of Care	HEDIS		Not Appealable	
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C21-Customer Service	CAHPS		Not Appealable	
C22-Rating of Health Care Quality	CAHPS		Not Appealable	
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C26-Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C27-Health Plan Quality Improvement	Star Ra ings		Not Appealable	
C28-Plan Makes Timely Decisions about Appeals	IRE			
C29-Reviewing Appeals Decisions	IRE			

Attachment A

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrec ly included in our results based on a technical issue associated with the non-standard manner in which the CMS caller asked the standard question. Please see the additional comments section below for the explanation.

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			
D02-Complaints about he 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 Ra ings		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	
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D11-MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12-Sta in Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any addi ional information relevant to your request)
Request for Informal Hearing related to SCAN Health Plan H5245 for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23. This cell is not large enough to include our justification, thus we have attached it to the e-mail request for the informal hearing as a Microsoft Word Document titled "SCAN H5245 Informal Hearing Request Justification"

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The ime required to complete this information collection is estimated to average 8 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Bal imore, Maryland 21244-1850.

SCAN H5245 Informal Hearing Request Justification.docx

We incorporate by reference and renew each and every one of our prior objections stated in our Request for Reconsideration for Measure C30 (attached hereto) based on the incorrect data set used to calculate SCAN's Star Rating that included call #C0600900 received by SCAN Health on 2/9/23. As detailed in our prior Request for Reconsideration, for call C0600900, there was a technical issue caused by the CMS caller that ultimately caused the call to exceed the 8 minute threshold: the CMS caller did not ask the question clearly, including multiple stumbles, speaking unusually slowly, and stating the plan name in a non-standard manner such that the interpreter had trouble understanding, requiring further clarification, and creating significant and unnecessary delay. Unfortunately, CMS's Reconsideration Decision ("Technical Report for SCAN Health Plan H5425") fails to meaningfully address the critical problems detailed in our Request for Reconsideration. We renew those same objections, as further detailed herein.

First: At Page 4 in the Reconsideration Decision, CMS states that "SCAN requests that call C0600900 be reclassified as a successful call in their results. This would adjust their score for measure C30 from 95% (4 stars) to 97% (5 stars)." To be clear: We requested, and now request again, that the call be either counted as a successful ("completed") call OR excluded from the C30 Star Rating measure. Either approach would result in SCAN Health's measure Star Rating increasing from 4 to 5 stars, and its overall Star Rating increasing to 4 Stars. This would result in SCAN qualifying for a quality bonus payment, as CMS rewards Medicare Advantage plans rated "4 stars or higher" with a quality bonus payment. *See, e.g.*, 42 U.S.C. § 1395w-23(o)(1), (3)(A)(i).

Second: SCAN previously argued that the result of the call C0600900 was impacted by how the caller asked the question, which was not consistent with CMS's standard protocol, causing confusion on the part of the interpreter; the caller's speech resulted in the question needing to be repeated, and thus led to the call exceeding the time limit. The Reconsideration Decision states that CMS "disagree[s] with [SCAN's] assertion that the caller deviated from the standard protocol," and includes a table (at 5-6) purporting to document the translation of the secret shopper's statements. Line 4 and 5 of the table include the following:

> *"4. Exactly what the interviewer actually asked in French: Bonjour. Êtes-vous la personne adéquate pour répondre aux questions concernant des avantages médicaux de Village Health HMO POS D-SNP? 5. Exactly what the interviewer actually asked translated to English: Hello. Are you the right person to answer questions about health benefits of Village Health HMO POS D-SNP?"*

But what is listed in line 4 of the table is not "exactly what the interviewer asked in French." CMS ignores the manner in which the question was delivered. SCAN outlined in its original request for reconsideration "exactly what the interviewer actually asked in French," with the secret shopper restarting the question and many long pauses, which caused the confusion for the interpreter and caused the need for the question to be repeated, which added over 34 seconds of time to the call and caused it to exceed the time limit. We encourage the reviewer to listen to the actual call to see why the description above does not appropriately represent the nature of the question:

French: Bonjour. "Êtes-vous la per……..Êtes-vous la personne adéquate pour répondre aux questions concernant les avantages médicaux…..de…uh….Village Health….. H-M-O……P-O-S…. C…..S-N-P?"

It took 25 seconds for the CMS caller to complete the question, because of the stumble, the need to start over, and the long pauses. The total elapsed time for the CMS caller to say "HMO POS CSNP" was 11 seconds. CMS claims in its Reconsideration Decision that "CMS callers are trained to ask questions in a conversational way" – but the way the CMS caller asked the question with the long pauses was not conversational at all. Thus, the interpreter was confused by the caller's slow reading of the individual letters in the plan name, and it was not clear that the caller was speaking the name of the plan. After the interpreter asks for the latter part of the question to be repeated, the CMS caller even goes so far as to clarify that it's the name of the plan ("the nom de plan") before she repeats it again. It is indisputable that the manner in which the question was asked caused confusion. Without that secret shopper's delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line.

Third: In our Request for Reconsideration, we included a recording of another French call (C1201277 that we received on 3/24/2023, attached hereto) where the exact same question was asked with the same plan name, and the CMS caller did ask the question in a conversational way without long pauses. The question was asked in 17 seconds (32% less time) and the plan name was very clear, and the interpreter had no issue understanding the question and did not need to ask for it to be repeated. CMS claims in the denial justification that "CMS asked the same question on both calls, and any difference in the way they were stated is down to the individual caller." But CMS also argues that "CMS callers are trained to ask the question in a conversational way." The way in which the challenged CMS caller asked the question was non-standard and caused confusion for the interpreter that led to the delay that caused the call to exceed the time limit. The Reconsideration Decision fails to provide any non-arbitrary rationale for its disparate treatment of call C0600900 and C1201277, with CMS stating (at 7) that any "differences in the way they [the questions] were stated is down to the individual caller, just like a non-test call would be, which is what CMS is testing." But that is exactly the point: CMS cannot provide any non-arbitrary justification for why SCAN Health should be penalized based on "differences in the way they [the questions] were stated [by] the individual caller." Indeed, CMS has taken the position elsewhere that it would not penalize Medicare Advantage plans for delays and confusion introduced even by interpreters in answering questions, as CMS "wouldn't hold that against you" and would not "count against you." 2016 CMS Call Center Monitoring Q&A at 3, https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting

Fourth: CMS's Reconsideration Decision also references that "SCAN's argument ignores the fact that it took over six and a half minutes for the interpreter to join the call to begin with." This is not an accurate representation of SCAN's argument at all. SCAN fully understands that it took that 6 minute and 35 seconds to get an interpreter on the line. SCAN would ask one simple question of the informal hearing reviewer:

Is 1 minute and 25 seconds enough time to complete the cycle of the CMS caller asking the standard question and getting the appropriate response from the customer service representative?

In its Reconsideration Decision, CMS ignores the fact that it is completely possible, and typical, to still have a successful call even in such a scenario, and CMS irrationally takes the position that if there is anything else irregular or inappropriate about the call, that the cause of the call failure is solely attributable to the time it took to get the interpreter on the line. That is not a fair and reasonable position – 1 minute and 25 seconds is more than enough time for the cycle to be completed when the standard question is asked clearly and appropriately. The reference call that we provided, C1201277, took 41 seconds to complete that cycle. The failed French call, C0600900, took 86 seconds to complete the cycle – 45 seconds longer than in call C1201277. Variations in individual callers should not result in it taking twice as much time to complete the cycle. This was not a normal variation in a conversational way of asking the standard question. 1 minute and 25 seconds is clearly sufficient to respond to a properly posed question, had the CMS caller posed one.

Fifth: In the Reconsideration Decision, CMS also includes 2023 statistics about the number of French calls to all plans, as well as to SCAN specifically, and claims that CMS asks the same question on all calls. That argument is not relevant to our reconsideration request - SCAN is not contending that CMS asks different questions on each call. SCAN is contending that the manner in which the CMS caller asked the question for the specific call in question was non-standard, given the stumbling and the long pauses, and inconsistent with the secret shopper's clearer manner of speech on call C1201277. The manner in which the question was asked caused the confusion for the interpreter that led to the delay that caused the call to exceed the time limit.

CMS goes on to argue in its denial justification that "call C0600900 is the only French language call that has been questioned for this year's study around the issue of how the introductory question was asked." That argument is also not relevant to SCAN's argument presented in our reconsideration. We are not questioning all other French calls. We are simply contending that for call C0600900, the question was asked in a non-standard manner that caused confusion for the interpreter, which led to the delay that cause the call to exceed the time limit.

In summary: As stated in our Request for Reconsideration, for call C0600900, the CMS caller's phrasing of the question and the way it was asked, including the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. The non-standard manner the question was asked resulted in an additional 34 seconds of time given the need to repeat the question. Without that 34-second delay caused by the non-standard manner in which the question was asked, the call would have been completed within the 8-minute time limit, even with the amount of time it took to get the interpreter on the line. That is why the call should either be deemed a successful call, or at a minimum, excluded from the sample for this star measure.

Additionally: The Reconsideration Decision asserts (at 2) that measure C30 is used to "ensure compliance with regulatory requirements, found at 42 C.F.R. §§ 422.111(h)." But the regulation upon which CMS relies states that "interpreters must be available for 80 percent of incoming calls requiring an interpreter within 8 minutes of reaching the customer service representative." Here, SCAN Health did have an interpreter "available" within 8 minutes of the caller reaching the customer service representative: The interpreter introduced himself at 6 minutes 35 seconds, and spent the remaining time in an interactive dialogue with the caller to interpret her question. "Available" simply means an interpreter is "present or ready for immediate use." Available, Meriam-Webster Dictionary (2024); see also United States v. Soybel, 13 F.4th 584, 595 (7th Cir. 2021) ("available" means "present or ready for immediate use"). That standard was clearly met here: The caller was "connected to an interpreter within 8 minutes," i.e., at 6:35. 86 Fed. Reg. 6007, 6007-08 (2021). Here, there is an arbitrary misalignment between CMS's stated goal in its regulation (to ensure that an interpreter is available, i.e. connected, within 8 minutes) and the rationale for its Reconsideration Decision (requiring SCAN Health to complete answering a caller's question within 8 minutes).

Slip Sheet for C0600900.WAV

Audio File Cannot Be Filed Electronically Pursuant to Local Civil Rule 5.4(e)

C0600900_Transcript.pdf

Filename: C0600900
Client: Latham & Watkins
Job ID: US1796158
Date: February 27, 2024
Transcript by TransPerfect

00:00:00.0
RECORDED VOICE 1: Thank you for calling SCAN Health Plan. In order to ensure the highest level of service, this call is recorded and/or monitored for quality and training purposes. You are not required to provide any health related information, unless used to determine enrolment eligibility. Interpreter services are available at no cost. TTY users dial 7-1-1. For English press 1. For other languages press 2.

00:00:33.2
Thank you for calling SCAN Health Plan. Your call is important to us. The call may be recorded and/or monitored for quality purposes. Please stay on the line and the next available representative will be with you shortly. If you would like to become a SCAN member, please stay on the line. If you are a SCAN member, please press 2. If you are a provider, please press 3.

[MUSIC]

00:01:08.5
RECORDED VOICE 2: Taking your medications as directed is one of the best ways to manage your health. If you take ongoing medications, ask for a three-month—

00:01:22.2
OPERATOR: Thanks for calling SCAN Health. This is Jesse. Who do I have the pleasure speaking with?

00:01:27.5
CALLER: Uhhh… French? I need French?

00:01:31.6
OPERATOR: Yes, of course. One moment please.

[MUSIC: 00:01:37 — 00:06:25]

00:06:28.6
OPERATOR: One moment please, I'm still trying to locate a translator.

[MUSIC: 00:6:52 — 00:08:05]

00:08:05.5
INTERPRETER: … the French Interpreter, everything you say will remain secret and confidential. How can I help you?

00:08:13.7
OPERATOR: I have someone on the line who speaks French. Please go ahead.

00:08:19.9

Filename: C0600900
Client: Latham & Watkins
Job ID: US1796158
Date: February 27, 2024
Transcript by TransPerfect

INTERPRETER: Hello. My name is [INDISCERNIBLE: 00:08:22]. I am your French interpreter. Everything you say is going to be private and confidential.

00:08:31.7
CALLER: Yes, good evening.

00:08:35.2
INTERPRETER: Good evening.

00:08:33.6
CALLER: Hello. I have, I have a question, uh… are you the per-- are you the right person to answer questions about the medical benefits of uh… Village Health HMO . . . -POS . . .C . . . -SNP?

00:09:04.3
INTERPRETER: Excuse me, ma'am. I missed that. The medical benefits of this village. Can you repeat it, please?

00:09:14.2
CALLER: Yes, that's the name of the plan. It's Village Health, then HMO . . .-POS . . .C- . . . SNP.

00:09:42.1
INTERPRETER: Are you the right person to answer questions about the plan Village plus HMO-POS C-SNP?

00:09:57.0
OPERATOR: Yes, of course. How may I assist you?

00:10:01.6
INTERPRETER: Of course. What can I do for you?

00:10:07.0
WOMAN: Thank you. This has been a test call for the Centers for Medicare and Medicaid Services. We have reached the time limit for this question. Have a good day.

00:10:16.7
OPERATOR: Thank you. You too. Thank you interpreter.

00:10:18.8
INTERPRETER: Interpreter 0629754 disconnecting. Thank you for using our service.

[00:10:29]

C1201277_Transcript.pdf

Call C1201277.
Latham & Watkins LLP
February 28, 2024
Transcript by TransPerfect

[00:00]

RECORDED VOICE 1: Thank you for calling Scan Health Plan. In order to ensure the highest level of service, this call is recorded and or monitored for quality and training purposes. You are not required to provide any health related information unless used to determine enrollment eligibility. Interpreter services are available at no cost. TTY users dial 701 for English press one for other languages. Press two. Thank you for calling Scan Health plan. Your call is important to us. The call may be recorded and or monitored for quality purposes. Please stay on the line and the next available representative will be with you shortly. If you would like to become a scan member, please stay on the line. If you are a scan member, please press two. If you are a provider, please press three.

[*MUSIC*]

[01:05] **RECORDED VOICE 1:** We're excited to announce that scan has been named one of the best Medicare Advantage plans in California for 2023 by us. News and world.

[01:24] **OPERATOR:** Thank you for calling Scan Health Plan. This is Tanya, who do I have the pleasure of speaking to this morning?

[01:28] **CALLER:** No, English French.

[01:31] **OPERATOR:** Of course, one moment please.

[*MUSIC*]

[03:37] **OPERATOR:** Ok Maryanne, we're both here, thank you.

[03:40] **INTERPRETER:** My name is Maryanne, I'm a translator, ID number 064487. She said: "Thank you for calling Scan Health. How can I help you?"

[03:53] **CALLER:** Hello. Are you the right person to answer questions about the medical benefits of Village Health HMO POS CSNP?

[04:16] **INTERPRETER:** Are you the right person to answer the medical advantage of [INDISCERNIBLE] Plan HMO POS CSNP.

[04:34] **OPERATOR:** Yes.

[04:38] **INTERPRETER:** Yes.

[04:41] **CALLER:** Ok.

[04:45] **CALLER:** Thank you for your time, this has been a test call on behalf of the center for Medicare and Medicaid Services, have a good day.

[04:52] **OPERATOR:** Thank you so much, both of you. Have a wonderful afternoon.

[05:00] **CALLER**: Thank you.

Call C1201277.
Latham & Watkins LLP
February 28, 2024
Transcript by TransPerfect

[05:01] **OPERATOR**: Thank you

QBP Reconsideration Form for SCAN Health Plan (H5425).msg

From: Michael Plumb <MPlumb@scanhealthplan.com>
Sent: Friday, November 10, 2023 12:14 AM
To: QBPAPPEALS@cms.hhs.gov
Cc: Moon Leung; Ginette Hawkins; Renee Delphin-Rodriguez
Subject: QBP Reconsideration Form for SCAN Health Plan (H5425)
Attachments: Request_For_Reconsideration_Form_2025 - SCAN Health Plan H5425.xlsm; C1201277_03242023.WAV; Attachment 1. Additional Details To Support QBP Reconsideration v3.docx; Attachment 1. Additional Details To Support QBP Reconsideration.docx

Attached please find SCAN Health Plan's Request for Reconsideration for MAPD contract H5425. Please note that in addition to the Excel form, we have attached two additional forms:

- An additional file (.wav format) that includes a recording of a call that we referenced in our justification for reconsideration.
- A Microsoft Word file that simply contains the explanation included in the "Additional Comments" portion of the Excel Form in row 69 (in case there are any issues reading the text pasted into the Excel form).

Please let us know if you have any questions.

Also, to ensure CMS receipt of this request for reconsideration, please respond to this email confirming its receipt. Thank you.

Michael Plumb
CFO, SCAN Health Plan

Attachment to 11/10/2023 Email: Request_For_Reconsideration_Form_2025 - SCAN Health Plan H5425.xlsm

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 he opportunity to request a reconsideration of how its Star Rating, for he given measure in question, was calculated. This is not an opportunity for an MA organiza ion to question how every measure was calculated. A request for reconsidera ion 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, hen Performance Metrics. On the Performance Metrics page select Reports, Costs and then MA QBP Ra ing. One form must be submitted for each contract for which reconsideration is requested. Complete the iden ifiable 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 hat he 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 November 17, 2023. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	H5425
Contact First Name (your first name):	Michael
Contact Last Name (your last name):	Plumb
Contact Ti le (your job ti le):	Chief Financial Officer
Contact Phone Number (your phone number, include extension if necessary):	714-655-9202
Contact email address (your email address):	mplumb@scanhealthplan.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 wi h 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 Heal h Care Quality	CAHPS		Not Appealable	
C23-Ra ing of Heal h Plan	CAHPS		Not Appealable	
C24-Care Coordina ion	CAHPS		Not Appealable	
C25-Complaints about the Health Plan	CTM		Not Appealable	
C26-Members Choosing to Leave he 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			

Attachment A

C30-Call Center – Foreign Language Interpreter and TTY Availability	Call Center		X	We beleive incorrect data was used in the calculation for this measure given that one of the foreign language interpreter availability calls (C0600900) is incorrectly included in our results based on a technical issue associated with the non-standard manner in which he CMS caller asked the standard question. Please see he additional comments section below for the explanation.

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			
D02-Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C25 above.
D03-Members Choosing to Leave he Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C26 above.
D04-Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05-Ra ing 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 addi ional information relevant to your request)

Request for Reconsidera ion for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by he CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of he CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long he pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused he interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask he question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to he time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through he question and was much clearer. The failed call missed he time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Addi ionally, in spite of the 25 seconds it took just to ask he standard question in call C0600900, if you exclude the additional time associated wi h the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state hat "For the interpreter availability measure to be complete, he CSR, with the interpreter's help, must be able to respond "yes" to the introductory question before the 8-minute timer expires." Time delays hat are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that his call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way he question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

Additional Note

It is also worth noting that ano her possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with he standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about [Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is iden ified in he technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing wi h Medicare Advantage products, asking the ques ion wi h "medical advantages" right before he Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of informa ion unless it displays a valid OMB control number. The valid OMB control number for this informa ion collection is 0938-1129 and form number CMS-10346 (Expires: 8/31/2024). The time required to complete this informa ion collection is estimated to average 8 hours, including he time to review instructions, search existing data resources, ga her the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time es imate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

Attachment to 11/10/2023 Email:
Slip Sheet for C1201277_03242023.WAV

Audio File Cannot Be Filed Electronically
Pursuant to Local Civil Rule 5.4(e)

Attachment to 11/10/2023 Email:
Attachment 1. Additional Details To Support QBP Reconsideration v3.docx

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For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "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." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

<u>Additional Note</u>
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about

[Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

Attachment to 11/10/2023 Email: Attachment 1. Additional Details To Support QBP Reconsideration.docx

Request for Reconsideration for Measure C30 – Call Center – Foreign Language Interpreter and TTY Availability based on incorrect data set used to calculate star rating that included call #C0600900 received 2/9/23

For call C0600900, there was a technical issue caused by the CMS caller's deviation from protocol that ultimately caused the call to exceed the 8 minute threshold. The issue was that the CMS caller did not ask the question clearly, including a stumble at the start, and speaking unusually slowly and stating the plan name in a non-standard manner that the interpreter had trouble understanding. The English translation of the CMS caller's question asked was "are you the per……are you the right person to answer questions about the medical advantages of……uhhh…..Village Health…..H-M-O……P-O-S…..C…..S-N-P?" [The dots represent pauses the CMS caller made in speaking] The total time taken to ask the question from beginning to end was 25 seconds, which demonstrates how long the pauses were. The CMS caller's phrasing of the question and the way it was asked, specifically the slow spelling out of the plan name, caused confusion on the part of the interpreter regarding the plan name, which in turn caused the interpreter to need to ask for the question to be repeated. It was the additional 34 second delay caused by the question needing to be repeated that ultimately caused the call to exceed the 8 minute threshold.

For comparison purposes, we have also attached a recording of another French language interpreter availability assessment call that we received this year (C1201277 that we received on 3/24/2023). In call C1201277, the CMS caller asked the same question more clearly without the stumbling and excessively slow spelling out of the plan name (which was the exact same plan name as in call C0600900). The total time taken to ask the question was just 17 seconds and did not result in the interpreter needing to have the question repeated in order to translate. The total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 41 seconds.

For call C0600900, the total elapsed time from when the caller first started the standard question to the time when the interpreter provided the translated "yes" response was 86 seconds – 45 seconds longer than in call C1201277 where the caller did not stumble through the question and was much clearer. The failed call missed the time cutoff by 31 seconds. Thus, were it not for the additional delay caused by the non-standard way the C0600900 CMS caller asked the question, call C0600900 would have passed and not failed. Additionally, in spite of the 25 seconds it took just to ask the standard question in call C0600900, if you exclude the additional time associated with the question having to be repeated (34 seconds), the call would have been completed within the time limit. The technical specifications for this measure C30 – Call Center – Foreign Language Interpreter and TTY Availability state that "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." Time delays that are caused by the CMS caller asking the question in a non-standard way, and thus causing confusion on the part of the interpreter and the need for the call to be repeated, should not be included in the evaluation of a specific call success. Thus, we believe that this call was incorrectly included as a failure in our data and should be reversed to be counted as a completed call since the time in excess of 8 minutes was due to the CMS's caller's failure to follow established CMS protocols. At a minimum, the non-standard way the question was asked should warrant exclusion of this call from the dataset for this measure. CMS mischaracterized the call as a failure, and this data inaccuracy led to a calculation error for our performance on the C30 measure.

<u>Additional Note</u>
It is also worth noting that another possible contributor to the problem with call C0600900 was a technical issue with the standard question asked – specifically, that the question asked was not consistent with the standard question outlined in the Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes. Page 17 of the technical notes state that the introductory question asked by CMS callers is "are you the right person to answer questions about

[Plan name's] health benefits?" However, in call C0600900, the CMS caller framed the question in a way different than what is identified in the technical notes. The caller asked "are you the right person to answer questions about the medical advantages of [Plan name]." When dealing with Medicare Advantage products, asking the question with "medical advantages" right before the Plan name can cause additional confusion for the interpreter, and was a proximate cause of call C0600900 exceeding the 8 minute time limit. Where a deviation from the published CMS protocols by CMS or its contractor is the cause of an MA plan exceeding the 8 minute threshold, it is not appropriate for CMS to penalize the MA plan.

EXHIBIT 5

2024 Data View: Medicare Report Card Master Table											
CONTRACT_ID	Organization Type	Contract Name	Organization Marketing Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines				HD2: Managing Chronic (Long Term) Conditions		
					C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine	C04: Monitoring Physical Activity	C05: Special Needs Plan (SNP) Care Management	C06: Care for Older Adults – Medication Review	C07: Care for Older Adults – Pain Assessment
					01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	03/2023 – 06/2023	07/19/2022 – 11/01/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022
H5425	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	79%	76%	74%	58%	79%	93%	97%

C08: Osteoporosis Management in Women who had a Fracture	C09: Diabetes Care – Eye Exam	C10: Diabetes Care – Blood Sugar Controlled	C11: Controlling High Blood Pressure	C12: Reducing the Risk of Falling	C13: Improving Bladder Control	C14: Medication Reconciliation Post-Discharge	C15: Plan All-Cause Readmissions	C16: Statin Therapy for Patients with Cardiovascular Disease	C17: Transitions of Care	C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	07/19/2022 – 11/01/2022	07/19/2022 – 11/01/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022
53%	84%	87%	81%	63%	53%	87%	12%	83%	64%	57%

HD3: Member Experience with Health Plan						HD4: Member Complaints and Changes in the Health Plan's Performance			HD5: Health Plan Customer Service		
C19: Getting Needed Care	C20: Getting Appointments and Care Quickly	C21: Customer Service	C22: Rating of Health Care Quality	C23: Rating of Health Plan	C24: Care Coordination	C25: Complaints about the Health Plan	C26: Members Choosing to Leave the Plan	C27: Health Plan Quality Improvement	C28: Plan Makes Timely Decisions about Appeals	C29: Reviewing Appeals Decisions	C30: Call Center – Foreign Language Interpreter and TTY Availability
03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	Not Applicable	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	02/2023– 05/2023
76	74	91	84	89	81	0.13	8%	Medicare shows only	99%	97%	95%

DD1: Drug Plan Customer Service	DD2: Member Complaints and Changes in the Drug Plan's Performance			DD3: Member Experience with the Drug Plan		DD4: Drug Safety and Accuracy of Drug Pricing					
D01: Call Center – Foreign Language Interpreter and TTY Availability	D02: Complaints about the Drug Plan	D03: Members Choosing to Leave the Plan	D04: Drug Plan Quality Improvement	D05: Rating of Drug Plan	D06: Getting Needed Prescription Drugs	D07: MPF Price Accuracy	D08: Medication Adherence for Diabetes Medications	D09: Medication Adherence for Hypertension (RAS antagonists)	D10: Medication Adherence for Cholesterol (Statins)	D11: MTM Program Completion Rate for CMR	D12: Statin Use in Persons with Diabetes (SUPD)
02/2023– 05/2023	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	Not Applicable	03/2023 – 06/2023	03/2023 – 06/2023	01/01/2022 – 9/30/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022
92%	0.13	8%	Medicare shows only	89	90	100	89%	90%	89%	85%	90%

2024 Star View: Medicare Report Card Master Table											
CONTRACT_ID	Organization Type	Contract Name	Organization Marketing Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines				HD2: Managing Chronic (Long Term) Conditions		
					C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine	C04: Monitoring Physical Activity	C05: Special Needs Plan (SNP) Care Management	C06: Care for Older Adults – Medication Review	C07: Care for Older Adults – Pain Assessment
					01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	03/2023 – 06/2023	07/19/2022 – 11/01/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022
H5425	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	5	4	4	5	4	4	5

C08: Osteoporosis Management in Women who had a Fracture	C09: Diabetes Care – Eye Exam	C10: Diabetes Care – Blood Sugar Controlled	C11: Controlling High Blood Pressure	C12: Reducing the Risk of Falling	C13: Improving Bladder Control	C14: Medication Reconciliation Post-Discharge	C15: Plan All-Cause Readmissions	C16: Statin Therapy for Patients with Cardiovascular Disease	C17: Transitions of Care	C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	07/19/2022 – 11/01/2022	07/19/2022 – 11/01/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022
3	5	5	4	4	5	5	2	2	4	3

HD3: Member Experience with Health Plan						HD4: Member Complaints and Changes in the Health Plan's Performance			HD5: Health Plan Customer Service		
C19: Getting Needed Care	C20: Getting Appointments and Care Quickly	C21: Customer Service	C22: Rating of Health Care Quality	C23: Rating of Health Plan	C24: Care Coordination	C25: Complaints about the Health Plan	C26: Members Choosing to Leave the Plan	C27: Health Plan Quality Improvement	C28: Plan Makes Timely Decisions about Appeals	C29: Reviewing Appeals Decisions	C30: Call Center – Foreign Language Interpreter and TTY Availability
03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	03/2023 – 06/2023	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	Not Applicable	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	02/2023– 05/2023
2	2	4	2	4	1	5	5	2	5	4	4

DD1: Drug Plan Customer Service	DD2: Member Complaints and Changes in the Drug Plan's Performance			DD3: Member Experience with the Drug Plan		DD4: Drug Safety and Accuracy of Drug Pricing					
D01: Call Center – Foreign Language Interpreter and TTY Availability	D02: Complaints about the Drug Plan	D03: Members Choosing to Leave the Plan	D04: Drug Plan Quality Improvement	D05: Rating of Drug Plan	D06: Getting Needed Prescription Drugs	D07: MPF Price Accuracy	D08: Medication Adherence for Diabetes Medications	D09: Medication Adherence for Hypertension (RAS antagonists)	D10: Medication Adherence for Cholesterol (Statins)	D11: MTM Program Completion Rate for CMR	D12: Statin Use in Persons with Diabetes (SUPD)
02/2023– 05/2023	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	Not Applicable	03/2023 – 06/2023	03/2023 – 06/2023	01/01/2022 – 9/30/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022	01/01/2022 – 12/31/2022
3	5	5	1	4	4	5	4	4	4	4	4

2024 Summary Star View: Medicare Report Card Master Table										
Contract Number	Organization Type	Contract Name	Organization Marketing Name	Parent Organization	SNP	2021 Disaster %	2022 Disaster %	2024 Part C Summary	2024 Part D Summary	2024 Overall
H5425	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	Yes	0	0	3.5	3.5	3.5

EXHIBIT 6

Medicare 2022 Part C & D Star Ratings Technical Notes

Updated – 10/04/2021

Document Change Log

Previous Version	Description of Change	Revision Date

OMB Approved Data Sources

The data collected for the Part C & D Star Ratings come from a variety of different data sources approved under the following Office of Management and Budget (OMB) Paperwork Reduction Act numbers:

Data Source	OMB Number
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0938-0732
Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

Table of Contents

DOCUMENT CHANGE LOG I
INTRODUCTION 1
DIFFERENCES BETWEEN THE 2021 STAR RATINGS AND 2022 STAR RATINGS 1
HEALTH/DRUG ORGANIZATION TYPES INCLUDED IN THE STAR RATINGS 2
Table 1: Contract Year 2022 Organization Types Reported in the 2022 Star Ratings 2
THE STAR RATINGS FRAMEWORK 2
Figure 1: The Four Levels of Star Ratings 3
Table 2: 5-Star Scale 3
Table 3: Relation of 2022 Organization Types to Contract Types and Highest Rating in the 2022 Star Ratings 4
SOURCES OF THE STAR RATINGS MEASURE DATA 4
Figure 2: The Four Categories of Data Sources 5
IMPROVEMENT MEASURES 5
Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type 5
CONTRACT ENROLLMENT DATA 5
HANDLING OF BIASED, ERRONEOUS, AND/OR NOT REPORTABLE (NR) DATA 5
SCALED REDUCTIONS FOR THE APPEALS MEASURES 6
DATA HANDLING OF MEASURES FOR CONTRACTS AFFECTED BY A MAJOR DISASTER 7
METHODOLOGY FOR ASSIGNING STARS TO THE PART C AND PART D MEASURES 9
A. Clustering 9
B. Relative Distribution and Significance Testing (CAHPS) 9
METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL 9
Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type 10
SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES 10
METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS 11
Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type 11
METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING 11
Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type 12
COMPLETING THE SUMMARY AND OVERALL RATING CALCULATIONS 12
APPLYING THE IMPROVEMENT MEASURE(S) 12
APPLYING THE REWARD FACTOR 13
Table 8: Performance Summary Thresholds 14
Table 9: Variance Thresholds 14
CATEGORICAL ADJUSTMENT INDEX (CAI) 14
Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating 16
Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating 16
Table 12: Final Adjustment Categories and CAI Values for the Overall Rating 16
Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary 17
Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary 17
Table 15: Final Adjustment Categories and CAI Values for the Part C Summary 17
Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary 18
Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary 18
Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary 18
Table 19: Categorization of Contract's Members into Quartiles of LIS/DE for the PDP Part D Summary 18
Table 20: Categorization of Contract's Members into Quartiles of Disability for the PDP Part D Summary 19
Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary 19

CALCULATION PRECISION **19**
ROUNDING RULES FOR MEASURE SCORES **19**
ROUNDING RULES FOR SUMMARY AND OVERALL RATINGS **20**
Table 22: Rounding Rules for Summary and Overall Ratings 20
METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON **20**
Figure 3: The High Performing Icon 20
METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON **20**
Figure 4: The Low Performing Icon 20
Table 23: Example LPI Contracts 21
MERGERS, NOVATIONS, AND CONSOLIDATIONS **21**
RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS **21**
SPECIAL NEEDS PLAN (SNP) DATA **21**
STAR RATINGS AND MARKETING **22**
CONTACT INFORMATION **22**
FRAMEWORK AND DEFINITIONS FOR THE DOMAIN AND MEASURE DETAILS SECTION **24**
PART C DOMAIN AND MEASURE DETAILS **25**
Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines **25**
Measure: C01 - Breast Cancer Screening 25
Measure: C02 - Colorectal Cancer Screening 26
Measure: C03 - Annual Flu Vaccine 27
Measure: C04 - Monitoring Physical Activity 28
Domain: 2 - Managing Chronic (Long Term) Conditions **30**
Measure: C05 - Special Needs Plan (SNP) Care Management 30
Measure: C06 - Care for Older Adults – Medication Review 32
Measure: C07 - Care for Older Adults – Pain Assessment 33
Measure: C08 - Osteoporosis Management in Women who had a Fracture 34
Measure: C09 - Diabetes Care – Eye Exam 35
Measure: C10 - Diabetes Care – Kidney Disease Monitoring 36
Measure: C11 - Diabetes Care – Blood Sugar Controlled 37
Measure: C12 - Rheumatoid Arthritis Management 39
Measure: C13 - Reducing the Risk of Falling 40
Measure: C14 - Improving Bladder Control 41
Measure: C15 - Medication Reconciliation Post-Discharge 42
Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease 43
Domain: 3 - Member Experience with Health Plan **46**
Measure: C17 - Getting Needed Care 46
Measure: C18 - Getting Appointments and Care Quickly 47
Measure: C19 - Customer Service 48
Measure: C20 - Rating of Health Care Quality 49
Measure: C21 - Rating of Health Plan 50
Measure: C22 - Care Coordination 50
Domain: 4 - Member Complaints and Changes in the Health Plan's Performance **52**
Measure: C23 - Complaints about the Health Plan 52
Measure: C24 - Members Choosing to Leave the Plan 53
Measure: C25 - Health Plan Quality Improvement 54
Domain: 5 - Health Plan Customer Service **56**
Measure: C26 - Plan Makes Timely Decisions about Appeals 56
Measure: C27 - Reviewing Appeals Decisions 57
Measure: C28 - Call Center – Foreign Language Interpreter and TTY Availability 58
PART D DOMAIN AND MEASURE DETAILS **60**
Domain: 1 - Drug Plan Customer Service **60**
Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability 60

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance 62
Measure: D02 - Complaints about the Drug Plan 62
Measure: D03 - Members Choosing to Leave the Plan 63
Measure: D04 - Drug Plan Quality Improvement 64
Domain: 3 - Member Experience with the Drug Plan 66
Measure: D05 - Rating of Drug Plan 66
Measure: D06 - Getting Needed Prescription Drugs 67
Domain: 4 - Drug Safety and Accuracy of Drug Pricing 68
Measure: D07 - MPF Price Accuracy 68
Measure: D08 - Medication Adherence for Diabetes Medications 69
Measure: D09 - Medication Adherence for Hypertension (RAS antagonists) 72
Measure: D10 - Medication Adherence for Cholesterol (Statins) 74
Measure: D11 - MTM Program Completion Rate for CMR 76
Measure: D12 - Statin Use in Persons with Diabetes (SUPD) 79

ATTACHMENT A: CAHPS CASE-MIX ADJUSTMENT 81
CAHPS Case-Mix Adjustment 81
Table A-1: Coefficients of Part C CAHPS Measures 81
Table A-2: Coefficients of Part D CAHPS Measures 83

ATTACHMENT B: CALCULATING MEASURE DATA FOR THE SURVIVING CONTRACT OF A CONSOLIDATION 84

ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES 85
Table C-1: National Averages for Part C Measures 85
Table C-2: National Averages for Part D Measures 86

ATTACHMENT D: PART C AND D DATA TIME FRAMES 87
Table D-1: Part C Measure Data Time Frames 87
Table D-2: Part D Measure Data Time Frames 88

ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES 89
1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management) 89
2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults) 90

ATTACHMENT F: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES 91
Table F-1: Part C Measure Weights 91
Table F-2: Part D Measure Weights 92

ATTACHMENT G: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES 93

ATTACHMENT H: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED 94
Calculating the Improvement Measure 94
General Standard Error Formula 95
Improvement Change Score Standard Error Numerical Example 95
Standard Error Formulas (SEF) for Specific Measures 95
1. SEF for Measures: C01, C02, C04, C05, C08 – C15, C16, C24, C26 – C28, D01, D03, D08 – D12 97
2. SEF for Measures: C06, C07 97
3. SEF for Measures: C03, C17 – C22, and D05, D06 97
4. SEF for Measures C23, D02 97

Star Ratings Measures Used in the Improvement Measures 98
Table H-1: Part C Measures Used in the Improvement Measure 98
Table H-2: Part D Measures Used in the Improvement Measure 99

ATTACHMENT I: STAR RATINGS MEASURE HISTORY 100
Table I-1: Part C Measure History 100
Table I-2: Part D Measure History 104
Table I-3: Common Part C & Part D Measure History 108

ATTACHMENT J: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS 109
Clustering Methodology Introduction 109
Figure J-1: Diagram showing gaps in data where cut points are assigned 109
Example 1 – Clustering Methodology for a Higher is Better measure 109

Table J-1: Medication Adherence for Diabetes Medications cut points example 110
Example 2 – Clustering Methodology for a Lower is Better measure 110
Table J-2: Members Choosing to Leave the Plan cut points example 110
Clustering Methodology Detail 110
1. Produce the individual measure distance matrix. 111
2. Create a tree of cluster assignments. 111
3. Select the final set of clusters from the tree of cluster assignments. 112
4. Final Thresholds 112
Table J-3: 2022 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds 113
Table J-4: 2022 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds 113
Relative Distribution and Significance Testing (CAHPS) Methodology 113
Table J-5: CAHPS Star Assignment Rules 114
Table J-6: CAHPS Star Assignment Alternate Representation 114
ATTACHMENT K: MEDICATION ADHERENCE MEASURE CALCULATIONS 116
Proportion of Days Covered Calculation 116
Example 1: Non-Overlapping Fills of Two Different Drugs 116
Table K-1: No Adjustment 116
Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products 116
Table K-2: Before Overlap Adjustment 116
Table K-3: After Overlap Adjustment 117
Example 3: Overlapping Fills of the Same and Different Target Drugs 117
Table K-4: Before Overlap Adjustment 117
Table K-5: After Overlap Adjustment 117
PDC Adjustment for Inpatient, Hospice, and Skilled Nursing Facility Stays Examples 118
Calculating the PDC Adjustment for IP Stays and SNF Stays 118
Example 1: Gap in Coverage after IP Stay 119
Table K-6: Before Adjustment 119
Table K-7: After Adjustment 119
Example 2: Gap in Coverage before IP Stay 119
Table K-8: Before Adjustment 119
Table K-9: After Adjustment 120
Example 3: Gap in Coverage Before and After IP Stay 120
Table K-10: Before Adjustment 120
Table K-11: After Adjustment 120
Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class 120
Table K-12: Before Adjustment 120
Table K-13: After Adjustment 121
ATTACHMENT L: METHODOLOGY FOR PRICE ACCURACY MEASURE 122
Example of Accuracy Index Calculation 125
Table L-1: Example of Price Accuracy Index Calculation 125
ATTACHMENT M: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES 126
Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure) 126
ATTACHMENT N: METHODOLOGY FOR THE PUERTO RICO MODEL 128
ATTACHMENT O: SCALED REDUCTIONS FOR APPEALS IRE DATA 131
Part C Scaled Reduction Methodology 131
Stage 1: Determine Whether the Contract is Subject to a Potential Reduction for the Part C Appeals Measures Due to an IRE Data Completeness Issue 131
Table O-1: Multiplying Factor to calculate the 3-month Projected Number of Cases Not Forwarded to the IRE 132
Table O-2: Identification of a Contract that is Subject to a Possible Scaled Reduction 132
Stage 2: Estimated Error Rate 132
Stage 3: Scaled Reduction 133
Table O-3: Thresholds and Associated Reductions 133
ATTACHMENT P: IDENTIFICATION OF CONTRACTS AFFECTED BY DISASTERS 135

Operational Steps to Calculating Enrollment Impacted in Affected Contracts **135**
Table P-1: List of Section 1135 waivers issued in relation to the FEMA major disaster declarations 135
Table P-2: List of FEMA disaster declarations issued as a result of the COVID-19 outbreak 135
Table P-3: Individual Assistance counties in FEMA Major Disaster Declared States Other than from the COVID-19 Pandemic 137
Table P-4: Organization type service areas and necessary transformations 137
Table P-5: Major disasters with associated enrollment months 137
Table P-6: How enrollment periods were combined for contracts experiencing multiple disasters 138
Example: **138**
Table P-7: Example contract HAAAA's service areas and enrollment during relevant disasters 139

ATTACHMENT Q: MISSING DATA MESSAGES **141**
Measure level messages **141**
Table Q-1: Measure level missing data messages 141
Assignment rules for Part C measure messages **141**
Assignment rules for Part D measure messages **145**
Table Q-2: MTM CMR reason(s) for display message conversion 146
Domain, Summary, and Overall level messages **147**
Table Q-3: Domain, summary, and overall level missing data messages 147
Assignment rules for Part C & Part D domain rating level messages **147**
Assignment rules for Part C & Part D summary rating level messages **147**
Assignment rules for overall rating level messages **147**
Disenrollment Reasons messages **148**
Table Q-4: Disenrollment reason missing data messages 148

ATTACHMENT R: GLOSSARY OF TERMS **149**

ATTACHMENT S: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE **152**
HPMS Star Ratings Module **152**
1. Measure Data page 152
Table S-1: Measure Data page sample 152
2. Measure Detail page 152
Table S-2: Measure Detail page fields 154
3. Measure Detail – Part C Appeals page 154
Table S-3: Measure Detail – Part C Appeals page fields 154
4. Measure Detail – SNP CM page 154
Table S-4: Measure Detail – SNP CM page fields 155
5. Measure Detail – SNP COA page 155
Table S-5: Measure Detail – SNP COA page fields 155
Table S-6: HEDIS 2020 Audit Designations and 2022 Star Ratings 155
6. Measure Detail – CTM page 156
Table S-7: Measure Detail – CTM page fields 156
7. Measure Detail – Disenrollment 156
Table S-8: Measure Detail – Disenrollment page fields 156
8. Measure Detail – DR (Disenrollment Reasons) 156
Table S-9: Measure Detail – Disenrollment Reasons page fields 156
9. Measure Detail – MTM page 157
Table S-10: Measure Detail – MTM page fields 157
10. Measure Detail – CAHPS page 157
Table S-11: Measure Detail – CAHPS page fields 158
11. Calculation Detail – CSR 158
Table S-12: Measure Detail – Part C Scaled Reductions page fields 158
12. Calculation Detail – MD 158
Table S-13: Calculation Detail – MD page fields 159
13. Calculation Detail – CAI 159
Table S-14: Measure Detail – CAI page fields 160
14. Measure Detail – HEDIS LE page 160
Table S-15: Measure Detail – HEDIS LE page fields 161
15. Measure Detail – C Disaster Results 161
Table S-16: Measure Detail – C Disaster Results 161

16. Measure Detail – D Disaster Results....161
Table S-17: Measure Detail – D Disaster Results....162
17. Measure Detail – C Improvement page....162
Table S-18: Part C Measure Improvement Results....162
18. Measure Detail – D Improvement page....162
Table S-19: Part D Measure Improvement Results....163
19. Measure Stars page....163
Table S-20: Measure Star page sample....163
20. Domain Stars page....163
Table S-21: Domain Star page sample....164
21. Part C Summary Rating page....164
Table S-22: Part C Summary Rating page fields....164
22. Part D Summary Rating page....164
Table S-23: Part D Summary Rating View....165
23. Overall Rating page....165
Table S-24: Overall Rating View....165
24. Highest Rating page....166
Table S-25: Highest Rating View....166
25. Low Performing Contract List....166
Table S-26: Low Performing Contract List....167
26. High Performing Contract List....167
Table S-27: High Performing Contract List....167
27. Technical Notes link....167
28. Medication NDC List....167
29. Part C and Part D Example Measure Data....168

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 '2022 Medicare Part C & D Star Ratings' because they are posted prior to the 2022 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 the 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 "2022" 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 the highest priority areas for quality measurement and improvement, including promote effective communication and coordination of care; promote effective prevention and treatment of chronic disease; work with communities to promote best practices of healthy living; make care affordable; make care safer by reducing harm caused by the delivery of care; and strengthen person and family engagement as partners in their care. The Star Ratings include measures applying to the following five broad categories:

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

Differences between the 2021 Star Ratings and 2022 Star Ratings

There have been several changes between the 2021 Star Ratings and the 2022 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2022 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment I.

- Changes
  a. For 2022 Star Ratings, the underlying data for HEDIS and CAHPS measures will resume use of the most recent data.
  b. Mean resampling was added to the hierarchical clustering methodology that is used to set cut points for non-CAHPS measures.
  c. Re-specified MPF Price Accuracy measure moved into the 2022 Star Ratings as a new measure.
  d. For 2022 Star Ratings only, expanded the existing improvement measure hold harmless provision to all contracts at the overall and summary rating levels.

e. For 2022 Star Ratings only, modify the disaster policy to remove application of the 60% rule and avoid the exclusion of contracts with 60% or more of their enrollees living in FEMA-designated Individual Assistance areas from calculation of the non-CAHPS measure-level cut points and calculation of the Reward Factor.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)

1) Part C measure – Care of Older Adults – Functional Status Assessment was temporarily moved to the display page for the 2022 and 2023 Star Ratings because NCQA made substantive changes to the measure specification.
2) For the 2022 and 2023 Star Ratings, *Improving or Maintaining Physical Health* and *Improving or Maintaining Mental Health* will be moved to the display page on CMS.gov due to validity concerns related to the COVID-19 public health emergency.

- Retired measures
  a. Part C measure – Adult BMI Assessment
  b. Part D measure – Appeals Auto-Forward
  c. Part D measure – Appeals Upheld

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 2022 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2022 Organization Types Reported in the 2022 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
Demonstration (Person Centered Community Care)	PCCC	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 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:

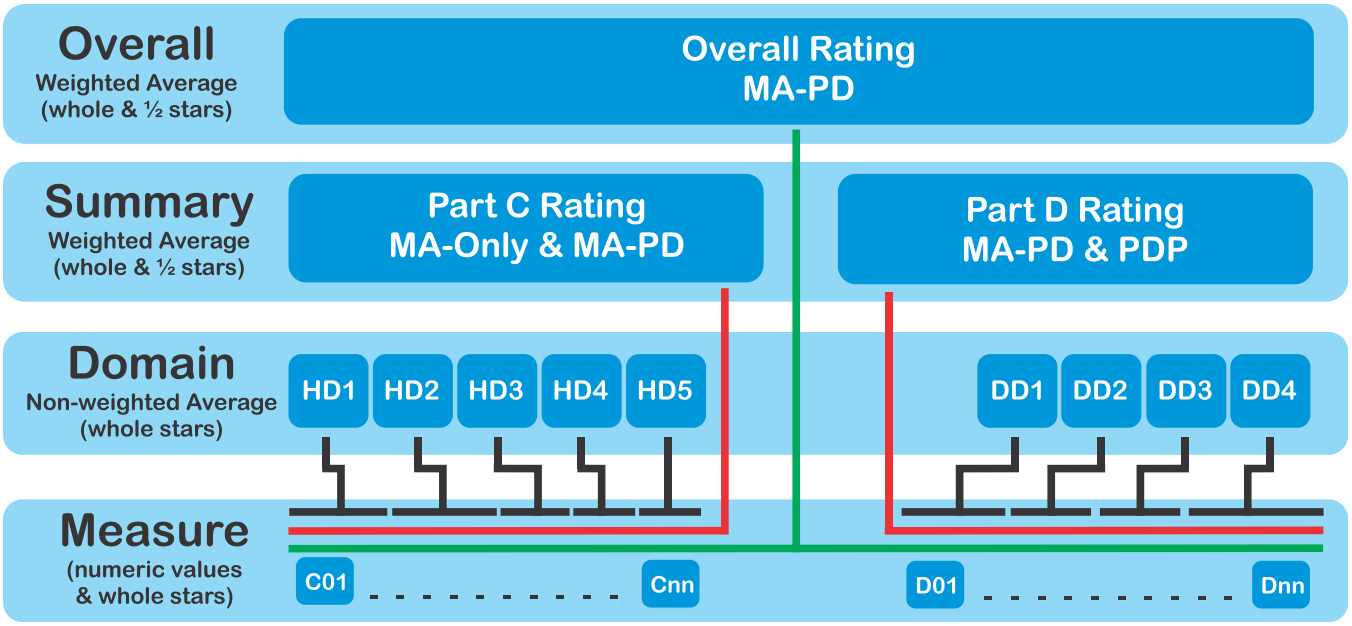
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 2022 Organization Types to Contract Types and Highest Rating in the 2022 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 2022 Star Ratings include a maximum of 9 domains comprised of a maximum of 40 measures.

- MA-Only contracts are measured on 5 domains with a maximum of 28 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 40 measures, 38 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 plan 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 H.

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. Table 5 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	12 of 24	14 of 27	10 of 19	12 of 23	N/A	12 of 24
D	5 of 9*	5 of 10	5 of 10	4 of 8	N/A	5 of 10	5 of 10*

* 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 the HPMS. 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 2020 through December 2020) 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 three Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. (For 2022 and 2023 Star Ratings, "The Care of Older Adults – Functional Status Assessment" measure has been moved to 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 2020 through December 2020), 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; a contract's failure to adhere to CMS-approved point-of-sale edits; 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. Note there is no minimum number of cases required for a contract's data to be subject to data integrity reviews.

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."

Scaled Reductions for the Appeals Measures

At present, there are two Star Ratings appeals measures that rely on data submitted to the IRE: Part C measures Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions. The completeness of the IRE data is critical to allow accurate measurement of each of the appeals measures. All contracts are responsible and held accountable for ensuring high quality and complete data to maintain the validity and reliability of the measures. CMS conducts an industry wide monitoring project to collect data to evaluate the timeliness of processing of Medicare Advantage (Part C) organization determinations and reconsiderations. Through this Timeliness Monitoring Project's data collection (TMP data), CMS can assess all sponsors' timeliness, as well as sponsor compliance with forwarding cases to the IRE.

CMS uses statistical criteria to reduce a contract's appeals measure-level Star Ratings for data that are not complete or lack integrity using TMP or audit data. The reduction is applied to the measure-level Star Ratings of the applicable appeals measures. Because there are varying degrees of data accuracy and integrity issues, the methodology for reductions reflects the degree of the data accuracy issue for a contract instead of a one-size-fits-all approach. The methodology employs scaled reductions (one-star, two-star, three-star, or four-star reduction) based on the degree of severity of missing or compromised IRE data. Contracts with the highest IRE data quality issues (i.e., largest percentage of missing or compromised data) receive the largest reductions, while contracts with a lower degree of missing IRE data receive a smaller reduction. The most severe reduction for IRE data completeness issues is a four-star reduction, thus resulting in measure-level Star Ratings of one star for the associated appeals measures. If a contract receives a reduction due to missing Part C IRE data, the reduction is applied to both of the contract's Part C appeals measures. If a contract fails to submit TMP data for CMS's review to ensure the completeness of their IRE data, the contract receives one-star for the associated appeals measures. (This is similar to how CMS treats measures that are dependent on contracts' completion of data validation of plan-reported data.)

CMS's scaled reduction methodology is a three-stage process using the TMP data or audit to determine: first, whether a contract may be subject to a potential reduction for the Part C appeals measures; second, as the basis for the determination of the estimated error rate; and finally, whether the estimated value is statistically significantly greater than the cut points for the scaled reductions of 1, 2, 3, or 4 stars. Details of the methodology are available in Attachment O.

Once the scaled reduction for a contract is identified using the methodology, the reduction is applied to a contract's associated appeals measure-level Star Ratings. Since the minimum measure-level Star Rating is one star, if the difference between the associated appeals measure-level Star Rating (before the application of the reduction) and the identified scaled reduction is less than one, the contract will receive a measure-level Star Rating of one star for the appeals measure. If a contract does not qualify for the Part C measures due to number of eligible cases (the denominator is less than or equal to 10), but is found to qualify for a reduction, the contract will receive the reduction.

If a scaled reduction is applied to the Part C appeals measure in either the current or the previous year, the associated appeals measures will not be included in the respective improvement measure.

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 published in the 2022 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.)

This section describes how the policy is implemented for measures from each of the different data sources in the 2022 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 membership affected for every contract being rated and will apply 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 2021 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 2021 or the 2022 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure).
  - As outlined in the COVID-19 interim final rule (CMS-1744-IFC) and 2021 Star Ratings Technical Notes, the final 2020 Star Ratings for CAHPS measures were carried forward for the 2021 Star Ratings. The final 2020 Star Ratings, which applied the disaster policy, were considered the 'baseline' or pre-adjustment stars within the 2021 Star Ratings. As such, when applying the disaster policy for CAHPS measures for the 2022 Star Ratings for doubly affected contracts, the baseline stars from 2021 and 2022 were compared and the higher star of the two was taken.
- HEDIS-HOS adjustments:
  - The HEDIS-HOS data used in the 2022 Star Ratings are adjusted for 2019 disasters (see Attachment P of the 2021 Star Ratings Technical Notes for the identification of contracts affected by 2019 disasters).
  - All affected contracts (i.e., contracts affected by 2019 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2021 or the 2022 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 2019 were also affected by disasters in 2018. These doubly-affected contracts receive the higher of the 2022 Star Rating or what the 2021 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2018 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 2021 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 2021 or 2022 Star Ratings measure stars (and corresponding measure scores).
    - As outlined in the COVID-19 interim final rule (CMS-1744-IFC) and 2021 Star Ratings Technical Notes, the final 2020 Star Ratings for HEDIS measures were carried forward for the 2021 Star Ratings. The final 2020 Star Ratings, which applied the disaster policy, were considered the 'baseline' or pre-adjustment stars within the 2021 Star Ratings. As such, when applying the disaster policy for HEDIS measures for the 2022 Star Ratings for doubly affected contracts, the baseline stars from 2021 and 2022 were compared and the higher star of the two was taken.
- Part C and D Call Center:
    - For all contracts, no adjustments were made.
- New measure
    - 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 the new MPF Price Accuracy measure. If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating.
    - A similar hold harmless provision is applied for the Part D summary ratings. If a contract has 25% or more affected members, the Part D summary rating is calculated "with" and "without" the new MPF Price Accuracy, and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary rating.
- All other measures:
    - Contracts with 25% or more affected members receive the higher of the 2021 or 2022 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 2020 were also affected by disasters in 2019. These doubly-affected contracts receive the higher of the 2022 Star Rating or what the 2021 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2019 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 2021 or 2022 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.

- Reward Factor:
    - For the 2022 Star Ratings only, we will not exclude contracts with 60% or more of their enrollees living in FEMA-designated Individual Assistance areas from calculation of the Reward Factor.
- Cut points
    - For the 2022 Star Ratings only, we will not exclude contracts with 60% or more of their enrollees living in FEMA-designated Individual Assistance areas from calculation of cut points for measures that use clustering methodology.

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 J explains the clustering and relative distribution and significance testing (used for CAHPS measures) methods in greater detail.

The *Cut Point Trend* document is posted on the website at http://go.cms.gov/partcanddstarratings and is updated after each rating cycle is released.

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.

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 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 3	3 of 4	N/A	3 of 4
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 8	5 of 9	7 of 12	6 of 11	5 of 9	N/A	5 of 9
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 Pricing and Patient Safety (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 2022 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by the outcome and intermediate outcome measures, then by patient experience/complaints and access measures, and finally the 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 F.

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	12 of 24	14 of 27	10 of 19	12 of 23	N/A	12 of 24
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 10 measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

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

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

There are a total of 40 measures (28 in Part C, 12 in Part D) in the 2022 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 36 distinct 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*	17 of 33	18 of 36	13 of 26	N/A	N/A	17 of 33*

* 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 30 measures to receive an overall rating.

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, for the 2022 Star Ratings, 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 (C25) 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 H. This section discusses whether and how to apply the improvement measures in calculating a contract's final summary and overall ratings.

For the 2022 Star Ratings only we expanded the hold harmless rule to include all contracts at the overall and summary ratings recognizing that the Public Health Emergency for the COVID-19 pandemic may have resulted in a decline in industry performance. CMS developed the following rules for the 2022 Star Ratings.

MA-PD Contracts

1. There are separate Part C and Part D improvement measures for MA-PD contracts.
    a. The Part C Improvement measure is used in calculating the Part C summary rating of an MA-PD contract.
    b. The Part D Improvement measure 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. Compare the two overall ratings calculated in steps 2 & 3, and use the highest of the two overall ratings calculated in steps 2 & 3.
5. Calculate the Part C summary rating for MA-PD contracts without including the Part C improvement measure.

6. Calculate the Part C summary rating for MA-PD contracts including the Part C improvement measure.
7. Compare the two Part C summary ratings calculated in steps 5 & 6, and use the highest of the two Part C summary ratings calculated in steps 5 & 6.
8. Calculate the Part D summary rating for MA-PD contracts without including the Part D improvement measure.
9. Calculate the Part D summary rating for MA-PD contracts including the Part D improvement measure.
10. Compare the two Part D summary ratings calculated in steps 8 & 9, and use the highest of the two Part D summary ratings calculated in steps 8 & 9.

MA-Only Contracts

- Only the Part C improvement measure is used for MA-Only contracts.
- Calculate the Part C summary rating for MA-Only contracts without including the Part C improvement measure.
- Calculate the Part C summary rating for MA-Only contracts with the Part C improvement measure.
- 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.

PDP Contracts

- Only the Part D improvement measure is used for PDP contracts.
- Calculate the Part D summary rating for PDP contracts without including the Part D improvement measure.
- Calculate the Part D summary rating for PDP contracts with the Part D improvement measure.
- 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.

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 F 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 G: 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 2022 Star Ratings:

Table 8: Performance Summary Thresholds

Improvement	MPF	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
Without	Without	65th	4.135135	4.086957	4.086957	4.084746
Without	With	65th	4.135135	4.083333	4.052632	4.083333
With	Without	65th	4.095238	4.142857	4.035714	4.090909
With	With	65th	4.095238	4.137931	4.000000	4.100000
Without	Without	85th	4.428571	4.434783	4.684211	4.346154
Without	With	85th	4.428571	4.416667	4.684211	4.350877
With	Without	85th	4.377778	4.428571	4.428571	4.338462
With	With	85th	4.377778	4.413793	4.379310	4.333333

Table 9: Variance Thresholds

Improvement	MPF	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
Without	Without	30th	.821053	.562907	.512861	.783410
Without	With	30th	.821053	.560185	.548090	.778913
With	Without	30th	.821221	.560762	.617347	.757019
With	With	30th	.821221	.562372	.682305	.755058
Without	Without	70th	1.218462	1.117989	.949380	1.132324
Without	With	70th	1.218462	1.092361	1.006424	1.122345
With	Without	70th	1.218821	1.088007	1.059311	1.098800
With	With	70th	1.218821	1.072688	1.079235	1.097165

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 Low Income Subsidy/Dual Eligible (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 Low Income Subsidy/Dual Eligible (LIS/DE) and disability status.

The CAI was developed using data collected for the 2021 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 2021 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 2021 measures used in the 2022 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 – Kidney Disease Monitoring (Part C)
- Diabetes Care – Blood Sugar Controlled (Part C)
- Rheumatoid Arthritis Management (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (Part C)
- Medication Reconciliation Post-Discharge (Part C)
- Statin Therapy for Patients with Cardiovascular Disease (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 and to yield a minimum number of 30 contracts per each final MA adjustment category and 10 contracts per each final PDP adjustment category. 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 N.

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 LIS/DE Beneficiaries
1	0.000000 to < 6.149984
2	>= 6.149984 to < 9.029351
3	>= 9.029351 to < 11.828362
4	>= 11.828362 to < 15.709822
5	>= 15.709822 to < 21.308980
6	>= 21.308980 to < 31.921094
7	>= 31.921094 to < 46.184837
8	>= 46.184837 to < 74.969719
9	>= 74.969719 to < 100.000000
10	100.00000

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

Disability Quintile	Percentage of Contract's Disabled Beneficiaries
1	>= 0.000000 to < 14.868805
2	>= 14.868805 to < 21.386431
3	>= 21.386431 to < 29.352138
4	>= 29.352138 to < 41.560510
5	>= 41.560510 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-L3 L1	D1 D2	-0.035526
2	L4-L9 L2-L8	D1 D2	-0.011166
3	L1-L4 L5-L8	D3-D5 D3	0.014507
4	L5-L7 L8 L9-L10 L10	D4-D5 D4 D2-D4 D1	0.050424
5	L8-L9	D5	0.102822
6	L10	D5	0.156984

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 LIS/DE Beneficiaries
1	>= 0.000000 to < 5.918327
2	>= 5.918327 to < 8.879143
3	>= 8.879143 to < 11.513779
4	>= 11.513779 to < 15.383500
5	>= 15.383500 to < 20.699729
6	>= 20.699729 to < 31.242256
7	>= 31.242256 to < 44.828861
8	>= 44.828861 to < 71.554504
9	>= 71.554504 to < 100.000000
10	100.00000

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

Disability Quintile	Percentage of Contract's Disabled Beneficiaries
1	>= 0.000000 to < 14.455232
2	>= 14.455232 to < 20.904509
3	>= 20.904509 to < 28.992403
4	>= 28.992403 to < 41.212156
5	>= 41.212156 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	-0.009257
2	L1-L7 L2-L10 L8	D2-D5 D1 D2-D3	0.008841
3	L8 L9-L10	D4-D5 D2-D4	0.038872
4	L9-L10	D5	0.077490

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 LIS/DE Beneficiaries
1	>= 0.000000 to < 6.898150
2	>= 6.898150 to < 9.508387
3	>= 9.508387 to < 12.948776
4	>= 12.948776 to < 17.545908
5	>= 17.545908 to < 24.508407
6	>= 24.508407 to < 36.853885
7	>= 36.853885 to < 55.757227
8	>= 55.757227 to < 87.511880
9	>= 87.511880 to < 100.000000
10	100.00000

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

Disability Quintile	Percentage of Contract's Disabled Beneficiaries
1	>= 0.000000 to < 15.512493
2	>= 15.512493 to < 22.834150
3	>= 22.834150 to < 30.915751
4	>= 30.915751 to < 44.143983
5	>= 44.143983 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-L7 L1	D1 D2	-0.052903
2	L2-L10 L8-L10	D2 D1	-0.014857
3	L1-L8 L1-L4	D3 D4-D5	0.015615
4	L9-L10 L7-L8 L5-L6	D3-D4 D4 D4-D5	0.063605
5	L7-L9	D5	0.149711
6	L10	D5	0.219180

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 LIS/DE Beneficiaries
1	>= 0.000000 to < 1.637509
2	>= 1.637509 to < 3.796364
3	>= 3.796364 to < 13.812463
4	>= 13.812463 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 Disabled Beneficiaries
1	>= 0.000000 to < 6.924101
2	>= 6.924101 to < 11.583226
3	>= 11.583226 to < 19.860555
4	>= 19.860555 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 four 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 Initial Group	Disability Quintile	CAI Value
1	L1-L2	D1-D3	-0.220831
2	L1-L3 L3-L4 L3	D4 D1-D2 D3	-0.111542
3	L4	D3-D4	0.094156

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

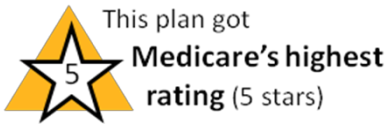
Raw Summary / Overall Score	Final Summary / Overall Rating
≥ 0.000000 and < 0.250000	0
≥ 0.250000 and < 0.750000	0.5
≥ 0.750000 and < 1.250000	1.0
≥ 1.250000 and < 1.750000	1.5
≥ 1.750000 and < 2.250000	2.0
≥ 2.250000 and < 2.750000	2.5
≥ 2.750000 and < 3.250000	3.0
≥ 3.250000 and < 3.750000	3.5
≥ 3.750000 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 2020, 2021, and 2022 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	2020 C	2021 C	2022 C	2020 D	2021 D	2022 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 Performer 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 2020 was at least 500 but less than 1,000 will be included in the Star Ratings in 2022 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.

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 2022 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' 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
- Data Integrity: PARTCDQA@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: CMSHPMS_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 Medicare.gov.
Description:	The English language description shown for the measure on the Medicare.gov. The text in this sub-section has been cognitively tested with beneficiaries to aid in their understanding the purpose of the measure.
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.
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.
NQF #:	The National Quality Framework (NQF) number for the measure or “None” if there is no equivalent measure with NQF endorsement.
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 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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 98
Metric:	The percentage of women MA enrollees 50 to 74 years of age (denominator) who had a mammogram to screen for breast cancer (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. 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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List). (optional) Bilateral mastectomy 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 (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set). • Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. • Both of the following (on the same or a different date of service): – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service). • Absence of the left breast (Absence of Left Breast Value Set) and absence of the

Title	Description
	right breast (Absence of Right Breast Value Set) on the same or different date of service. • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Preventive Care
NQF #:	2372
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 < 61 %	>= 61 % to < 69 %	>= 69 % to < 76 %	>= 76 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 109
Metric:	The percentage of MA enrollees aged 50 to 75 (denominator) who had appropriate screenings for colorectal cancer (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.

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. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. (optional) Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Preventive Care
NQF #:	0034
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 < 62 %	>= 62 % to < 71 %	>= 71 % to < 80 %	>= 80 %

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, 2020?
Data Source Category:	Survey of Enrollees

Title	Description
General Notes:	This measure is not case-mix adjusted. CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Preventive Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 65	>= 65 to < 70	>= 70 to < 76	>= 76 to < 80	>= 80

These technical notes show the base group cut points for CAHPS measures; please see the Attachment J 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 2020 Specifications for The Medicare Health Outcomes Survey Volume 6, page 37
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 21 Follow-up Data collection (2020) and Cohort 23 Baseline data collection (2020). HOS Survey Question 46: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.

Title	Description
	HOS Survey Question 47: 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 46 are excluded from results calculations for Question 47. 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:	08/17/2020 – 11/09/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2019 disasters.
Meaningful Measure Area:	Preventive Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 42 %	>= 42 % to < 47 %	>= 47 % to < 52 %	>= 52 % to < 57 %	>= 57 %

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 Part C Reporting Requirements. Validation for data performed during the 2020 Data Validation cycle.
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 30, 2021) 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: • 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) Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov. 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.”

Title	Description

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: 01/01/2020 – 12/31/2020

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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.

Meaningful Measure Area: Management of Chronic Conditions

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 45 %	>= 45 % to < 59 %	>= 59 % to < 73 %	>= 73 % to < 87 %	>= 87 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 121
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 2019 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Medication Management
NQF #:	0553
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
< 48 %	>= 48 % to < 71 %	>= 71 % to < 84 %	>= 84 % to < 95 %	>= 95 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 121
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 2019 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Preventive Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 55 %	>= 55 % to < 76 %	>= 76 % to < 87 %	>= 87 % 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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 225
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 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. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0053
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 < 40 %	>= 40 % to < 50 %	>= 50 % to < 68 %	>= 68 %

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:	Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees 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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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

Title	Description
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0055
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
< 52 %	>= 52 % to < 62 %	>= 62 % to < 71 %	>= 71 % to < 79 %	>= 79 %

Measure: C10 - Diabetes Care – Kidney Disease Monitoring

Title	Description
Label for Stars:	Kidney Function Testing for Members with Diabetes
Label for Data:	Kidney Function Testing for Members with Diabetes
Description:	Percent of plan members with diabetes who had a kidney function test during the year.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy 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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded.

Title	Description
	Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0062
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
< 82 %	>= 82 % to < 88 %	>= 88 % to < 94 %	>= 94 % to < 97 %	>= 97 %

Measure: C11 - 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:	Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees 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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year.

Title	Description
	(optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0059
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

Title	Description				
	< 41 %	>= 41 % to < 60 %	>= 60 % to < 72 %	>= 72 % to < 81 %	>= 81 %

Measure: C12 - Rheumatoid Arthritis Management

Title	Description
Label for Stars:	Rheumatoid Arthritis Management
Label for Data:	Rheumatoid Arthritis Management
Description:	Percent of plan members with rheumatoid arthritis who got one or more prescriptions for an anti-rheumatic drug.
HEDIS Label:	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 220
Metric:	The percentage of MA members who were diagnosed with rheumatoid arthritis during the measurement year (denominator), and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude from Medicare reporting members age 66 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. Exclude members from all product lines age 81 and older as of December 31 of the measurement year with frailty. Exclude members from all product lines age 66 and older as of December 31 of the measurement year with advanced illness and frailty. Members must meet both the frailty and advanced illness criteria to be excluded. (optional) • A diagnosis of HIV (HIV Value Set) any time during the member's history through December 31 of the measurement year. • A diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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

Title	Description
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0054
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
< 68 %	>= 68 % to < 75 %	>= 75 % to < 79 %	>= 79 % to < 85 %	>= 85 %

Measure: C13 - 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 2020 Specifications for The Medicare Health Outcomes Survey Volume 6, page 40
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 21 Follow-up Data collection (2020) and Cohort 23 Baseline data collection (2020). HOS Survey Question 48: 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 49: Did you fall in the past 12 months? HOS Survey Question 50: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 51: 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 48 or Question 51 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

Title	Description
	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:	08/17/2020 – 11/09/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2019 disasters.
Meaningful Measure Area:	Preventable Healthcare Harm
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 48 %	>= 48 % to < 55 %	>= 55 % to < 64 %	>= 64 % to < 72 %	>= 72 %

Measure: C14 - 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 2020 Specifications for The Medicare Health Outcomes Survey Volume 6, page 34
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 21 Follow-up Data collection (2020) and Cohort 23 Baseline data collection (2020). HOS Survey Question 42: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 45: 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: • Q42 = "Yes."

Title	Description
	• Q45 = "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: • Q45 = "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:	08/17/2020 – 11/09/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2019 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 42 %	>= 42 % to < 45 %	>= 45 % to < 49 %	>= 49 % to < 53 %	>= 53 %

Measure: C15 - 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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 308

Title	Description
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:	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Medication Management
NQF #:	0097
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 < 56 %	>= 56 % to < 69 %	>= 69 % to < 82 %	>= 82 %

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 2020 and Measurement Year 2021 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

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. • In vitro fertilization (IVF Value Set) 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 (ESRD Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) 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. – 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 (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List). Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2020 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2020 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	Not Applicable

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	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 76 %	>= 76 % to < 81 %	>= 81 % to < 84 %	>= 84 % to < 89 %	>= 89 %

Domain: 3 - Member Experience with Health Plan

Measure: C17 - 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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	0006
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
< 79	>= 79 to < 82	>= 82 to < 84	>= 84 to < 85	>= 85

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

Measure: C18 - 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? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	0006
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
< 75	>= 75 to < 77	>= 77 to < 80	>= 80 to < 82	>= 82

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

Measure: C19 - 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 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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	0006
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 < 90	>= 90 to < 91	>= 91 to < 92	>= 92

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

Measure: C20 - Rating of Health Care Quality

Title	Description
Label for Stars:	Member's Rating of Health Care Quality
Label for Data:	Member's 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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	0006
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
< 85	>= 85 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 J for the CAHPS Methodology for final star assignment rules.

Measure: C21 - Rating of Health Plan

Title	Description
Label for Stars:	Member's Rating of Health Plan
Label for Data:	Member's 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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	0006
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
< 85	>= 85 to < 86	>= 86 to < 88	>= 88 to < 90	>= 90

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

Measure: C22 - 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.)

Title	Description
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 visited your personal doctor for 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? • 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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Transfer of Health Information and Interoperability
NQF #:	Not Applicable
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 J for the CAHPS Methodology for final star assignment rules.

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

Measure: C23 - 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:	Percent of members filing complaints 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 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 2020 complaints made by June 30, 2021 are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
Data Source Category:	CMS Administrative Data
Exclusions:	On March 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:	01/01/2020 – 12/31/2020
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:	2

Title	Description
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
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
> 1.14	> 0.79 to <= 1.14	> 0.37 to <= 0.79	> 0.17 to <= 0.37	<= 0.17

Measure: C24 - 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, 2020–December 31, 2020 (numerator) divided by all members enrolled in the contract at any time during 2020 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2020 and 12/31/2020 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan

Title	Description
	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:	01/01/2020 – 12/31/2020
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:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 44 %	> 29 % to <= 44 %	> 16 % to <= 29 %	> 9 % to <= 16 %	<= 9 %

Measure: C25 - 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.

Title	Description
	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 2021 and 2022 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2021 and 2022 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.
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:	Patient Focused Episode of Care
NQF #:	Not Applicable
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
< -0.12	>= -0.12 to < 0	>= 0 to < 0.185185	>= 0.185185 to < 0.34375	>= 0.34375

Domain: 5 - Health Plan Customer Service

Measure: C26 - 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. (This description has been updated to better explain the measure. There have been no changes to the measure.)
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 dismissed because the plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed/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 for reasons other than the 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 Dismissed/Plan Agreed to Cover]) - [Late]
Data Time Frame:	01/01/2020 – 12/31/2020
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Appropriate Use of Healthcare
NQF #:	Not Applicable

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
< 64 %	>= 64 % to < 80 %	>= 80 % to < 90 %	>= 90 % to < 97 %	>= 97 %

Measure: C27 - 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. (This description has been updated to better explain the measure. There have been no changes to the measure.)
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, 2021, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2021 are not reflected in these data 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:	01/01/2020 – 12/31/2020
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.

Title	Description
Meaningful Measure Area:	Appropriate Use of Healthcare
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 69 %	>= 69 % to < 84 %	>= 84 % to < 91 %	>= 91 % to < 96 %	>= 96 %

Measure: C28 - 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 the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2021 – 06/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	No adjustment for 2019 or 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care

Title	Description

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 32 %	>= 32 % to < 61 %	>= 61 % to < 78 %	>= 78 % to < 94 %	>= 94 %

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 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 MA-PDs, PDPs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2021 – 06/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	No adjustment for 2019 or 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Title	Description

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 25 %	>= 25 % to < 59 %	>= 59 % to < 84 %	>= 84 % to < 94 %	>= 94 %
PDP	< 63 %	>= 63 % to < 80 %	>= 80 % to < 89 %	>= 89 % to < 97 %	>= 97 %

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:	Percent of members filing complaints 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 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 2020 complaints made by June 30, 2021 are captured Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
Data Source Category:	CMS Administrative Data
Exclusions:	On March 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:	01/01/2020 – 12/31/2020
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:	2

Title	Description
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
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	> 1.14	> 0.79 to <= 1.14	> 0.37 to <= 0.79	> 0.17 to <= 0.37	<= 0.17
PDP	> 0.21	> 0.15 to <= 0.21	> 0.1 to <= 0.15	> 0.03 to <= 0.1	<= 0.03

Measure: D03 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2020–December 31, 2020 (numerator) divided by all members enrolled in the contract at any time during 2020 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2020 and 12/31/2020 who disenrolled from the contract with any one of the following disenrollment reason codes:

Title	Description
	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:	01/01/2020 – 12/31/2020
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:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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 %

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.

Title	Description
	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 2021 and 2022 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2021 and 2022 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.
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:	Patient Focused Episode of Care
NQF #:	Not Applicable
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	< -0.2	>= -0.2 to < 0	>= 0 to < 0.428571	>= 0.428571 to < 0.68421	>= 0.684211
PDP	NA	NA	>= 0 to < 0.545455	>= 0.545455 to < 0.80952	>= 0.809524

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 Questions (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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
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 < 85	>= 85 to < 87	>= 87 to < 88	>= 88
PDP	< 80	>= 80 to < 82	>= 82 to < 84	>= 84 to < 87	>= 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment J 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 2021. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2021 – 05/2021
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Patient's Experience of Care
NQF #:	Not Applicable
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	< 89	>= 89 to < 90	>= 90 to < 91	>= 91 to < 92	>= 92
PDP	< 89	>= 89 to < 90	>= 90 to < 91	>= 91 to < 92	>= 92

These technical notes show the base group cut points for CAHPS measures; please see the Attachment J 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 prices members actually pay for their drugs to the drug prices the plan provided for this website (Medicare's Plan Finder website). Higher scores are better because they mean the plan provided more accurate prices
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF—that is, the reported price is higher than the actual price—will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than PF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than PF)/ (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: .5 x (100 – ((accuracy index - 1) x 100)) + .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: PDE data and MPF Pricing Files are the primary data sources. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used. Post-reconciliation PDE adjustments are not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	A contract with less than 30 PDE claims over the measurement period. 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.

Title	Description
	• 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 L: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2020 – 09/30/2020
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	No adjustment for 2019 or 2020 disasters.
Meaningful Measure Area:	Transfer of Health Information and Interoperability
NQF #:	Not Applicable
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	< 73	>= 73 to < 83	>= 83 to < 91	>= 91 to < 96	>= 96
PDP	< 84	>= 84 to < 88	>= 88 to < 94	>= 94 to < 97	>= 97

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 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, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2

Title	Description
	(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. 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 and obsolete NDC date methodology 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 2020 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2020-December 31, 2020. 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 2020 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), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10 CM codes, and SNF/IP stays for MA-PD beneficiaries. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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:

Title	Description
	• Hospice enrollment • 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, 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 inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment K: 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:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0541
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	< 84 %	>= 84 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 90 %

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 *ACE (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. The Part D 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 Part D Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC date methodology 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 Drug Data Processing Systems (DDPS) and accepted by the 2020 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2020-December 31, 2020. 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 2020 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.

Title	Description
	Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and 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. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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: • Hospice enrollment • 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 inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment K: 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:	01/01/2020 – 12/31/2020
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0541
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	< 74 %	>= 74 % to < 82 %	>= 82 % to < 87 %	>= 87 % to < 90 %	>= 90 %
PDP	< 85 %	>= 85 % to < 88 %	>= 88 % to < 89 %	>= 89 % to < 91 %	>= 91 %

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. 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 and obsolete NDC date methodology maintained by the PQA. The complete NDC list is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data

Title	Description
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2020 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2020-December 31, 2020. 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 2020 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10 CM codes, and SNF/IP stays for MA-PD beneficiaries. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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: • Hospice enrollment • 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).

Title	Description
	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 inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment K: 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:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	0541
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	< 78 %	>= 78 % to < 83 %	>= 83 % to < 87 %	>= 87 % to < 91 %	>= 91 %
PDP	< 82 %	>= 82 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 90 %

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Stars:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period.

Title	Description
	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 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. 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:	Additional data sources used to calculate the measure: Medicare Enrollment Database (EDB) File. Data were reported by contracts to CMS per the Part D Reporting Requirements. Validation of these data was performed retrospectively during the 2021 Data Validation cycle.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2021) are excluded and listed as "No data available." The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation. 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

Title	Description

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.

• HICN (or MBI) or RRB Number (Element B)
• Met the specified targeting criteria per CMS – Part D requirements (Element F)
• Date of MTM program enrollment (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 P)
• Date(s) of CMR(s) (Element Q)

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 M 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 CMSHPMS_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: 01/01/2020 – 12/31/2020

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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.

Meaningful Measure Area: Medication Management

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 54 %	>= 54 % to < 72 %	>= 72 % to < 82 %	>= 82 % to < 89 %	>= 89 %
PDP	< 31 %	>= 31 % to < 47 %	>= 47 % to < 61 %	>= 61 % to < 74 %	>= 74 %

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 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 during the measurement period (denominator). The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2020 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2020 – December 31, 2020. 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 2020 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 Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify diagnoses based on ICD-10-CM codes. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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:

Title	Description
	• Hospice enrollment • 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 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:	01/01/2020 – 12/31/2020
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 (2021-2022) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Management of Chronic Conditions
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 76 %	>= 76 % to < 80 %	>= 80 % to < 84 %	>= 84 % to < 88 %	>= 88 %
PDP	< 77 %	>= 77 % to < 79 %	>= 79 % to < 82 %	>= 82 % to < 84 %	>= 84 %

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 dual eligibility and education among other variables. The table below includes the case-mix variables and shows 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, on the original scale of the item or composite, as presented in plan reports.

For example, for the measure "Getting Appointments and Care Quickly," the model coefficient for "age 75-79" is 0.0165, indicating that respondents in that age range tend to score their plans 0.0165 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, Medicaid dual eligibles tend to respond 0.0333 points lower on this item than otherwise similar non-duals. 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 are Medicaid dual eligibles 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. In the tables we report the average of the model coefficients for these several items, for each of the categories (rows) of the table, as a summary of the adjustment for the composite. For more detailed information on the application of CAHPS case-mix adjustment, including item-level coefficients, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Table A-1: Coefficients of Part C CAHPS Measures

Predictor	C03: Annual Flu Vaccine	C17: Getting Needed Care (Comp)	C18: Getting Appointments and Care Quickly (Comp)	C19: Customer Service (Comp)	C20: Rating of Health Care Quality	C21: Rating of Health Plan	C22: Care Coordination (Comp)
Age: 64 or under	N/A	0.0209	0.0072	0.0033	0.0399	-0.0590	0.0132
Age: 65 – 69	N/A	-0.0147	-0.0137	0.0067	-0.0263	-0.0692	0.0011
Age: 75 – 79	N/A	0.0076	0.0165	0.0110	0.0592	0.0730	0.0011
Age: 80 – 84	N/A	0.0134	0.0135	-0.0050	-0.0280	0.0499	-0.0110
Age: 85 and older	N/A	-0.0078	0.0052	-0.0163	0.0455	0.0591	-0.0471
Less than an 8th grade education	N/A	-0.0716	-0.0389	-0.0255	-0.0937	0.0136	-0.0046
Some high school	N/A	-0.0204	-0.0222	-0.0211	-0.0177	0.0733	0.0057
Some college	N/A	-0.0244	-0.0073	-0.0239	-0.0923	-0.1452	-0.0044
College graduate	N/A	-0.0581	-0.0202	-0.0398	-0.1676	-0.2480	-0.0336
More than a bachelor's degree	N/A	-0.0534	-0.0124	-0.0759	-0.1926	-0.2843	-0.0246
General health rating: excellent	N/A	0.0745	0.0836	0.0515	0.3707	0.2565	0.0189
General health rating: very good	N/A	0.0655	0.0581	0.0117	0.1985	0.1354	0.0263
General health rating: fair	N/A	-0.0511	-0.0461	-0.0352	-0.2114	-0.1479	-0.0449
General health rating: poor	N/A	-0.0793	-0.0669	-0.0413	-0.3875	-0.2832	-0.0692
Mental health rating: excellent	N/A	0.1556	0.1060	0.0756	0.4725	0.3643	0.1312
Mental health rating: very good	N/A	0.0692	0.0458	0.0363	0.2282	0.1808	0.0676
Mental health rating: fair	N/A	-0.0537	-0.0168	-0.0234	-0.1744	-0.0721	-0.0344
Mental health rating: poor	N/A	-0.1263	-0.0556	-0.0526	-0.3999	-0.3171	-0.0928
Proxy helped	N/A	-0.0007	-0.0511	-0.0431	-0.0412	0.0037	0.0317
Proxy answered	N/A	0.0327	0.0479	-0.0342	0.1098	-0.0276	0.0589

Predictor	C03: Annual Flu Vaccine	C17: Getting Needed Care (Comp)	C18: Getting Appointments and Care Quickly (Comp)	C19: Customer Service (Comp)	C20: Rating of Health Care Quality	C21: Rating of Health Plan	C22: Care Coordination (Comp)
Medicaid dual eligible	N/A	-0.0426	-0.0333	0.0000	-0.1114	0.2395	-0.0195
Low-income subsidy (LIS)	N/A	-0.0571	-0.0928	0.0310	-0.0236	-0.0795	-0.0056
Asian Language	N/A	-0.1285	-0.2614	-0.2294	0.3081	-0.2369	-0.2465

Table A-2: Coefficients of Part D CAHPS Measures

Predictor	MA-PD D05: Rating of Drug Plan	MA-PD D06: Getting Needed Prescription Drugs (Comp)	PDP D05: Rating of Drug Plan	PDP D06: Getting Needed Prescription Drugs (Comp)
Age: 64 or under	-0.1123	-0.0169	-0.2559	-0.0599
Age: 65 – 69	-0.0815	-0.0169	-0.0715	0.0171
Age: 75 – 79	0.1185	0.0163	0.1282	0.0093
Age: 80 – 84	0.0962	0.0017	0.3069	0.0296
Age: 85 and older	0.2266	0.0139	0.3577	0.0469
Less than an 8th grade education	-0.0309	-0.0736	-0.1390	-0.0504
Some high school	0.0137	-0.0416	0.1416	-0.0454
Some college	-0.1456	-0.0399	-0.0908	-0.0318
College graduate	-0.2635	-0.0470	-0.2164	-0.1095
More than a bachelor's degree	-0.3366	-0.0595	-0.3067	-0.0476
General health rating: excellent	0.2424	0.0187	0.2632	0.0458
General health rating: very good	0.2048	0.0378	0.3116	0.0556
General health rating: fair	-0.1667	-0.0452	-0.1593	-0.0598
General health rating: poor	-0.2875	-0.0821	-0.5318	-0.1404
Mental health rating: excellent	0.3274	0.0972	0.2455	0.0649
Mental health rating: very good	0.1689	0.0607	0.0871	0.0219
Mental health rating: fair	-0.0625	-0.0151	-0.1908	-0.0514
Mental health rating: poor	-0.2182	-0.0853	-0.3990	-0.0558
Proxy helped	-0.1366	-0.0093	-0.1249	-0.0965
Proxy answered	0.0266	0.0689	0.2282	0.0940
Medicaid dual eligible	0.5545	0.0175	0.8806	0.0579
Low-income subsidy (LIS)	0.3072	0.0079	0.7575	0.1201
Asian Language	-0.0080	-0.1468	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 measure. The table below lists the enrollment used for each type of measure and the rule followed to determine the month(s) of enrollment.

Type of Measure	Rule for Which Month of Enrollment is Used	Month(s) of Enrollment Used for 2022 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2021
Call Center	Average enrollment during the study period	Feb 2021 – June 2021
HOS	Enrollment at the time survey sample is pulled	January 2018
HEDIS/HOS	Enrollment at the time survey sample is pulled	January 2020
HEDIS	Enrollment in July of the measurement period	July 2020
All Other Measures	Enrollment in July of the measurement period	July 2020

Example Calculation

Contract ID	Surviving or Consumed Contract	Value for Breast Cancer Screening (BCS) Measure	July 2020 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

Value for BCS for HAAAA = $\frac{75.13 * 43{,}326 + 50.91 * 20{,}933}{43{,}326 + 20{,}933} = 67.24$

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 the numeric and star values for each measure reported in the 2022 Star Ratings[1].

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	71%	3.9
C02	Colorectal Cancer Screening	74%	3.9
C03	Annual Flu Vaccine	74%	3.4
C04	Monitoring Physical Activity	50%	3.1
C05	Special Needs Plan (SNP) Care Management	74%	3.6
C06	Care for Older Adults – Medication Review	92%	4.4
C07	Care for Older Adults – Pain Assessment	92%	4.4
C08	Osteoporosis Management in Women who had a Fracture	47%	3.1
C09	Diabetes Care – Eye Exam	73%	3.8
C10	Diabetes Care – Kidney Disease Monitoring	95%	4.2
C11	Diabetes Care – Blood Sugar Controlled	78%	4.3
C12	Rheumatoid Arthritis Management	80%	3.7
C13	Reducing the Risk of Falling	55%	2.5
C14	Improving Bladder Control	46%	2.7
C15	Medication Reconciliation Post-Discharge	68%	3.5
C16	Statin Therapy for Patients with Cardiovascular Disease	84%	3.5
C17	Getting Needed Care	83	3.6
C18	Getting Appointments and Care Quickly	79	3.6
C19	Customer Service	91	3.8
C20	Rating of Health Care Quality	87	3.6
C21	Rating of Health Plan	88	3.5
C22	Care Coordination	87	3.7
C23	Complaints about the Health Plan	0.21	4.7
C24	Members Choosing to Leave the Plan	13%	4.1
C25	Health Plan Quality Improvement	Medicare shows only a Star Rating for this topic	3.7
C26	Plan Makes Timely Decisions about Appeals	96%	4.6
C27	Reviewing Appeals Decisions	95%	4.6
C28	Call Center – Foreign Language Interpreter and TTY Availability	92%	4.6

[1] All contracts are weighted equally in these averages and averages were calculated after adjustments were made for contracts affected by disasters.

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	91%	4.5	91%	4.2
D02	Complaints about the Drug Plan	0.21	4.7	0.06	4.8
D03	Members Choosing to Leave the Plan	14%	4.1	9%	4.2
D04	Drug Plan Quality Improvement	Medicare shows only a Star Rating for this topic	4.2	Medicare shows only a Star Rating for this topic	4.1
D05	Rating of Drug Plan	87	3.4	85	3.8
D06	Getting Needed Prescription Drugs	91	3.8	91	3.9
D07	MPF Price Accuracy	92	4.0	91	3.3
D08	Medication Adherence for Diabetes Medications	86%	3.7	86%	3.9
D09	Medication Adherence for Hypertension (RAS antagonists)	87%	3.9	89%	3.5
D10	Medication Adherence for Cholesterol (Statins)	86%	3.6	87%	3.6
D11	MTM Program Completion Rate for CMR	84%	4.0	54%	3.7
D12	Statin Use in Persons with Diabetes (SUPD)	83%	3.4	81%	3.3

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
C01	Breast Cancer Screening	HEDIS	01/01/2020 – 12/31/2020
C02	Colorectal Cancer Screening	HEDIS	01/01/2020 – 12/31/2020
C03	Annual Flu Vaccine	CAHPS	03/2021 – 05/2021
C04	Monitoring Physical Activity	HEDIS / HOS	08/17/2020 – 11/09/2020
C05	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2020 – 12/31/2020
C06	Care for Older Adults – Medication Review	HEDIS	01/01/2020 – 12/31/2020
C07	Care for Older Adults – Pain Assessment	HEDIS	01/01/2020 – 12/31/2020
C08	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2020 – 12/31/2020
C09	Diabetes Care – Eye Exam	HEDIS	01/01/2020 – 12/31/2020
C10	Diabetes Care – Kidney Disease Monitoring	HEDIS	01/01/2020 – 12/31/2020
C11	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2020 – 12/31/2020
C12	Rheumatoid Arthritis Management	HEDIS	01/01/2020 – 12/31/2020
C13	Reducing the Risk of Falling	HEDIS / HOS	08/17/2020 – 11/09/2020
C14	Improving Bladder Control	HEDIS / HOS	08/17/2020 – 11/09/2020
C15	Medication Reconciliation Post-Discharge	HEDIS	01/01/2020 – 12/31/2020
C16	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2020 – 12/31/2020
C17	Getting Needed Care	CAHPS	03/2021 – 05/2021
C18	Getting Appointments and Care Quickly	CAHPS	03/2021 – 05/2021
C19	Customer Service	CAHPS	03/2021 – 05/2021
C20	Rating of Health Care Quality	CAHPS	03/2021 – 05/2021
C21	Rating of Health Plan	CAHPS	03/2021 – 05/2021
C22	Care Coordination	CAHPS	03/2021 – 05/2021
C23	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2020 – 12/31/2020
C24	Members Choosing to Leave the Plan	MBDSS	01/01/2020 – 12/31/2020
C25	Health Plan Quality Improvement	Star Ratings	Not Applicable
C26	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2020 – 12/31/2020
C27	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2020 – 12/31/2020
C28	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2021 – 06/2021

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	02/2021 – 06/2021
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2020 – 12/31/2020
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2020 – 12/31/2020
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2021 – 05/2021
D06	Getting Needed Prescription Drugs	CAHPS	03/2021 – 05/2021
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2020 – 09/30/2020
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2020 – 12/31/2020
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2020 – 12/31/2020
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2020 – 12/31/2020
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2020 – 12/31/2020
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2020 – 12/31/2020

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 2020.

Step 2: Exclude any PBP that is not required to report data for the contract year 2020 Part C SNP Care Reporting Requirements, based on terminations on or before the end of the contract year. This exclusion is consistent with the statement from page 4 of the CY 2020 Medicare Part C Plan Reporting Requirements Technical Specifications Document: "If a plan terminates before or at the end of its contract year (CY), it is not required to report and/or have its data validated for that CY." This excludes:

- PBPs that terminate in transition from CY 2020 to CY 2021 according to the plan crosswalk
- Contracts that terminate on or before 12/31/2020 according to the Contract Info extract

We then also **exclude** those that are **not required to undergo data validation (DV)** for the contract year 2020 Part C SNP Care Reporting Requirements, based on terminations on or before the deadline for submission of DV results to CMS. This exclusion is consistent with the following statement under section, Types of Organizations Required to Undergo Data Validation, of the Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual:

"A sponsoring organization that terminates its contract(s) to offer Medicare Part C and/or Part D benefits, or that is subject to a CMS termination of its contract(s), is not required to undergo a DV review for the final contract year's reported data. Similarly, for reporting sections that are reported at the plan benefit package (PBP) level, PBPs that terminate are not required to undergo a DV review for the final year's reported data."

This excludes: Contracts and PBP with an effective termination data that occurs between 1/1/2021 and 6/30/2021 according to the Contract Info extract

Step 3: After removing contract/PBP 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 2020 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 2020 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/PBPs 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 is 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 an audit designation 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.

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: Weights Assigned to Individual Performance Measures

Table F-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 – Kidney Disease Monitoring	Process Measure	1
C11	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C12	Rheumatoid Arthritis Management	Process Measure	1
C13	Reducing the Risk of Falling	Process Measure	1
C14	Improving Bladder Control	Process Measure	1
C15	Medication Reconciliation Post-Discharge	Process Measure	1
C16	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C17	Getting Needed Care	Patients' Experience and Complaints Measure	2
C18	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
C19	Customer Service	Patients' Experience and Complaints Measure	2
C20	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
C21	Rating of Health Plan	Patients' Experience and Complaints Measure	2
C22	Care Coordination	Patients' Experience and Complaints Measure	2
C23	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
C24	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
C25	Health Plan Quality Improvement	Improvement Measure	5
C26	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
C27	Reviewing Appeals Decisions	Measures Capturing Access	2
C28	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

Table F-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary and MA-PD Overall
D01	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
D02	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2
D03	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
D04	Drug Plan Quality Improvement	Improvement Measure	5
D05	Rating of Drug Plan	Patients' Experience and Complaints Measure	2
D06	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2
D07	MPF Price Accuracy	Process Measure	1
D08	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
D09	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
D10*	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
D11*	MTM Program Completion Rate for CMR	Process Measure	1
D12*	Statin Use in Persons with Diabetes (SUPD)	Intermediate Outcome Measure	3

*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 G: 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 H: 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 2021 and 2022.

For measures where a higher score is better:

Improvement Change Score = Score in 2022 - Score in 2021

For measures where a lower score is better:

Improvement Change Score = Score in 2021 - Score in 2022

An eligible measure was defined as a measure for which a contract was scored in both the 2021 and 2022 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 2021 and 2022 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.

Net Improvement = Number of significantly improved measures - Number of significantly declined measures

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

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 2

Process measure: Weight of 1

Specific weights for each measure, which may deviate from the general scheme above are described in Attachment F. 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.

$$\text{Improvement Measure Score} = \frac{\text{Net_Imp_Process} + 2 * \text{Net_Imp_PtExp} + 3 * \text{Net_Imp_Outcome}}{\text{Elig_Process} + 2 * \text{Elig_PtExp} + 3 * \text{Elig_Outcome}}$$

Net_Imp_Process = Net improvement for process measures
Net_Imp_PtExp = Net improvement for patient experience/complaints and access measures
Net_Imp_Outcome = Net improvement for outcome and intermediate outcome measures

Elig_Process = Number of eligible process measures
Elig_PtExp = Number of eligible patient experience/complaints and access measures
Elig_Outcome = Number of eligible outcome and intermediate outcome 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 2022 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2021 standard error for contract i on measure C01

Y_{i2} Represents the 2022 rate for contract i on measure C01

Y_{i1} Represents the 2021 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 (2022 and 2021). 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. 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 2022 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. SEF for Measures: C01, C02, C04, C05, C08 – C15, C16, C24, C26 – C28, D01, D03, D08 – D12

$$SE_y = \sqrt{\frac{Score_y*(100-Score_y)}{Denominator_y}}$$

for y = 2021, 2022

$Denominator_y$ 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 = 2021, 2022 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 = 2021, 2022. 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 = 2021, 2022. 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 2021, Contract Year 2022 and i = Contract i

3. SEF for Measures: C03, C17 – C22, and D05, D06

The CAHPS measure standard errors for 2021 and 2022 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.

4. SEF for Measures C23, D02

$$SE_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{NumDays}$$

NumDays: 2021 = 365, 2022 = 366

Star Ratings Measures Used in the Improvement Measures

Table H-1: Part C Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.913775
C02	Colorectal Cancer Screening	Included	0.850379
C03	Annual Flu Vaccine	Included	0.910521
C04	Monitoring Physical Activity	Included	0.788152
C05	Special Needs Plan (SNP) Care Management	Included	0.942420
C06	Care for Older Adults – Medication Review	Included	0.736729
C07	Care for Older Adults – Pain Assessment	Included	0.755806
C08	Osteoporosis Management in Women who had a Fracture	Included	0.859077
C09	Diabetes Care – Eye Exam	Included	0.870609
C10	Diabetes Care – Kidney Disease Monitoring	Included	0.730755
C11	Diabetes Care – Blood Sugar Controlled	Included	0.830188
C12	Rheumatoid Arthritis Management	Included	0.827099
C13	Reducing the Risk of Falling	Included	0.863851
C14	Improving Bladder Control	Included	0.387248
C15	Medication Reconciliation Post-Discharge	Included	0.770412
C16	Statin Therapy for Patients with Cardiovascular Disease	Included	0.662942
C17	Getting Needed Care	Included	0.866520
C18	Getting Appointments and Care Quickly	Included	0.901652
C19	Customer Service	Included	0.808043
C20	Rating of Health Care Quality	Included	0.823226
C21	Rating of Health Plan	Included	0.877050
C22	Care Coordination	Included	0.803061
C23	Complaints about the Health Plan	Included	0.863306
C24	Members Choosing to Leave the Plan	Included	0.896082
C25	Health Plan Quality Improvement	Not Included	-
C26	Plan Makes Timely Decisions about Appeals	Included	0.751799
C27	Reviewing Appeals Decisions	Included	0.783861
C28	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.236221

Table H-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	0.269569
D02	Complaints about the Drug Plan	Included	0.869576
D03	Members Choosing to Leave the Plan	Included	0.897686
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.856959
D06	Getting Needed Prescription Drugs	Included	0.775214
D07	MPF Price Accuracy	Not Included	-
D08	Medication Adherence for Diabetes Medications	Included	0.834265
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.848225
D10	Medication Adherence for Cholesterol (Statins)	Included	0.856100
D11	MTM Program Completion Rate for CMR	Included	0.903783
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.876982

Attachment I: 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 I-1: Part C Measure History

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
C	Access to Primary Care Doctor Visits	HEDIS	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11	C13	C12	C13	
C	Adult BMI Assessment	HEDIS		C07	C07	C07	C07	C07	C07	C08	C10	C10	C12	DMC05			
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06	C07	C06	C07	
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC04	C28	
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS					DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05	C06	C05	C06	
C	Asthma Medication Ratio	HEDIS					DMC18	DMC27									
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32	C33	C30		
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01	C01	C01	C01	
C	Call Answer Timeliness	HEDIS							DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC01	C20	
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09	C34	C31		
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC01	DMC10	DMC10	DMC10	DMC11	DMC11	DMC12		DMC15	DMC15					
C	Call Center – CSR Understandability	Call Center Monitoring													DMC02		
C	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36	C36	C33		
C	Call Center – Information Accuracy	Call Center Monitoring									DMC10	DMC10	DMC10	C35	C32		
C	Cardiovascular Care – Cholesterol Screening	HEDIS								C02	C03	C03	C03	C03		C03	A
C	Care Coordination	CAHPS	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29					
C	Care for Older Adults – Functional Status Assessment	HEDIS		C10	C10	C10	C10	C10	C10	C11	C12	C12	C14				
C	Care for Older Adults – Medication Review	HEDIS	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13				
C	Care for Older Adults – Pain Assessment	HEDIS	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13	C15				
C	Cholesterol Screening	HEDIS													C03		B
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02	C02	C02	C02	C02	

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
C	Complaints about the Health Plan	CTM	C23/ D02	C27/ D04	C28/ D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06	C30	C26		
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	DMC04	DMC04	DMC04	DMC04	DMC04	DMC04	DMC05	C32	
C	Controlling Blood Pressure	HEDIS	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21	C19	C15	C29	
C	Customer Service	CAHPS	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28	C27	C23	C22	
C	Diabetes Care	HEDIS													C14		C
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19	C17		C26	D
C	Diabetes Care – Cholesterol Controlled	HEDIS								C17	C18	C18	C20	C18		C27	D
C	Diabetes Care – Cholesterol Screening	HEDIS								C03	C04	C04	C04	C04		C04	A
C	Diabetes Care – Eye Exam	HEDIS	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17	C15		C24	D
C	Diabetes Care – Kidney Disease Monitoring	HEDIS	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18	C16		C25	D
C	Doctor Follow up for Depression	HEDIS														C15	
C	Doctors who Communicate Well	CAHPS	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08	C25	C21	C21	
C	Engagement of Alcohol or other Drug Treatment	HEDIS	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19						
C	Enrollment Timeliness	MARx					DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03	DMD03		
C	Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	HEDIS	DMC17	DMC17	DMC18												
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	DMC03	C14	
C	Getting Appointments and Care Quickly	CAHPS	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27	C26	C22	C17	
C	Getting Needed Care	CAHPS	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26	C24	C20	C16	
C	Glaucoma Testing	HEDIS									C05	C05	C05	C05	C04	C05	
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11					
C	Health Plan Quality Improvement	Star Ratings	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33					
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24									
C	Improving Bladder Control	HEDIS / HOS	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23	C22	C18	C33	
C	Improving or Maintaining Mental Health	HOS	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09	C10	C09	C10	

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
C	Improving or Maintaining Physical Health	HOS	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08	C09	C08	C09	
C	Initiation of Alcohol or other Drug Treatment	HEDIS	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18						
C	Medication Management for People With Asthma	HEDIS						DMC26									
C	Medication Reconciliation Post-Discharge	HEDIS	C15	C19	C19	C20	C20	DMC23									
C	Members Choosing to Leave the Plan	MBDSS	C24/D03	C28/ D05	C29/ D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01	C29 / D10		
C	Monitoring Physical Activity	HEDIS / HOS	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10	C12	C11	C12	
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16	C14	C13	C23	
C	Osteoporosis Testing	HEDIS / HOS	DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06	C11	C10	C11	
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17						
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16						
C	Plan All-Cause Readmissions	HEDIS	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23	C25				
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE) / Maximus	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34	C31	C27	C35	
C	Pneumonia Vaccine	CAHPS	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07	C08	C07	C08	
C	Rating of Health Care Quality	CAHPS	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29	C28	C24	C18	
C	Rating of Health Plan	CAHPS	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30	C29	C25	C19	
C	Reducing the Risk of Falling	HEDIS / HOS	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24	C23	C19	C34	
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	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35	C32	C28	C36	
C	Rheumatoid Arthritis Management	HEDIS	C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22	C20	C16	C30	
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14					
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C16	C20	C21	C22	DMC17	DMC25									

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07	C21	C17	C31	
C	Transitions of Care – Average	HEDIS	DMC22	DMC22	DMC23												
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC18	DMC18	DMC19												
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC19	DMC19	DMC20												
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC20	DMC20	DMC21												
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC21	DMC21	DMC22												

Notes:

A: Part of composite measure Cholesterol Screening in 2010
B: Composite Measure - combined Cardiovascular Care – Cholesterol Screening and Diabetes Care – Cholesterol Screening measures
C: Composite Measure - combined Diabetes Care – Blood Sugar Controlled, Diabetes Care – Cholesterol Controlled, Diabetes Care – Eye Exam, and Diabetes Care – Kidney Disease Monitoring measures
D: Part of composite measure Diabetes Care in 2010

Table I-2: Part D Measure History

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)											DMD03	D07	D07		
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data												DMD07			
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	DMD08	DMD12	DMD14	DMD16	DMD18										
D	Appeals Auto–Forward	Independent Review Entity (IRE) / Maximus		D02	D02	D02	D02	D02	D02	D01	D02	D03	D03	D05	D05	D05	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus		D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	D06	D06	D06	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	D10	D11		
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	D01	D01	D01	
D	Call Center – Calls Disconnected - Pharmacist	Call Center Monitoring													DMD05	D04	
D	Call Center – Calls Disconnected When Customer Calls Drug Plan	Call Center Monitoring	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	DMD04	DMD04	D02	
D	Call Center – CSR Understandability	Call Center Monitoring													DMD06		
D	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	D01	D01	D01	D01	D01	D01	D01		D01	D02	D02	D04	D04		
D	Call Center – Information Accuracy	Call Center Monitoring									DMD05	DMD05	DMD06	D03	D03		
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	D02	D02	D03	
D	Complaint Resolution	Complaints Tracking Module (CTM)													DMD07		
D	Complaints – Benefits	Complaints Tracking Module (CTM)														D07	
D	Complaints – Enrollment	Complaints Tracking Module (CTM)												D08	D08	D08	
D	Complaints – Other	Complaints Tracking Module (CTM)												D09	D09	D10	
D	Complaints – Pricing	Complaints Tracking Module (CTM)														D09	

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C25/ 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	DMD06	DMD09		
D	Diabetes Treatment	Prescription Drug Event (PDE) Data								D10	D12	D15	D14	D17	D19		
D	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	Acumen / OIS (LIS Match Rates)		DMD06	DMD07	DMD07	DMD07	DMD07	DMD07	DMD05	DMD08	DMD08	DMD09	D14	D15	D15	
D	Drug Plan Quality Improvement	Star Ratings	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	DMD05	DMD08		
D	Enrollment Timeliness	MARx					DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03	DMD03		
D	Formulary Administration Analysis	Part D Sponsor				DMD15	DMD17										
D	Getting Information From Drug Plan	CAHPS						DMD10	DMD10	DMD09	DMD14	D10	D09	D11	D12	D12	
D	Getting Needed Prescription Drugs	CAHPS	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	D13	D14	D14	
D	Grievance Rate	Part C & D Plan Reporting	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	D16	D18	D19	
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	D10	D12	D12	D12	D13	D14	D14	D13	D15	D18	D17				
D	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) Data	D08	D10	D10	D10	D11	D12	D12	D11	D13	D16	D15				
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16				
D	Member Retention	MBDSS														D11	
D	Members Choosing to Leave the Plan	MBDSS	C27/ D03	C29 / D05	C30 / D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01	C29 / D10		
D	MPF – Composite	PDE Data, MPF Pricing Files											D12	D15			B
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10			D16	D17	A
D	MPF – Updates	PDE Data, MPF Pricing Files									DMD09	DMD09	DMD10	DMD08	DMD10	D16	

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	D09	D09	D09	D10	D10	D10	D08	D10	D13			D17	D18	A
D	MTM Program Completion Rate for CMR	Prescription Drug Event (PDE) Data	D11	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12					
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	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	DMD20													
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	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	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	D12	D13	D13	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13							
D	Reminders to take medications	CAHPS	DMD07	DMD11	DMD12	DMD13	DMD14	DMD16	DMD16	DMD14							
D	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Data	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	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	DMD01	DMD01		
D	Transition monitoring	Transition Monitoring Program Analysis				DMD11											D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis					DMD12	DMD14	DMD14	DMD12							C
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis					DMD11	DMD13	DMD13	DMD11							C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data		DMD15													
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data	DMD11	DMD18													

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	Notes
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	DMD12	DMD19													

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012
B: Composite measure - combined MPF - Accuracy and MPF Stability
C: Part of composite measure Transition Monitoring - Composite starting in 2019
D: Composite Measure – “Transition monitoring - failure rate for drugs within classes of clinical concern” and “Transition monitoring - failure rate for all other drugs”

Table I-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07	C33 / D10
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey	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	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	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	DME04	DME04	DME04	DME04				
E	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	Disenrollment Reasons Survey	DME05	DME05	DME05	DME05	DME06	DME06	DME06	DME06				
E	Enrollment Timeliness	MARx					DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
E	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		

Attachment J: 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 J-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 measures 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 measures 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 J-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). The 2022 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 the diagram 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 J-1: Medication Adherence for Diabetes Medications cut points example

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 %

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%. 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). 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% are assigned a rating of three stars. For a conversion to four stars, a measure score of at least 87% to less than 91% is needed. A rating of five stars is assigned to any measures 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 2022 cut points for *Members Choosing to Leave the Plan* in Table J-2 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately. The 2022 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 the diagram above 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 is 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%) are assigned a rating of four stars. A rating of three stars is assigned to measure scores greater than 16% up to a maximum value of 29%. A rating of two stars is assigned to a measure score that is greater than 29% up to and including 44%. A rating of one star is 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 J-2: Members Choosing to Leave the Plan cut points example

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 %

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.

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. 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 J-3 and J-4 show the mean resampling estimated thresholds for the 2022 Star Ratings that are used to assign stars. The thresholds printed in measure details above use the observed scores in each star category. 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.

Table J-3: 2022 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	**< 38 %**	**>= 38 % to < 61 %**	>= 61 % to < 69 %	>= 69 % to < 76 %	>= 76 %
C02	**< 48 %**	**>= 48 % to < 62 %**	>= 62 % to < 71 %	>= 71 % to < 80 %	>= 80 %
C04	< 42 %	>= 42 % to < 47 %	>= 47 % to < 52 %	>= 52 % to < 57 %	>= 57 %
C05	< 45 %	>= 45 % to < 59 %	>= 59 % to < 73 %	>= 73 % to < 87 %	>= 87 %
C06	< 48 %	>= 48 % to < 71 %	>= 71 % to < 84 %	>= 84 % to < 95 %	>= 95 %
C07	< 55 %	>= 55 % to < 76 %	>= 76 % to < 87 %	>= 87 % to < 96 %	>= 96 %
C08	< 27 %	>= 27 % to < 40 %	>= 40 % to < 50 %	>= 50 % to < 68 %	>= 68 %
C09	< 52 %	>= 52 % to < 62 %	>= 62 % to < 71 %	>= 71 % to < 79 %	>= 79 %
C10	**< 75 %**	**>= 75 % to < 88 %**	>= 88 % to < 94 %	>= 94 % to < 97 %	>= 97 %
C11	**< 40 %**	**>= 40 % to < 60 %**	>= 60 % to < 72 %	>= 72 % to < 81 %	>= 81 %
C12	< 68 %	>= 68 % to < 75 %	>= 75 % to < 79 %	>= 79 % to < 85 %	>= 85 %
C13	< 48 %	>= 48 % to < 55 %	>= 55 % to < 64 %	>= 64 % to < 72 %	>= 72 %
C14	< 42 %	>= 42 % to < 45 %	>= 45 % to < 49 %	>= 49 % to < 53 %	>= 53 %
C15	< 39 %	>= 39 % to < 56 %	>= 56 % to < 69 %	>= 69 % to < 82 %	>= 82 %
C16	< 76 %	>= 76 % to < 81 %	>= 81 % to < 84 %	>= 84 % to < 89 %	>= 89 %
C23	**> 1.39**	**> 0.81 to <= 1.39**	**> 0.37 to <= 0.81**	> 0.17 to <= 0.37	<= 0.17
C24	> 44 %	> 29 % to <= 44 %	> 16 % to <= 29 %	> 9 % to <= 16 %	<= 9 %
C25	**< -0.139885**	**>= -0.139885 to < 0**	**>= 0 to < 0.184235**	**>= 0.184235 to < 0.34342**	**>= 0.34342**
C26	< 64 %	>= 64 % to < 80 %	>= 80 % to < 90 %	>= 90 % to < 97 %	>= 97 %
C27	**< 65 %**	**>= 65 % to < 84 %**	>= 84 % to < 91 %	>= 91 % to < 96 %	>= 96 %
C28	**< 31 %**	**>= 31 % to < 54 %**	**>= 54 % to < 78 %**	>= 78 % to < 94 %	>= 94 %

Notes: Bolded cells identify mean resampling-estimated cut points that differ from the cut points printed in the measure details section.

Table J-4: 2022 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	< 25 %	>= 25 % to < 59 %	>= 59 % to < 84 %	>= 84 % to < 94 %	>= 94 %
D01	PDP	**< 55 %**	**>= 55 % to < 78 %**	**>= 78 % to < 88 %**	**>= 88 % to < 97 %**	>= 97 %
D02	MA-PD	**> 1.39**	**> 0.81 to <= 1.39**	**> 0.37 to <= 0.81**	> 0.17 to <= 0.37	<= 0.17
D02	PDP	**> 0.31**	**> 0.19 to <= 0.31**	**> 0.1 to <= 0.19**	> 0.03 to <= 0.1	<= 0.03
D03	MA-PD	> 44 %	> 29 % to <= 44 %	> 16 % to <= 29 %	> 9 % to <= 16 %	<= 9 %
D03	PDP	**> 21 %**	**> 14 % to <= 21 %**	**> 9 % to <= 14 %**	> 6 % to <= 9 %	<= 6 %
D04	MA-PD	**< -0.235985**	**>= -0.235985 to < 0**	**>= 0 to < 0.427285**	**>= 0.427285 to < 0.683861**	**>= 0.683861**
D04	PDP			**>= 0 to < 0.535174**	**>= 0.535174 to < 0.797005**	**>= 0.797005**
D07	MA-PD	< 73	>= 73 to < 83	>= 83 to < 91	>= 91 to < 96	>= 96
D07	PDP	< 84	>= 84 to < 88	>= 88 to < 94	>= 94 to < 97	>= 97
D08	MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 87 %	>= 87 % to < 91 %	>= 91 %
D08	PDP	< 84 %	>= 84 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 90 %
D09	MA-PD	**< 73 %**	**>= 73 % to < 82 %**	>= 82 % to < 87 %	>= 87 % to < 90 %	>= 90 %
D09	PDP	< 85 %	>= 85 % to < 88 %	>= 88 % to < 89 %	>= 89 % to < 91 %	>= 91 %
D10	MA-PD	< 78 %	>= 78 % to < 83 %	>= 83 % to < 87 %	>= 87 % to < 91 %	>= 91 %
D10	PDP	< 82 %	>= 82 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 90 %
D11	MA-PD	**< 52 %**	**>= 52 % to < 72 %**	>= 72 % to < 82 %	>= 82 % to < 89 %	>= 89 %
D11	PDP	< 31 %	**>= 31 % to < 46 %**	**>= 46 % to < 61 %**	**>= 61 % to < 73 %**	**>= 73 %**
D12	MA-PD	< 76 %	>= 76 % to < 80 %	>= 80 % to < 84 %	>= 84 % to < 88 %	>= 88 %
D12	PDP	< 77 %	>= 77 % to < 79 %	>= 79 % to < 82 %	>= 82 % to < 84 %	>= 84 %

Notes: Bolded cells identify mean-resampling estimated cut points that differ from the cut points printed in the measure details section.

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 in the document, "Instructions for Analyzing Data from CAHPS® Surveys: Using the CAHPS Analysis Program Version 4.1."

Tables J-5 and J-6 contain the rules applied to determine the final CAHPS measure star value.

Table J-5: 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 J-6: 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.

Attachment K: 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 'Days Covered Modification for Inpatient Stays and Skilled Nursing Facility 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 K-1: No Adjustment

	January		February		March	
	1/1/2020	1/16/2020	2/1/2020	2/16/2020	3/1/2020	3/16/2020
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 K-2: Before Overlap Adjustment

	January		February		March	
	1/1/2020	1/16/2020	2/1/2020	2/16/2020	3/1/2020	3/16/2020
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 59
Measurement Period: 90
PDC: 59/90 = 66%

Table K-3: After Overlap Adjustment

	January		February		March	
	1/1/2020	1/16/2020	2/1/2020	2/16/2020	3/1/2020	3/16/2020
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 K-4: Before Overlap Adjustment

	January		February		March		April	
	1/1/2020	1/16/2020	2/1/2020	2/16/2020	3/1/2020	3/16/2020	4/1/2020	4/16/2020
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 K-5: After Overlap Adjustment

	January		February		March		April	
	1/1/2020	1/16/2020	2/1/2020	2/16/2020	3/1/2020	3/16/2020	4/1/2020	4/16/2020
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, Hospice, 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. 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 2019 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries. 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 2021 Star Ratings (2020 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 cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP

stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

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. 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 K-6.

Table K-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 K-7.

Table K-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. 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 K-8.

Table K-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 K-9.

Table K-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. 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 K-10.

Table K-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 K-11.

Table K-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. 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 K-12.

Table K-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 K-13.

Table K-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 L: Methodology for Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (PF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the PF price to the PDE price and determining the magnitude and frequency of differences found when the PDE price exceeds the PF price. This document summarizes the methods currently used to construct each contract's PF Composite Price Accuracy Score.

Contract Selection

The Part D Star Ratings rely in part on the submission of pricing data to PF. 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.

PF Composite Price Accuracy Score

To calculate the PF 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 PF 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 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.

[1] 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 Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] 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 PF reference NDCs.

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 PF prices are not updated during this last quarter.

The PF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the PF. The contract's PF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and PF total cost,[4] and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to PF prices.

Once PF unit ingredient costs are assigned, the PF ingredient cost is calculated by multiplying the unit costs reported on PF by the quantity listed on the PDE. The PDE cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the PF TC is the sum of the PF ingredient cost and the PF 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 PF TC. If the PDE TC is lower than or equal to the PF 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 PF TC, then the claim receives a score equal to the difference between the PDE TC and the PF TC.[5] [6]The contract level PF 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 PF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the PF TC. Note that the best possible PF Price Accuracy Index is 1, and the best possible PF Claim Percentage Index is 0. This occurs when the PF TC is never lower than the PDE TC. The formulas below illustrate the calculation of the contract level PF Price Accuracy Index and PF Claim Percentage Index:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i, and

TC_{iPF} is the ingredient cost plus dispensing fee calculated from PF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i Claims_{iPDE>PF}}{\sum_i Claims_{iTotal}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.
[4] PF total costs are rounded to the nearest cent. For example, if the PF total cost is $10.237, then it is rounded to $10.24. PF unit costs are not rounded.
[5] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded PF cost by at least a cent ($0.01) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded PF cost is $10.24, the 1-cent difference would be counted towards plan's accuracy score. However, if the rounded PF cost is higher than $10.24, the difference would not be considered problematic, and it would not count towards the plan's accuracy score.
[6] The PF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the PF price is lower than the floor price, the PDE price is compared against the floor price.

$\text{Claims}_{\text{iPDE >PF}}$ is the total number of claims where the PDE price is greater than the rounded PF 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 PF Composite Price Accuracy score:

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{PF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

The PF Composite Price Accuracy Score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table L-1 shows an example of the PF 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 PF data that had been submitted by the contract and posted on Medicare.gov 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 PF 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 PF cost is computed as the quantity dispensed from PDE multiplied by the PF unit cost plus the PF 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 PF cost. When PDE cost is less than or equal to the rounded PF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table L-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	PF Data Biweekly Posting Period	PF Data Unit Cost	PF Data Dispensing Fee Brand	PF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost PF	Calculated Value Amount that PDE is higher than PF
A	111	01/08/2020	3.82	2	60	60	01/06/20 - 01/19/20	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2020	0.98	2	30	60	01/20/20 - 02/02/20	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2020	10.48	1.5	24	28	02/03/20 - 02/16/20	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2020	47	1.5	90	30	02/17/20 - 03/01/20	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
											PF Composite Price Accuracy Score			71

PDE = Prescription Drug Event
PF = Plan Finder

Attachment M: 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 2020. 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 2020.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2021), or that were not required to participate in data validation. The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation.

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.

- HICN (or MBI) or RRB Number (Element B)
- Met the specified targeting criteria per CMS – Part D requirements (Element F)
- Date of MTM program enrollment (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 P)
- Date(s) of CMR(s) (Element Q)

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 2020 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 2020 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 2020 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 N: 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 2022 Star Ratings are developed using the following sources of information:

- The 2019 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL);
- The 2019 ACS 5-year estimates for the percentage of people living below 150% of the FPL;[1] 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 2020 provided, for beneficiaries who were alive at least through December 2020 and in the 10 US states with the highest poverty rates, the percentage of each contract's beneficiaries who were DE and 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. Beneficiaries who were LIS were determined using the monthly beneficiary LIS status codes. Beneficiaries were classified LIS/DE by combining the beneficiaries identified as DE and beneficiaries identified as LIS.
- The Puerto Rico DE percentages came from the average percentage of Medicaid beneficiaries from the HPMS monthly contract enrollment data for the 2020 measurement year.

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 2019 1-year data from ACS ((https://www.census.gov/content/dam/Census/library/publications/2020/acs/acsbr20-04.pdf, see Table 1). *The states identified are: Alabama, Arkansas, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, Tennessee, 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 2022 Star Ratings adjustment, the data used for the model development included a total of 87 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

[1] The most recent ACS 5-year estimates are employed for the model development. For the 2022 Star Ratings, the most recent data are the 2019 ACS 5-year estimates.

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 2019 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 2019. 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 0.909523.

$$\widehat{\text{LIS/DE}} = (0.911539 \times \text{contract's DE percentage}) + (\text{intercept})$$

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 (30.635907%) 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	60.600000%
Percent of residents in the 10 poorest US states below 150% of FPL	27.331987%
Observed average LIS/DE percentage in the 10 poorest US states	35.876282%
Observed average DE percentage in Puerto Rico contracts	30.635907%

The product thus becomes $\left(35.876282 \times \frac{60.600000}{27.331987}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(35.876282 \times \frac{60.600000}{27.331987}\right) - (0.911539 \times 30.635907)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{LIS/DE} = (0.911539 \times \text{contract's DE percentage}) + \left(\left(35.876282 \times \frac{60.600000}{27.331987}\right) - (0.911539 \times 30.635907)\right)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 25%, the value of 25.000000% is used in the model developed.

$$\widehat{LIS/DE} = (0.911539 \times \text{contract's DE percentage}) + \left(\left(35.876282 \times \frac{60.600000}{27.331987}\right) - (0.911539 \times 30.635907)\right)$$

The contracts percentage of 25.000000% is substituted into the Puerto Rico model.

$$\widehat{LIS/DE} = (0.911539 \times 25.000000) + \left(\left(35.876282 \times \frac{60.600000}{27.331987}\right) - (0.911539 \times 30.635907)\right)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 25.000000% is 74.406911%.

The final adjustment category for the CAI adjustment is identified using the DE percentage of 25.000000% and the LIS/DE percentage 74.406911%.

Attachment O: Scaled Reductions for Appeals IRE Data

Part C Scaled Reduction Methodology

CMS's scaled reduction methodology is a three-stage process that uses the Timeliness Monitoring Project (TMP) or audit data as the means to determine: first, whether a contract may be subject to a potential reduction for the Part C appeals measures due to an IRE data completeness issue; second, as the basis to determine the estimated error rate; and finally, to see whether the estimated error rate is statistically significantly greater than established thresholds for a scaled reduction.

Stage 1: Determine Whether the Contract is Subject to a Potential Reduction for the Part C Appeals Measures Due to an IRE Data Completeness Issue

Step 1A: Data Source and Data Values

The scaled reduction methodology uses the data submitted for the Timeliness Monitoring Project (TMP) for the measurement year that is associated with the Star Ratings' year. For example, the 2022 Star Ratings scaled reductions are based on the 2020 TMP data submitted in 2021. The data, submitted at the Parent Organization level, are disaggregated to the contract level for analysis.

The following information is needed to begin the steps to determine whether a contract will be subject to a possible scaled reduction for their Part C appeals measures because of data integrity issues. The information is available in HPMS during Plan Preview. The field name in HPMS is provided within parentheses after the description in the bulleted list below.

- Number of Cases Not Forwarded to the IRE (Cases Not Forwarded to IRE)
- Number of Cases Forwarded to the IRE (Cases Forwarded to IRE)
- Total Number of Cases that Should Have Been Forwarded to the IRE (Total IRE Cases)
- TMP Data Collection Period (Months)
- Part C Calculated Error Rate

The Total Number of Cases that Should Have Been Forwarded to the IRE is calculated by adding the Number of Cases Not Forwarded to the IRE (Cases Not Forwarded to IRE) and the Number of Cases Forwarded to the IRE (Cases Forwarded to IRE) (Equation A).

Equation (A)

Total Number of Cases that Should Have Been Forwarded to IRE =
Number of Cases Not Forwarded to IRE + Number of Cases Forwarded to IRE

Step 1B: Part C Calculated Error Rate

Using the values in Step 1A, determine the Part C Calculated Error Rate.

The Calculated Error Rate is the quotient of the Number of Cases Not Forwarded to the IRE during the TMP collection period and the Total Number of Cases that Should Have Been Forwarded to the IRE in the same period (Equation B).

Equation (B)

$$\text{Part C Calculated Error Rate} = \frac{\text{Number of Cases Not Forwarded to the IRE}}{\text{Total Number of Cases that Should Have Been Forwarded to the IRE}}$$

Step 1C: 3-month Projected Number of Cases

Since the timeframe for the TMP or audit data is dependent on a contract's enrollment, a 3-month Projected Number of Cases Not Forwarded to the IRE is determined to allow a consistent application of the developed criteria.

To calculate a contract's 3-month Projected Number of Cases Not Forwarded to the IRE, first identify the multiplying factor using Table O-1. Locate the row (months) that corresponds to the TMP Data Collection Period.

Table O-1: Multiplying Factor to calculate the 3-month Projected Number of Cases Not Forwarded to the IRE

TMP Data Collection Period (Months)	Multiplying Factor for the 3-month Projected Number of Cases Not Forwarded to IRE
1	3.0
2	1.5
3	1.0

Next, multiply the Number of Cases Not Forwarded to the IRE that was posted in HPMS by the factor identified in Table 1 for the contract (Equation C). The product is the 3-month Projected Number of Cases Not Forwarded to the IRE.

Equation (C)

3-month Projected Number of Cases Not Forwarded to the IRE =
Multiplying Factor x Number of Cases Not Forwarded to IRE in the TMP period

Step 1D: Subject to Reduction

Criteria were developed to determine if a contract's Part C appeals measures may be subject to a possible IRE data completeness reduction.

A contract is subject to a possible reduction due to lack of IRE data completeness if both conditions are met:

- The Calculated Error Rate is 20% or more.
- The 3-month Projected Number of Cases Not Forwarded to the IRE is at least 10.

Using the Part C Calculated Error Rate and the 3-month Projected Number of Cases Not Forwarded to the IRE, check the criteria to determine if the contract is subject to a possible reduction. Table O-2 below is provided to determine if a contract is subject to a possible reduction.

Table O-2: Identification of a Contract that is Subject to a Possible Scaled Reduction

Calculated Error Rate	3-month Projected Number of Cases Not Forwarded to IRE	Contract Subject to a Possible Reduction
Less than 20%	Less than 10 cases	No
Less than 20%	10 cases or more	No
At Least 20%	Less than 10 cases	No
At Least 20%	10 cases or more	Yes

If a contract is not subject to a possible reduction, the contract will receive the measure-level Star Ratings for the Part C appeals measures determined by the specification detailed in the section regarding the Methodology for Assigning Stars to the Part C and Part D measures in this document.

If a contract is subject to a possible reduction, then continue to Stage 2.

Stage 2: Estimated Error Rate

Step 2A: Lower Bound of the Score Interval

Using the Part C Calculated Error Rate in Step 1B, the lower bound of the confidence interval (Wilson Score Interval) is determined and used to statistically test the value against a set of thresholds to identify the scaled reduction for a contract's Part C appeals measures.

To determine the lower bound, first, the midpoint of the interval must be calculated. There are two values needed to calculate the midpoint of the interval for a contract – the Part C Calculated Error Rate and the Total Number of Cases that Should Have Been Forwarded to the IRE in the TMP Data Collection Period.[1]

Substitute the Calculated Error Rate and the Total Number of Cases that Should Have Been Forwarded to the IRE for the Total Number of Cases in Equation (D). The z value used for the calculation of the interval is 1.959964.[2]

Equation (D)

$$\text{Midpoint} = \text{Calculated Error Rate} \times \left(\frac{\text{Total Number of Cases}}{\text{Total Number of Cases} + z^2}\right) + \frac{1}{2}\left(\frac{z^2}{\text{Total Number of Cases} + z^2}\right)$$

Once the midpoint is calculated, determine the value of the lower bound of the interval.

The lower bound of the interval is found by substituting the value determined for the midpoint, the Calculated Error Rate, the value of 1.959964 for z, and the Total Number of Cases that Should Have Been Forwarded to the IRE for the value for n in Equation (E).

Equation (E)

$$\text{Lower Bound} = \text{Midpoint} - z \times \sqrt{\frac{1}{n + z^2}\left[(\text{Calculated Error Rate})\,(1\text{-Calculated Error Rate})\left(\frac{n}{n + z^2}\right) + \frac{1}{4}\left(\frac{z^2}{n + z^2}\right)\right]}$$

Convert the lower bound to a percent by multiplying by 100.

Stage 3: Scaled Reduction

Step 3A: Statistical Testing

Once the value of the lower bound is determined (Stage 2), the value is compared to the thresholds in Table O-3 to determine if a contract's estimated value is significantly greater than the thresholds.

Using the calculated value for the lower bound in Step 2A, identify the value(s) in the table for which the calculated lower bound exceeds the threshold in the row. Next, identify the highest threshold that the lower bound exceeds.

Note: A contract's lower bound can be statistically significantly higher for more than one threshold. The scaled reduction will be determined by the highest associated scaled reduction.

Table O-3: Thresholds and Associated Reductions

Threshold	Reduction for Incomplete IRE Data (Stars)
20%	1
40%	2
60%	3
80%	4

Using the highest threshold in Table P-3 that the contract's lower bound exceeds, identify the associated reduction for incomplete IRE data.

Step 3B: Application of the Scaled Reduction

[1] The Total Number of Cases that Should Have Been Forwarded to the IRE in the TMP Data Collection Period is not the same as the 3-month Projected Number of Cases Not Forwarded to the IRE determined in Step 1C.

[2] The z used for the calculated of the interval corresponds to a level of statistical significance of 0.05.

The identified scaled reduction in Table P-3 is subtracted from the measure-level Star Rating for both Part C appeals measure-level Star Ratings. If the resulting measure-level Star Rating is less than one-star, the measure is assigned one star.

Note: If the Part C appeals measures receive a scaled reduction, the Part C appeals measures would not be eligible for inclusion in of the Part C improvement measure.

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 2022 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html) documented 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 §423.86(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[1], U.S. territory or tribal government designated in a major disaster declaration under the Stafford Act.

1) 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

1) Major disaster areas are identified by the Federal Emergency Management Agency (FEMA) website at: https://www.fema.gov/disasters.

Table P-1 contains the list of Section 1135 waivers issued by the HHS Secretary along with associated FEMA major disaster information that falls within the performance period for the 2022 Star Ratings and Table P-2 contains the list of FEMA major disaster declarations issued as a result of the COVID-19 outbreak.

Table P-1: List of 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 Major Disaster Declaration	FEMA Incident Type	Affected State	Incident Start Date	Declared Major Disaster
03/13/2020	Nationwide as a result of COVID-19 outbreak	See Table P-2	2019 novel coronavirus (COVID-19) pandemic	Nationwide	01/27/2020	See Table P-2
08/26/2020	California Wildfires	DR-4558	Wildfires	California	08/14/2020	08/22/2020
	California Wildfires	DR-4659	Wildfires	California		
08/26/2020	Hurricane Laura	DR-4559	Hurricane	Louisiana	08/22/2020	08/28/2020
09/16/2020	Oregon Wildfires	DR-4562	Wildfires	Oregon	09/07/2020	09/15/2020

Table P-2: List of FEMA disaster declarations issued as a result of the COVID-19 outbreak

FEMA Major Disaster Declaration	Affected State
DR-4503	Alabama
DR-4533	Alaska
DR-4524	Arizona
DR-4518	Arkansas
DR-4482	California
DR-4498	Colorado
DR-4500	Connecticut

[1] The Census Bureau has been charged by the U.S. Congress to maintain the geographic reference information for the United States and its territories. The full definition of "county or statistically equivalent entities" can be found at their website https://www.census.gov/geo/reference/gtc/gtc_cou.html.

FEMA Major Disaster Declaration	Affected State
DR-4526	Delaware
DR-4502	Washington D.C.
DR-4486	Florida
DR-4501	Georgia
DR-4495	Guam
DR-4510	Hawaii
DR-4534	Idaho
DR-4489	Illinois
DR-4529	Indiana
DR-4483	Iowa
DR-4504	Kansas
DR-4497	Kentucky
DR-4484	Louisiana
DR-4522	Maine
DR-4491	Maryland
DR-4496	Massachusetts
DR-4494	Michigan
DR-4531	Minnesota
DR-4528	Mississippi
DR-4490	Missouri
DR-4508	Montana
DR-4521	Nebraska
DR-4508	Nevada
DR-4516	New Hampshire
DR-4488	New Jersey
DR-4515	New Mexico
DR-4480	New York
DR-4487	North Carolina
DR-4509	North Dakota
DR-4507	Ohio
DR-4530	Oklahoma
DR-4499	Oregon
DR-4506	Pennsylvania
DR-4493	Puerto Rico
DR-4505	Rhode Island
DR-4492	South Carolina
DR-4527	South Dakota
DR-4514	Tennessee
DR-4485	Texas
DR-4513	U.S. Virgin Islands
DR-4525	Utah
DR-4532	Vermont
DR-4512	Virginia
DR-4481	Washington
DR-4517	West Virginia
DR-4520	Wisconsin
DR-4535	Wyoming
DR-4558	California
DR-4559	Louisiana
DR-4562	Oregon

- 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.

  Table P-3 list all of the FEMA major disaster declarations other than the COVID-19 Pandemic from Table P-1 along with the state and associated Individual Assistance counties, if any.

Table P-3: Individual Assistance counties in FEMA Major Disaster Declared States Other than from the COVID-19 Pandemic

FEMA Declaration	State	FEMA Individual Assistance Counties
DR-4558	California	Lake, Monterey, Napa, San Mateo, Santa Cruz, Solano, Sonoma, Yola
DR-4559	Louisiana	Acadia, Allen, Beauregard, Calcasieu, Cameron, Grant, Jackson, Jefferson, Davis, Lincoln, Natchitoches, Ouachita, Rapides, Sabine, Vermilion, Vernon, Winn
DR-4562	Oregon	Clackamas, Douglas, Jackson, Klamath, Lane, Lincoln, Linn, Marion

- 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-4 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-4: 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 to the service area from all contracts created in Step 3 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 spread across the second half of the performance period. 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-5 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-5: Major disasters with associated enrollment months

FEMA Declaration	State	Start Date	Declaration Date	Enroll File	Enroll Cut Off
COVID-19 outbreak (see table P-2)	Nationwide	01/27/2020	Various	N/A*	N/A*
DR-4558	California	08/14/2020	08/22/2020	N/A*	N/A*
DR-4559	Louisiana	08/22/2020	08/28/2020	N/A*	N/A*
DR-4562	Oregon	09/07/2020	09/15/2020	N/A*	N/A*

*Not applicable for the 2022 Star Ratings because all contracts that were active in 2020 qualify for the disaster adjustment as a result of the COVID-19 pandemic.

- Calculate impacted enrollments by contract taking into account contracts experiencing multiple disasters. Because of the varying sizes of the areas served by the contracts being rated, it is common for a contract to be affected by more than one of the disasters. To account for this, CMS rolled up the enrollment for each contract at the state/county level and then when more than one enrollment period applied an average of the enrollments from each of corresponding enrollment periods where the contract was affected was used.

  Table P-6 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-6: How enrollment periods were combined for contracts experiencing multiple disasters

Formula ID	Enrolled 2020_10	Enrolled 2020_11	Enrolled 2020_12	Enrollment Used
B	True	True	True	(2020_10 + 2020_11 + 2020_12) / 3
C	True	True		(2020_10 + 2020_11) / 2
F	True		True	(2020_10 + 2020_12) / 2
H	True			2020_10
J		True	True	(2020_11 + 2020_12) / 2
L		True		2020_11
N			True	2020_12
P				0 (zero)

- Using the enrollment for the contract developed in Step 7, 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, 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, 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. (For 2022 Star Ratings, the 60% threshold does not apply.)

Example:

For this example, steps 1 and 2 use the disasters and counties that have already been defined in Tables P-1 & P-3. 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-7 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-7. Rows marked TRUE are matches from Individual Assistance counties in disasters DR-4332 and D-4344 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 2019/09 & 2019/11. Columns for all enrollment periods are included in table P-7, but only the valid enrollment periods contain the necessary data.

Step 7, the average enrollment is calculated for the included enrollment periods. The formula for average enrollment comes from the Table Q-5 row F under the column Formula ID. The result of each average calculation for each county in the example contract's service area is shown in the final column of Table P-7.

Table P-7: Example contract HAAAA's service areas and enrollment during relevant disasters

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 2020/09	Enrolled 2020/10	Enrolled 2020/11	Enrolled 2021/01	Average Enrollment
06003	Alpine	CA	No	FALSE	8	-	8	-	8
06009	Calaveras	CA	No	FALSE	849	-	850	-	850
06011	Colusa	CA	No	FALSE	168	-	166	-	167
06015	Del Norte	CA	No	FALSE	369	-	360	-	364
06023	Humboldt	CA	No	FALSE	702	-	710	-	706
06045	Mendocino	CA	No	TRUE	428	-	429	-	428
06049	Modoc	CA	No	FALSE	157	-	158	-	158
06063	Plumas	CA	No	FALSE	182	-	181	-	182
06093	Siskiyou	CA	No	FALSE	798	-	800	-	799
06105	Trinity	CA	No	FALSE	150	-	150	-	150
48043	Brewster	TX	Yes	FALSE	16	-	15	-	16
48047	Brooks	TX	Yes	FALSE	28	-	27	-	28
48049	Brown	TX	Yes	FALSE	64	-	65	-	64
48057	Calhoun	TX	Yes	TRUE	28	-	28	-	28
48093	Comanche	TX	Yes	FALSE	33	-	32	-	32
48103	Crane	TX	Yes	FALSE	8	-	8	-	8
48109	Culberson	TX	Yes	FALSE	3	-	3	-	3
48123	DeWitt	TX	Yes	TRUE	26	-	26	-	26
48131	Duval	TX	Yes	FALSE	30	-	28	-	29
48133	Eastland	TX	Yes	FALSE	64	-	62	-	63
48143	Erath	TX	Yes	FALSE	61	-	59	-	60
48163	Frio	TX	Yes	FALSE	43	-	42	-	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	-	17
48175	Goliad	TX	Yes	TRUE	18	-	18	-	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	-	41
48237	Jack	TX	Yes	FALSE	35	-	34	-	34
48239	Jackson	TX	Yes	TRUE	30	-	30	-	30
48255	Karnes	TX	Yes	TRUE	19	-	19	-	19
48265	Kerr	TX	Yes	FALSE	85	-	86	-	86
48283	La Salle	TX	Yes	FALSE	25	-	25	-	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	-	24
48301	Loving	TX	Yes	FALSE	0	-	0	-	0
48311	McMullen	TX	Yes	FALSE	4	-	4	-	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	-	142
48323	Maverick	TX	Yes	FALSE	160	-	156	-	158
48371	Pecos	TX	Yes	FALSE	20	-	21	-	20
48377	Presidio	TX	Yes	FALSE	50	-	49	-	50
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

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 2020/09	Enrolled 2020/10	Enrolled 2020/11	Enrolled 2021/01	Average Enrollment
48495	Winkler	TX	Yes	FALSE	20	-	20	-	20

Step 8, sum the average enrollment from all rows from Table Q-6. The total comes out to 5,120 for contract HAAAA.

Step 9, sum the average enrollment from all the rows from Table Q-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 (C26 & C27):

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 > 01/01/2020?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C17, C18, C19, C20, C21, & C22):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2020?
  - 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 (C28):

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 > 01/01/2021?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C23):

Is the contract effective date > 01/01/2020?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2020?
  - 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 (C01, C02, C06 – C12, C15 & C16):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2020?
  - 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
    - NA: Display message: Not enough data available
    - 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: 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 > 01/01/2019?
  - 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 SNP offered in 2022= No?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2020?
  - 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
    - NA: Display message: Not enough data available
    - 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: Display the HEDIS measure numeric rate
      - No: Display message: No data available

HEDIS / HOS measures (C04, C13, & C14):

Is there a valid HEDIS / HOS numeric rate?
- Yes: Display the HEDIS / HOS numeric rate
- No: Is the contract effective date > 01/01/2019?
  - Yes: Display message: Plan too new to be measured
  - No: Is the 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 (C24):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date ≥ 01/01/2021?
  - 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 SNP offered in 2022 = No?
- 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 > 01/01/2020?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C25):

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 > 01/01/2020?
  - 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 > 07/01/2020?
  - 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 > 01/01/2021?
    - 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 > 01/01/2020?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2020?
  - 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 > 01/01/2020?
  - 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 ≥ 01/01/2021?
  - 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 > 9/30/2020?
- 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):

Is the contract effective date > 12/31/2020?
- 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

Patient Safety measure – MTM CMR (D11)

Is the contract effective date > 12/31/2020?
- Yes: Display message: Plan too new to be measured
- No: Is Part D Offered=False?
  - Yes: Display message: Plan not required to report measure
  - No: 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

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 all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
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 > 01/01/2020?
  - 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 > 01/01/2020?
  - 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 > 01/01/2020?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2022 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 > 1/1/2020?
- 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 D plan or re-enroll into their existing Medicare Part D Plan or change into another Medicare Part D plan is known as the Annual Election Period (AEP). Beneficiaries can also switch to a Medicare Advantage Plan that has a Prescription Drug Plan (MA-PD). The chosen Medicare Part 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.
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.
ICEP	The 3 months immediately before beneficiaries are entitled to Medicare Part A and enrolled in Part B are known as the Initial Coverage Election Period (ICEP). Beneficiaries may choose a Medicare health plan during their ICEP and the plan must accept them unless it has reached its limit in the number of members. This limit is approved by CMS.
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.
IVR	Interactive voice response (IVR) is a technology that allows a computer to interact with humans through the use of voice and dual-tone multi-frequency keypad inputs.
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 2022 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						
				HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	01/01/2020 - 12/31/2020	01/01/2020 - 12/31/2020	03/2021 - 05/2021
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 page

The Measure Detail page contains the underlying data used for the Part C and Part D Complaints (C23/D02) and Part C Appeals measures (C26 & C27). 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 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 < 800 Enrolled	Yes / No, Yes = average enrollment < 800, No = average enrollment ≥ 800
Part C Total Appeals Cases	Total number of Part C appeals cases processed by the IRE (Maximus)
Part C Appeals Upheld	Number of Part C appeals which were upheld
Part C Appeals Overturned	Number of Part C appeals which were overturned
Part C Appeals Partly Overturned	Number of Part C appeals which were partially overturned
Part C Appeals Dismissed	Number of Part C appeals which were dismissed
Part C Appeals Withdrawn	Number of Part C appeals which were withdrawn
Part C Late Appeals	Number of Part C appeals which Maximus considered to be late
Part C Percent of Timely Appeals	Percent of Part C appeals which were processed in a timely manner

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 (C26) and Reviewing Appeals Decisions (C27). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2022 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, 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, Overturn MCO Denial, Partly Overturn MCO Denial, Unspecified, Uphold MCO Denial, Withdraw Appeal)
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 – SNP COA page

The Measure Detail – SNP COA page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adult measures (C06 & C07). The formulas used to calculate these SNP measures are detailed in Attachment E. This page is available during the first plan preview. Table S-5 below explains each of the columns displayed on this page.

Table S-5: Measure Detail – SNP COA 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
Eligible Population – MR	The Eligible population - Medication Review, entered by the contract into NCQA IDSS (Field: eligpopmr)
Eligible Population – PA	The Eligible population - Pain Assessment, entered by the contract into NCQA IDSS (Field: eligpopps)
Average Plan Enrollment	The average enrollment in the PBP during 2020 (see section Contract Enrollment Data)
COA – MR Rate	The COA Medication Review Rate calculated by the NCQA data submission tool (Field: ratemr)
COA – PA Rate	The COA Pain Assessment Rate calculated by the NCQA data submission tool (Field: rateps)
COA - MR Audit Designation	The audit designation for the COA Medication Review Rate (the audit codes defined next table)
COA – PA Audit Designation	The audit designation for the COA Pain Assessment Rate (the audit codes defined next table)

Table S-6: HEDIS 2020 Audit Designations and 2022 Star Ratings

Audit Designation	NCQA Description	Resultant Star Rating
R	Reportable	Assigned 1 to 5 stars depending on reported value
BR	Biased Rate	1 star, numeric data set to “CMS identified issues with this plan’s data”
NA	Small Denominator	“Not enough data available”
NB	No Benefit	“Benefit not offered by plan”
NR	Not Reported	1 star, numeric data set to “CMS identified issues with this plan’s data”
NQ	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 (C23/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 Lead	The complaint lead 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 (C24/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 (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 comes from surveys sent to enrollees who disenrolled between 1/1/2020 and 12/31/2020. 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 M. 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 HICN (or 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 HICN (or 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 (C17), Getting Appointments and Care Quickly (C18), Customer Service (C19), Rating of Health Care Quality (C20), Rating of Health Plan (C21), Care Coordination (C22), 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, Not Reported)
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 – CSR

The Calculation Detail – CSR (Part C Scaled Reduction) page contains the underlying data used in calculating the reduction applied to the two Part C appeals measures. This page is available during the first plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Measure Detail – Part C Scaled Reductions 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
TMP Time Period	The time period associated with the TMP data submission; a zero indicates contract did not submit data
Cases Not Forwarded to IRE	The number of cases not forwarded to the IRE in the TMP time period
Cases Forwarded to IRE	The number of cases forwarded to the IRE in the TMP time period
Total IRE Cases	The total number of cases that should have been forwarded to the IRE in the TMP time period
TMP data submitted	A flag that indicates whether the contract submitted TMP data (Yes/No)
Projected Cases	The projected number of cases not forwarded to the IRE in a three-month period
Calculated Error Rate	The Calculated Error Rate is the quotient of Cases Not forwarded to IRE and Total IRE cases
Lower Bound	Lower Bound of the Score Interval
Part C Appeals Reduction	Part C Appeals measures Star Ratings reduction due to IRE completeness issues

12. 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-13 below explains the columns displayed on this page.

Table S-13: 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
2020 Disaster Flag	Indicates if the contract was affected by a 2020 disaster or not (valid values “Affected”, “Not Affected” or “Too New“)
2020 Total Cnty in SA	The total number of counties in the contract’s 2020 service area (SA)
2020 Num Cnty IA	The number of counties from the contract’s total SA designated as FEMA Individual Assistance (IA) counties in a 2020 disaster
2020 IA Non-Employer	The number of members in Non-Employer PBPs residing in the contract SA designated FEMA IA counties in a 2020 disaster
2020 IA Employer	The number of members in Employer PBPs residing in the contract SA designated FEMA IA counties in a 2020 disaster
2020 IA Total Enrolled	The total number of members residing in the contract SA designated FEMA IA counties in a 2020 disaster
2020 Total Non-Employer	The total number of members in Non-Employer PBPs in the contract’s 2020 SA
2020 Total Employer	The total number of members in Employer PBPs residing in the contract’s 2020 SA
2020 Total Enrolled	The total number of members residing in the contract’s 2020 SA
2020 IA %	The percent of members living in IA areas in a 2020 disaster (IA Total Enrolled)/(Total Enrolled)
2020 IA % Rounded	The percent of members living in IA areas in a 2020 disaster rounded to an integer
2020 >25%	Flag that indicates if the contract has meet the 25% threshold for 2020 disasters (Yes: >= 25 %, No: <25%)
2019 Disaster Flag	Indicates if the contract was affected by a 2019 disaster or not (valid values “Affected”, “Not Affected” or “Too New“)
2019 Total Cnty in SA	The total number of counties in the contract’s 2019 service area (SA)
2019 Num Cnty IA	The number of counties from the contract’s total SA designated as FEMA Individual Assistance (IA) counties in a 2019 disaster
2019 IA Non-Employer	The number of members in Non-Employer PBPs residing in the contract SA designated FEMA IA counties in a 2019 disaster
2019 IA Employer	The number of members in Employer PBPs residing in the contract SA designated FEMA IA counties in a 2019 disaster
2019 IA Total Enrolled	The total number of members residing in the contract SA designated FEMA IA counties in a 2019 disaster
2019 Total Non-Employer	The total number of members in Non-Employer PBPs in the contract’s 2019 SA
2019 Total Employer	The total number of members in Employer PBPs residing in the contract’s 2019 SA
2019 Total Enrolled	The total number of members residing in the contract’s 2019 SA
2019 IA %	The percent of members living in IA areas in a 2019 disaster (IA Total Enrolled)/(Total Enrolled)
2019 IA % Rounded	The percent of members living in IA areas in a 2019 disaster rounded to an integer
2019 >25%	Flag that indicates if the contract has meet the 25% threshold for 2019 disasters (Yes: >= 25 %, No: <25%)
2019 >60%	Flag that indicates if the contract has meet the 60% threshold for 2019 disasters (Yes: >= 60 %, No: <60%)

13. 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-14 below explains the columns displayed on this page.

Table S-14: 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
# LIS/DE	The number of LIS/DE enrolled in the contract
# 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

14. 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 – C12, C15 – C16) data for contracts with ≥ 500 and < 1,000 members enrolled in July of the measurement year (July 01, 2020). This page is available during the second plan preview. Table S-15 below explains each of the columns displayed on this page.

Table S-15: 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 2020
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

15. Measure Detail – C Disaster 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-16 below explains the columns displayed on this page.

Table S-16: Measure Detail – C Disaster 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 2022 Star Ratings Part C measure ID
2021 Value	The numeric measure value for the contract from the 2021 Star Ratings
2021 Star	The measure star for the contract from the 2021 Star Ratings
2022 Value	The numeric measure value for the contract from the 2022 Star Ratings
2022 Star	The measure star for the contract from the 2022 Star Ratings
Final Value	The measure value to be used in the 2022 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2022 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 – D Disaster 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-17 below explains the columns displayed on this page.

Table S-17: Measure Detail – D Disaster 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 2022 Star Ratings Part D measure ID
2021 Value	The numeric measure value for the contract from the 2021 Star Ratings
2021 Star	The measure star for the contract from the 2021 Star Ratings
2022 Value	The numeric measure value for the contract from the 2022 Star Ratings
2022 Star	The measure star for the contract from the 2022 Star Ratings
Final Value	The measure value to be used in the 2022 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2022 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

17. 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 contain the final numeric Part C improvement score. This numeric result from step 4 is described in Attachment H: "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-18 below.

Table S-18: 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

18. 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 contain the final numeric Part D improvement

score. This numeric result from step 4 is described in Attachment H: "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-19 below.

Table S-19: 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

19. 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-20 below shows a sample of the left hand most columns shown in HPMS.

Table S-20: Measure Star page sample

Medicare Star Ratings Report Card Master Table						
				HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	01/01/2020 - 12/31/2020	01/01/2020 - 12/31/2020	03/2021 - 05/2021
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

20. 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-21 below shows a sample of the left hand most columns shown in HPMS.

Table S-21: 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

21. 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-22 below explains each of the columns contained on this page.

Table S-22: 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	The percentage of members living in an Individual Assistance area 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 (C31)? (Yes/No)
2022 Part C Summary Rating	The final rounded 2022 Part C Summary Rating

22. 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-23 below explains each of the columns contained on this page.

Table S-23: 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	The percentage of members living in an Individual Assistance area 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 (D06)? (Yes/No)
2022 Part D Summary Rating	The final rounded 2022 Part D Summary Rating

23. 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-24 below explains each of the columns contained on this page.

Table S-24: 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	The percentage of members living in an Individual Assistance area 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
2022 Part C Summary Rating	The 2022 Part C Summary Rating
2022 Part D Summary Rating	The 2022 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

HPMS Field Label	Field Description
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 (C31 & D06)? (Yes/No)
2022 Overall Rating	The final 2022 Overall Rating

24. Highest Rating page

The Highest Rating page displays the highest rating for contracts. This page is available during the second plan preview. Table S-25 below explains each of the columns contained on this page.

Table S-25: Highest 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
2022 Highest Rating	The 2022 Highest Rating

25. 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-26 below explains each of the columns contained on this page.

Table S-26: 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”
2020 C Summary	The 2020 Part C Summary Rating earned by the contract
2020 D Summary	The 2020 Part D Summary Rating earned by the contract
2021 C Summary	The 2021 Part C Summary Rating earned by the contract
2021 D Summary	The 2021 Part D Summary Rating earned by the contract
2022 C Summary	The 2022 Part C Summary Rating earned by the contract
2022 D Summary	The 2022 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.

26. 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-27 below explains each of the columns contained on this page.

Table S-27: 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

27. Technical Notes link

The Technical Notes link provides the user with a copy of the 2022 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 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 2022 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.

28. 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.

29. 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 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, and two flags identifying contracts with > 25 percent of enrollees living in an area affected by a disaster. There is also a flag in the Part D measure file identifying contracts as MAPD or PDP. This downloadable is in Zip format and contains two Excel files.

EXHIBIT 7

Medicare 2023 Part C & D Star Ratings Technical Notes

Updated – 01/19/2023

Document Change Log

Previous Version	Description of Change	Revision Date
9/28/2022	Fixed a typo in the 1- and 2- star cut points for measure C24 and D02 (MAPD cut points only) and fixed a typo in the description of the restricted range cap under Methodology for Assigning Stars to the Part C and Part D Measures and in Attachment J.	1/19/2023

OMB Approved Data Sources

The data collected for the Part C & D Star Ratings come from a variety of different data sources approved under the following Office of Management and Budget (OMB) Paperwork Reduction Act numbers:

Data Source	OMB Number
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0938-0732
Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

Table of Contents

DOCUMENT CHANGE LOG I

INTRODUCTION 1

DIFFERENCES BETWEEN THE 2022 STAR RATINGS AND 2023 STAR RATINGS 1

HEALTH/DRUG ORGANIZATION TYPES INCLUDED IN THE STAR RATINGS 2
Table 1: Contract Year 2023 Organization Types Reported in the 2023 Star Ratings 2

THE STAR RATINGS FRAMEWORK 2
Figure 1: The Four Levels of Star Ratings 3
Table 2: 5-Star Scale 3
Table 3: Relation of 2023 Organization Types to Contract Types and Highest Rating in the 2023 Star Ratings 3

SOURCES OF THE STAR RATINGS MEASURE DATA 4
Figure 2: The Four Categories of Data Sources 4

IMPROVEMENT MEASURES 4
Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type 5

CONTRACT ENROLLMENT DATA 5

HANDLING OF BIASED, ERRONEOUS, AND/OR NOT REPORTABLE (NR) DATA 5

SCALED REDUCTIONS FOR THE APPEALS MEASURES 6

DATA HANDLING OF MEASURES FOR CONTRACTS AFFECTED BY A MAJOR DISASTER 6

METHODOLOGY FOR ASSIGNING STARS TO THE PART C AND PART D MEASURES 9

A. Clustering 9

B. Relative Distribution and Significance Testing (CAHPS) 9

METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL 9
Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type 10

SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES 10

METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS 10
Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type 11

METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING 11
Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type 11

COMPLETING THE SUMMARY AND OVERALL RATING CALCULATIONS 12

APPLYING THE IMPROVEMENT MEASURE(S) 12

APPLYING THE REWARD FACTOR 13
Table 8: Performance Summary Thresholds 14
Table 9: Variance Thresholds 14

CATEGORICAL ADJUSTMENT INDEX (CAI) 14
Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating 16
Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating 16
Table 12: Final Adjustment Categories and CAI Values for the Overall Rating 16
Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary 17
Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary 17
Table 15: Final Adjustment Categories and CAI Values for the Part C Summary 17
Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary 18
Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary 18
Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary 18
Table 19: Categorization of Contract's Members into Quartiles of LIS/DE for the PDP Part D Summary 18

Table 20: Categorization of Contract's Members into Quartiles of Disability for the PDP Part D Summary 19
Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary 19

CALCULATION PRECISION 19

ROUNDING RULES FOR MEASURE SCORES 19

ROUNDING RULES FOR SUMMARY AND OVERALL RATINGS 20
Table 22: Rounding Rules for Summary and Overall Ratings 20

METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON 20
Figure 3: The High Performing Icon 20

METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON 20
Figure 4: The Low Performing Icon 21
Table 23: Example LPI Contracts 21

MERGERS, NOVATIONS, AND CONSOLIDATIONS 21

RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS 22

SPECIAL NEEDS PLAN (SNP) DATA 22

STAR RATINGS AND MARKETING 22

CONTACT INFORMATION 22

FRAMEWORK AND DEFINITIONS FOR THE DOMAIN AND MEASURE DETAILS SECTION 24

PART C DOMAIN AND MEASURE DETAILS 26

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines 26
Measure: C01 - Breast Cancer Screening 26
Measure: C02 - Colorectal Cancer Screening 28
Measure: C03 - Annual Flu Vaccine 29
Measure: C04 - Monitoring Physical Activity 30

Domain: 2 - Managing Chronic (Long Term) Conditions 33
Measure: C05 - Special Needs Plan (SNP) Care Management 33
Measure: C06 - Care for Older Adults – Medication Review 36
Measure: C07 - Care for Older Adults – Pain Assessment 38
Measure: C08 - Osteoporosis Management in Women who had a Fracture 40
Measure: C09 - Diabetes Care – Eye Exam 41
Measure: C10 - Diabetes Care – Kidney Disease Monitoring 44
Measure: C11 - Diabetes Care – Blood Sugar Controlled 45
Measure: C12 - Controlling Blood Pressure 47
Measure: C13 - Reducing the Risk of Falling 50
Measure: C14 - Improving Bladder Control 51
Measure: C15 - Medication Reconciliation Post-Discharge 53
Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease 54

Domain: 3 - Member Experience with Health Plan 57
Measure: C17 - Getting Needed Care 57
Measure: C18 - Getting Appointments and Care Quickly 59
Measure: C19 - Customer Service 60
Measure: C20 - Rating of Health Care Quality 61
Measure: C21 - Rating of Health Plan 64
Measure: C22 - Care Coordination 66

Domain: 4 - Member Complaints and Changes in the Health Plan's Performance 68
Measure: C23 - Complaints about the Health Plan 68
Measure: C24 - Members Choosing to Leave the Plan 69
Measure: C25 - Health Plan Quality Improvement 71

Domain: 5 - Health Plan Customer Service 73
Measure: C26 - Plan Makes Timely Decisions about Appeals 73
Measure: C27 - Reviewing Appeals Decisions 74

Measure: C28 - Call Center – Foreign Language Interpreter and TTY Availability 76

PART D DOMAIN AND MEASURE DETAILS 78

Domain: 1 - Drug Plan Customer Service 78
Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability 78

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance 80
Measure: D02 - Complaints about the Drug Plan 80
Measure: D03 - Members Choosing to Leave the Plan 81
Measure: D04 - Drug Plan Quality Improvement 83

Domain: 3 - Member Experience with the Drug Plan 85
Measure: D05 - Rating of Drug Plan 85
Measure: D06 - Getting Needed Prescription Drugs 86

Domain: 4 - Drug Safety and Accuracy of Drug Pricing 88
Measure: D07 - MPF Price Accuracy 88
Measure: D08 - Medication Adherence for Diabetes Medications 89
Measure: D09 - Medication Adherence for Hypertension (RAS antagonists) 92
Measure: D10 - Medication Adherence for Cholesterol (Statins) 95
Measure: D11 - MTM Program Completion Rate for CMR 98
Measure: D12 - Statin Use in Persons with Diabetes (SUPD) 102

ATTACHMENT A: CAHPS CASE-MIX ADJUSTMENT 105

CAHPS Case-Mix Adjustment 105
Table A-1: Coefficients of Part C CAHPS Measures 105
Table A-2: Coefficients of Part D CAHPS Measures 107

ATTACHMENT B: CALCULATING MEASURE DATA FOR THE SURVIVING CONTRACT OF A CONSOLIDATION 108

ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES 109
Table C-1: National Averages for Part C Measures 109
Table C-2: National Averages for Part D Measures 110

ATTACHMENT D: PART C AND D DATA TIME FRAMES 111
Table D-1: Part C Measure Data Time Frames 111
Table D-2: Part D Measure Data Time Frames 112

ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES 113
1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management) 113
2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults) 114

ATTACHMENT F: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES 116
Table F-1: Part C Measure Weights 116
Table F-2: Part D Measure Weights 117

ATTACHMENT G: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES 118

ATTACHMENT H: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED 119

Calculating the Improvement Measure 119

General Standard Error Formula 120

Improvement Change Score Standard Error Numerical Example 120

Standard Error Formulas (SEF) for Specific Measures 121
1. SEF for Measures: C01, C02, C04, C05, C08 – C11, C13 – C16, C24, C26 – C28, D01, D03, D08 – D12 121
2. SEF for Measures: C06, C07 121
3. SEF for Measures: C03, C17 – C22, and D05, D06 121
4. SEF for Measures C23, D02 121
5. SEF for Measure D07 122

Star Ratings Measures Used in the Improvement Measures 122
Table H-2: Part D Measures Used in the Improvement Measure 123

ATTACHMENT I: STAR RATINGS MEASURE HISTORY 124

Table I-1: Part C Measure History 124
Table I-2: Part D Measure History 129
Table I-3: Common Part C & Part D Measure History 133

ATTACHMENT J: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS 134

Clustering Methodology Introduction 134

Example 1 – Clustering Methodology for a Higher is Better measure 134
Table J-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes 135

Example 2 – Clustering Methodology for a Lower is Better measure 135
Table J-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes 135

Clustering Methodology Detail 136
1. Produce the individual measure distance matrix. 136
2. Create a tree of cluster assignments. 136
3. Select the final set of clusters from the tree of cluster assignments. 137
4. Final Thresholds 137
Table J-3: 2023 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds 138
Table J-4: 2023 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds 139

Relative Distribution and Significance Testing (CAHPS) Methodology 139
Table J-5: CAHPS Star Assignment Rules 140
Table J-6: CAHPS Star Assignment Alternate Representation 140
Table J-7: CAHPS Measure 12% Reliability Cutoffs 141

ATTACHMENT K: MEDICATION ADHERENCE MEASURE CALCULATIONS 142

Proportion of Days Covered Calculation 142

Example 1: Non-Overlapping Fills of Two Different Drugs 142
Table K-1: No Adjustment 142

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products 142
Table K-2: Before Overlap Adjustment 143
Table K-3: After Overlap Adjustment 143

Example 3: Overlapping Fills of the Same and Different Target Drugs 143
Table K-4: Before Overlap Adjustment 143
Table K-5: After Overlap Adjustment 143

PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples 144

Calculating the PDC Adjustment for IP Stays and SNF Stays 144

Example 1: Gap in Coverage after IP Stay 145
Table K-6: Before Adjustment 145
Table K-7: After Adjustment 145

Example 2: Gap in Coverage before IP Stay 145
Table K-8: Before Adjustment 146
Table K-9: After Adjustment 146

Example 3: Gap in Coverage Before and After IP Stay 146
Table K-10: Before Adjustment 146
Table K-11: After Adjustment 147

Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class 147
Table K-12: Before Adjustment 147
Table K-13: After Adjustment 147

ATTACHMENT L: METHODOLOGY FOR PRICE ACCURACY MEASURE 148

ATTACHMENT M: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES 153

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure) 153

ATTACHMENT N: METHODOLOGY FOR THE PUERTO RICO MODEL 155

ATTACHMENT O: SCALED REDUCTIONS FOR APPEALS IRE DATA 158

Part C Scaled Reduction Methodology 158

Stage 1: Determine Whether the Contract is Subject to a Potential Reduction for the Part C Appeals Measures Due to an IRE Data Completeness Issue **158**
Table O-1: Multiplying Factor to calculate the 3-month Projected Number of Cases Not Forwarded to the IRE 159
Table O-2: Identification of a Contract that is Subject to a Possible Scaled Reduction 159
Stage 2: Estimated Error Rate **159**
Stage 3: Scaled Reduction **160**
Table O-3: Thresholds and Associated Reductions 160
ATTACHMENT P: IDENTIFICATION OF CONTRACTS AFFECTED BY DISASTERS **162**
Operational Steps to Calculating Enrollment Impacted in Affected Contracts. **162**
Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations 162
Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States 163
Table P-3: Organization type service areas and necessary transformations 163
Table P-4: Major Disasters with associated enrollment months 164
Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters 164
Example: **165**
Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters 165
ATTACHMENT Q: MISSING DATA MESSAGES **167**
Measure level messages **167**
Table Q-1: Measure level missing data messages 167
Assignment rules for Part C measure messages **167**
Assignment rules for Part D measure messages **171**
Domain, Summary, and Overall level messages **173**
Table Q-3: Domain, Summary, and Overall level missing data messages 173
Assignment rules for Part C & Part D domain rating level messages **173**
Assignment rules for Part C & Part D summary rating level messages **173**
Assignment rules for overall rating level messages **174**
Disenrollment Reasons messages **175**
Table Q-4: Disenrollment Reason missing data messages 175
ATTACHMENT R: GLOSSARY OF TERMS **176**
ATTACHMENT S: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE **179**
HPMS Star Ratings Module **179**
1. Measure Data page 179
Table S-1: Measure Data page sample 179
2. Measure Detail page 179
Table S-2: Measure Detail page fields 180
3. Measure Detail – Part C Appeals page 180
Table S-3: Measure Detail – Part C Appeals page fields 180
4. Measure Detail – SNP CM page 181
Table S-4: Measure Detail – SNP CM page fields 181
5. Measure Detail – SNP COA page 181
Table S-5: Measure Detail – SNP COA page fields 181
Table S-6: HEDIS 2021 Audit Designations and 2023 Star Ratings 182
6. Measure Detail – CTM page 182
Table S-7: Measure Detail – CTM page fields 182
7. Measure Detail – Disenrollment 182
Table S-8: Measure Detail – Disenrollment page fields 183
8. Measure Detail – DR (Disenrollment Reasons) 183
Table S-9: Measure Detail – Disenrollment Reasons page fields 183
9. Measure Detail – MTM page 183
Table S-10: Measure Detail – MTM page fields 184
10. Measure Detail – CAHPS page 184
Table S-11: Measure Detail – CAHPS page fields 185
11. Calculation Detail – CSR 185

Table S-12: Measure Detail – Part C Scaled Reductions page fields 185
12. Calculation Detail – MD 186
Table S-13: Calculation Detail – MD page fields 186
13. Calculation Detail – CAI 186
Table S-14: Measure Detail – CAI page fields 187
14. Measure Detail – HEDIS LE page 187
Table S-15: Measure Detail – HEDIS LE page fields 188
15. Measure Detail – C MD Results 188
Table S-16: Measure Detail – C MD Results 188
16. Measure Detail – D MD Results 188
Table S-17: Measure Detail – D MD Results 189
17. Measure Detail – C Improvement page 189
Table S-18: Part C Measure Improvement Results 189
18. Measure Detail – D Improvement page 189
Table S-19: Part D Measure Improvement Results 190
19. Measure Stars page 190
Table S-20: Measure Stars page sample 190
20. Domain Stars page 190
Table S-21: Domain Star page sample 191
21. Part C Summary Rating page 191
Table S-22: Part C Summary Rating page fields 191
22. Part D Summary Rating page 191
Table S-23: Part D Summary Rating View 192
23. Overall Rating page 192
Table S-24: Overall Rating View 193
24. Low Performing Contract List 193
Table S-25: Low Performing Contract List 193
25. High Performing Contract List 194
Table S-26: High Performing Contract List 194
26. Technical Notes link 194
27. Medication NDC List 194
28. Part C and Part D Example Measure Data 194

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 '2023 Medicare Part C & D Star Ratings' because they are posted prior to the 2023 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 "2023" for the report period. See Attachment S: Health Plan Management System Module Reference for descriptions of the HPMS pages.

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

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

Differences between the 2022 Star Ratings and 2023 Star Ratings

There have been several changes between the 2022 Star Ratings and the 2023 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2023 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment I.

- Changes
    a. Guardrails were added to the hierarchical clustering methodology that is used to set cut points for non-CAHPS measures.
    b. The measure weight of the patient experience/complaints and access measures was increased from a weight of 2 to a weight of 4.
    c. Re-specified Part C Controlling Blood Pressure measure moved into the 2023 Star Ratings as a new measure with a weight of 1 for the first year.

d. The Part D Statin Use in Persons with Diabetes measure was recategorized as a process measure with a weight of 1.
e. For 2023 Star Ratings only, modify the disaster policy to remove application of the 60% rule and avoid the exclusion of contracts with 60% or more of their enrollees living in FEMA-designated Individual Assistance areas from calculation of the measure-level cut points for the 3 HEDIS-HOS measures (Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control).

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. None
- Retired measures
  a. Part C measure – Rheumatoid Arthritis Management

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 2023 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2023 Organization Types Reported in the 2023 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
Demonstration (Person Centered Community Care)	PCCC	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:

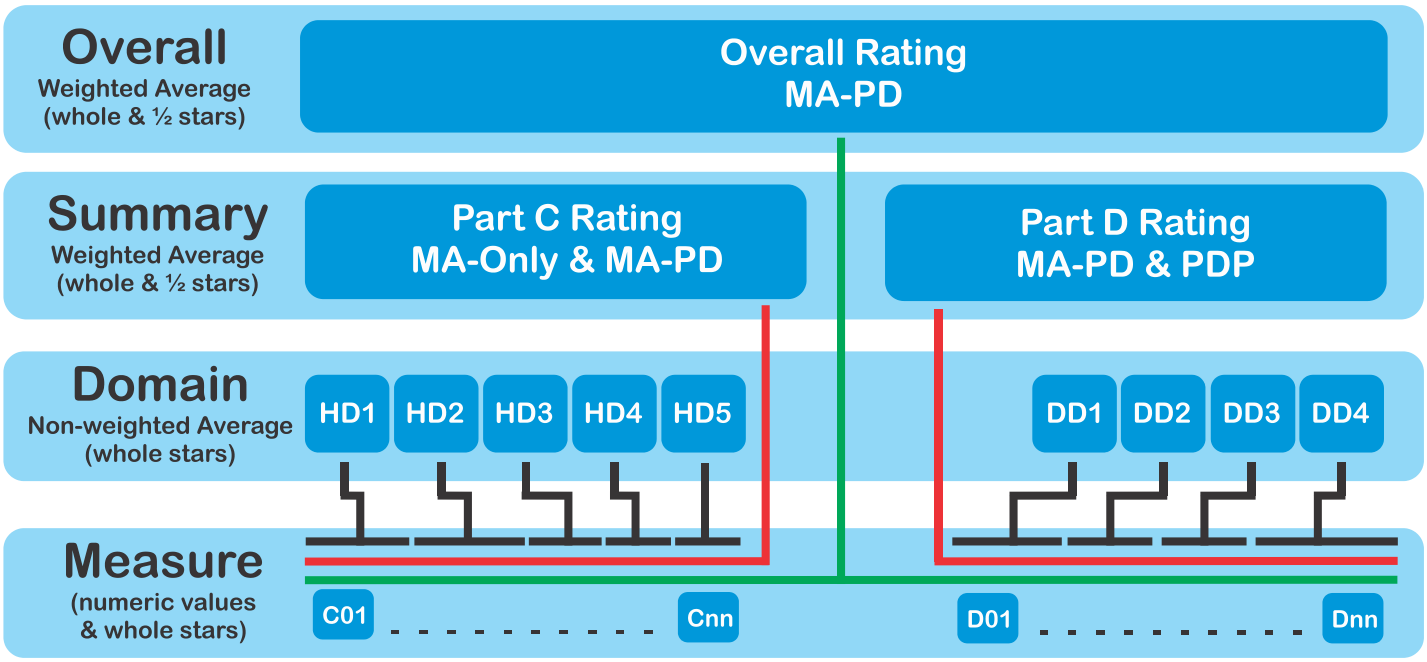
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 2023 Organization Types to Contract Types and Highest Rating in the 2023 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 2023 Star Ratings include a maximum of 9 domains comprised of a maximum of 40 measures.

- MA-Only contracts are measured on 5 domains with a maximum of 28 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 40 measures, 38 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 H.

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 21	12 of 23	13 of 26	9 of 18	11 of 22	N/A	12 of 23
D	5 of 10*	5 of 11	5 of 11	5 of 9	N/A	5 of 11	5 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 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 2021 through December 2021) 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 of 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 2021 through December 2021), 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."

Scaled Reductions for the Appeals Measures

There are two Part C Star Ratings appeals measures that rely on data submitted to the IRE: Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions. The completeness of the IRE data is critical to allow accurate measurement of each of the appeals measures. All contracts are responsible and held accountable for ensuring high quality and complete data to maintain the validity and reliability of the measures. CMS conducts an industry wide monitoring project to collect data to evaluate the timeliness of processing of Medicare Advantage (Part C) organization determinations and reconsiderations. Through this Timeliness Monitoring Project's data collection (TMP data), CMS can assess all sponsors' timeliness, as well as sponsor compliance with forwarding cases to the IRE.

CMS uses statistical criteria to reduce a contract's appeals measure-level Star Ratings for data that are not complete or lack integrity using TMP or audit data. The reduction is applied to the measure-level Star Ratings of the applicable Part C appeals measures. Because there are varying degrees of data accuracy and integrity issues, the methodology for reductions reflects the degree of the data accuracy issue for a contract instead of a one-size-fits-all approach. The methodology employs scaled reductions (one-star, two-star, three-star, or four-star reduction) based on the degree of severity of missing or compromised IRE data. Contracts with the highest IRE data quality issues (i.e., largest percentage of missing or compromised data) receive the largest reductions, while contracts with a lower degree of missing IRE data receive a smaller reduction. The most severe reduction for IRE data completeness issues is a four-star reduction, thus resulting in measure-level Star Ratings of one star for the associated appeals measures. If a contract receives a reduction due to missing Part C IRE data, the reduction is applied to both of the contract's Part C appeals measures. If a contract fails to submit TMP data for CMS's review to ensure the completeness of their IRE data, the contract receives one-star for the associated appeals measures. (This is similar to how CMS treats measures that are dependent on contracts' completion of data validation of plan-reported data.)

CMS's scaled reduction methodology is a three-stage process using the TMP data or audit to determine: first, whether a contract may be subject to a potential reduction for the Part C appeals measures; second, as the basis for the determination of the estimated error rate; and finally, whether the estimated value is statistically significantly greater than the cut points for the scaled reductions of 1, 2, 3, or 4 stars. Details of the methodology are available in Attachment O.

Once the scaled reduction for a contract is identified using the methodology, the reduction is applied to a contract's associated appeals measure-level Star Ratings. Since the minimum measure-level Star Rating is one star, if the difference between the associated appeals measure-level Star Rating (before the application of the reduction) and the identified scaled reduction is less than one, the contract will receive a measure-level Star Rating of one star for the appeals measure. If a contract does not qualify for the Part C measures due to number of eligible cases (the denominator is less than or equal to 10), but is found to qualify for a reduction, the contract will receive the reduction.

If a scaled reduction is applied to the Part C appeals measure in either the current or the previous year, the associated appeals measures will not be included in the Health Plan Quality Improvement measure.

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 2023 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 2023 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 2022 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 2022 or the 2023 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 than began in 2021 were also affected by disasters in 2020. These doubly-affected contracts receive the higher of the 2023 Star Rating or what the 2022 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2020 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected). For example, if doubly-affected contract reverted back to the 2021 Star Rating on a given measure in the 2022 Star Ratings, the 2021 Star Rating is *not* used in determining the 2023 Star Rating. Rather the 2023 Star Rating is compared to what the 2022 Star Rating would have been absent any disaster adjustments.
- HEDIS-HOS adjustments:
  - The HEDIS-HOS data used in the 2023 Star Ratings are adjusted for 2020 disasters (see Attachment P of the 2022 Star Ratings Technical Notes for the identification of contracts affected by 2020 disasters).
  - All affected contracts (i.e., contracts affected by 2020 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2022 or the 2023 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 2020 were also affected by disasters in 2019. These doubly-affected contracts receive the higher of the 2023 Star Rating or what the 2022 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2019 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 2022 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 2022 or 2023 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 2021 were also affected by disasters in 2020. These doubly-affected contracts receive the higher of the 2023 Star Rating or what the 2022 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2020 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 the new Controlling Blood Pressure measure. If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating.
  - A similar hold harmless provision is applied for the Part C summary ratings. If a contract has 25% or more affected members, the Part C summary rating is calculated "with" and "without" the new Controlling Blood Pressure, and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary rating.
- All other measures:
  - Contracts with 25% or more affected members receive the higher of the 2022 or 2023 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 2021 were also affected by disasters in 2020. These doubly-affected contracts receive the higher of the 2023 Star Rating or what the 2022 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2020 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 2022 or 2023 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.
- Reward Factor:
  - Affected contracts with 60% or more of their enrollees impacted by a 2021 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. For the 2023 Star Ratings only, we will not exclude contracts with 60% or more of their enrollees living in FEMA-designated Individual Assistance areas from calculation of cut points for the 3 HEDIS-HOS measures.

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 J explains the clustering and relative distribution and significance testing (used for CAHPS measures) methods in greater detail.

The *Cut Point Trend* document is posted at http://go.cms.gov/partcanddstarratings and is updated after each rating cycle is released.

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.

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 3	3 of 4	N/A	3 of 4
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 8	5 of 9	7 of 12	6 of 11	5 of 9	N/A	5 of 9
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 2023 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 F.

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	12 of 24	14 of 27	10 of 19	12 of 23	N/A	12 of 24
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 10 measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

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

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

There are a total of 40 measures (28 in Part C, 12 in Part D) in the 2023 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 36 distinct 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*	17 of 33	18 of 36	13 of 26	N/A	N/A	17 of 33*

* 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 30 measures to receive an overall rating.

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 (C25) 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 H. 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 (C25 & D04) for MA-PD contracts.
   a. C25 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 calculated in steps 2 & 3, and use the highest of the two overall ratings calculated in steps 2 & 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 (C25) 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 F 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 G: 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 2023 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	CBP	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
Without	Without	65th	4.032787	3.906250	3.781250	3.927536
Without	With	65th	4.016949	3.906250	3.781250	3.927711
With	Without	65th	3.935484	3.756757	3.533333	3.821053
With	With	65th	3.910448	3.756757	3.533333	3.822917
Without	Without	85th	4.396226	4.304348	4.260870	4.282353
Without	With	85th	4.389831	4.304348	4.260870	4.289157
With	Without	85th	4.285714	4.162162	4.000000	4.130435
With	With	85th	4.281250	4.162162	4.000000	4.129032

Table 9: Variance Thresholds

Improvement	CBP	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
Without	Without	30th	0.773524	0.698347	0.698677	0.820659
Without	With	30th	0.780467	0.698347	0.698677	0.821593
With	Without	30th	0.911204	0.893750	1.000000	0.987805
With	With	30th	0.908360	0.893750	1.000000	0.979066
Without	Without	70th	1.309487	1.304197	1.542578	1.272909
Without	With	70th	1.289129	1.304197	1.542578	1.260422
With	Without	70th	1.423713	1.408000	1.836725	1.418960
With	With	70th	1.406087	1.408000	1.836725	1.399747

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 Low Income Subsidy/Dual Eligible (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 Low Income Subsidy/Dual Eligible (LIS/DE) and disability status.

The CAI values use data collected for the 2022 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 2022 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 2022 measures used in the 2023 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 – Kidney Disease Monitoring (Part C)
- Diabetes Care – Blood Sugar Controlled (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (Part C)
- Medication Reconciliation Post-Discharge (Part C)
- Statin Therapy for Patients with Cardiovascular Disease (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 and to yield a minimum number of 30 contracts per each final MA adjustment category and 10 contracts per each final PDP adjustment category. 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 N.

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 < 6.636703
2	>= 6.636703 to < 8.833416
3	>= 8.833416 to < 12.406991
4	>= 12.406991 to < 17.221680
5	>= 17.221680 to < 22.740404
6	>= 22.740404 to < 31.938126
7	>= 31.938126 to < 50.303478
8	>= 50.303478 to < 77.133401
9	>= 77.133401 to < 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 < 15.332047
2	>= 15.332047 to < 21.434998
3	>= 21.434998 to < 29.201102
4	>= 29.201102 to < 43.125000
5	>= 43.125000 to <= 100.000000

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

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

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.044794
2	L2-L8 L1-L7 L1-L2	D1 D2 D3	-0.016360
3	L9-L10 L8-L10 L3-L8 L1-L5	D1 D2 D3 D4-D5	0.008196
4	L6-L8 L6	D4 D5	0.045676
5	L9-L10 L7-L9	D3-D4 D5	0.077717
6	L10	D5	0.142258

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 < 5.844156
2	>= 5.844156 to < 8.692308
3	>= 8.692308 to < 11.865055
4	>= 11.865055 to < 16.507177
5	>= 16.507177 to < 22.201963
6	>= 22.201963 to < 31.440558
7	>= 31.440558 to < 50.133240
8	>= 50.133240 to < 76.898900
9	>= 76.898900 to < 100.000000
10	100.00000

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 < 14.996720
2	>= 14.996720 to < 21.145603
3	>= 21.145603 to < 29.176165
4	>= 29.176165 to < 42.283120
5	>= 42.283120 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	-0.021744
2	L2-L7	D1-D2	-0.002883
	L1	D2	
3	L8-L10	D1-D2	0.007550
	L1-L9	D3	
4	L1-L8	D4	0.020107
	L1-L6	D5	
5	L9	D4	0.076339
	L7-L9	D5	
6	L10	D3-D5	0.126289

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 < 6.776647
2	>= 6.776647 to < 9.259475
3	>= 9.259475 to < 13.325541
4	>= 13.325541 to < 18.778871
5	>= 18.778871 to < 25.422963
6	>= 25.422963 to < 35.273728
7	>= 35.273728 to < 58.639605
8	>= 58.639605 to < 97.117517
9	>= 97.117517 to < 100.000000
10	100.00000

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 < 16.180982
2	>= 16.180982 to < 23.081612
3	>= 23.081612 to < 31.298400
4	>= 31.298400 to < 45.808383
5	45.808383 to <= 100.000000

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

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

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.036570
2	L2-L7 L1	D1-D2 D2	-0.023380
3	L8-L10 L1-L8 L1-L6 L1-L5	D1-D2 D3 D4 D5	0.025305
4	L9-L10 L7-L10 L6-L9	D3 D4 D5	0.074240
5	L10	D5	0.137103

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 < 1.435897
2	>= 1.435897 to < 3.064169
3	>= 3.064169 to < 8.762958
4	>= 8.762958 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 < 6.753247
2	>= 6.753247 to < 10.728911
3	>= 10.728911 to < 15.021379
4	>= 15.021379 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 Initial Group	Disability Quintile	CAI Value
1	L1	D1-D3	-0.301451
2	L2-L4 L1-L3	D1-D3 D4	-0.135053
3	L4	D4	0.069749

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

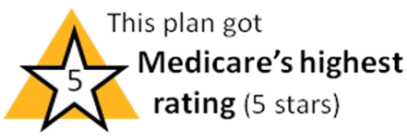
Raw Summary / Overall Score	Final Summary / Overall Rating
≥ 0.000000 and < 0.250000	0
≥ 0.250000 and < 0.750000	0.5
≥ 0.750000 and < 1.250000	1.0
≥ 1.250000 and < 1.750000	1.5
≥ 1.750000 and < 2.250000	2.0
≥ 2.250000 and < 2.750000	2.5
≥ 2.750000 and < 3.250000	3.0
≥ 3.250000 and < 3.750000	3.5
≥ 3.750000 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 2021, 2022, and 2023 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	2021 C	2022 C	2023 C	2021 D	2022 D	2023 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 2021 was at least 500 but less than 1,000 will be included in the Star Ratings in 2023 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.

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 2023 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' 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
- Data Integrity: PARTCDQA@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: CMSHPMS_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.

Title	Description
Case-Mix Adjusted:	Indicates if the data are case mix adjusted prior to being used for the Star Ratings.
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.
NQF #:	The National Quality Framework (NQF) number for the measure or “None” if there is no equivalent measure with NQF endorsement.
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 or measures with substantive specification changes for the first three years, the cut points are after the application of mean resampling and guardrails. The Health Plan Quality Improvement and Drug Plan Quality Improvement measure cut points are after 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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 98
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:	• 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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year (optional) Bilateral mastectomy 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 (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier

Title	Description
	(Bilateral Modifier Value Set). • Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. • Both of the following (on the same or a different date of service): – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service). • Absence of the left breast (Absence of Left Breast Value Set) and absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service. • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Wellness and Prevention
NQF #:	2372
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	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 43 %	>= 43 % to < 62 %	>= 62 % to < 70 %	>= 70 % to < 77 %	>= 77 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 109

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

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 (all product lines) with frailty (Frailty Value Set) ***and*** advanced illness during the measurement year.
• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year
(optional) Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2021 – 12/31/2021

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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Wellness and Prevention
NQF #:	0034
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
< 43 %	>= 43 % to < 60 %	>= 60 % to < 71 %	>= 71 % to < 79 %	>= 79 %

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, 2021?

Title	Description
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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Wellness and Prevention
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 64	>= 64 to < 69	>= 69 to < 75	>= 75 to < 79	>= 79

These technical notes show the base group cut points for CAHPS measures; please see the Attachment J 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

Title	Description
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 2020 Specifications for the Medicare Health Outcomes Survey Volume 6, page 37
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 22 Follow-up Data collection (2021) and Cohort 24 Baseline data collection (2021). HOS Survey Question 46: 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 47: 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 46 are excluded from results calculations for Question 47. 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:	07/19/2021 – 11/01/2021
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

Title	Description
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Wellness and Prevention
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 44 %	>= 44 % to < 49 %	>= 49 % to < 53 %	>= 53 % to < 57 %	>= 57 %

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 Part C Reporting Requirements. Validation for data performed during the 2022 Data Validation cycle.
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 30, 2022) 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: • 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)

Title	Description
	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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	Not Applicable

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	No	Yes	Yes	No	No	No

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 46 %	>= 46 % to < 62 %	>= 62 % to < 75 %	>= 75 % to < 85 %	>= 85 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 121
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 2020 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2021 – 12/31/2021
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

Title	Description
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Seamless Care Coordination
NQF #:	0553
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
< 43 %	>= 43 % to < 70 %	>= 70 % to < 82 %	>= 82 % to < 93 %	>= 93 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 121
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 2020 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Wellness and Prevention

Title	Description

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 50 %	>= 50 % to < 71 %	>= 71 % to < 85 %	>= 85 % to < 94 %	>= 94 %

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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 225
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 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. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0053
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
< 32 %	>= 32 % to < 45 %	>= 45 % to < 55 %	>= 55 % to < 73 %	>= 73 %

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:	Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 184
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 (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year.

Title	Description
	• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), 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 (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0055
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	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 47 %	>= 47 % to < 61 %	>= 61 % to < 71 %	>= 71 % to < 79 %	>= 79 %

Measure: C10 - Diabetes Care – Kidney Disease Monitoring

Title	Description
Label for Stars:	Kidney Function Testing for Members with Diabetes
Label for Data:	Kidney Function Testing for Members with Diabetes
Description:	Percent of plan members with diabetes who had a kidney function test during the year.
HEDIS Label:	Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy 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 (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), 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 (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.

Title	Description
Data Time Frame:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0062
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
< 80 %	>= 80 % to < 93 %	>= 93 % to < 95 %	>= 95 % to < 97 %	>= 97 %

Measure: C11 - 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:	Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2020 and Measurement Year 2021 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

Title	Description
	(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 (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), 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 (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No

Title	Description
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0059
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 < 62 %	>= 62 % to < 75 %	>= 75 % to < 83 %	>= 83 %

Measure: C12 - 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 Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS MY 2020 and 2021 Technical Specifications Volume 2, page 153
Metric:	The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose 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.

Title	Description
	• Members 81 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year. • A dispensed dementia medication. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (Optional) • Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis. • Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. • Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcomes Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Chronic Conditions

Title	Description

NQF #: 0054

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
< 48 %	>= 48 % to < 63 %	>= 63 % to < 73 %	>= 73 % to < 80 %	>= 80 %

Measure: C13 - 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 2020 Specifications for the Medicare Health Outcomes Survey Volume 6, page 39
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 22 Follow-up Data collection (2021) and Cohort 24 Baseline data collection (2021). HOS Survey Question 48: 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 49: Did you fall in the past 12 months? HOS Survey Question 50: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 51: 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 48 or Question 51 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:	07/19/2021 – 11/01/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Safety
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 46 %	>= 46 % to < 53 %	>= 53 % to < 60 %	>= 60 % to < 69 %	>= 69 %

Measure: C14 - 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 2020 Specifications for the Medicare Health Outcomes Survey Volume 6, page 34
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

Title	Description
Data Source Description:	Cohort 22 Follow-up Data collection (2021) and Cohort 24 Baseline data collection (2021). HOS Survey Question 42: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 45: 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: • Q42 = "Yes." • Q45 = "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: • Q45 = "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:	07/19/2021 – 11/01/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2020 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	Not Applicable

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
< 39 %	>= 39 % to < 43 %	>= 43 % to < 48 %	>= 48 % to < 53 %	>= 53 %

Measure: C15 - 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 2020 and Measurement Year 2021 Technical Specifications Volume 2, page 308
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:	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Seamless Care Coordination
NQF #:	0097
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
< 43 %	>= 43 % to < 57 %	>= 57 % to < 69 %	>= 69 % to < 82 %	>= 82 %

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 2020 and Measurement Year 2021 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 (Pregnancy Value Set) during the measurement year or year prior to the measurement year.

Title	Description
	• In vitro fertilization (IVF Value Set) 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 (ESRD Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) 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. – 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 (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List). Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2021 – 12/31/2021
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

Title	Description
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 75 %	>= 75 % to < 81 %	>= 81 % to < 85 %	>= 85 % to < 89 %	>= 89 %

Domain: 3 - Member Experience with Health Plan

Measure: C17 - 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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.

Title	Description
Meaningful Measure Area:	Person-Centered Care
NQF #:	0006
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
< 78	>= 78 to < 80	>= 80 to < 82	>= 82 to < 84	>= 84

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

Measure: C18 - 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? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.

Title	Description
Meaningful Measure Area:	Person-Centered Care
NQF #:	0006
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
< 73	>= 73 to < 76	>= 76 to < 78	>= 78 to < 80	>= 80

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

Measure: C19 - 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 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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Title	Description
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care
NQF #:	0006
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 J for the CAHPS Methodology for final star assignment rules.

Measure: C20 - Rating of Health Care Quality

Title	Description
Label for Stars:	Member's Rating of Health Care Quality
Label for Data:	Member's 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

Title	Description

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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2022 – 06/2022

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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Person-Centered Care

NQF #: 0006

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 J for the CAHPS Methodology for final star assignment rules.

Measure: C21 - Rating of Health Plan

Title	Description
Label for Stars:	Member's Rating of Health Plan
Label for Data:	Member's 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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
	Person-Centered Care
NQF #:	0006
Data Display:	Numeric 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
< 84	>= 84 to < 85	>= 85 to < 88	>= 88 to < 89	>= 89

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

Measure: C22 - 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 visited your personal doctor for 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? • 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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Seamless Care Coordination
NQF #:	Not Applicable
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
< 83	>= 83 to < 85	>= 85 to < 86	>= 86 to < 87	>= 87

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

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

Measure: C23 - 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:	Percent of members filing complaints 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 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 2021 complaints made by June 30, 2022 are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care
NQF #:	Not Applicable
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
> 1.52	> 0.89 to <= 1.52	> 0.5 to <= 0.89	> 0.19 to <= 0.5	<= 0.19

Measure: C24 - 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, 2021–December 31, 2021 (numerator) divided by all members enrolled in the contract at any time during 2021 (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 1/1/2021 and 12/31/2021 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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 39 %	> 24 % to <= 39 %	> 15 % to <= 24 %	> 7 % to <= 15 %	<= 7 %

Measure: C25 - 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 2022 and 2023 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2022 and 2023 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.

Title	Description
General Notes:	Attachment H 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
NQF #:	Not Applicable
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
< -0.298771	>= -0.298771 to < 0	>= 0 to < 0.101745	>= 0.101745 to < 0.328141	>= 0.328141

Domain: 5 - Health Plan Customer Service

Measure: C26 - 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. (This description has been updated to better explain the measure. There have been no changes to the measure.)
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 dismissed because the plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed 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 for reasons other than the 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 Dismissed Because Plan Agreed to Cover]) - [Late]
Data Time Frame:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Affordability and Efficiency
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 59 %	>= 59 % to < 75 %	>= 75 % to < 85 %	>= 85 % to < 97 %	>= 97 %

Measure: C27 - 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. (This description has been updated to better explain the measure. There have been no changes to the measure.)
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, 2022, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or

Title	Description

after June 30, 2022 are not reflected in these data 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: 01/01/2021 – 12/31/2021

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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Affordability and Efficiency

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 68 %	>= 68 % to < 83 %	>= 83 % to < 91 %	>= 91 % to < 97 %	>= 97 %

Measure: C28 - 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 the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2022 – 05/2022
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:	No adjustment for 2020 or 2021 disasters.

Title	Description
Meaningful Measure Area:	Person-centered Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 36 %	>= 36 % to < 59 %	>= 59 % to < 83 %	>= 83 % to < 94 %	>= 94 %

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 the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2022 – 05/2022
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 2020 or 2021 disasters.

Meaningful Measure Area: Person-Centered Care

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 30 %	>= 30 % to < 64 %	>= 64 % to < 80 %	>= 80 % to < 91 %	>= 91 %
PDP	< 60 %	>= 60 % to < 75 %	>= 75 % to < 91 %	>= 91 % to < 97 %	>= 97 %

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:	Percent of members filing complaints 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 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 2021 complaints made by June 30, 2022 are captured Complaint rates per 1,000 enrollees are adjusted to a 30-day basis.
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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care
NQF #:	Not Applicable
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	> 1.52	> 0.89 to <= 1.52	> 0.5 to <= 0.89	> 0.19 to <= 0.5	<= 0.19
PDP	> 0.34	> 0.22 to <= 0.34	> 0.13 to <= 0.22	> 0.06 to <= 0.13	<= 0.06

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, 2021–December 31, 2021 (numerator) divided by all members enrolled in the contract at any time during 2021 (denominator).
Primary Data Source:	MBDSS

Title	Description
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2021 and 12/31/2021 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:	01/01/2021 – 12/31/2021
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No

Title	Description
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 39 %	> 24 % to <= 39 %	> 15 % to <= 24 %	> 7 % to <= 15 %	<= 7 %
PDP	> 23 %	> 16 % to <= 23 %	> 11 % to <= 16 %	> 7 % to <= 11 %	<= 7 %

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 2022 and 2023 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings

Title	Description
Data Source Description:	2022 and 2023 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.
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
NQF #:	Not Applicable
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	< -0.325131	>= -0.325131 to < 0	>= 0 to < 0.159307	>= 0.159307 to < 0.391045	>= 0.391045
PDP	< -0.237362	>= -0.237362 to < 0	>= 0 to < 0.389234	>= 0.389234 to < 0.851667	>= 0.851667

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 Questions (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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2022 – 06/2022
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care

Title	Description

NQF #: Not Applicable

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	< 83	>= 83 to < 85	>= 85 to < 87	>=87 to < 88	>= 88
PDP	< 79	>= 79 to < 80	>= 80 to < 83	>= 83 to < 87	>= 87

These technical notes show the base group cut points for CAHPS measures; please see the Attachment J 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 2022. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2022 – 06/2022

Title	Description
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Person-Centered Care
NQF #:	Not Applicable
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	< 88	>= 88 to < 89	>= 89 to < 91	>= 91 to < 92	>= 92
PDP	< 87	>= 87 to < 88	>= 88 to < 90	>= 90 to < 92	>= 92

These technical notes show the base group cut points for CAHPS measures; please see the Attachment J 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 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 PF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than PF)/ (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: .5 x (100 – ((accuracy index - 1) x 100)) + .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: PDE data and MPF Pricing Files are the primary data sources. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used. Post-reconciliation PDE adjustments are not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	A contract with less than 30 PDE claims over the measurement period. 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

Title	Description
	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 L: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2021 – 09/30/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Affordability and Efficiency
NQF #:	Not Applicable
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	< 72	>= 72 to < 86	>= 86 to < 93	>= 93 to < 97	>= 97
PDP	< 90	>= 90 to < 94	>= 94 to < 96	>= 96 to < 99	>= 99

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 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, 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. 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 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 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

Title	Description
	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), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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: • Hospice enrollment • 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, 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 inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment K: 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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0541
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	< 79 %	>= 79 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %
PDP	< 84 %	>= 84 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 90 %

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

Title	Description
	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. The Part D 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 Part D 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 to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available).

Title	Description
	• EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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: • Hospice enrollment • 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 inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment K: 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:	01/01/2021 – 12/31/2021
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0541
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	< 78 %	>= 78 % to < 86 %	>= 86 % to < 89 %	>= 89 % to < 91 %	>= 91 %
PDP	< 86 %	>= 86 % to < 89 %	>= 89 % to < 91 %	>= 91 % to < 96 %	>= 96 %

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).

Title	Description
	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. 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 the CMS Drug Data Processing Systems (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021-December 31, 2021. 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 2021 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates

Title	Description
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 inpatient (IP) settings, and stays in skilled nursing facilities (SNFs). The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment K: 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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Chronic Conditions
NQF #:	0541

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 81 %	>= 81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %
PDP	< 84 %	>= 84 % to < 87 %	>= 87 % to < 88 %	>= 88 % to < 90 %	>= 90 %

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Stars:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are 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

Title	Description
	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. 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 2021 Part D Reporting Requirements (data pulled June 2022). Validation of these data was performed retrospectively during the 2022 data validation cycle (deadline June 30, 2022 and data validation results pulled July 2022). Additionally, the Medicare Enrollment Database (EDB) is used for hospice enrollment (data pulled March 2022).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2022) are excluded and listed as "No data available." The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation. 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) • Met the specified targeting criteria per CMS – Part D requirements (Element F) • Date of MTM program enrollment (Element I) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element L) • Received annual CMR with written summary in CMS standardized format (Element Q) • Date(s) of CMR(s) (Element R) 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

Title	Description
	Attachment M 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 CMSHPMS_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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Seamless Care Coordination
NQF #:	Not Applicable
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 47 %	>= 47 % to < 67 %	>= 67 % to < 82 %	>= 82 % to < 89 %	>= 89 %
PDP	< 34 %	>= 34 % to < 49 %	>= 49 % to < 62 %	>= 62 % to < 78 %	>= 78 %

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 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 Pharmacy Quality Alliance (PQA). See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2021 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2021 – December 31, 2021. 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 2021 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 Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), the Encounter Data Systems (EDS), and the Risk Adjustment Processing System (RAPS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period).

Title	Description
	• 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. • RAPS is used for diagnosis information, RxHCC - Dialysis Status (most recent available Payment Year).
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 • Liver Disease • 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 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:	01/01/2021 – 12/31/2021
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 (2022-2023) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Chronic Conditions

NQF #: Not Applicable

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 80 %	>= 80 % to < 84 %	>= 84 % to < 86 %	>= 86 % to < 90 %	>= 90 %
PDP	< 80 %	>= 80 % to < 82 %	>= 82 % to < 84 %	>= 84 % to < 86 %	>= 86 %

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 dual eligibility and education among other variables. 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, on the original scale of the item or composite, as presented in plan reports.

For example, for the measure "Getting Appointments and Care Quickly," the model coefficient for "age 75-79" is 0.0322, indicating that respondents in that age range tend to score their plans 0.0322 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, Medicaid dual eligibles tend to respond 0.0103 points lower on this item than otherwise similar non-duals. 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 are Medicaid dual eligibles 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. In the tables we report the average of the model coefficients for these several items, for each of the categories (rows) of the table, as a summary of the adjustment for the composite. For more detailed information on the application of CAHPS case-mix adjustment, including item-level coefficients, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Table A-1: Coefficients of Part C CAHPS Measures

Predictor	C03: Annual Flu Vaccine	C17: Getting Needed Care (Comp)	C18: Getting Appointments and Care Quickly (Comp)	C19: Customer Service (Comp)	C20: Rating of Health Care Quality	C21: Rating of Health Plan	C22: Care Coordination (Comp)
Age: 64 or under	N/A	0.0117	0.0142	-0.0009	-0.0502	-0.0849	0.0177
Age: 65 – 69	N/A	-0.0174	-0.0001	-0.0152	-0.0697	-0.0883	-0.0167
Age: 75 – 79	N/A	0.0184	0.0322	-0.0111	0.0261	0.0474	-0.0125
Age: 80 – 84	N/A	0.0103	0.0357	-0.0111	0.0299	0.0910	-0.0280
Age: 85 and older	N/A	0.0081	0.0065	-0.0234	0.0242	0.0663	-0.0693
Less than an 8th grade education	N/A	-0.0291	-0.0563	-0.0194	0.0079	0.0356	-0.0161
Some high school	N/A	-0.0116	-0.0149	0.0108	0.0176	0.0896	0.0077
Some college	N/A	-0.0267	-0.0199	-0.0112	-0.1238	-0.1623	-0.0357
College graduate	N/A	-0.0433	-0.0176	-0.0373	-0.1123	-0.2140	-0.0529
More than a bachelor's degree	N/A	-0.0837	-0.0284	-0.0820	-0.2191	-0.3616	-0.0443
General health rating: excellent	N/A	0.0693	0.0903	0.0450	0.3535	0.2377	0.0440
General health rating: very good	N/A	0.0515	0.0515	0.0270	0.2128	0.1345	0.0400
General health rating: fair	N/A	-0.0557	-0.0637	-0.0078	-0.2617	-0.1348	-0.0301
General health rating: poor	N/A	-0.0966	-0.0674	-0.0602	-0.5058	-0.3701	-0.0528
Mental health rating: excellent	N/A	0.1704	0.1087	0.0967	0.4161	0.3217	0.1262
Mental health rating: very good	N/A	0.0932	0.0751	0.0447	0.1984	0.1503	0.0636
Mental health rating: fair	N/A	-0.0608	-0.0343	-0.0408	-0.1347	-0.1404	-0.0548

Predictor	C03: Annual Flu Vaccine	C17: Getting Needed Care (Comp)	C18: Getting Appointments and Care Quickly (Comp)	C19: Customer Service (Comp)	C20: Rating of Health Care Quality	C21: Rating of Health Plan	C22: Care Coordination (Comp)
Mental health rating: poor	N/A	-0.1353	-0.0898	-0.0512	-0.4440	-0.4034	-0.0697
Proxy helped	N/A	0.0034	-0.0126	-0.0494	-0.1597	-0.0481	0.0104
Proxy answered	N/A	0.0491	0.0439	0.0232	0.1209	0.0889	0.0227
Medicaid dual eligible	N/A	-0.0107	-0.0103	-0.0129	0.0652	0.3090	-0.0009
Low-income subsidy (LIS)	N/A	-0.0268	-0.0601	-0.0254	-0.0482	0.0082	0.0113
Asian Language	N/A	-0.0607	-0.1575	-0.0075	0.3067	-0.1629	-0.0227

Table A-2: Coefficients of Part D CAHPS Measures

Predictor	MA-PD D05: Rating of Drug Plan	MA-PD D06: Getting Needed Prescription Drugs (Comp)	PDP D05: Rating of Drug Plan	PDP D06: Getting Needed Prescription Drugs (Comp)
Age: 64 or under	-0.1499	-0.0445	-0.0098	0.0148
Age: 65 – 69	-0.1644	-0.0193	-0.3052	-0.0413
Age: 75 – 79	0.1157	0.0056	0.1275	0.0272
Age: 80 – 84	0.1244	0.0009	0.3156	0.0246
Age: 85 and older	0.2172	0.0052	0.3568	0.0382
Less than an 8th grade education	0.0514	-0.0232	-0.1655	-0.0333
Some high school	0.0781	-0.0087	0.1881	-0.0491
Some college	-0.1918	-0.0307	-0.0950	-0.0405
College graduate	-0.2269	-0.0412	-0.0997	-0.0476
More than a bachelor's degree	-0.3418	-0.0815	-0.2220	-0.0848
General health rating: excellent	0.2703	0.0434	0.3332	0.0498
General health rating: very good	0.2070	0.0351	0.1939	0.0521
General health rating: fair	-0.1402	-0.0372	-0.1426	-0.0715
General health rating: poor	-0.4256	-0.1039	-0.6455	-0.0760
Mental health rating: excellent	0.3039	0.0975	0.1324	0.0647
Mental health rating: very good	0.1518	0.0531	0.0713	0.0100
Mental health rating: fair	-0.0560	-0.0357	-0.1568	-0.0028
Mental health rating: poor	-0.2670	-0.0589	0.0482	0.0217
Proxy helped	-0.1184	-0.0429	-0.1199	-0.0073
Proxy answered	-0.0016	0.0176	0.1867	0.0002
Medicaid dual eligible	0.5044	0.0400	0.8962	0.0503
Low-income subsidy (LIS)	0.2810	0.0065	0.8890	0.0741
Asian Language	-0.3796	-0.1409	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 measure. The table below lists the enrollment used for each type of measure and the rule followed to determine the month(s) of enrollment.

Type of Measure	Rule for Which Month of Enrollment is Used	Month(s) of Enrollment Used for 2023 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2022
Call Center	Average enrollment during the study period	Feb 2022 – May 2022
HOS	Enrollment at the time survey sample is pulled	April 2021
HEDIS-HOS	Enrollment at the time survey sample is pulled	April 2021
HEDIS	Enrollment in July of the measurement period	July 2021
All Other Measures	Enrollment in July of the measurement period	July 2021

Example Calculation

Contract ID	Surviving or Consumed Contract	Value for Breast Cancer Screening (BCS) Measure	July 2021 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

Value for BCS for HAAAA = $\frac{75.13*43{,}326+50.91*20{,}933}{43{,}326+20{,}933}$ = 67.24

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 the numeric and star values for each measure reported in the 2023 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	70%	3.7
C02	Colorectal Cancer Screening	72%	3.8
C03	Annual Flu Vaccine	73%	3.2
C04	Monitoring Physical Activity	51%	3.2
C05	Special Needs Plan (SNP) Care Management	73%	3.3
C06	Care for Older Adults – Medication Review	91%	4.4
C07	Care for Older Adults – Pain Assessment	90%	4.3
C08	Osteoporosis Management in Women who had a Fracture	45%	2.6
C09	Diabetes Care – Eye Exam	72%	3.7
C10	Diabetes Care – Kidney Disease Monitoring	95%	3.9
C11	Diabetes Care – Blood Sugar Controlled	78%	4.1
C12	Controlling Blood Pressure	71%	3.5
C13	Reducing the Risk of Falling	56%	2.9
C14	Improving Bladder Control	46%	3.3
C15	Medication Reconciliation Post-Discharge	67%	3.4
C16	Statin Therapy for Patients with Cardiovascular Disease	84%	3.5
C17	Getting Needed Care	81	3.4
C18	Getting Appointments and Care Quickly	77	3.5
C19	Customer Service	90	3.4
C20	Rating of Health Care Quality	86	3.4
C21	Rating of Health Plan	87	3.2
C22	Care Coordination	86	3.5
C23	Complaints about the Health Plan	0.31	4.3
C24	Members Choosing to Leave the Plan	17%	3.5
C25	Health Plan Quality Improvement	Medicare only shows a Star Rating for this topic	2.6
C26	Plan Makes Timely Decisions about Appeals	95%	4.6
C27	Reviewing Appeals Decisions	95%	4.4
C28	Call Center – Foreign Language Interpreter and TTY Availability	90%	4.3

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	90%	4.4	90%	4.1
D02	Complaints about the Drug Plan	0.31	4.3	0.08	4.4
D03	Members Choosing to Leave the Plan	17%	3.5	11%	4.0
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this topic	2.7	Medicare only shows a Star Rating for this topic	2.2
D05	Rating of Drug Plan	86	3.2	83	3.3
D06	Getting Needed Prescription Drugs	90	3.4	90	3.5
D07	MPF Price Accuracy	95	4.2	95	3.5
D08	Medication Adherence for Diabetes Medications	86%	3.0	86%	2.9
D09	Medication Adherence for Hypertension (RAS antagonists)	87%	3.4	89%	2.7
D10	Medication Adherence for Cholesterol (Statins)	86%	3.1	87%	3.1
D11	MTM Program Completion Rate for CMR	83%	3.9	54%	3.1
D12	Statin Use in Persons with Diabetes (SUPD)	85%	3.1	82%	2.9

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	01/01/2021 – 12/31/2021
C02	Colorectal Cancer Screening	HEDIS	01/01/2021 – 12/31/2021
C03	Annual Flu Vaccine	CAHPS	03/2022 – 06/2022
C04	Monitoring Physical Activity	HEDIS-HOS	07/19/2021 – 11/01/2021
C05	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2021 – 12/31/2021
C06	Care for Older Adults – Medication Review	HEDIS	01/01/2021 – 12/31/2021
C07	Care for Older Adults – Pain Assessment	HEDIS	01/01/2021 – 12/31/2021
C08	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2021 – 12/31/2021
C09	Diabetes Care – Eye Exam	HEDIS	01/01/2021 – 12/31/2021
C10	Diabetes Care – Kidney Disease Monitoring	HEDIS	01/01/2021 – 12/31/2021
C11	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2021 – 12/31/2021
C12	Controlling Blood Pressure	HEDIS	01/01/2021 – 12/31/2021
C13	Reducing the Risk of Falling	HEDIS-HOS	07/19/2021 – 11/01/2021
C14	Improving Bladder Control	HEDIS-HOS	07/19/2021 – 11/01/2021
C15	Medication Reconciliation Post-Discharge	HEDIS	01/01/2021 – 12/31/2021
C16	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2021 – 12/31/2021
C17	Getting Needed Care	CAHPS	03/2022 – 06/2022
C18	Getting Appointments and Care Quickly	CAHPS	03/2022 – 06/2022
C19	Customer Service	CAHPS	03/2022 – 06/2022
C20	Rating of Health Care Quality	CAHPS	03/2022 – 06/2022
C21	Rating of Health Plan	CAHPS	03/2022 – 06/2022
C22	Care Coordination	CAHPS	03/2022 – 06/2022
C23	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2021 – 12/31/2021
C24	Members Choosing to Leave the Plan	MBDSS	01/01/2021 – 12/31/2021
C25	Health Plan Quality Improvement	Star Ratings	Not Applicable
C26	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2021 – 12/31/2021
C27	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2021 – 12/31/2021
C28	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2022 – 05/2022

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	02/2022 – 05/2022
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2021 – 12/31/2021
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2021 – 12/31/2021
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2022 – 06/2022
D06	Getting Needed Prescription Drugs	CAHPS	03/2022 – 06/2022
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2021 – 09/30/2021
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2021 – 12/31/2021
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2021 – 12/31/2021
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2021 – 12/31/2021
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2021 – 12/31/2021
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2021 – 12/31/2021

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 2021.

Step 2: Exclude any PBP that is not required to report data for the contract year 2021 Part C SNP Care Reporting Requirements, based on terminations on or before the end of the contract year. This exclusion is consistent with the statement from page 6 of the CY 2021 Medicare Part C Plan Reporting Requirements Technical Specifications Document: "**Note:** Contracts and Plans terminating prior to July 1 of the following year and are identified in HPMS as a termed contract do not report Part C contract and PBP level data."

This excludes:

- PBPs that terminate in transition from CY 2021 to CY 2022 according to the plan crosswalk
- Contracts that terminate on or before 07/01/2022 according to the Contract Info extract

We then also **exclude** those that are **not required to undergo data validation (DV)** for the contract year 2021 Part C SNP Care Reporting Requirements, based on terminations on or before the deadline for submission of DV results to CMS. This exclusion is consistent with the information found in the Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual.

This excludes: Contracts and PBP with an effective termination date that occurs between 1/1/2021 and 6/30/2022 according to the Contract Info extract.

Step 3: After removing contract/PBP 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 2021 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 2021 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/PBPs 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.

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: Weights Assigned to Individual Performance Measures

Table F-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 – Kidney Disease Monitoring	Process Measure	1
C11	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C12	Controlling Blood Pressure	Intermediate Outcome Measure	1*
C13	Reducing the Risk of Falling	Process Measure	1
C14	Improving Bladder Control	Process Measure	1
C15	Medication Reconciliation Post-Discharge	Process Measure	1
C16	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C17	Getting Needed Care	Patients' Experience and Complaints Measure	4
C18	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	4
C19	Customer Service	Patients' Experience and Complaints Measure	4
C20	Rating of Health Care Quality	Patients' Experience and Complaints Measure	4
C21	Rating of Health Plan	Patients' Experience and Complaints Measure	4
C22	Care Coordination	Patients' Experience and Complaints Measure	4
C23	Complaints about the Health Plan	Patients' Experience and Complaints Measure	4
C24	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4
C25	Health Plan Quality Improvement	Improvement Measure	5
C26	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	4
C27	Reviewing Appeals Decisions	Measures Capturing Access	4
C28	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4

*Controlling Blood Pressure has a weight of 1 for the 2023 Star Ratings because it is considered a new measure.

Table F-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 G: 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 H: 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 2022 and 2023.

For measures where a higher score is better:

Improvement Change Score = Score in 2023 - Score in 2022

For measures where a lower score is better:

Improvement Change Score = Score in 2022 - Score in 2023

An eligible measure was defined as a measure for which a contract was scored in both the 2022 and 2023 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 2022 and 2023 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.

Net Improvement = Number of significantly improved measures - 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 F. 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 2023 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2022 standard error for contract i on measure C01

Y_{i2} Represents the 2023 rate for contract i on measure C01

Y_{i1} Represents the 2022 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 (2023 and 2022). 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. 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 2023 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. **SEF for Measures: C01, C02, C04, C05, C08 – C11, C13 – C16, C24, C26 – C28, D01, D03, D08 – D12**

$$SE_y = \sqrt{\frac{Score_y*(100-Score_y)}{Denominator_y}}$$

for y = 2022, 2023

$Denominator_y$ 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 = 2022, 2023 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 = 2022, 2023. 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 = 2022, 2023. 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 2022, Contract Year 2023 and i = Contract i

3. **SEF for Measures: C03, C17 – C22, and D05, D06**

The CAHPS measure standard errors for 2022 and 2023 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.

4. **SEF for Measures C23, D02**

$$SE_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{NumDays}$$

NumDays: 2022 = 365, 2023 = 365

5. SEF for Measure D07

The standard error of the MPF Composite Price Accuracy Score for each contract is calculated using a bootstrap approach, following the steps outlined below:

1. From the set of PDEs used in calculating the MPF Composite Price Accuracy score for the contract, take 1,000 random samples of size n with replacement, where n is the number of PDEs that went into the MPF score calculation for the contract.

2. For each of the 1,000 random samples from Step 1, calculate the unrounded MPF Composite Price Accuracy score using the n PDEs in the sample. Let *yi* be the *ith* MPF score, where *i=1,…,1000.*

3. Calculate the standard error of the MPF Composite Price Accuracy Score as s, the standard deviation of the unrounded MPF Composite Price Accuracy score for the contract using the 1,000 MPF scores *y1,y2,…,y1000* computed in Step 2 using the following formula, where $\bar{y}$ is the mean of *y1,y2,…,y1000*:

$$s = \sqrt{\frac{\sum_{i=1}^{1000}(y_i - \bar{y})^2}{999}}$$

Star Ratings Measures Used in the Improvement Measures

Table H-1: Part C Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.929051
C02	Colorectal Cancer Screening	Included	0.889957
C03	Annual Flu Vaccine	Included	0.900371
C04	Monitoring Physical Activity	Included	0.870336
C05	Special Needs Plan (SNP) Care Management	Included	0.877704
C06	Care for Older Adults – Medication Review	Included	0.806582
C07	Care for Older Adults – Pain Assessment	Included	0.593374
C08	Osteoporosis Management in Women who had a Fracture	Included	0.871296
C09	Diabetes Care – Eye Exam	Included	0.842275
C10	Diabetes Care – Kidney Disease Monitoring	Included	0.800000
C11	Diabetes Care – Blood Sugar Controlled	Included	0.879453
C12	Controlling Blood Pressure	Not Included	-
C13	Reducing the Risk of Falling	Included	0.880108
C14	Improving Bladder Control	Included	0.661257
C15	Medication Reconciliation Post-Discharge	Included	0.863865
C16	Statin Therapy for Patients with Cardiovascular Disease	Included	0.718938
C17	Getting Needed Care	Included	0.789093
C18	Getting Appointments and Care Quickly	Included	0.851148
C19	Customer Service	Included	0.704632
C20	Rating of Health Care Quality	Included	0.736625
C21	Rating of Health Plan	Included	0.832466

Measure ID	Measure Name	Measure Usage	Correlation
C22	Care Coordination	Included	0.720071
C23	Complaints about the Health Plan	Included	0.908641
C24	Members Choosing to Leave the Plan	Included	0.876567
C25	Health Plan Quality Improvement	Not Included	-
C26	Plan Makes Timely Decisions about Appeals	Included	0.698541
C27	Reviewing Appeals Decisions	Included	0.612420
C28	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.247614

Table H-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	0.378928
D02	Complaints about the Drug Plan	Included	0.908820
D03	Members Choosing to Leave the Plan	Included	0.875496
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.852082
D06	Getting Needed Prescription Drugs	Included	0.703528
D07	MPF Price Accuracy	Included	0.622922
D08	Medication Adherence for Diabetes Medications	Included	0.709996
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.836304
D10	Medication Adherence for Cholesterol (Statins)	Included	0.833282
D11	MTM Program Completion Rate for CMR	Included	0.820363
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.836582

Attachment I: 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 I-1: Part C Measure History

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
C	Access to Primary Care Doctor Visits	HEDIS	DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11	C13	C12	
C	Adult BMI Assessment	HEDIS			C07	C07	C07	C07	C07	C07	C08	C10	C10	C12	DMC05		
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06	C07	C06	
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC04	
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS						DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05	C06	C05	
C	Asthma Medication Ratio	HEDIS						DMC18	DMC27								
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32	C33	C30	
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01	C01	C01	
C	Call Answer Timeliness	HEDIS								DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC01	
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09	C34	C31	
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC09	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC12		DMC15	DMC15				
C	Call Center – CSR Understandability	Call Center Monitoring														DMC02	
C	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36	C36	C33	
C	Call Center – Information Accuracy	Call Center Monitoring										DMC10	DMC10	DMC10	C35	C32	
C	Cardiac Rehabilitation	HEDIS	DMC27														
C	Cardiovascular Care – Cholesterol Screening	HEDIS									C02	C03	C03	C03	C03		A
C	Care Coordination	CAHPS	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29				

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
C	Care for Older Adults – Functional Status Assessment	HEDIS			C10	C10	C10	C10	C10	C10	C11	C12	C12	C14			
C	Care for Older Adults – Medication Review	HEDIS	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13			
C	Care for Older Adults – Pain Assessment	HEDIS	C07	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13	C15			
C	Cholesterol Screening	HEDIS														C03	B
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02	C02	C02	C02	
C	Complaints about the Health Plan	CTM	C23/D02	C23/D02	C27/D04	C28/D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06	C30	C26	
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	DMC04	DMC04	DMC04	DMC04	DMC04	DMC04	DMC05	
C	Controlling Blood Pressure	HEDIS	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21	C19	C15	
C	Customer Service	CAHPS	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28	C27	C23	
C	Diabetes Care	HEDIS														C14	C
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19	C17		D
C	Diabetes Care – Cholesterol Controlled	HEDIS									C17	C18	C18	C20	C18		D
C	Diabetes Care – Cholesterol Screening	HEDIS									C03	C04	C04	C04	C04		A
C	Diabetes Care – Eye Exam	HEDIS	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17	C15		D
C	Diabetes Care – Kidney Disease Monitoring	HEDIS	C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18	C16		D
C	Doctors who Communicate Well	CAHPS	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08	C25	C21	
C	Engagement of Alcohol or other Drug Treatment	HEDIS	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19					
C	Enrollment Timeliness	MARx						DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03	DMD03	
C	Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	HEDIS	DMC15	DMC17	DMC17	DMC18											

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
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	DMC03	
C	Getting Appointments and Care Quickly	CAHPS	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27	C26	C22	
C	Getting Needed Care	CAHPS	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26	C24	C20	
C	Glaucoma Testing	HEDIS										C05	C05	C05	C05	C04	
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11				
C	Health Plan Quality Improvement	Star Ratings	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33				
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24								
C	Improving Bladder Control	HEDIS-HOS	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23	C22	C18	
C	Improving or Maintaining Mental Health	HOS	DMC25	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09	C10	C09	
C	Improving or Maintaining Physical Health	HOS	DMC26	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08	C09	C08	
C	Initiation of Alcohol or other Drug Treatment	HEDIS	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18					
C	Medication Management for People With Asthma	HEDIS							DMC26								
C	Medication Reconciliation Post-Discharge	HEDIS	C15	C15	C19	C19	C20	C20	DMC23								
C	Members Choosing to Leave the Plan	MBDSS	C24/D03	C24/D03	C28/D05	C29/D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01	C29 / D10	
C	Monitoring Physical Activity	HEDIS-HOS	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10	C12	C11	
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16	C14	C13	
C	Osteoporosis Testing	HEDIS-HOS		DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06	C11	C10	
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17					
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16					

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
C	Plan All-Cause Readmissions	HEDIS	DMC21	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23	C25			
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE) / Maximus	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34	C31	C27	
C	Pneumonia Vaccine	CAHPS	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07	C08	C07	
C	Rating of Health Care Quality	CAHPS	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29	C28	C24	
C	Rating of Health Plan	CAHPS	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30	C29	C25	
C	Reducing the Risk of Falling	HEDIS-HOS	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24	C23	C19	
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	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35	C32	C28	
C	Rheumatoid Arthritis Management	HEDIS		C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22	C20	C16	
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14				
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C16	C16	C20	C21	C22	DMC17	DMC25								
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC04	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07	C21	C17	
C	Transitions of Care – Average	HEDIS	DMC20	DMC22	DMC22	DMC23											
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC18	DMC18	DMC19											
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC19	DMC19	DMC20											
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC20	DMC20	DMC21											

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC19	DMC21	DMC21	DMC22											

Notes:

A: Part of composite measure Cholesterol Screening in 2010
B: Composite Measure - combined Cardiovascular Care – Cholesterol Screening and Diabetes Care – Cholesterol Screening measures
C: Composite Measure - combined Diabetes Care – Blood Sugar Controlled, Diabetes Care – Cholesterol Controlled, Diabetes Care – Eye Exam, and Diabetes Care – Kidney Disease Monitoring measures
D: Part of composite measure Diabetes Care in 2010

Table I-2: Part D Measure History

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)												DMD03	D07	D07	
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data													DMD07		
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	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	D05	D05	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus			D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	D06	D06	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	D10	D11	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	D01	D01	
D	Call Center – Calls Disconnected - Pharmacist	Call Center Monitoring														DMD05	
D	Call Center – Calls Disconnected When Customer Calls Drug Plan	Call Center Monitoring	DMD01	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	DMD04	DMD04	
D	Call Center – CSR Understandability	Call Center Monitoring														DMD06	
D	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	D01	D01	D01	D01	D01	D01	D01	D01		D01	D02	D02	D04	D04	
D	Call Center – Information Accuracy	Call Center Monitoring										DMD05	DMD05	DMD06	D03	D03	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	D02	D02	
D	Complaint Resolution	Complaints Tracking Module (CTM)														DMD07	
D	Complaints – Enrollment	Complaints Tracking Module (CTM)													D08	D08	
D	Complaints – Other	Complaints Tracking Module (CTM)													D09	D09	

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C25/ D02	C25/ 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	DMD06	DMD09	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data									D10	D12	D15	D14	D17	D19	
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	D14	D15	
D	Drug Plan Quality Improvement	Star Ratings	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	DMD05	DMD08	
D	Enrollment Timeliness	MARx						DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03	DMD03	
D	Formulary Administration Analysis	Part D Sponsor					DMD15	DMD17									
D	Getting Information From Drug Plan	CAHPS							DMD10	DMD10	DMD09	DMD14	D10	D09	D11	D12	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	D13	D14	
D	Grievance Rate	Part C & D Plan Reporting	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	D16	D18	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15														
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	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	D10	D10	D10	D11	D12	D12	D11	D13	D16	D15			
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16			
D	Members Choosing to Leave the Plan	MBDSS	C27/ D03	C27/ D03	C29 / D05	C30 / D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	DME01	C29 / D10	
D	MPF – Composite	PDE Data, MPF Pricing Files												D12	D15		B
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10			D16	A

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
D	MPF – Updates	PDE Data, MPF Pricing Files										DMD09	DMD09	DMD10	DMD08	DMD10	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	D07	D09	D09	D09	D10	D10	D10	D08	D10	D13			D17	A
D	MTM Program Completion Rate for CMR	Prescription Drug Event (PDE) Data	D11	D11	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12				
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	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	DMD20												
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	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	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	D12	D13	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13						
D	Reminders to take medications	CAHPS	DMD07	DMD07	DMD11	DMD12	DMD13	DMD14	DMD16	DMD16	DMD14						
D	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Data	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	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	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis					DMD11										D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis						DMD12	DMD14	DMD14	DMD12						C
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis						DMD11	DMD13	DMD13	DMD11						C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data			DMD15												

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	Notes
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data		DMD11	DMD18												
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data		DMD12	DMD19												

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012
B: Composite measure - combined MPF - Accuracy and MPF Stability
C: Part of composite measure Transition Monitoring - Composite starting in 2019
D: Composite Measure – “Transition monitoring - failure rate for drugs within classes of clinical concern” and “Transition monitoring - failure rate for all other drugs”

Table I-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07	C33 / D10
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey	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	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	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	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	DME06	DME06	DME06	DME06				
E	Enrollment Timeliness	MARx						DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
E	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		

Attachment J: 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.

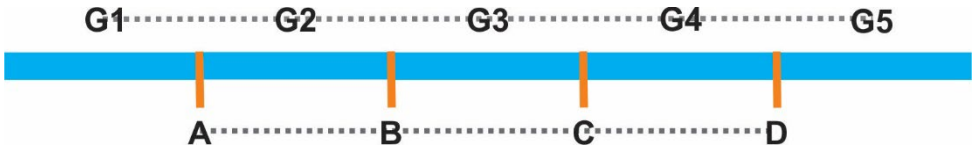
Clustering Methodology Introduction

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 J-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 J-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 the diagram 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 J-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 %

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 J-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 the diagram 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 J-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 %

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.

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. Tables J-3 and J-4 show the mean resampling estimated thresholds for the 2023 Star Ratings. 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. 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.

Table J-3: 2023 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	< 44 %	>= 44 % to < 62 %	>= 62 % to < 70 %	>= 70 % to < 77 %	>= 77 %
C02	< 38 %	>= 38 % to < 60 %	>= 60 % to < 71 %	>= 71 % to < 79 %	>= 79 %
C04	< 44 %	>= 44 % to < 49 %	>= 49 % to < 53 %	>= 53 % to < 57 %	>= 57 %
C05	< 46 %	>= 46 % to < 62 %	>= 62 % to < 75 %	>= 75 % to < 85 %	>= 85 %
C06	< 36 %	>= 36 % to < 70 %	>= 70 % to < 82 %	>= 82 % to < 93 %	>= 93 %
C07	< 29 %	>= 29 % to < 58 %	>= 58 % to < 85 %	>= 85 % to < 94 %	>= 94 %
C08	< 34 %	>= 34 % to < 47 %	>= 47 % to < 60 %	>= 60 % to < 76 %	>= 76 %
C09	< 47 %	>= 47 % to < 61 %	>= 61 % to < 71 %	>= 71 % to < 79 %	>= 79 %
C10	< 86 %	>= 86 % to < 93 %	>= 93 % to < 95 %	>= 95 % to < 97 %	>= 97 %
C11	< 39 %	>= 39 % to < 62 %	>= 62 % to < 75 %	>= 75 % to < 83 %	>= 83 %
C12	< 48 %	>= 48 % to < 63 %	>= 63 % to < 73 %	>= 73 % to < 80 %	>= 80 %
C13	< 46 %	>= 46 % to < 53 %	>= 53 % to < 60 %	>= 60 % to < 69 %	>= 69 %
C14	< 39 %	>= 39 % to < 43 %	>= 43 % to < 48 %	>= 48 % to < 53 %	>= 53 %
C15	< 43 %	>= 43 % to < 57 %	>= 57 % to < 69 %	>= 69 % to < 82 %	>= 82 %
C16	< 75 %	>= 75 % to < 81 %	>= 81 % to < 85 %	>= 85 % to < 89 %	>= 89 %
C23	> 1.59	> 0.89 to <= 1.59	> 0.5 to <= 0.89	> 0.19 to <= 0.5	<= 0.19
C24	> 37 %	> 24 % to <= 37 %	> 15 % to <= 24 %	> 7 % to <= 15 %	<= 7 %
C25	< -0.298771	>= -0.298771 to < 0	>= 0 to < 0.101745	>= 0.101745 to < 0.328141	>= 0.328141
C26	< 31 %	>= 31 % to < 59 %	>= 59 % to < 82 %	>= 82 % to < 97 %	>= 97 %
C27	< 68 %	>= 68 % to < 83 %	>= 83 % to < 91 %	>= 91 % to < 97 %	>= 97 %
C28	< 47 %	>= 47 % to < 77 %	>= 77 % to < 87 %	>= 87 % to < 94 %	>= 94 %

Notes: These are not the final thresholds for the 2023 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table J-4: 2023 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	< 57 %	>= 57 % to < 68 %	>= 68 % to < 80 %	>= 80 % to < 91 %	>= 91 %
D01	PDP	< 60 %	>= 60 % to < 75 %	>= 75 % to < 91 %	>= 91 % to < 97 %	>= 97 %
D02	MA-PD	> 1.59	> 0.89 to <= 1.59	> 0.5 to <= 0.89	> 0.19 to <= 0.5	<= 0.19
D02	PDP	> 0.41	> 0.26 to <= 0.41	> 0.13 to <= 0.26	> 0.06 to <= 0.13	<= 0.06
D03	MA-PD	> 37 %	> 24 % to <= 37 %	> 15 % to <= 24 %	> 7 % to <= 15 %	<= 7 %
D03	PDP	> 23 %	> 16 % to <= 23 %	> 11 % to <= 16 %	> 7 % to <= 11 %	<= 7 %
D04	MA-PD	< -0.325131	>= -0.325131 to < 0	>= 0 to < 0.159307	>= 0.159307 to < 0.391045	>= 0.391045
D04	PDP	< -0.237362	>= -0.237362 to < 0	>= 0 to < 0.389234	>= 0.389234 to < 0.851667	>= 0.851667
D07	MA-PD	< 72	>= 72 to < 86	>= 86 to < 93	>= 93 to < 97	>= 97
D07	PDP	< 90	>= 90 to < 94	>= 94 to < 96	>= 96 to < 99	>= 99
D08	MA-PD	< 79 %	>= 79 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %
D08	PDP	< 84 %	>= 84 % to < 86 %	>= 86 % to < 88 %	>= 88 % to < 90 %	>= 90 %
D09	MA-PD	< 83 %	>= 83 % to < 86 %	>= 86 % to < 89 %	>= 89 % to < 91 %	>= 91 %
D09	PDP	< 86 %	>= 86 % to < 89 %	>= 89 % to < 91 %	>= 91 % to < 96 %	>= 96 %
D10	MA-PD	< 81 %	>= 81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %
D10	PDP	< 84 %	>= 84 % to < 87 %	>= 87 % to < 88 %	>= 88 % to < 90 %	>= 90 %
D11	MA-PD	< 41 %	>= 41 % to < 67 %	>= 67 % to < 82 %	>= 82 % to < 89 %	>= 89 %
D11	PDP	< 34 %	>= 34 % to < 49 %	>= 49 % to < 62 %	>= 62 % to < 78 %	>= 78 %
D12	MA-PD	< 80 %	>= 80 % to < 84 %	>= 84 % to < 86 %	>= 86 % to < 90 %	>= 90 %
D12	PDP	< 80 %	>= 80 % to < 82 %	>= 82 % to < 84 %	>= 84 % to < 86 %	>= 86 %

Notes: These are not the final thresholds for the 2023 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

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. 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) * 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 in the document, “Instructions for Analyzing Data from CAHPS® Surveys in SAS®: Using the CAHPS Analysis Program Version 5.0” available at https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/2020-instructions-for-analyzing-data.pdf.

Tables J-5 and J-6 contain the rules applied to determine the final CAHPS measure star value.

Table J-5: 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 J-6: 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 J-7 contains the 12% reliability cutoffs.

Table J-7: CAHPS Measure 12% Reliability Cutoffs

Measure	**12% reliability cutoff**
Annual Flu Vaccine	0.835984*
Getting Needed Care	0.706322
Getting Appointments and Care Quickly	0.743328
Customer Service	0.648893
Rating of Health Care Quality	0.630180
Rating of Health Plan	0.814507*
Care Coordination	0.628480
Rating of Drug Plan (MA-PD)	0.770040*
Getting Needed Prescription Drugs (MA-PD)	0.608964
Rating of Drug Plan (PDP)	0.944925*
Getting Needed Prescription Drugs (PDP)	0.868278*

*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, so these cutoffs did not affect low reliability designation.

Attachment K: 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 'Days Covered Modification for Inpatient Stays and Skilled Nursing Facility 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 K-1: No Adjustment

	January		February		March	
	1/1/2021	1/16/2021	2/1/2021	2/16/2021	3/1/2021	3/16/2021
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 K-2: Before Overlap Adjustment

	January		February		March	
	1/1/2021	1/16/2021	2/1/2021	2/16/2021	3/1/2021	3/16/2021
Lisinopril	15	16				
Lisinopril & HCTZ		16	15			
Benazepril & HCTZ			15	13		

PDC Calculation
Covered Days: 59
Measurement Period: 90
PDC: 59/90 = 66%

Table K-3: After Overlap Adjustment

	January		February		March	
	1/1/2021	1/16/2021	2/1/2021	2/16/2021	3/1/2021	3/16/2021
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 K-4: Before Overlap Adjustment

	January		February		March		April	
	1/1/2021	1/16/2021	2/1/2021	2/16/2021	3/1/2021	3/16/2021	4/1/2021	4/16/2021
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 K-5: After Overlap Adjustment

	January		February		March		April	
	1/1/2021	1/16/2021	2/1/2021	2/16/2021	3/1/2021	3/16/2021	4/1/2021	4/16/2021
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. 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 2019 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries. 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 2021 Star Ratings (2020 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 cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

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. 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 K-6.

Table K-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 K-7.

Table K-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. 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 K-8.

Table K-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 K-9.

Table K-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. 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 K-10.

Table K-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 K-11.

Table K-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. 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 K-12.

Table K-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 K-13.

Table K-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 L: Methodology for Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (PF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the PF price to the PDE price and determining the magnitude and frequency of differences found when the PDE price exceeds the PF price. This document summarizes the methods currently used to construct each contract's PF Composite Price Accuracy Score.

Contract Selection

The Part D Star Ratings rely in part on the submission of pricing data to PF. 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.

PF Composite Price Accuracy Score

To calculate the PF 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 PF 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 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.

[1] 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 Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] 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 PF reference NDCs.

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 PF prices are not updated during this last quarter.

The PF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the PF. The contract's PF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and PF total cost,[4] and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to PF prices.

Once PF unit ingredient costs are assigned, the PF ingredient cost is calculated by multiplying the unit costs reported on PF by the quantity listed on the PDE. The PDE cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the PF TC is the sum of the PF ingredient cost and the PF 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 PF TC. If the PDE TC is lower than or equal to the PF 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 PF TC, then the claim receives a score equal to the difference between the PDE TC and the PF TC. [5] [6]The contract level PF 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 PF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the PF TC. Note that the best possible PF Price Accuracy Index is 1, and the best possible PF Claim Percentage Index is 0. This occurs when the PF TC is never lower than the PDE TC. The formulas below illustrate the calculation of the contract level PF Price Accuracy Index and PF Claim Percentage Index:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i, and

TC_{iPF} is the ingredient cost plus dispensing fee calculated from PF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{iPDE>PF}}{\sum_i \text{Claims}_{iTotal}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.
[4] PF total costs are rounded to the nearest cent. For example, if the PF total cost is $10.237, then it is rounded to $10.24. PF unit costs are not rounded.
[5] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded PF cost by at least a cent ($0.01) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded PF cost is $10.24, the 1-cent difference would be counted towards plan's accuracy score. However, if the rounded PF cost is higher than $10.24, the difference would not be considered problematic, and it would not count towards the plan's accuracy score.
[6] The PF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the PF price is lower than the floor price, the PDE price is compared against the floor price.

$\text{Claims}_{\text{iPDE>PF}}$ is the total number of claims where the PDE price is greater than the rounded PF 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 PF Composite Price Accuracy score:

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{PF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

The PF Composite Price Accuracy Score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table L-1 shows an example of the PF 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 PF data that had been submitted by the contract and posted on Medicare.gov 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 PF 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 PF cost is computed as the quantity dispensed from PDE multiplied by the PF unit cost plus the PF 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 PF cost. When PDE cost is less than or equal to the rounded PF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table L-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	PF Data Biweekly Posting Period	PF Data Unit Cost	PF Data Dispensing Fee Brand	PF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost PF	Calculated Value Amount that PDE is higher than PF
A	111	01/08/2021	3.82	2	60	60	01/06/21 - 01/19/21	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2021	0.98	2	30	60	01/20/21 - 02/02/21	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2021	10.48	1.5	24	28	02/03/21 - 02/16/21	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2021	47	1.5	90	30	02/17/21 - 03/01/21	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
											PF Composite Price Accuracy Score			71

PDE = Prescription Drug Event

PF = Plan Finder

Attachment M: 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 2021. 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 2021.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2022), or that were not required to participate in data validation. The current MTM requirements are waived for the PBPs approved to participate in the Enhanced MTM Model and data on participating PBPs must not be reported per the Part D Reporting Requirements under the current MTM program. This MTM data will instead be reported in accordance with model terms and conditions and not included in the measure calculation.

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)
- Met the specified targeting criteria per CMS – Part D requirements (Element F)
- Date of MTM program enrollment (Element I)
- Date met the specified targeting criteria per CMS – Part D requirements (Element J)
- Date of MTM program opt-out, if applicable (Element L)
- Received annual CMR with written summary in CMS standardized format (Element Q)
- Date(s) of CMR(s) (Element R)

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 2021MTM 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 2021MTM 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 2021MTM 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 N: 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 2023 Star Ratings are developed using the following sources of information:

- The 2019 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2019 ACS 5-year estimates for the percentage of people living below 150% of the FPL;[1] 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 2021 provided for beneficiaries who were alive at least through December 2021, 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 2019 1-year data from ACS (https://www.census.gov/content/dam/Census/library/publications/2020/acs/acsbr20-04.pdf, see Table 1). *The states identified are: Alabama, Arkansas, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, Tennessee, 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 2023 Star Ratings adjustment, the data used for the model development included a total of 99 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.

[1] Due to the COVID-19 pandemic, the 2020 ACS data did not meet the Census Bureau's statistical quality standards, and normal data products were not released. Therefore, for the 2023 Star Ratings, the 2019 ACS estimates were used, as they reflect the most recent non-experimental estimates currently available. For more information see https://www.census.gov/library/working-papers/2021/acs/2021_Rothbaum_01.html.

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 2019 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 2019. 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:

$$\widehat{\text{LIS/DE}} = \left(\text{ Slope} \times \text{contract's DE percentage}\right) + \left(\text{ intercept}\right)$$

Using the data from the 10 highest poverty states, the estimated slope was calculated to be 0.919172.

$$\widehat{\text{LIS/DE}} = \left(0.919172 \times \text{contract's DE percentage}\right) + \left(\text{ intercept}\right)$$

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 (35.846594%) 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	60.600000%
Percent of residents in the 10 poorest US states below 150% of FPL	27.331987%
Observed average LIS/DE percentage in the 10 poorest US states	37.891295%
Observed average DE percentage in Puerto Rico contracts	35.846594%

The product thus becomes $\left(37.891295 \times \frac{60.600000}{27.331987}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(37.891295 \times \frac{60.600000}{27.331987}\right) - (0.919172 \times 35.846594)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.919172 \times \text{contract's DE percentage}) + \left(\left(37.891295 \times \frac{60.600000}{27.331987}\right) - (0.919172 \times 35.846594)\right)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 25%, the value of 25.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.919172 \times \text{contract's DE percentage}) + \left(\left(37.891295 \times \frac{60.600000}{27.331987}\right) - (0.919172 \times 35.846594)\right)$$

The contracts percentage of 25.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.919172 \times 25.000000) + \left(\left(37.891295 \times \frac{60.600000}{27.331987}\right) - (0.919172 \times 35.846594)\right)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 25.000000% is 74.042026%.

The final adjustment category for the CAI adjustment is identified using the DE percentage of 25.000000% and the LIS/DE percentage 74.042026%.

Attachment O: Scaled Reductions for Appeals IRE Data

Part C Scaled Reduction Methodology

CMS's scaled reduction methodology is a three-stage process that uses the Timeliness Monitoring Project (TMP) or audit data as the means to determine: first, whether a contract may be subject to a potential reduction for the Part C appeals measures due to an IRE data completeness issue; second, as the basis to determine the estimated error rate; and finally, to see whether the estimated error rate is statistically significantly greater than established thresholds for a scaled reduction.

Stage 1: Determine Whether the Contract is Subject to a Potential Reduction for the Part C Appeals Measures Due to an IRE Data Completeness Issue

Step 1A: Data Source and Data Values

The scaled reduction methodology uses the data submitted for the Timeliness Monitoring Project (TMP) for the measurement year that is associated with the Star Ratings' year. For example, the 2023 Star Ratings scaled reductions are based on the 2021 TMP data submitted in 2022. The data, submitted at the Parent Organization level, are disaggregated to the contract level for analysis.

The following information is needed to begin the steps to determine whether a contract will be subject to a possible scaled reduction for their Part C appeals measures because of data integrity issues. The information is available in HPMS during Plan Preview. The field name in HPMS is provided within parentheses after the description in the bulleted list below.

- Number of Cases Not Forwarded to the IRE (Cases Not Forwarded to IRE)
- Number of Cases Forwarded to the IRE (Cases Forwarded to IRE)
- Total Number of Cases that Should Have Been Forwarded to the IRE (Total IRE Cases)
- TMP Data Collection Period (Months)
- Part C Calculated Error Rate

The Total Number of Cases that Should Have Been Forwarded to the IRE is calculated by adding the Number of Cases Not Forwarded to the IRE (Cases Not Forwarded to IRE) and the Number of Cases Forwarded to the IRE (Cases Forwarded to IRE) (Equation A).

Equation (A)

Total Number of Cases that Should Have Been Forwarded to IRE =
Number of Cases Not Forwarded to IRE + Number of Cases Forwarded to IRE

Step 1B: Part C Calculated Error Rate

Using the values in Step 1A, determine the Part C Calculated Error Rate.

The Calculated Error Rate is the quotient of the Number of Cases Not Forwarded to the IRE during the TMP collection period and the Total Number of Cases that Should Have Been Forwarded to the IRE in the same period (Equation B).

Equation (B)

$$\text{Part C Calculated Error Rate} = \frac{\text{Number of Cases Not Forwarded to the IRE}}{\text{Total Number of Cases that Should Have Been Forwarded to the IRE}}$$

Step 1C: 3-month Projected Number of Cases

Since the timeframe for the TMP or audit data is dependent on a contract's enrollment, a 3-month Projected Number of Cases Not Forwarded to the IRE is determined to allow a consistent application of the developed criteria.

To calculate a contract's 3-month Projected Number of Cases Not Forwarded to the IRE, first identify the multiplying factor using Table O-1. Locate the row (months) that corresponds to the TMP Data Collection Period.

Table O-1: Multiplying Factor to calculate the 3-month Projected Number of Cases Not Forwarded to the IRE

TMP Data Collection Period (Months)	Multiplying Factor for the 3-month Projected Number of Cases Not Forwarded to IRE
1	3.0
2	1.5
3	1.0

Next, multiply the Number of Cases Not Forwarded to the IRE that was posted in HPMS by the factor identified in Table 1 for the contract (Equation C). The product is the 3-month Projected Number of Cases Not Forwarded to the IRE.

Equation (C)

3-month Projected Number of Cases Not Forwarded to the IRE =
Multiplying Factor x Number of Cases Not Forwarded to IRE in the TMP period

Step 1D: Subject to Reduction

Criteria were developed to determine if a contract's Part C appeals measures may be subject to a possible IRE data completeness reduction.

A contract is subject to a possible reduction due to lack of IRE data completeness if both conditions are met:

- The Calculated Error Rate is 20% or more.
- The 3-month Projected Number of Cases Not Forwarded to the IRE is at least 10.

Using the Part C Calculated Error Rate and the 3-month Projected Number of Cases Not Forwarded to the IRE, check the criteria to determine if the contract is subject to a possible reduction. Table O-2 below is provided to determine if a contract is subject to a possible reduction.

Table O-2: Identification of a Contract that is Subject to a Possible Scaled Reduction

Calculated Error Rate	3-month Projected Number of Cases Not Forwarded to IRE	Contract Subject to a Possible Reduction
Less than 20%	Less than 10 cases	No
Less than 20%	10 cases or more	No
At Least 20%	Less than 10 cases	No
At Least 20%	10 cases or more	Yes

If a contract is not subject to a possible reduction, the contract will receive the measure-level Star Ratings for the Part C appeals measures determined by the specification detailed in the section regarding the Methodology for Assigning Stars to the Part C and Part D measures in this document.

If a contract is subject to a possible reduction, then continue to Stage 2.

Stage 2: Estimated Error Rate

Step 2A: Lower Bound of the Score Interval

Using the Part C Calculated Error Rate in Step 1B, the lower bound of the confidence interval (Wilson Score Interval) is determined and used to statistically test the value against a set of thresholds to identify the scaled reduction for a contract's Part C appeals measures.

To determine the lower bound, first, the midpoint of the interval must be calculated. There are two values needed to calculate the midpoint of the interval for a contract – the Part C Calculated Error Rate and the Total Number of Cases that Should Have Been Forwarded to the IRE in the TMP Data Collection Period.[1]

Substitute the Calculated Error Rate and the Total Number of Cases that Should Have Been Forwarded to the IRE for the Total Number of Cases in Equation (D). The z value used for the calculation of the interval is 1.959964.[2]

Equation (D)

$$\text{Midpoint} = \text{Calculated Error Rate} \times \left(\frac{\text{Total Number of Cases}}{\text{Total Number of Cases} + z^2}\right) + \frac{1}{2}\left(\frac{z^2}{\text{Total Number of Cases} + z^2}\right)$$

Once the midpoint is calculated, determine the value of the lower bound of the interval.

The lower bound of the interval is found by substituting the value determined for the midpoint, the Calculated Error Rate, the value of 1.959964 for z, and the Total Number of Cases that Should Have Been Forwarded to the IRE for the value for n in Equation (E).

Equation (E)

$$\text{Lower Bound} = \text{Midpoint} - z \times \sqrt{\frac{1}{n + z^2}\left[(\text{Calculated Error Rate})\,(1-\text{Calculated Error Rate})\left(\frac{n}{n + z^2}\right) + \frac{1}{4}\left(\frac{z^2}{n + z^2}\right)\right]}$$

Convert the lower bound to a percent by multiplying by 100.

Stage 3: Scaled Reduction

Step 3A: Statistical Testing

Once the value of the lower bound is determined (Stage 2), the value is compared to the thresholds in Table O-3 to determine if a contract's estimated value is significantly greater than the thresholds.

Using the calculated value for the lower bound in Step 2A, identify the value(s) in the table for which the calculated lower bound exceeds the threshold in the row. Next, identify the highest threshold that the lower bound exceeds.

Note: A contract's lower bound can be statistically significantly higher for more than one threshold. The scaled reduction will be determined by the highest associated scaled reduction.

Table O-3: Thresholds and Associated Reductions

Threshold	Reduction for Incomplete IRE Data (Stars)
20%	1
40%	2
60%	3
80%	4

Using the highest threshold in Table P-3 that the contract's lower bound exceeds, identify the associated reduction for incomplete IRE data.

[1] The Total Number of Cases that Should Have Been Forwarded to the IRE in the TMP Data Collection Period is not the same as the 3-month Projected Number of Cases Not Forwarded to the IRE determined in Step 1C.
[2] The z used for the calculation of the interval corresponds to a level of statistical significance of 0.05.

Step 3B: Application of the Scaled Reduction

The identified scaled reduction in Table O-3 is subtracted from the measure-level Star Rating for both Part C appeals measure-level Star Ratings. If the resulting measure-level Star Rating is less than one-star, the measure is assigned one star.

Note: If the Part C appeals measures receive a scaled reduction in either measurement year included in the Part C improvement measure, the Part C appeals measures would not be eligible for inclusion in the Part C improvement measure.

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 2023 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 2023 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
2/17/2021	Texas Severe Winter Storms	Winter Storms	Texas	2/11/2021
8/30/2021	Hurricane Ida	Hurricane	Louisiana and Mississippi	8/26/2021
9/3/2021	Remnants of Hurricane Ida	Hurricane	New York and New Jersey	9/1/2021

- 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
4586-DR-TX	Texas	Anderson, Angelina, Aransas, Atascosa, Austin, Bandera, Bastrop, Bee, Bell, Bexar, Blanco, Bosque, Bowie, Brazoria, Brazos, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Cameron, Chambers, Cherokee, Collin, Colorado, Comal, Comanche, Cooke, Coryell, Dallas, DeWitt, Denton, Duval, Eastland, Ector, Ellis, Erath, Falls, Fannin, Fort Bend, Freestone, Galveston, Gillespie, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hardin, Harris, Harrison, Hays, Henderson, Hidalgo, Hill, Hood, Houston, Howard, Hunt, Jackson, Jasper, Jefferson, Jim Hogg, Jim Wells, Johnson, Jones, Karnes, Kaufman, Kendall, Kerr, Kleberg, Lamar, Lavaca, Leon, Liberty, Limestone, Llano, Lubbock, Madison, Matagorda, Maverick, McLennan, Medina, Milam, Montague, Montgomery, Nacogdoches, Navarro, Newton, Nueces, Orange, Palo Pinto, Panola, Parker, Polk, Robertson, Rockwall, Rusk, Sabine, San Jacinto, San Patricio, Scurry, Shackelford, Shelby, Smith, Stephens, Tarrant, Taylor, Tom Green, Travis, Trinity, Tyler, Upshur, Val Verde, Van Zandt, Victoria, Walker, Waller, Washington, Webb, Wharton, Wichita, Willacy, Williamson, Wilson, Wise, and Wood.
4611-DR-LA	Louisiana	Ascension, Assumption, East Baton Rouge, East Feliciana, Iberia, Iberville, Jefferson, Lafourche, Livingston, Orleans, Plaquemines, Pointe Coupee, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Martin, St. Mary, St. Tammany, Tangipahoa, Terrebonne, Washington, West Baton Rouge, and West Feliciana.
4626-DR-MS	Mississippi	Amite, Hancock, Harrison, Jackson, Pearl River, Pike, Walthall, and Wilkinson.
4615-DR-NY	New York	Bronx, Dutchess, Kings, Nassau, Orange, Queens, Richmond, Rockland, Suffolk, and Westchester.
4614-DR-NJ	New Jersey	Bergen, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Morris, Passaic, Somerset, Union, and Warren.

- 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
4586-DR-TX	Texas	02/11/2021	Feb. 5, 2021	March, 2021
4611-DR-LA	Louisiana	08/26/2021	Sep.10, 2021	Oct., 2021
4626-DR-MS	Mississippi	08/26/2021	Sep.10, 2021	Oct., 2021
4615-DR-NY	New York	09/01/2021	Sep.10, 2021	Oct., 2021
4614-DR-NJ	New Jersey	09/01/2021	Sep.10, 2021	Oct., 2021

- Calculate impacted enrollment by contract taking into account contracts experiencing multiple disasters. Because of the varying sizes of the areas served by the contracts being rated, it is common for a contract to be affected by more than one of the disasters. To account for this, CMS rolled up the enrollment for each contract at the state/county level and then when more than one enrollment period applied an average of the enrollments from each of corresponding enrollment periods where the contract was affected was used.

  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

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48143	Erath	TX	Yes	FALSE	61	-	59	60
48163	Frio	TX	Yes	FALSE	43	-	42	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	17
48175	Goliad	TX	Yes	TRUE	18	-	18	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	41
48237	Jack	TX	Yes	FALSE	35	-	34	34
48239	Jackson	TX	Yes	TRUE	30	-	30	30
48255	Karnes	TX	Yes	TRUE	19	-	19	19
48265	Kerr	TX	Yes	FALSE	85	-	86	86
48283	La Salle	TX	Yes	FALSE	25	-	25	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	24
48301	Loving	TX	Yes	FALSE	0	-	0	0
48311	McMullen	TX	Yes	FALSE	4	-	4	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	142
48323	Maverick	TX	Yes	FALSE	160	-	156	158
48371	Pecos	TX	Yes	FALSE	20	-	21	20
48377	Presidio	TX	Yes	FALSE	50	-	49	50
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 (C26 & C27):

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 > 01/01/2021?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C17, C18, C19, C20, C21, & C22):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date > 07/01/2021?
  - 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 (C28):

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 > 01/01/2022?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C23):

Is the contract effective date > 01/01/2021?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2021?
  - 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 (C01, C02, C06 – C12, C15 & C16):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment < 500 in July 2021?
  - 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: 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: What is the status?
          - NA: Display message: Not enough data available
          - R: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date > 01/01/2021?
  - 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 2023?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2021?
  - 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, C13, & C14):

Is there a valid HEDIS-HOS numeric rate?
- Yes: Display the HEDIS-HOS numeric rate
- No: Is the contract effective date > 01/01/2020?
  - Yes: Display message: Plan too new to be measured
  - No: Is the 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 (C24):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date > 01/01/2021?
  - 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 2023?
- 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 > 01/01/2021?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C25):

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 > 01/01/2021?
  - 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 > 07/01/2021?
  - 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 > 01/01/2022?
    - 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 > 01/01/2021?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2021?
  - 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 > 01/01/2021?
  - 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 > 01/01/2021?
  - 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 > 9/30/2021?
- 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 > 12/31/2021?
- 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 > 12/31/2021?
- 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 all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
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 > 01/01/2021?
  - 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 > 01/01/2021?
  - 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 > 01/01/2021?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2023 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 > 1/1/2021?
- 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.
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 2023 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
				01/01/2021 - 12/31/2021	01/01/2021 - 12/31/2021	03/2022 - 06/2022
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 page

The Measure Detail page contains the underlying data used for the Part C and Part D Complaints (C23/D02) and Part C Appeals measures (C26 & C27). 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 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
Part C Total Appeals Cases	Total number of Part C appeals cases processed by the IRE (Maximus)
Part C Appeals Upheld	Number of Part C appeals which were upheld (unfavorable)
Part C Appeals Overturned	Number of Part C appeals which were overturned (favorable)
Part C Appeals Partly Overturned	Number of Part C appeals which were partially overturned (partially favorable)
Part C Appeals Dismissed	Number of Part C appeals which were dismissed
Part C Appeals Withdrawn	Number of Part C appeals which were withdrawn
Part C Late Appeals	Number of Part C appeals which Maximus considered to be late
Part C Percent of Timely Appeals	Percent of Part C appeals which were processed in a timely manner

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 (C26) and Reviewing Appeals Decisions (C27). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2023 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	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.
Appeal Decision	Decision associated with the appeal (Dismiss Appeal, Overturn MCO Denial, Partly Overturn MCO Denial, Unspecified, Uphold MCO Denial, Withdraw Appeal)
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 – SNP COA page

The Measure Detail – SNP COA page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adults measures (C06 & C07). The formulas used to calculate these SNP measures are detailed in Attachment E. 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 – SNP COA 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
Eligible Population – MR	The Eligible population - Medication Review, entered by the contract into NCQA IDSS (Field: eligpopmr)
Eligible Population – PA	The Eligible population - Pain Assessment, entered by the contract into NCQA IDSS (Field: eligpopps)
Average Plan Enrollment	The average enrollment in the PBP during 2020 (see section Contract Enrollment Data)
COA – MR Rate	The COA Medication Review Rate calculated by the NCQA data submission tool (Field: ratemr)
COA – PA Rate	The COA Pain Assessment Rate calculated by the NCQA data submission tool (Field: rateps)
COA - MR Audit Designation	The audit designation for the COA Medication Review Rate (the audit codes defined next table)
COA – PA Audit Designation	The audit designation for the COA Pain Assessment Rate (the audit codes defined next table)
COA – MR Status	The status for the COA Medication Review Rate
COA – PA Status	The status for the COA Pain Assessment Rate

Table S-6: HEDIS 2021 Audit Designations and 2023 Star Ratings

Audit Designation	NCQA Description	Resultant Star Rating
R	Reportable	Assigned 1 to 5 stars depending on reported value
BR	Biased Rate	1 star, numeric data set to "CMS identified issues with this plan's data"
NA	Small Denominator	"Not enough data available"
NB	No Benefit	"Benefit not offered by plan"
NR	Not Reported	1 star, numeric data set to "CMS identified issues with this plan's data"
NQ	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 (C23/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 (C24/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 1/1/2021 and 12/31/2021. 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 M. 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 M. (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 (C17), Getting Appointments and Care Quickly (C18), Customer Service (C19), Rating of Health Care Quality (C20), Rating of Health Plan (C21), Care Coordination (C22), 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 – CSR

The Calculation Detail – CSR (Part C Scaled Reduction) page contains the underlying data used in calculating the reduction applied to the two Part C appeals measures. This page is available during the first plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Measure Detail – Part C Scaled Reductions 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
TMP Time Period	The time period associated with the TMP data submission; a zero indicates contract did not submit data
Cases Not Forwarded to IRE	The number of cases not forwarded to the IRE in the TMP time period
Cases Forwarded to IRE	The number of cases forwarded to the IRE in the TMP time period
Total IRE Cases	The total number of cases that should have been forwarded to the IRE in the TMP time period
TMP data submitted	A flag that indicates whether the contract submitted TMP data (Yes/No)
Projected Cases	The projected number of cases not forwarded to the IRE in a three-month period
Calculated Error Rate	The Calculated Error Rate is the quotient of Cases Not forwarded to IRE and Total IRE cases
Lower Bound	Lower Bound of the Score Interval
Part C Appeals Reduction	Part C Appeals measures Star Ratings reduction due to IRE completeness issues

12. 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-13 below explains the columns displayed on this page.

Table S-13: 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 2021	Indicates if the contract was affected by a 2021 disaster or not (valid values “Affected”, “Not Affected” or “Too New“)
Total Cnty in SA 2021	The total number of counties in the contract’s 2021 service area (SA)
Num Cnty IA 2021	The number of counties from the contract’s total SA designated as FEMA Individual Assistance (IA) counties in a 2021 disaster
IA Enrolled 2021	The number of members residing in the contract SA designated FEMA IA counties in a 2021 disaster
Total Enrolled 2021	The total number of members residing in the contract’s 2021 SA
IA % 2021	The percent of members living in IA areas in a 2021 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2021	The percent of members living in IA areas in a 2021 disaster rounded to an integer
>25% 2021	Flag that indicates if the contract has met the 25% threshold for 2021 disasters (Yes: >= 25 %, No: <25%)
>60% 2021	Flag that indicates if the contract has met the 60% threshold for 2021 disasters (Yes: >= 60 %, No: <60%)
Disaster Flag 2020	Indicates if the contract was affected by a 2020 disaster or not (valid values “Affected”, “Not Affected” or “Too New“)
Total Cnty in SA 2020	The total number of counties in the contract’s 2020 service area (SA)
Num Cnty IA 2020	The number of counties from the contract’s total SA designated as FEMA Individual Assistance (IA) counties in a 2020 disaster
IA Enrolled 2020	The number of members residing in the contract SA designated FEMA IA counties in a 2020 disaster
Total Enrolled 2020	The total number of members residing in the contract’s 2020 SA
IA % 2020	The percent of members living in IA areas in a 2020 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2020	The percent of members living in IA areas in a 2020 disaster rounded to an integer
>=25% 2020	Flag that indicates if the contract has met the 25% threshold for 2020 disasters (Yes: >= 25 %, No: <25%)

13. 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-14 below explains the columns displayed on this page.

Table S-14: 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

14. 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 – C12, C15 – C16) data for contracts with ≥ 500 and < 1,000 members enrolled in July of the measurement year (July 01, 2021). This page is available during the second plan preview. Table S-15 below explains each of the columns displayed on this page.

Table S-15: 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 2021
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

15. 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-16 below explains the columns displayed on this page.

Table S-16: 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 2023 Star Ratings Part C measure ID
2022 Value	The numeric measure value for the contract from the 2022 Star Ratings
2022 Star	The measure star for the contract from the 2022 Star Ratings
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
Final Value	The measure value to be used in the 2023 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2023 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 – 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-17 below explains the columns displayed on this page.

Table S-17: 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 2023 Star Ratings Part D measure ID
2022 Value	The numeric measure value for the contract from the 2022 Star Ratings
2022 Star	The measure star for the contract from the 2022 Star Ratings
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
Final Value	The measure value to be used in the 2023 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2023 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

17. 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 H: “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-18 below.

Table S-18: 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

18. 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 H: "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-19 below.

Table S-19: 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

19. 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-20 below shows a sample of the left hand most columns shown in HPMS.

Table S-20: 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
				01/01/2021 - 12/31/2021	01/01/2021 - 12/31/2021	03/2022 - 06/2022
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

20. 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-21 below shows a sample of the left hand most columns shown in HPMS.

Table S-21: 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

21. 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-22 below explains each of the columns contained on this page.

Table S-22: 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 2020	The percentage of members living in an Individual Assistance area in 2020 rounded to an integer
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 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 (C31)? (Yes/No)
CBP Measure Usage	Did the final Part C summary rating come from the calculation using the CBP measure (C12)? (Yes/No)
2023 Part C Summary Rating	The final rounded 2023 Part C Summary Rating

22. 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-23 below explains each of the columns contained on this page.

Table S-23: 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 2020	The percentage of members living in an Individual Assistance area in 2020 rounded to an integer
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 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 (D06)? (Yes/No)
2023 Part D Summary Rating	The final rounded 2023 Part D Summary Rating

23. 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-24 below explains each of the columns contained on this page.

Table S-24: 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 2020	The percentage of members living in an Individual Assistance area in 2020 rounded to an integer
Major Disaster Percentage 2021	The percentage of members living in an Individual Assistance area in 2021 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
2023 Part C Summary Rating	The 2023 Part C Summary Rating
2023 Part D Summary Rating	The 2023 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 (C31 & D06)? (Yes/No)
CBP Measure Usage	Did the final overall rating come from the calculation using the CBP measure (C12)? (Yes/No)
2023 Overall Rating	The final 2023 Overall Rating

24. 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-25 below explains each of the columns contained on this page.

Table S-25: 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”
2021 C Summary	The 2021 Part C Summary Rating earned by the contract
2021 D Summary	The 2021 Part D Summary Rating earned by the contract

HPMS Field Label	Field Description
2022 C Summary	The 2022 Part C Summary Rating earned by the contract
2022 D Summary	The 2022 Part D Summary Rating earned by the contract
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
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.

25. 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-26 below explains each of the columns contained on this page.

Table S-26: 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

26. Technical Notes link

The Technical Notes link provides the user with a copy of the 2023 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 2023 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.

27. 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.

28. 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 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, 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 Part D measure file identifying contracts as MAPD or PDP. This downloadable is in Zip format and contains two Excel files.

EXHIBIT 8

Medicare 2024 Part C & D Star Ratings Technical Notes

Updated – 12/13/2023

Document Change Log

Previous Version	Description of Change	Revision Date
09/29/2023	Corrected reopening decision deadline in the data source description for C29 in Measure Details section.	11/08/2023
09/29/2023	Updated 2024 measure IDs for display measures in Attachment J.	11/08/2023

OMB Approved Data Sources

The data collected for the Part C & D Star Ratings come from a variety of different data sources approved under the following Office of Management and Budget (OMB) Paperwork Reduction Act numbers:

Data Source	OMB Number
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0938-0732
Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

Table of Contents

DOCUMENT CHANGE LOG I
OMB APPROVED DATA SOURCES I
INTRODUCTION 9
DIFFERENCES BETWEEN THE 2023 STAR RATINGS AND 2024 STAR RATINGS 9
HEALTH/DRUG ORGANIZATION TYPES INCLUDED IN THE STAR RATINGS 10
Table 1: Contract Year 2024 Organization Types Reported in the 2024 Star Ratings 11
THE STAR RATINGS FRAMEWORK 11
Figure 1: The Four Levels of Star Ratings 12
Table 2: 5-Star Scale 12
Table 3: Relation of 2024 Organization Types to Contract Types and Highest Rating in the 2024 Star Ratings 12
SOURCES OF THE STAR RATINGS MEASURE DATA 13
Figure 2: The Four Categories of Data Sources 13
IMPROVEMENT MEASURES 13
Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type 14
CONTRACT ENROLLMENT DATA 14
HANDLING OF BIASED, ERRONEOUS, AND/OR NOT REPORTABLE (NR) DATA 14
DATA HANDLING OF MEASURES FOR CONTRACTS AFFECTED BY A MAJOR DISASTER 15
METHODOLOGY FOR ASSIGNING STARS TO THE PART C AND PART D MEASURES 17
A. Clustering 17
B. Relative Distribution and Significance Testing (CAHPS) 18
METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL 18
Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type 19
SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES 19
METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS 19
Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type 20
METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING 20
Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type 21
COMPLETING THE SUMMARY AND OVERALL RATING CALCULATIONS 21
APPLYING THE IMPROVEMENT MEASURE(S) 21
APPLYING THE REWARD FACTOR 22
Table 8: Performance Summary Thresholds 23
Table 9: Variance Thresholds 23
CATEGORICAL ADJUSTMENT INDEX (CAI) 23
Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating 25
Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating 25
Table 12: Final Adjustment Categories and CAI Values for the Overall Rating 26
Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary 26
Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary 27
Table 15: Final Adjustment Categories and CAI Values for the Part C Summary 27
Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary 27

Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary 28
Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary 28
Table 19: Categorization of Contract's Members into Quintiles of LIS/DE for the PDP Part D Summary 28
Table 20: Categorization of Contract's Members into Quintiles of Disability for the PDP Part D Summary 29
Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary 29
CALCULATION PRECISION 29
ROUNDING RULES FOR MEASURE SCORES 30
ROUNDING RULES FOR SUMMARY AND OVERALL RATINGS 30
Table 22: Rounding Rules for Summary and Overall Ratings 30
METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON 30
Figure 3: The High Performing Icon 31
METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON 31
Figure 4: The Low Performing Icon 31
Table 23: Example LPI Contracts 31
MERGERS, NOVATIONS, AND CONSOLIDATIONS 31
RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS 32
SPECIAL NEEDS PLAN (SNP) DATA 32
STAR RATINGS AND MARKETING 33
CONTACT INFORMATION 33
FRAMEWORK AND DEFINITIONS FOR THE DOMAIN AND MEASURE DETAILS SECTION 33
PART C DOMAIN AND MEASURE DETAILS 36
Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines 36
Measure: C01 - Breast Cancer Screening 36
Measure: C02 - Colorectal Cancer Screening 38
Measure: C03 - Annual Flu Vaccine 39
Measure: C04 - Monitoring Physical Activity 41
Domain: 2 - Managing Chronic (Long Term) Conditions 43
Measure: C05 - Special Needs Plan (SNP) Care Management 43
Measure: C06 - Care for Older Adults – Medication Review 46
Measure: C07 - Care for Older Adults – Pain Assessment 47
Measure: C08 - Osteoporosis Management in Women who had a Fracture 48
Measure: C09 - Diabetes Care – Eye Exam 50
Measure: C10 - Diabetes Care – Blood Sugar Controlled 51
Measure: C11 - Controlling Blood Pressure 53
Measure: C12 - Reducing the Risk of Falling 55
Measure: C13 - Improving Bladder Control 57
Measure: C14 - Medication Reconciliation Post-Discharge 59
Measure: C15 - Plan All-Cause Readmissions 60
Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease 61
Measure: C17 - Transitions of Care 63
Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions 65
Domain: 3 - Member Experience with Health Plan 67
Measure: C19 - Getting Needed Care 67
Measure: C20 - Getting Appointments and Care Quickly 68
Measure: C21 - Customer Service 69
Measure: C22 - Rating of Health Care Quality 70
Measure: C23 - Rating of Health Plan 72
Measure: C24 - Care Coordination 73
Domain: 4 - Member Complaints and Changes in the Health Plan's Performance 75

Measure: C25 - Complaints about the Health Plan 75
Measure: C26 - Members Choosing to Leave the Plan 76
Measure: C27 - Health Plan Quality Improvement 78
Domain: 5 - Health Plan Customer Service 80
Measure: C28 - Plan Makes Timely Decisions about Appeals 80
Measure: C29 - Reviewing Appeals Decisions 81
Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability 83
PART D DOMAIN AND MEASURE DETAILS 85
Domain: 1 - Drug Plan Customer Service 85
Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability 85
Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance 87
Measure: D02 - Complaints about the Drug Plan 87
Measure: D03 - Members Choosing to Leave the Plan 88
Measure: D04 - Drug Plan Quality Improvement 90
Domain: 3 - Member Experience with the Drug Plan 92
Measure: D05 - Rating of Drug Plan 92
Measure: D06 - Getting Needed Prescription Drugs 93
Domain: 4 - Drug Safety and Accuracy of Drug Pricing 95
Measure: D07 - MPF Price Accuracy 95
Measure: D08 - Medication Adherence for Diabetes Medications 97
Measure: D09 - Medication Adherence for Hypertension (RAS antagonists) 100
Measure: D10 - Medication Adherence for Cholesterol (Statins) 103
Measure: D11 - MTM Program Completion Rate for CMR 105
Measure: D12 - Statin Use in Persons with Diabetes (SUPD) 108
ATTACHMENT A: CAHPS CASE-MIX ADJUSTMENT 111
CAHPS Case-Mix Adjustment 111
Table A-1: Coefficients of Part C Getting Needed Care (C19) CAHPS Measure Composite Items 112
Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C20) CAHPS Measure Composite Items 113
Table A-3: Coefficients of Part C Customer Service (C21) CAHPS Measure Composite Items 114
Table A-4: Coefficients of Part C Stand-alone CAHPS Measures 115
Table A-5: Coefficients of Part C Care Coordination (C24) CAHPS Measure Composite Items 116
Table A-6: Coefficients of Part D CAHPS Stand-alone Measures 117
Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items 118
ATTACHMENT B: CALCULATING MEASURE DATA FOR THE SURVIVING CONTRACT OF A CONSOLIDATION 119
First Year Following a Consolidation 119
Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation 119
Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation 119
Second Year Following a Consolidation 119
ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES 120
Table C-1: National Averages for Part C Measures 120
Table C-2: National Averages for Part D Measures 121
ATTACHMENT D: PART C AND D DATA TIME FRAMES 122
Table D-1: Part C Measure Data Time Frames 122
Table D-2: Part D Measure Data Time Frames 123
ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES 124
1. Medicare Part C Reporting Requirements Measure (C05: SNP Care Management) 124
2. NCQA HEDIS Measures - (C06 – C07: Care for Older Adults) 124
Table E-1: Example Calculation Using Effectiveness of Care Rate 125
ATTACHMENT F: CALCULATING MEASURE C15: PLAN ALL-CAUSE READMISSIONS 126
Example: Calculating the final rate for Contract 1 126
ATTACHMENT G: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES 127

Table G-1: Part C Measure Weights 127
Table G-2: Part D Measure Weights 129

ATTACHMENT H: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES 130

ATTACHMENT I: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED 131

Calculating the Improvement Measure 131

General Standard Error Formula 132

Improvement Change Score Standard Error Numerical Example 132

Standard Error Formulas (SEF) for Specific Measures 133

1. SEF for Measures: C01, C02, C04, C05, C08 – C14, C16, C26, C28 – C30, D01, D03, D08 – D12 133
2. SEF for Measures: C06, C07 133
3. SEF for Measures: C03, C19 – C24, and D05, D06 133
4. SEF for Measures C25, D02 134
5. SEF for Measure D07 135

Star Ratings Measures Used in the Improvement Measures 136

Table I-1: Part C Measures Used in the Improvement Measure 136

ATTACHMENT J: STAR RATINGS MEASURE HISTORY 138

Table J-1: Part C Measure History 138
Table J-2: Part D Measure History 143
Table J-3: Common Part C & Part D Measure History 147

ATTACHMENT K: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS 148

Clustering Methodology Introduction 148

Figure K-1: Diagram showing gaps in data where cut points are assigned. 148

Example 1 – Clustering Methodology for a Higher is Better measure 148

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes 149

Figure K-2: Diagram showing star assignment based cut points. 149

Example 2 – Clustering Methodology for a Lower is Better measure 149

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes 149

Clustering Methodology Detail 150

1. Produce the individual measure distance matrix. 150
2. Create a tree of cluster assignments. 151
3. Select the final set of clusters from the tree of cluster assignments. 151
4. Final Thresholds 152

Determining Stars from Scores and Thresholds 152

Table K-3: 2024 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds 153
Table K-4: 2024 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds 154
Table K-5: 2024 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs 155
Table K-6: 2024 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs 156
Table K-7: 2023 Star Ratings Part C Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds 157
Table K-8: 2023 Star Ratings Part D Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds 158

Relative Distribution and Significance Testing (CAHPS) Methodology 158

Table K-9: CAHPS Star Assignment Rules 159
Table K-10: CAHPS Star Assignment Alternate Representation 160
Table K-11: CAHPS Measure 12% Reliability Cutoffs 160

ATTACHMENT L: MEDICATION ADHERENCE MEASURE CALCULATIONS 161

Proportion of Days Covered Calculation 161

Example 1: Non-Overlapping Fills of Two Different Drugs 161

Table L-1: No Adjustment 161

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products 161

Table L-2: Before Overlap Adjustment 162

Table L-3: After Overlap Adjustment 162
Example 3: Overlapping Fills of the Same and Different Target Drugs 162
Table L-4: Before Overlap Adjustment 162
Table L-5: After Overlap Adjustment 163
PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples 163
Calculating the PDC Adjustment for IP Stays and SNF Stays 163
Example 1: Gap in Coverage after IP Stay 164
Table L-6: Before Adjustment 164
Table L-7: After Adjustment 165
Example 2: Gap in Coverage before IP Stay 165
Table L-8: Before Adjustment 165
Table L-9: After Adjustment 165
Example 3: Gap in Coverage Before and After IP Stay 165
Table L-10: Before Adjustment 166
Table L-11: After Adjustment 166
Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class 166
Table L-12: Before Adjustment 166
Table L-13: After Adjustment 167
ATTACHMENT M: METHODOLOGY FOR PRICE ACCURACY MEASURE 168
Contract Selection 168
MPF Composite Price Accuracy Score 168
Example of Accuracy Index Calculation 171
Table M-1: Example of Price Accuracy Index Calculation 172
PDE = PRESCRIPTION DRUG EVENT 172
MPF = MEDICARE PLAN FINDER 172
ATTACHMENT N: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES 173
Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure) 173
ATTACHMENT O: METHODOLOGY FOR THE PUERTO RICO MODEL 175
Model 176
Example 177
ATTACHMENT P: IDENTIFICATION OF CONTRACTS AFFECTED BY DISASTERS 178
Operational Steps to Calculating Enrollment Impacted in Affected Contracts. 178
Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations 178
Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States 179
Table P-3: Organization type service areas and necessary transformations 179
Table P-4: Major Disasters with associated enrollment months 180
Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters 180
Example: 181
Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters 181
ATTACHMENT Q: MISSING DATA MESSAGES 183
Measure level messages 183
Table Q-1: Measure level missing data messages 183
Assignment rules for Part C measure messages 183
Assignment rules for Part D measure messages 187
Table Q-2: MTM CMR Reason(s) for Display Message conversion 189
Domain, Summary, and Overall level messages 189
Table Q-3: Domain, Summary, and Overall level missing data messages 189
Assignment rules for Part C & Part D domain rating level messages 189
Assignment rules for Part C & Part D summary rating level messages 189

Assignment rules for overall rating level messages **190**
Disenrollment Reasons messages **190**
Table Q-4: Disenrollment Reason missing data messages 190
ATTACHMENT R: GLOSSARY OF TERMS **191**
ATTACHMENT S: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE **195**
HPMS Star Ratings Module **195**
1. Measure Data page 195
Table S-1: Measure Data page sample 195
Medicare Star Ratings Report Card Master Table 195
2. Measure Detail – CTM Summary page 196
Table S-2: Measure Detail – CTM Summary page fields 197
3. Measure Detail – Part C Appeals page 197
Table S-3: Measure Detail – Part C Appeals page fields 197
4. Measure Detail – SNP CM page 198
Table S-4: Measure Detail – SNP CM page fields 198
5. Measure Detail – HEDIS page 198
Table S-5: Measure Detail – HEDISpage fields 199
Table S-6: HEDIS 2022 Audit Designations and 2024 Star Ratings 199
6. Measure Detail – CTM page 199
Table S-7: Measure Detail – CTM page fields 200
7. Measure Detail – Disenrollment 200
Table S-8: Measure Detail – Disenrollment page fields 200
8. Measure Detail – DR (Disenrollment Reasons) 200
Table S-9: Measure Detail – Disenrollment Reasons page fields 201
9. Measure Detail – MTM page 201
Table S-10: Measure Detail – MTM page fields 201
10. Measure Detail – CAHPS page 202
Table S-11: Measure Detail – CAHPS page fields 202
11. Calculation Detail – MD 202
Table S-12: Calculation Detail – MD page fields 203
12. Calculation Detail – CAI 203
Table S-13: Measure Detail – CAI page fields 204
13. Measure Detail – HEDIS LE page 204
Table S-14: Measure Detail – HEDIS LE page fields 205
14. Measure Detail – C MD Results 205
Table S-15: Measure Detail – C MD Results 205
15. Measure Detail – D MD Results 205
Table S-16: Measure Detail – D MD Results 206
16. Measure Detail – C Improvement page 206
Table S-17: Part C Measure Improvement Results 206
17. Measure Detail – D Improvement page 206
Table S-18: Part D Measure Improvement Results 207
18. Measure Stars page 207
Table S-19: Measure Stars page sample 207
Medicare Star Ratings Report Card Master Table 207
19. Domain Stars page 207
Table S-20: Domain Star page sample 208
Medicare Star Ratings Report Card Master Table 208
20. Part C Summary Rating page 208
Table S-21: Part C Summary Rating page fields 208
21. Part D Summary Rating page 209
Table S-22: Part D Summary Rating View 209
22. Overall Rating page 209
Table S-23: Overall Rating View 210
23. Low Performing Contract List 210
Table S-24: Low Performing Contract List 211
24. High Performing Contract List 211

Table S-25: High Performing Contract List 211
25. Technical Notes link 211
26. Medication NDC List 212
27. Part C and Part D Example Measure Data 212

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 '2024 Medicare Part C & D Star Ratings' because they are posted prior to the 2024 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 "2024" for the report period. See Attachment S: Health Plan Management System Module Reference for descriptions of the HPMS pages.

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

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

Differences between the 2023 Star Ratings and 2024 Star Ratings

There have been several changes between the 2023 Star Ratings and the 2024 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2024 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment J.

- Changes
    a. Tukey outer fence outlier deletion was added to the hierarchical clustering methodology that is used to set cut points for non-CAHPS measures.
    b. The disaster policy was modified to include data integrity issues in the definition of missing data, such that disaster-affected contracts with a data integrity issue on a given measure received the final measure rating from the current year.

c. The weight for the Part C Controlling Blood Pressure measure was increased to 3.
d. Re-specified Part C Plan All-Cause Readmissions measure moved into the 2024 Star Ratings as a new measure with a weight of 1 for the first year.
e. The Part C Transitions of Care measure was added to the 2024 Star Ratings with a weight of 1.
f. The Part C Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measure was added to the 2024 Star Ratings with a weight of 1.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. None
- Retired measures
  a. Part C measure – Diabetes Care – Kidney Disease Monitoring

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 2024 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2024 Organization Types Reported in the 2024 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:

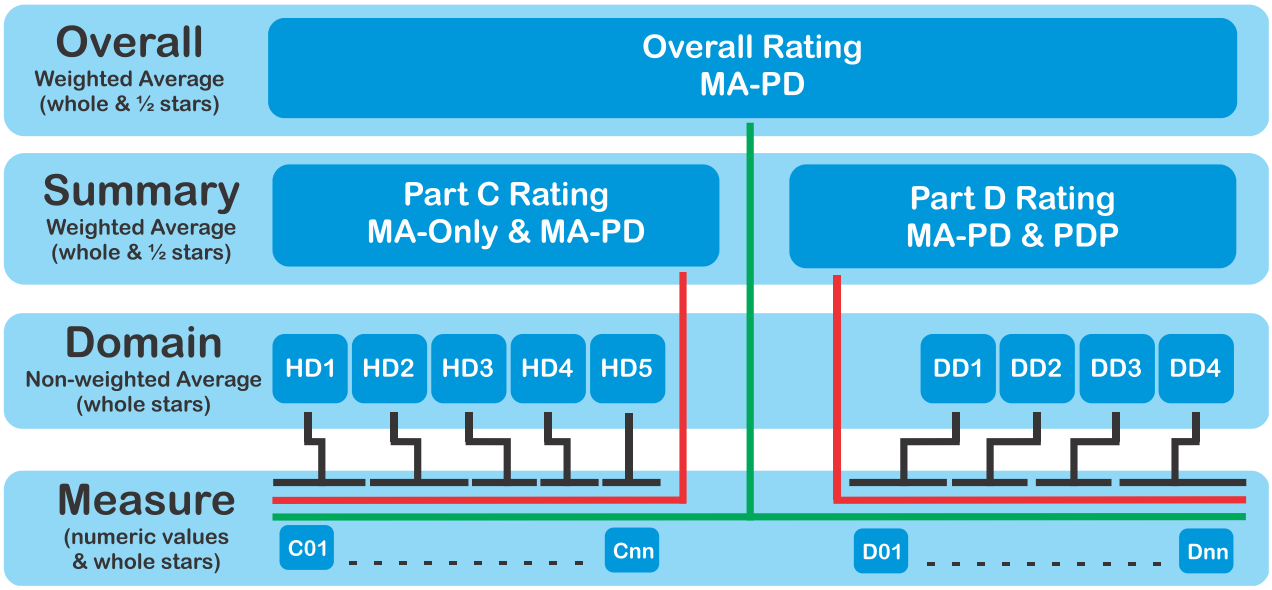
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 2024 Organization Types to Contract Types and Highest Rating in the 2024 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 2024 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 21	12 of 23	13 of 26	7 of 14	11 of 22	N/A	12 of 23
D	5 of 10*	6of 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 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 2022 through December 2022) 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 2022 through December 2022), 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 2024 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 2024 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 2023 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 2023 or the 2024 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 than began in 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Ratings 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). For example, if doubly-affected contract reverted back to the 2022 Star Rating on a given measure in the 2023 Star Ratings, the 2022 Star Rating is *not* used in determining the 2024 Star Rating. Rather the 2024 Star Rating is compared to what the 2023 Star Rating would have been absent any disaster adjustments.
- HEDIS-HOS adjustments:
  - The HEDIS-HOS data used in the 2024 Star Ratings are adjusted for 2021 disasters (see Attachment P of the 2023 Star Ratings Technical Notes for the identification of contracts affected by 2021 disasters).
  - All affected contracts (i.e., contracts affected by 2021 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2023 or the 2024 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 2021 were also affected by disasters in 2020. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 Star Rating would have been in the absence of any adjustments that took into account the effects of the

2020 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 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 2023 or 2024 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 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 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).
- 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 the new Transitions of Care and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measures and respecified Plan All-Cause Readmissions measure. If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating.
  - A similar hold harmless provision is applied for the Part C summary ratings. If a contract has 25% or more affected members, the Part C summary rating is calculated "with" and "without" the new Transitions of Care and Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measures and respecified Plan All-Cause Readmissions measure, and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary rating.
- All other measures:
  - Contracts with 25% or more affected members receive the higher of the 2023 or 2024 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 2022 were also affected by disasters in 2021. These doubly-affected contracts receive the higher of the 2024 Star Rating or what the 2023 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).
- 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 2023 or 2024 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 2022 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.

The *Cut Point Trend* document is posted at http://go.cms.gov/partcanddstarratings and is updated after each rating cycle is released.

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 2024 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 2024 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 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.

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 less than 30th percentile),
  - medium (greater than or equal to 30th to less than 70th percentile) and
  - high (greater than or equal to 70th percentile)
- Develop the reward factor as follows:
  - r-Factor = 0.4 (for contract w/ low variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.3 (for contract w/ medium variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor = 0.2 (for contract w/ low variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.1 (for contract w/ medium variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor = 0.0 (for all other contracts)

Tables 8 and 9 show the final threshold values used in reward factor calculations for the 2024 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	65th	3.783333	3.702703	3.500000	3.700515
With	With	85th	4.121212	4.000000	3.857143	3.989691
With	Without	65th	3.810345	3.702703	3.500000	3.724138
With	Without	85th	4.169231	4.000000	3.857143	4.030928
Without	With	65th	3.848485	3.71875	3.631579	3.741573
Without	With	85th	4.169231	4.09375	3.937500	4.061111
Without	Without	65th	3.873016	3.71875	3.631579	3.759036
Without	Without	85th	4.225806	4.09375	3.937500	4.102564

Table 9: Variance Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	30th	0.924375	0.860382	0.965801	0.972245
With	With	70th	1.482292	1.536357	1.548310	1.460744
With	Without	30th	0.894302	0.860382	0.965801	0.952953
With	Without	70th	1.486442	1.536357	1.548310	1.454437
Without	With	30th	0.876231	0.806738	0.751953	0.917753
Without	With	70th	1.485714	1.557540	1.419580	1.489974
Without	Without	30th	0.845782	0.806738	0.751953	0.893483
Without	Without	70th	1.496943	1.557540	1.419580	1.479720

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 2023 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 2023 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 2023 measures used in the 2024 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)
- Statin Therapy for Patients with Cardiovascular Disease (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 quintiles 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 and to yield a minimum number of 30 contracts per each final MA adjustment category and 5 contracts per each final PDP adjustment category. 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 6.301653
2	6.301653 to less than 8.983864
3	8.983864 to less than 12.272291
4	12.272291 to less than 17.623062
5	17.623062 to less than 23.811644
6	23.811644 to less than 32.478787
7	32.478787 to less than 48.171334
8	48.171334 to less than 76.744186
9	76.744186 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 15.246926
2	15.246926 to less than 22.226124
3	22.226124 to less than 29.541446
4	29.541446 to less than 43.095797
5	43.095797 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 - L3	D1	-0.024917
2	L4-L10 L1-L10 L1-L4	D1 D2 D3	-0.001531
3	L5-L6 L1-L6	D3 D4-D5	0.016703
4	L7-L9 L7-L8 L7	D3 D4 D5	0.036199
5	L8	D5	0.067616
6	L10 L9-L10 L9	D3 D4 D5	0.087672
7	L10	D5	0.133273

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 5.758017
2	5.758017 to less than 8.524590
3	8.524590 to less than 11.765670
4	11.765670 to less than 17.215998
5	17.215998 to less than 23.365002
6	23.365002 to less than 31.600120
7	31.600120 to less than 46.717818
8	46.717818 to less than 74.752781
9	74.752781 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 14.974530
2	14.974530 to less than 21.948529
3	21.948529 to less than 29.414572
4	29.414572 to less than 42.395693
5	42.395693 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-L7 L1-L6 L1-L5 L1-L4	D1 D2 D3 D4	-0.003487
2	L8-L10 L7-L10 L6-L7 L5-L6 L1-L5	D1 D2 D3 D4 D5	0.006987
3	L8-L10 L7-L8 L6-L7	D3 D4 D5	0.022797
4	L8	D5	0.044588
5	L9-L10	D4-D5	0.066880

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 6.507512
2	6.507512 to less than 9.702347
3	9.702347 to less than 13.812027
4	13.812027 to less than 19.485294
5	19.485294 to less than 26.769231
6	26.769231 to less than 38.003026
7	38.003026 to less than 58.059701
8	58.059701 to less than 93.000000
9	93.000000 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 15.588308
2	15.588308 to less than 23.253251
3	23.253251 to less than 32.385819
4	32.385819 to less than 46.047270
5	46.047270 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-L3	D1	-0.035219
2	L4-L8	D1	-0.018599
	L1-L7	D2	
3	L1-L6	D3	0.009901
	L1-L5	D4-D5	
	L9	D1	
	L8-L9	D2	
4	L7-L8	D3	0.034454
	L6-L7	D4	
	L6	D5	
5	L8	D4	0.079744
	L7-L8	D5	
6	L10	D1-D4	0.110538
	L9	D3-D5	
7	L10	D5	0.124667

Tables 19 and 20 provide the range of the percentages that correspond to the LIS/DE and disability quintiles for the initial categories for the determination of the CAI values for the PDP Part D summary. Quintiles 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 Quintiles of LIS/DE for the PDP Part D Summary

LIS/DE Quintile	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 1.243781
2	1.243781 to less than 2.398356
3	2.398356 to less than 4.421104
4	4.421104 to less than 10.174281
5	10.174281 to 100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 6.154784
2	6.154784 to less than 8.398344
3	8.398344 to less than 11.264808
4	11.264808 to less than 15.616311
5	15.616311 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 five 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 Quintile	Disability Quintile	CAI Value
1	L1	D1	-0.317950
2	L2 L1-L2	D1 D2	-0.172794
3	L3-L5 L1-L3 L1	D1-D2 D3 D4	-0.139296
4	L4-L5 L2-L5 L1-L4	D3 D4 D5	-0.067530
5	L5	D5	0.043919

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

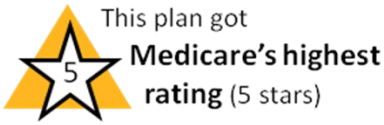
Raw Summary / Overall Score	Final Summary / Overall Rating
0.000000 to less than 0.250000	0
0.250000 to less than 0.750000	0.5
0.750000 to less than 1.250000	1.0
1.250000 to less than 1.750000	1.5
1.750000 to less than2.250000	2.0
2.250000 to less than2.750000	2.5
2.750000 to less than3.250000	3.0
3.250000 to less than 3.750000	3.5
3.750000 to less than 4.250000	4.0
4.250000 to less than 4.750000	4.5
4.750000 to 5.000000	5.0

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

Methodology for Calculating the High Performing Icon

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

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past two years (i.e., the 2022, 2023, and 2024 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	2022 C	2023 C	2024 C	2022 D	2023 D	2024 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 2022 was at least 500 but less than 1,000 will be included in the Star Ratings in 2024 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 2024 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' 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: CMSHPMS_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.
Weighting Category:	The weighting category of this measure.

Title	Description
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 or measures with substantive specification changes for the first three years, the cut points are after the application of Tukey outlier deletion, mean resampling, and guardrails. 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 2022 Technical Specifications Volume 2, page 95
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:	• 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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: – At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). – A dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set)

Title	Description
	during the measurement year (optional) Bilateral mastectomy 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 (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set). • Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. • Both of the following (on the same or a different date of service): – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same date of service). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same date of service). • Absence of the left breast (Absence of Left Breast Value Set) and absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service. • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) and right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
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

Title	Description
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 52%	52% to less than 63%	63% to less than 71%	71% to less than 79%	greater than or equal to 79%

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 2022 Technical Specifications Volume 2, page 105
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 (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year (optional) Refer to Administrative Specification for

Title	Description
	exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of 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 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00139-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 50%	50% to less than 61%	61% to less than 71%	71% to less than 80%	greater than or equal to 80%

Measure: C03 - Annual Flu Vaccine

Title	Description
Label for Stars:	Yearly Flu Vaccine
Label for Data:	Yearly Flu Vaccine

Title	Description
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, 2022?
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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00259-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
less than 63%	63% to less than 67%	67% to less than 74%	74% to less than 78%	greater than or equal to78%

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 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 37
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 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). 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:	07/19/2022 – 11/01/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00540-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 42%	42% to less than 48%	48% to less than 53%	53% to less than 58%	greater than or equal to 58%

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 Part C Reporting Requirements. Validation for data performed during the 2023 Data Validation cycle.
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 30, 2023) 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: • 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:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Title	Description
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00685-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 42%	42% to less than 57%	57% to less than 74%	74% to less than 85%	greater than or equal to 85%

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 2022 Technical Specifications Volume 2, page 118
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 2022 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2022 – 12/31/2022
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

Title	Description
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00110-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 72%	72% to less than 84%	84% to less than 93%	93% to less than 98%	greater than or equal to 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 2022 Technical Specifications Volume 2, page 118
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 2022 SNP Comprehensive Report were excluded from this measure.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00111-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 74%	74% to less than 83%	83% to less than 91%	91% to less than 96%	greater than or equal to 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 2022 Technical Specifications Volume 2, page 228
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

Title	Description
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 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. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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

Title	Description				
	less than 29%	29% to less than 42%	42% to less than 55%	55% to less than 71%	greater than or equal to 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 2022 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 (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), 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 (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same.

Title	Description
	If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00203-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 52%	52% to less than 65%	65% to less than 73%	73% to less than 81%	greater than or equal to 81%

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

Title	Description
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 2022 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 (all product lines) with both frailty (Frailty Value Set) and advanced illness (Advanced Illness Value Set) during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), 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 (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00204-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 58%	58% to less than 72%	72% to less than 80%	80% to less than 87%	greater than or equal to 87%

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 2022 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 BP was adequately controlled (<140/90 mm Hg) (numerator).
Primary Data Source:	HEDIS

Title	Description

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 frailty (Frailty Value Set) during the measurement year.
- Members 66–80 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year.
- A dispensed dementia medication.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

(Optional)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2022 – 12/31/2022

General Trend: Higher is better

Title	Description
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00167-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 58%	58% to less than 68%	68% to less than 74%	74% to less than 82%	greater than or equal to 82%

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 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 39
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).

Title	Description
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). 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:	07/19/2022 – 11/01/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.
Meaningful Measure Area:	Safety

Title	Description
CMIT #:	00646-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 47%	47% to less than 53%	53% to less than 60%	60% to less than 70%	greater than or equal to 70%

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 2021 Specifications for the Medicare Health Outcomes Survey Volume 6, page 34
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 23 Follow-up Data collection (2022) and Cohort 25 Baseline data collection (2022). 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:

Title	Description

- 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: 07/19/2022 – 11/01/2022

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 (2023-2024) for contracts with 25% or more enrolled affected by 2021 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00378-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 38%	38% to less than 42%	42% to less than 47%	47% to less than 51%	greater than or equal to 51%

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 2022 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:	Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination

Title	Description
CMIT #:	00441-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 38%	38% to less than 52%	52% to less than 68%	68% to less than 82%	greater than or equal to 82%

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 2022 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 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 MeasureC15: 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. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

Title	Description
	• A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2021 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2021 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: 01/01/2022 – 12/31/2022

General Trend: Lower is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Included

Case-Mix Adjusted: Yes

Weighting Category: Outcome Measure

Weighting Value: 1

Major Disaster: New Measure Hold Harmless Provision.

Meaningful Measure Area: Admissions and Readmissions to Hospitals

CMIT #: 00561-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
greater than 13%	greater than 11% to less than or equal to 13%	greater than 10% to less than or equal to 11%	greater than 8% to less than or equal to 10%	less than or equal to 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 2022 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 (Pregnancy Value Set) during the measurement year or year prior to the measurement year. • In vitro fertilization (IVF Value Set) 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 (ESRD Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) 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. – 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 (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:

Title	Description

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
- A dispensed dementia medication (Dementia Medications List).

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2022 – 12/31/2022

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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00700-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%

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 2022 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:	Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days) are excluded. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. 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). 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 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00729-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 40%	40% to less than 52%	52% to less than 64%	64% to less than 78%	greater than or equal to 78%

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 2022 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

Title	Description
Data Source Category:	Health and Drug Plans
Exclusions:	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 (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient 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 Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2022 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2022 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	New Measure Hold Harmless Provision.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00263-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 44%	44% to less than 53%	53% to less than 60%	60% to less than 68%	greater than or equal to 68%

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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 76	76 to less than 78	78 to less than 81	81 to less than 83	greater than or equal to 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? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 74	74 to less than 76	76 to less than 78	78 to less than 80	greater than or equal to 80

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):

Title	Description
	• In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?

Data Source Category: Survey of Enrollees

General Notes: CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 88	88 to less than 89	89 to less than 90	90 to less than 92	greater than or equal to 92

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

Measure: 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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00642-01-C-PARTC
Data Display:	Numeric 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
less than 84	84 to less than 85	85 to less than 87	87 to less than 88	greater than or equal to 88

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

Measure: 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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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

Title	Description

Weighting Value: 4

Major Disaster: Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 84	84 to less than 85	85 to less than 88	88 to less than 89	greater than or equal to 89

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

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 visited your personal doctor for 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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2023 – 06/2023

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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 83	83 to less than 84	84 to less than 86	86 to less than 87	greater than or equal to 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.

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 2022 complaints made by June 30, 2023 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:	01/01/2022 – 12/31/2022

Title	Description
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
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 0.75	less than 0.5 to 0.75	less than 0.32 to 0.5	less than 0.14 to 0.32	less than or equal to 0.14

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, 2022–December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (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 1/1/2022 and 12/31/2022 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:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 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
less than 41%	less than 29% to 41%	less than 18% to 29%	less than 10% to 18%	less than or equal to 10%

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 2022 and 2023 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2022 and 2023 Star Ratings

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

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than -0.246067	-0.246067 to less than 0	0 to less than 0.173502	0.173502 to less than 0.393451	greater than or equal to 0.393451

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 dismissed because the plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Dismissed 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 for reasons other than the 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 Dismissed Because Plan Agreed to Cover]) - [Late] Note: 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:

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

Title	Description
Data Time Frame:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00562-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 84%	84% to less than 88%	88% to less than 94%	94% to less than 98%	greater than or equal to 98%

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.
Metric:	Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as:

Title	Description
	([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2023, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2023 are not reflected in these data 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:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00652-01-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	Yes	Yes	No	Yes

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 87%	87% to less than 92%	92% to less than 96%	96% to less than 100%	equal to 100%

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 the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 – 05/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	No adjustment for 2021 or 2022 disasters.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00096-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
less than 72%	72% to less than 83%	83% to less than 92%	92% to less than 97%	greater than or equal to 97%

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 the CallCenterMonitoring@cms.hhs.gov
Data Time Frame:	02/2023 – 05/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access

Title	Description

Weighting Value: 4

Major Disaster: No adjustment for 2021 or 2022 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 73%	73% to less than 86%	86% to less than 96%	96% to less than 99%	greater than or equal to 99%
PDP	less than 91%	91% to less than 97%	97% to less than 98%	98% to less than 100%	equal to100%

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 2022 complaints made by June 30, 2023 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:	01/01/2022 – 12/31/2022

Title	Description
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
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 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	less than 0.75	greater than0.5 to 0.75	greater than 0.32 to 0.5	greater than 0.14 to 0.32	less than or equal to 0.14
PDP	greater than 0.14	greater than0.09 to 0.14	greater than 0.06 to 0.09	greater than 0.02 to 0.06	less than or equal to 0.02

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, 2022–December 31, 2022 (numerator) divided by all members enrolled in the contract at any time during 2022 (denominator).

Title	Description
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2022 and 12/31/2022 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:	01/01/2022 – 12/31/2022
General Trend:	Lower is better
Statistical Method:	Clustering

Title	Description
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than10% to 18%	less than or equal to 10%
PDP	greater than 23%	greater than 17% to 23%	greater than 11% to 17%	greater than 7% to 11%	less than or equal to 7%

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.

Title	Description
	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 2023 and 2024 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2023 and 2024 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than -0.253472	-0.253472 to less than 0	0 to less than 0.193739	0.193739 to less than 0.458889	greater or equal to 0.458889
PDP	less than -0.123026	-0.123026 to less than 0	0 to less than 0.214538	0.214538 to less than 0.401223	greater than or equal to 0.401223

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 Questions (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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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	less than 84	84 to less than 85	85 to less than 87	87 to less than 89	greater than or equal to 89
PDP	less than 80	80 to less than 81	81 to less than 83	83 to less than 87	greater than or equal to 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 2023. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2023 – 06/2023
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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	less than 87	87 to less than 89	89 to less than90	90 to less than 91	greater than or equal to 91
PDP	less than 87	87 to less than88	88 to less than 90	90 to less than 91	greater than or equal to 91

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

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder website. Higher scores are better because they mean the plan provided more accurate prices.
Metri	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: .5 x (100 – ((accuracy index – 1) x 100)) + .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 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022- September 30, 2022. 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 2022 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.

Title	Description
Data Source Category:	Data Collected by CMS Contractors
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:	01/01/2022 – 09/30/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00452-01-C-PARTD

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	Yes	No	Yes	Yes

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 94	94 to less than 96	96 to less than 98	98 to less than 99	greater than or equal to 99
PDP	less than 96	96 to less than 97	97 to less than 98	98 to less than 99	greater than or equal to 99

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description

Label for Stars: Taking Diabetes Medication 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 *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, 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.

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.

Title	Description
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 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. 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 2022 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). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify 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: • Hospice enrollment • 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.

Title	Description
	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 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 inpatient (IP) settings, and stays in skilled nursing facilities (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:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00436-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 80%	80% to less than 84%	84% to less than 88%	88% to less than 90%	greater than or equal to 90%
PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than93%	greater than or equal to 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. The Part D 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 Part D 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 to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. 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 2022 PDE submission deadline are used to calculate this measure. PDE claims are limited to

Title	Description
	members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), and the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and 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: • Hospice enrollment • 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 inpatient (IP) settings, and stays in skilled nursing facilities (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.

Title	Description

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

Data Time Frame: 01/01/2022 – 12/31/2022

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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00437-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 82%	82% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
PDP	less than 87%	87% to less than 89%	89% to less than 91%	91% to less than 94%	greater than or equal to 94%

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. 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 the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022-December 31, 2022. 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 2022 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 Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify 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: • Hospice enrollment • 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 inpatient (IP) settings, and stays in skilled nursing facilities (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.
Data Time Frame:	01/01/2022 – 12/31/2022

Title	Description
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00435-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 82%	82% to less than 86%	86% to less than 88%	88% to less than 91%	greater than or equal to 91%
PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%

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 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. 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 2022 Part D Reporting Requirements (data pulled June 2023). Validation of these data was performed retrospectively during the 2023 data validation cycle (deadline June 30, 2023 and data validation results pulled July 2023). Additionally, the Medicare Enrollment Database (EDB) is used for hospice enrollment (data pulled March 2023).
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 30, 2023) are excluded and listed as “No data available.” 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 F) • 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:	01/01/2022 – 12/31/2022
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included

Title	Description
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2023-2024) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00454-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 67%	67% to less than 77%	77% to less than 85%	85% to less than 92%	greater than or equal to 92%
PDP	less than 34%	34% to less than 52%	52% to less than 63%	63% to less than 77%	greater than or equal to 77%

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.

Title	Description
	The SUPD measure is adapted from the measure concept that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The SUPD measure is calculated using the National Drug Code (NDC) lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS Drug Data Processing Systems (DDPS) and accepted by the 2022 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2022 – December 31, 2022. 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 2022 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 Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). • CME is used for enrollment information. • EDB is used for hospice enrollment and ESRD status (dialysis start and end dates within the measurement period). • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify 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

Title	Description
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 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:	01/01/2022 – 12/31/2022
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 (2023-2024) for contracts with 25% or more enrolled affected by 2022 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	less than 81%	81% to less than 86%	86% to less than 88%	88% to less than 92%	greater than or equal to 92%
PDP	less than 81%	81% to less than 83%	83% to less than 85%	85% to less than 87%	greater than or equal to 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 measure "Rating of Health Care Quality," the model coefficient for "age 75-79" is 0.0521, indicating that respondents in that age range tend to score their plans 0.0521 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, Medicaid dual eligibles tend to respond 0.0322 points lower on this item than otherwise similar non-duals. 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 are Medicaid dual eligibles 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	0.0414	-0.0138
Age: 65 – 69	0.0069	-0.0144
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0241	-0.0047
Age: 80 – 84	0.0101	0.0030
Age: 85 and older	0.0122	-0.0184
Less than an 8th grade education	0.0147	-0.0513
Some high school	0.0152	0.0390
High school graduate	0.0000	0.0000
Some college	-0.0174	-0.0368
College graduate	-0.0451	-0.0436
More than a bachelor's degree	-0.0861	-0.0641
General health rating: excellent	0.1082	0.0313
General health rating: very good	0.0623	0.0552
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0744	-0.0488
General health rating: poor	-0.0956	-0.1716
Mental health rating: excellent	0.1989	0.2116
Mental health rating: very good	0.0973	0.1005
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0560	-0.0609
Mental health rating: poor	-0.0956	-0.1199
Proxy helped	0.0318	0.0089
Proxy answered	0.0170	0.0893
Medicaid dual eligible	0.0019	-0.0222
Low-income subsidy (LIS)	0.0088	-0.0506
Asian survey language	0.0527	-0.1072

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	Wait Less Than 15 Minutes
Age: 64 or under	-0.0044	0.0542	-0.0653
Age: 65 – 69	0.0333	0.0009	-0.0177
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	0.0401	0.0218	0.0122
Age: 80 – 84	0.0326	0.0389	-0.0077
Age: 85 and older	0.0710	0.0243	0.0141
Less than an 8th grade education	0.0230	-0.0306	-0.0526
Some high school	0.0125	-0.0357	0.0548
High school graduate	0.0000	0.0000	0.0000
Some college	0.0023	-0.0203	0.0344
College graduate	0.0086	-0.0511	0.0225
More than a bachelor's degree	-0.0137	-0.0717	0.0122
General health rating: excellent	0.1011	0.0186	0.2354
General health rating: very good	0.0425	0.0092	0.0974
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0476	-0.0439	-0.0891
General health rating: poor	-0.0857	-0.0784	-0.1452
Mental health rating: excellent	0.1801	0.1525	0.1130
Mental health rating: very good	0.0698	0.0749	0.0421
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0306	-0.0406	-0.0215
Mental health rating: poor	-0.0917	-0.0721	0.0829
Proxy helped	0.0512	-0.0061	-0.0675
Proxy answered	0.0764	0.0762	-0.0235
Medicaid dual eligible	-0.0436	-0.0336	-0.0196
Low-income subsidy (LIS)	0.0031	-0.0299	0.0143
Asian survey language	-0.2210	-0.2959	-0.0893

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	0.0170	0.0369	-0.0096
Age: 65 – 69	0.0067	0.0112	-0.0096
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0082	0.0074	-0.0132
Age: 80 – 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	-0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian survey language	-0.1493	-0.0986	-0.1499

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	Paperwork Easy	Plan Customer Service Gives Information	Plan Customer Service Courtesy and Respect
Age: 64 or under	0.0170	0.0369	-0.0096
Age: 65 – 69	0.0067	0.0112	-0.0096
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0082	0.0074	-0.0132
Age: 80 – 84	-0.0240	-0.0097	-0.0201
Age: 85 and older	-0.0152	0.0039	0.0036
Less than an 8th grade education	-0.0299	-0.0156	-0.0191
Some high school	-0.0184	-0.0061	-0.0111
High school graduate	0.0000	0.0000	0.0000
Some college	-0.0084	-0.0679	-0.0218
College graduate	-0.0151	-0.0890	-0.0221
More than a bachelor's degree	-0.0392	-0.1450	-0.0353
General health rating: excellent	0.0196	0.0352	0.0266
General health rating: very good	0.0082	0.0461	0.0116
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0249	-0.0314	0.0039
General health rating: poor	-0.0321	-0.0346	-0.0327
Mental health rating: excellent	0.0611	0.1837	0.0895
Mental health rating: very good	0.0350	0.0735	0.0397
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0372	-0.0363	-0.0244
Mental health rating: poor	-0.0980	-0.1784	-0.1015
Proxy helped	-0.0749	0.0000	-0.0225
Proxy answered	0.0045	0.0391	0.0029
Medicaid dual eligible	-0.0658	0.0405	-0.0137
Low-income subsidy (LIS)	0.0063	0.0068	0.0222
Asian survey language	-0.1493	-0.0986	-0.1499

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	0.0046	-0.0114	-0.0013	0.0402	-0.0265
Age: 65 – 69	-0.0528	-0.0120	-0.0077	0.0376	-0.0073
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0282	0.0151	-0.0080	-0.0344	0.0022
Age: 80 – 84	-0.0190	0.0006	0.0066	-0.1098	-0.0094
Age: 85 and older	-0.0895	-0.0232	-0.0263	-0.1662	-0.0021
Less than an 8th grade education	0.0260	0.1001	-0.0047	0.0194	-0.0268
Some high school	-0.0135	0.0669	0.0250	-0.0074	-0.0330
High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Some college	-0.0034	-0.0245	-0.0377	-0.0035	-0.0055
College graduate	-0.0332	-0.0389	-0.0417	-0.0222	-0.0205
More than a bachelor's degree	-0.0216	-0.0856	-0.0365	-0.0587	-0.0065
General health rating: excellent	-0.0008	-0.0270	0.0860	0.1207	-0.0079
General health rating: very good	-0.0111	-0.0040	0.0423	0.0601	0.0247
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0650	-0.0502	-0.0635	-0.0435	-0.0308
General health rating: poor	-0.1020	-0.1222	-0.1524	-0.1039	-0.0726
Mental health rating: excellent	0.1224	0.1946	0.1645	0.1768	0.0931
Mental health rating: very good	0.0304	0.0808	0.0931	0.0867	0.0571
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0391	-0.1002	-0.0407	-0.0597	-0.0274
Mental health rating: poor	-0.0342	-0.1422	-0.0559	-0.0531	-0.0843
Proxy helped	0.0196	-0.0021	-0.0019	0.0816	-0.0079
Proxy answered	-0.0020	-0.0433	0.0655	0.0710	0.0457
Medicaid dual eligible	-0.0061	0.0613	-0.0082	0.0014	-0.0122
Low-income subsidy (LIS)	-0.0318	0.1438	0.0131	-0.0131	0.0067
Asian survey language	0.1027	-0.1596	0.1903	-0.1308	-0.1026

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	-0.1891	-0.3770
Age: 65 – 69	-0.1095	-0.1195
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.1042	0.1631
Age: 80 – 84	0.1505	0.2597
Age: 85 and older	0.1974	0.5198
Less than an 8th grade education	0.0703	-0.1769
Some high school	0.0425	0.0060
High school graduate	0.0000	0.0000
Some college	-0.2087	-0.3485
College graduate	-0.3306	-0.1539
More than a bachelor's degree	-0.4426	-0.5077
General health rating: excellent	0.2238	0.1233
General health rating: very good	0.1922	0.0239
General health rating: good	0.0000	0.0000
General health rating: fair	-0.1861	-0.2132
General health rating: poor	-0.4147	-0.3450
Mental health rating: excellent	0.3268	0.1120
Mental health rating: very good	0.1035	0.0617
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1101	-0.2242
Mental health rating: poor	-0.1847	-0.9212
Proxy helped	-0.1628	-0.2064
Proxy answered	-0.0284	0.2563
Medicaid dual eligible	0.3942	0.8442
Low-income subsidy (LIS)	0.3567	0.5929
Asian survey language	-0.3631	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	-0.0603	-0.0276	-0.1955	-0.1288
Age: 65 – 69	-0.0152	-0.0062	-0.0411	-0.0108
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	0.0204	0.0136	0.0322	0.0381
Age: 80 – 84	0.0462	0.0168	0.0365	0.0418
Age: 85 and older	0.0138	-0.0005	0.0134	-0.0303
Less than an 8th grade education	-0.0556	-0.0378	-0.0470	-0.0335
Some high school	-0.0062	-0.0187	-0.1264	-0.1132
High school graduate	0.0000	0.0000	0.0000	0.0000
Some college	-0.0375	-0.0425	-0.0692	-0.0427
College graduate	-0.0481	-0.0536	-0.0365	-0.0826
More than a bachelor's degree	-0.0618	-0.0857	-0.1088	-0.1149
General health rating: excellent	0.0306	0.0514	0.0839	0.0712
General health rating: very good	0.0473	0.0425	0.0331	0.0552
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0529	-0.0442	-0.1217	-0.0595
General health rating: poor	-0.1323	-0.1428	-0.2777	-0.1987
Mental health rating: excellent	0.0988	0.1109	-0.0206	0.0334
Mental health rating: very good	0.0502	0.0555	-0.0026	0.0256
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0506	-0.0467	-0.1631	-0.0679
Mental health rating: poor	-0.0532	-0.0254	-0.3480	-0.2465
Proxy helped	-0.0094	0.0049	-0.0014	-0.0612
Proxy answered	0.0294	0.0411	0.1625	0.0613
Medicaid dual eligible	0.0413	0.0149	0.0288	0.0656
Low-income subsidy (LIS)	0.0669	0.0170	0.1885	0.1608
Asian survey language	-0.0583	0.0220	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 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 2024 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2023
Call Center	Average enrollment during the study period	Feb 2023 – May 2023
HOS	Enrollment at the time survey sample is pulled	April 2022
HEDIS-HOS	Enrollment at the time survey sample is pulled	April 2022
HEDIS	Enrollment in July of the measurement period	July 2022
All Other Measures	Enrollment in July of the measurement period	July 2022

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 2022 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

$$\text{Value for BCS for HAAAA} = \frac{75.13*43,326+50.91*20,933}{43,326+20,933} = 67.24$$

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 the average of contract numeric and star values for each measure reported in the 2024 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	72%	3.7
C02	Colorectal Cancer Screening	71%	3.7
C03	Annual Flu Vaccine	72%	3.1
C04	Monitoring Physical Activity	50%	3.0
C05	Special Needs Plan (SNP) Care Management	72%	3.4
C06	Care for Older Adults – Medication Review	91%	3.8
C07	Care for Older Adults – Pain Assessment	91%	3.9
C08	Osteoporosis Management in Women who had a Fracture	44%	2.6
C09	Diabetes Care – Eye Exam	72%	3.5
C10	Diabetes Care – Blood Sugar Controlled	79%	3.6
C11	Controlling Blood Pressure	73%	3.4
C12	Reducing the Risk of Falling	56%	2.9
C13	Improving Bladder Control	45%	3.2
C14	Medication Reconciliation Post-Discharge	65%	3.4
C15	Plan All-Cause Readmissions	11%	2.9
C16	Statin Therapy for Patients with Cardiovascular Disease	85%	3.3
C17	Transitions of Care	51%	2.5
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	56%	3.0
C19	Getting Needed Care	80	3.4
C20	Getting Appointments and Care Quickly	77	3.5
C21	Customer Service	90	3.6
C22	Rating of Health Care Quality	86	3.3
C23	Rating of Health Plan	87	3.1
C24	Care Coordination	86	3.6
C25	Complaints about the Health Plan	0.32	3.9
C26	Members Choosing to Leave the Plan	19%	3.6
C27	Health Plan Quality Improvement	Medicare only shows a Star Rating for this topic	3.0
C28	Plan Makes Timely Decisions about Appeals	94%	4.1
C29	Reviewing Appeals Decisions	95%	3.6
C30	Call Center – Foreign Language Interpreter and TTY Availability	93%	4.3

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%	3.7	94%	3.0
D02	Complaints about the Drug Plan	0.33	3.9	0.05	3.9
D03	Members Choosing to Leave the Plan	19%	3.6	12%	3.8
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this topic	3.4	Medicare only shows a Star Rating for this topic	2.9
D05	Rating of Drug Plan	87	3.2	83	3.4
D06	Getting Needed Prescription Drugs	90	3.5	89	3.5
D07	MPF Price Accuracy	97	3.6	97	3.6
D08	Medication Adherence for Diabetes Medications	86%	3.3	86%	2.6
D09	Medication Adherence for Hypertension (RAS antagonists)	88%	3.4	89%	2.6
D10	Medication Adherence for Cholesterol (Statins)	87%	3.2	87%	3.0
D11	MTM Program Completion Rate for CMR	84%	3.5	56%	3.2
D12	Statin Use in Persons with Diabetes (SUPD)	85%	2.7	82%	2.4

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	01/01/2022 – 12/31/2022
C02	Colorectal Cancer Screening	HEDIS	01/01/2022 – 12/31/2022
C03	Annual Flu Vaccine	CAHPS	03/2023 – 06/2023
C04	Monitoring Physical Activity	HEDIS-HOS	07/19/2022 – 11/01/2022
C05	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2022 – 12/31/2022
C06	Care for Older Adults – Medication Review	HEDIS	01/01/2022 – 12/31/2022
C07	Care for Older Adults – Pain Assessment	HEDIS	01/01/2022 – 12/31/2022
C08	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2022 – 12/31/2022
C09	Diabetes Care – Eye Exam	HEDIS	01/01/2022 – 12/31/2022
C10	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2022 – 12/31/2022
C11	Controlling Blood Pressure	HEDIS	01/01/2022 – 12/31/2022
C12	Reducing the Risk of Falling	HEDIS-HOS	07/19/2022 – 11/01/2022
C13	Improving Bladder Control	HEDIS-HOS	07/19/2022 – 11/01/2022
C14	Medication Reconciliation Post-Discharge	HEDIS	01/01/2022 – 12/31/2022
C15	Plan All-Cause Readmission	HEDIS	01/01/2022 – 12/31/2022
C16	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2022 – 12/31/2022
C17	Transitions of Care	HEDIS	01/01/2022 – 12/31/2022
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2022 – 12/31/2022
C19	Getting Needed Care	CAHPS	03/2023 – 06/2023
C20	Getting Appointments and Care Quickly	CAHPS	03/2023 – 06/2023
C21	Customer Service	CAHPS	03/2023 – 06/2023
C22	Rating of Health Care Quality	CAHPS	03/2023 – 06/2023
C23	Rating of Health Plan	CAHPS	03/2023 – 06/2023
C24	Care Coordination	CAHPS	03/2023 – 06/2023
C25	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2022 – 12/31/2022
C26	Members Choosing to Leave the Plan	MBDSS	01/01/2022 – 12/31/2022
C27	Health Plan Quality Improvement	Star Ratings	Not Applicable
C28	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2022 – 12/31/2022
C29	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2022 – 12/31/2022
C30	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2023 – 05/2023

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	02/2023 – 05/2023
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2022 – 12/31/2022
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2022 – 12/31/2022
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2023 – 06/2023
D06	Getting Needed Prescription Drugs	CAHPS	03/2023 – 06/2023
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2022 – 09/30/2022
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2022 – 12/31/2022
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2022 – 12/31/2022

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 2022.

Step 2: Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), or that were not required to participate in data validation. This exclusion is consistent with the statement from page 6 of the CY 2022 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 07/01/2023 according to the Contract Info extract

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 2022 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 2022 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 2023 HEDIS® Public Use File (PUF)[1] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (18-64) indicator (IndicatorKey = 202025_20) and the PCR (65+) indicator (IndicatorKey = 202111_20).

For each contract, calculate the (18+) Denominator, ObservedCount, and ExpectedCount:

Denominator(18+) = Denominator(18-64) + Denominator(65+)
ObservedCount(18+) = ObservedCount(18-64) + ObservedCount(65+)
ExpectedCount(18+) = ExpectedCount(18-64) + ExpectedCount(65+)

Using these (18+) values, calculate the (18+) Observed-over-Expected ratio (OE):

$$OE(18+) = \left(\frac{ObservedCount(18+)}{ExpectedCount(18+)}\right)$$

And the national average of the (18+) Observed Rate:

$$NatAvgObs(18+) = Average\left(\left(\frac{ObservedCount(18+)_1}{Denominator(18+)_1}\right) + \ldots + \left(\frac{ObservedCount(18+)_n}{Denominator(18+)_n}\right)\right)$$

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) OE larger than or equal to 0.2 and less than or equal to 5.0.
For each contract, calculate the Final Rate and convert to percentages:

$$Final\ Rate(18+) = OE(18+) \times NatAvgObs(18+) \times 100$$

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	Indicator Key	Denominator	Observed Count	Expected Count
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

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{8+641}{214+4,792}\right) + \left(\frac{12+688}{225+4,761}\right) + \left(\frac{31+1,126}{573+8,629}\right) + \left(\frac{0+79}{12+533}\right)\right)$$

$$\text{NatAvgObs} = 0.135181$$

$$\text{OE Contract 1} = \left(\frac{8+641}{12+642}\right) = 0.992355$$

$$\text{Final Rate Contract 1} = 0.992355 \times 0.135181 \times 100 = 13.41$$

Final Rate reported for Contract 1 = 13%

The actual calculated National Observed Rate used in the 2024 Star Ratings was 0.109719901931738.

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	1*
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

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
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

*Plan All-Cause Readmissions has a weight of 1 for the 2024 Star Ratings because it is considered a new measure.

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):

$$s_j^2 = \frac{n_j}{(n_j - 1)(\sum_{i=1}^{n_j} w_{ij})} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j\right)^2\right]$$

Thus, the $\bar{x}_j$'s are the new summary (or overall) Star Ratings for the contracts. The variance estimate, s_j^2 , simply replaces the non-weighted variance estimate that was previously used for the r-Factor calculation. For all contracts *j*, $w_{ij} = w_i$ (i.e., the performance measure weights are the same for all contracts when estimating a given Star Rating (Part C or Part D summary or MA-PD overall ratings).

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

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

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2023 and 2024.

For measures where a higher score is better:

Improvement Change Score = Score in 2024 - Score in 2023

For measures where a lower score is better:

Improvement Change Score = Score in 2023 - Score in 2024

An eligible measure was defined as a measure for which a contract was scored in both the 2023 and 2024 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 2023 and 2024 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.

Net Improvement = Number of significantly improved measures - 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 2024 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2023 standard error for contract i on measure C01

Y_{i2} Represents the 2024 rate for contract i on measure C01

Y_{i1} Represents the 2023 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 (2024 and 2023). 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. 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 2024 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, C26, C28 – C30, D01, D03, D08 – D12

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y = 2023, 2024
$Denominator_y$ 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 = 2023, 2024 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 = 2023, 2024. 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 = 2023, 2024. 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 2023, Contract Year 2024 and i = Contract i

3. SEF for Measures: C03, C19 – C24, and D05, D06

The CAHPS measure standard errors for 2023 and 2024 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.

4. SEF for Measures C25, D02

$$SE_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{\text{NumDays}}$$

NumDays: 2023 = 365, 2024 = 365

5. 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 Claim 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 = 2023, 2024.

    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.
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 = 2023, 2024

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	0.927677
C02	Colorectal Cancer Screening	Included	0.743188
C03	Annual Flu Vaccine	Included	0.903184
C04	Monitoring Physical Activity	Included	0.839155
C05	Special Needs Plan (SNP) Care Management	Included	0.899492
C06	Care for Older Adults – Medication Review	Included	0.507510
C07	Care for Older Adults – Pain Assessment	Included	0.399811
C08	Osteoporosis Management in Women who had a Fracture	Included	0.861517
C09	Diabetes Care – Eye Exam	Included	0.853405
C10	Diabetes Care – Blood Sugar Controlled	Included	0.827107
C11	Controlling Blood Pressure	Included	0.786307
C12	Reducing the Risk of Falling	Included	0.830616
C13	Improving Bladder Control	Included	0.474745
C14	Medication Reconciliation Post-Discharge	Included	0.844615
C15	Plan All-Cause Readmissions	Not Included	-
C16	Statin Therapy for Patients with Cardiovascular Disease	Included	0.681168
C17	Transitions of Care	Not Included	-
C18	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Not Included	-
C19	Getting Needed Care	Included	0.788466
C20	Getting Appointments and Care Quickly	Included	0.798595
C21	Customer Service	Included	0.736046
C22	Rating of Health Care Quality	Included	0.699480
C23	Rating of Health Plan	Included	0.877493
C24	Care Coordination	Included	0.692131
C25	Complaints about the Health Plan	Included	0.871058
C26	Members Choosing to Leave the Plan	Included	0.902728
C27	Health Plan Quality Improvement	Not Included	-
C28	Plan Makes Timely Decisions about Appeals	Included	0.715785
C29	Reviewing Appeals Decisions	Included	0.641752
C30	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.207234

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	0.179690
D02	Complaints about the Drug Plan	Included	0.873781
D03	Members Choosing to Leave the Plan	Included	0.899679
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.863090
D06	Getting Needed Prescription Drugs	Included	0.716532
D07	MPF Price Accuracy	Included	0.660011
D08	Medication Adherence for Diabetes Medications	Included	0.715904
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.781854
D10	Medication Adherence for Cholesterol (Statins)	Included	0.829572
D11	MTM Program Completion Rate for CMR	Included	0.847085
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.833716

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	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Access to Primary Care Doctor Visits	HEDIS		DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11	C13
C	Adult BMI Assessment	HEDIS				C07	C07	C07	C07	C07	C07	C08	C10	C10	C12	DMC05
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06	C07
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS							DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05	C06
C	Asthma Medication Ratio	HEDIS							DMC18	DMC27						
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32	C33
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01	C01
C	Call Answer Timeliness	HEDIS									DMC02	DMC02	DMC02	DMC02	DMC02	DMC02
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09	C34
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	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	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36	C36
C	Call Center – Information Accuracy	Call Center Monitoring											DMC10	DMC10	DMC10	C35
C	Cardiac Rehabilitation – Achievement	HEDIS	DMC25	DMC29												
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC30												
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC31												
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DCM32												
C	Cardiovascular Care – Cholesterol Screening	HEDIS										C02	C03	C03	C03	C03
C	Care Coordination	CAHPS	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29		

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Care for Older Adults – Functional Status Assessment	HEDIS	DMC21	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12	C14	
C	Care for Older Adults – Medication Review	HEDIS	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13	
C	Care for Older Adults – Pain Assessment	HEDIS	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	C01	C02	C02	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29													
C	Complaints about the Health Plan	CTM	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	C30
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	DMC04	DMC04	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21	C19
C	Customer Service	CAHPS	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28	C27
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C10	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19	C17
C	Diabetes Care – Cholesterol Controlled	HEDIS										C17	C18	C18	C20	C18
C	Diabetes Care – Cholesterol Screening	HEDIS										C03	C04	C04	C04	C04
C	Diabetes Care – Eye Exam	HEDIS	C09	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17	C15
C	Diabetes Care – Kidney Disease Monitoring	HEDIS		C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18	C16
C	Doctors who Communicate Well	CAHPS	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08	C25
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	DMC13	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19			
C	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
C	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	C18	DMC15	DMC17	DMC17	DMC18									

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
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	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27	C26
C	Getting Needed Care	CAHPS	C19	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26	C24
C	Glaucoma Testing	HEDIS											C05	C05	C05	C05
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		
C	Health Plan Quality Improvement	Star Ratings	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33		
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24						
C	Improving Bladder Control	HEDIS-HOS	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23	C22
C	Improving or Maintaining Mental Health	HOS	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09	C10
C	Improving or Maintaining Physical Health	HOS	DMC24	DMC28	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08	C09
C	Initiation and Engagement of Substance Use Disorder (SUD) Treatment Average	HEDIS	DMC14													
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18			
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	DMC22	DMC26												
C	Medication Management for People With Asthma	HEDIS								DMC26						
C	Medication Reconciliation Post-Discharge	HEDIS	C14	C15	C15	C19	C19	C20	C20	DMC23						
C	Members Choosing to Leave the Plan	MBDSS	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	DME01
C	Monitoring Physical Activity	HEDIS-HOS	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10	C12
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C08	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16	C14
C	Osteoporosis Testing	HEDIS-HOS			DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06	C11
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17			

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16			
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC24												
C	Plan All-Cause Readmissions	HEDIS	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	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34	C31
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07	C08
C	Rating of Health Care Quality	CAHPS	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29	C28
C	Rating of Health Plan	CAHPS	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30	C29
C	Reducing the Risk of Falling	HEDIS-HOS	C12	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24	C23
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	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35	C32
C	Rheumatoid Arthritis Management	HEDIS			C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22	C20
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14		
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C16	C16	C16	C20	C21	C22	DMC17	DMC25						
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS	DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07	C21
C	Transitions of Care – Average	HEDIS	C17	DMC20	DMC22	DMC22	DMC23									
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC18	DMC18	DMC19									
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC19	DMC19	DMC20									
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC20	DMC20	DMC21									

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC19	DMC19	DMC21	DMC21	DMC22									

Table J-2: Part D Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)													DMD03	D07	
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data														DMD07	
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	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	D05	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus				D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	D06	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	D10	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	D01	
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	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	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	D02	D02	D04	
D	Call Center – Information Accuracy	Call Center Monitoring											DMD05	DMD05	DMD06	D03	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	D02	
D	Complaint Resolution	Complaints Tracking Module (CTM)															
D	Complaints – Enrollment	Complaints Tracking Module (CTM)														D08	
D	Complaints – Other	Complaints Tracking Module (CTM)														D09	

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	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	DMD06	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data										D10	D12	D15	D14	D17	
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	D14	
D	Drug Plan Quality Improvement	Star Ratings	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	DMD05	
D	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03	
D	Formulary Administration Analysis	Part D Sponsor						DMD15	DMD17								
D	Getting Information From Drug Plan	CAHPS								DMD10	DMD10	DMD09	DMD14	D10	D09	D11	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	D13	
D	Grievance Rate	Part C & D Plan Reporting	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	D16	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15	DMD15													
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	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	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	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16		
D	Members Choosing to Leave the Plan	MBDSS	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	DME01	
D	MPF – Composite	PDE Data, MPF Pricing Files													D12	D15	B

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	Notes
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD03	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10			A
D	MPF – Updates	PDE Data, MPF Pricing Files											DMD09	DMD09	DMD10	DMD08	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	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	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12			
D	Persistence to Basal Insulin (PST-INS)	Prescription Drug Event (PDE) Data	DMD16														
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	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	DMD20											
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	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	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	D12	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13					
D	Reminders to take medications	CAHPS	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	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	DMD02	
D	Timely Receipt of Case Files for Appeals	Independent Review Entity (IRE) / Maximus				DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis						DMD11									D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis							DMD12	DMD14	DMD14	DMD12					C

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	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	DMD18											
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	DMD12	DMD12	DMD12	DMD19											

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012

B: Composite measure - combined MPF - Accuracy and MPF Stability

C: Part of composite measure Transition Monitoring - Composite starting in 2019

D: Composite Measure – “Transition monitoring - failure rate for drugs within classes of clinical concern” and “Transition monitoring - failure rate for all other drugs”

Table J-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07	C33 / D10
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey	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	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	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	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	DME06	DME06	DME06	DME06				
E	Enrollment Timeliness	MARx							DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	DMD03
E	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		

Attachment K: Individual Measure Star Assignment Process

This attachment provides detailed information about the clustering and the relative distribution and significance testing (CAHPS) methodologies used to assign stars to individual measures.

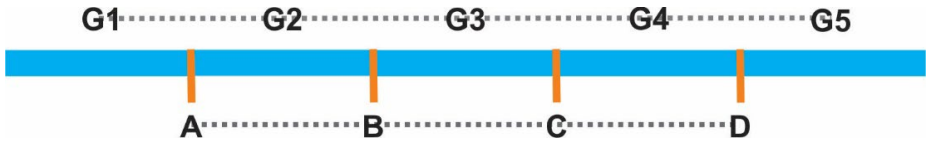
Clustering Methodology Introduction

To separate a distribution of scores into distinct groups or categories, a set of values must be identified to separate one group from another group. The set of values that break the distribution of the scores into non-overlapping groups is the set of cut points.

For each individual measure, CMS determines the measure cut points using the information provided from the hierarchical clustering algorithm in SAS, described in "Clustering Methodology Detail" below. Conceptually, the clustering algorithm identifies the natural gaps that exist within the distribution of the scores and creates groups (clusters) that are then used to identify the cut points that result in the creation of a pre-specified number of categories.

For Star Ratings, the algorithm is run with the goal of determining the four cut points (labeled in the Figure J-1 below as A, B, C, and D) that are used to create the five non-overlapping groups that correspond to each of the Star Ratings (labeled in the diagram below as G1, G2, G3, G4, and G5). For Part D measures, CMS determines MA-PD and PDP cut points separately. Data identified to be biased, erroneous, or excluded by disaster rules are removed from the algorithm. The scores are grouped such that scores within the same Star Rating category are as similar as possible, and scores in different categories are as different as possible.

Figure K-1: Diagram showing gaps in data where cut points are assigned.



As mentioned, the cut points are used to create five non-overlapping groups. The value of the lower bound for each group is included in the category, while the value of the upper bound is not included in the category. CMS does not require the same number of observations (contracts) within each group. The groups are identified such that within a group the measure scores must be similar to each other and between groups, the measure scores in one group are not similar to measure scores in another group. The groups are then used for the conversion of the measure scores to one of five Star Ratings categories. For most measures, a higher score is better, and thus, the group with the highest range of measure scores is converted to a rating of five stars. An example of a measure for which higher is better is *Medication Adherence for Diabetes Medications*. For some measures a lower score is better, and thus, the group with the lowest range of measure scores is converted to a rating of five stars. An example of a measure for which a lower score is better is *Members Choosing to Leave the Plan*.

Example 1 – Clustering Methodology for a Higher is Better measure

Consider the information provided for the cut points for *Medication Adherence for Diabetes Medications* in Table K-1 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately (e.g., different cut points are calculated for MA-PD and PDPs). If the MA-PD cut points identified using the clustering algorithm are 80%, 85%, 87%, and 91%; for PDPs, the cut points are 84%, 86%, 88%, and 90%. (The set of values corresponds to the cut points in figure J-2 below as A, B, C, and D and the categories for each of the five Star Ratings are indicated above each group.) Since a measure score can only assume a value between 0% and 100% (including 0% and 100%), the one-star and five-star categories contain only a single value in the table below as the upper or lower bound.

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	less than 80%	80% to less than 85%	85% to less than 87%	87% to less than 91%	greater than or equal to 91%
PDP	less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	greater than or equal to 90%

Figure K-2: Diagram showing star assignment based cut points.

Since higher is better for *Medication Adherence for Diabetes Medications*, a rating of one star is assigned to all MA-PD measure scores below 80% in this example. For each of the other Star Rating categories, the value of the lower bound is included in the rating category, while the upper bound value is not included. Focusing solely on the cut points for MA-PDs, a rating of two stars is assigned to each measure score that is at least 80% (the first cut point) to less than 85% (the second cut point) in this example. Since measure scores are reported as percentages with no decimal places, any measure score of 80% to 84% would be assigned two stars, while a measure score of 85% would be assigned a rating of three stars. Measure scores that are at least 85% to less than 87% would be assigned a rating of three stars. For a conversion to four stars, a measure score of at least 87% to less than 91% would be needed. A rating of five stars would be assigned to any measure score of 91% or more. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Example 2 – Clustering Methodology for a Lower is Better measure

Consider the information provided for the cut points for *Members Choosing to Leave the Plan* in Table K-2 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately. In the example, the MA-PD cut points for *Members Choosing to Leave the Plan* determined using the clustering algorithm are 44%, 29%, 16%, and 9%; for PDPs, the cut points are 20%, 13%, 19%, and 6%. (These correspond to the cut points in figure 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	greater than 44%	greater than 29% to 44%	greater than 16% to 29%	greater than 9% to 16%	less than or equal to 9%
PDP	greater than 20%	greater than13% to 20%	greater than 9% to 13%	greater than 6% to 9%	less than or equal to 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 2024 Star Ratings. Tables K-5 and K-6 show the upper and lower Tukey outlier cutoffs.

Table K-3: 2024 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	less than 52%	52% to less than 63%	63% to less than 71%	71% to less than 79%	greater than or equal to 79%
C02	less than 48%	48% to less than 60%	60% to less than 71%	71% to less than 80%	greater than or equal to 80%
C04	less than 42%	42% to less than 48%	48% to less than 53%	53% to less than 58%	greater than or equal to 58%
C05	less than 42%	42% to less than 55%	55% to less than 74%	74% to less than 85%	greater than or equal to 85%
C06	less than 72%	72% to less than 84%	84% to less than 93%	93% to less than 98%	greater than or equal to 98%
C07	less than 74%	74% to less than 83%	83% to less than 91%	91% to less than 96%	greater than or equal to 96%
C08	less than 28%	28% to less than 39%	39% to less than 50%	50% to less than 60%	greater than or equal to 60%
C09	less than 53%	53% to less than 65%	65% to less than 73%	73% to less than 81%	greater than or equal to 81%
C10	less than 57%	57% to less than 72%	72% to less than 80%	80% to less than 87%	greater than or equal to 87%
C11	less than 58%	58% to less than 68%	68% to less than 74%	74% to less than 82%	greater than or equal to 82%
C12	less than 47%	47% to less than 53%	53% to less than 60%	60% to less than 70%	greater than or equal to 70%
C13	less than 38%	38% to less than 42%	42% to less than 47%	47% to less than 51%	greater than or equal to 51%
C14	less than 31%	31% to less than 51%	51% to less than 68%	68% to less than 82%	greater than or equal to 82%
C15	greater than 13%	greater than 11% to 13%	greater than 10% to 11%	greater than 8% to 10%	less than or equal to 8%
C16	less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%
C17	less than 40%	40 % to less than 52 %	52% to less than 64%	64% to less than 78%	greater than or equal to 78%
C18	less than 44%	44% to less than 53%	53% to less than 60%	60% to less than 68%	greater than or equal to 68%
C25	greater than 1	greater than 0.6 to 1	greater than 0.33 to 0.6	greater than 0.14 to 0.33	less than or equal to 0.14
C26	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than 10% to 18%	less than or equal to 10%
C27	less than -0.246067	-0.246067 to less than 0	0 to less than 0.173502	0.173502 to less than 0.393451	greater than or equal to 0.393451
C28	less than 77%	77% to less than 86%	86% to less than 94%	94% to less than 98%	greater than or equal to 98%
C29	less than 87%	87% to less than 92%	92% to less than 96%	96% to less than 100%	greater than or equal to 100%
C30	less than 87%	87% to less than 90%	90% to less than 94%	94% to less than 97%	greater than or equal to 97%

Notes: These are not the final thresholds for the 2024 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2024 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	less than 85%	85% to less than 91%	91% to less than 96%	96% to less than 99%	greater than or equal to 99%
D01	PDP	less than 95%	95% to less than 97%	97% to less than 98%	98% to less than100%	greater than or equal to 100%
D02	MA-PD	greater than 1	less than 0.6 to 1	greater than 0.33 to 0.6	greater than 0.14 to 0.33	less than or equal to 0.14
D02	PDP	greater than 0.12	greater than 0.08 to 0.12	greater than 0.05 to 0.08	greater than 0.02 to 0.05	less than or equal to 0.02
D03	MA-PD	greater than 41%	greater than 29% to 41%	greater than 18% to 29%	greater than 10% to 18%	less than or equal to 10%
D03	PDP	greater than 25%	greater than 17% to 25%	greater than 11% to 17%	greater than 7% to 11%	less than or equal to 7%
D04	MA-PD	less than -0.253472	-0.253472 to less than 0	0 to less than 0.193739	0.193739 to less than 0.458889	greater than or equal to 0.458889
D04	PDP	less than -0.123026	-0.123026 to less than 0	0 to less than 0.214538	0.214538 to less than 0.401223	greater than or equal to 0.401223
D07	MA-PD	less than 94	94 to less than 96	96 to less than 98	98 to less than 99	greater than or equal to 99
D07	PDP	less than 96	96 to less than 97	97 to less than 98	98 to less than 99	greater than or equal to 99
D08	MA-PD	less than 80%	80% to less than 84%	84% to less than 88%	88% to less than 90%	greater than or equal to 90%
D08	PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%
D09	MA-PD	less than 82%	82% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
D09	PDP	less than 87%	87% to less than 89%	89% to less than 91%	91% to less than 94%	greater than or equal to 94%
D10	MA-PD	less than 82%	82% to less than 86%	86% to less than 88%	88% to less than 91%	greater than or equal to 91%
D10	PDP	less than 84%	84% to less than 87%	87% to less than 89%	89% to less than 93%	greater than or equal to 93%
D11	MA-PD	less than 67%	67% to less than 77%	77% to less than 85%	85% to less than 92%	greater than or equal to 92%
D11	PDP	less than 34%	34% to less than 52%	52% to less than 63%	63% to less than 77%	greater than or equal to 77%
D12	MA-PD	less than 81%	81% to less than 86%	86% to less than 88%	88% to less than 92%	greater than or equal to 92%
D12	PDP	less than 81%	81% to less than 83%	83% to less than 85%	85% to less than 87%	greater than or equal to 87%

Notes: These are not the final thresholds for the 2024 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2024 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	30	100
C02	26	100
C04	25	74
C05	0	100
C06	59	100
C07	57	100
C08	0	100
C09	27	100
C10	38	100
C11	38	100
C12	27	83
C13	24	66
C14	0	100
C15	4	18
C16	71	99
C17	0	100
C18	28	84
C25	0	1.41
C26	0	87.5
C27 (improve)	0	0.807245
C27 (decline)	-0.726192	0
C28	70	100
C29	78	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: 2024 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	1.41
D03	MA-PD	0	87.5
D04 (improve)	MA-PD	0	1.297044
D04 (decline)	MA-PD	-0.7343755	0
D07	MA-PD	91	105
D08	MA-PD	72	100
D09	MA-PD	74	100
D10	MA-PD	73	100
D11	MA-PD	53	100
D12	MA-PD	68	100
D01	PDP	86	100
D02	PDP	0	0.26
D03	PDP	0	62
D04 (improve)	PDP	0	0.96875
D04 (decline)	PDP	-1.130433	0
D07	PDP	94	101
D08	PDP	76	97
D09	PDP	80	97.5
D10	PDP	77	98
D11	PDP	0	100
D12	PDP	72	93

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. 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) * 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.

When we proposed and finalized Tukey outlier deletion in the 2021 final rule (CMS–4190–F), we described that in the first year of adding Tukey outlier deletion, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years. For the purposes of calculating the guardrails for the 2024 Star Ratings, the 2023 Star Ratings cut points were rerun including mean resampling, Tukey outlier deletion and no guardrails. These rerun 2023 Star Ratings cut points serve as the basis for applying the guardrails for the 2024 Star Ratings and are shown in Tables K-7 and K-8.

Table K-7: 2023 Star Ratings Part C Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	less than 50%	50% to less than 63%	63% to less than 71%	71% to less than 76%	greater than or equal to 76%
C02	less than 55%	55% to less than 66%	66% to less than 74%	74% to less than 81%	greater than or equal to 81%
C04	less than 44%	44% to less than 49%	49% to less than 53%	53% to less than 57%	greater than or equal to 57%
C05	less than 46%	46% to less than 62%	62% to less than 75%	75% to less than 85%	greater than or equal to 85%
C06	less than 73%	73% to less than 82%	82% to less than 91%	91% to less than 96%	greater than or equal to 96%
C07	less than 73%	73% to less than 83%	83% to less than 89%	89% to less than 95%	greater than or equal to 95%
C08	less than 34%	34% to less than 47%	47% to less than 60%	60% to less than 76%	greater than or equal to 76%
C09	less than 47%	47% to less than 61%	61% to less than 71%	71% to less than 79%	greater than or equal to 79%
C10	less than 63%	63% to less than 72%	72% to less than 80%	80% to less than 86%	greater than or equal to 86%
C12	less than 46%	46 % to less than 53 %	53% to less than 60%	60% to less than 69%	greater than or equal to 69%
C13	less than 39%	39 % to less than 43 %	43% to less than 48%	48% to less than 53%	greater than or equal to 53%
C14	less than 43%	43 % to less than 57 %	57% to less than 69%	69% to less than 82%	greater than or equal to 82%
C16	less than 79%	79% to less than 84%	84% to less than 86%	86% to less than 89%	greater than or equal to 89%
C25	greater than 0.68	greater than 0.68 to 0.43	greater than 0.43 to 0.25	greater than 0.25 to 0.12	less than or equal to 0.12
C26	less than 37%	37% to less than 24%	24% to less than 15%	15% to less than 7%	greater than or equal to 7%
C28	less than 89%	89% to less than 93%	93% to less than 97%	97% to less than 100%	equal to 100%
C29	less than 84%	84% to less than 90%	90% to less than 95%	95% to less than 98%	greater than or equal to 98%
C30	less than 67%	67% to less than 78%	78% to less than 87%	87% to less than 94%	greater than or equal to 94%

Table K-8: 2023 Star Ratings Part D Mean Resampling and Tukey Outlier Deletion Non-CAHPS Measure Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	less than 68%	68% to less than 81%	81% to less than 91%	91% to less than 97%	greater than or equal to 97%
D01	PDP	less than 86%	86% to less than 92%	92% to less than 97%	97% to less than 100%	equal to 100%
D02	MA-PD	greater than 0.68	greater than 0.68 to 0.43	greater than 0.43 to 0.25	greater than 0.25 to 0.12	less than or equal to 0.12
D02	PDP	greater than 0.15	greater than 0.15 to 0.1	greater than 0.1 to 0.07	greater than 0.07 to 0.03	less than or equal to 0.03
D03	MA-PD	greater than 37%	greater than 37% to 24%	greater than 24% to 15%	greater than 15 % to 7%	less than or equal to 7%
D03	PDP	greater than 18%	greater than 18% to13%	greater than 13% to 9%	greater than 9% to 5%	less than or equal to 5%
D08	MA-PD	less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	greater than or equal to 92%
D08	PDP	less than 84%	84% to less than 86%	86% to less than 88%	88% to less than 90%	greater than or equal to 90%
D09	MA-PD	less than 83%	83% to less than 86%	86% to less than 89%	89% to less than 91%	greater than or equal to 91%
D09	PDP	less than 86%	86% to less than 88%	88% to less than 89%	89% to less than 91%	greater than or equal to 91%
D10	MA-PD	less than 81%	81% to less than 85%	85% to less than 88%	88% to less than 92%	greater than or equal to 92%
D10	PDP	less than 86%	86% to less than 87%	87% to less than 88%	88% to less than 90%	greater than or equal to 90%
D11	MA-PD	less than 68%	68% to less than 78%	78% to less than 84 %	84% to less than 91%	greater than or equal to 91%
D11	PDP	less than 34%	34% to less than 49%	49% to less than 62%	62% to less than 78%	greater than or equal to 78%
D12	MA-PD	less than 80%	80% to less than 84%	84% to less than 86%	86% to less than 90%	greater than or equal to 90%
D12	PDP	less than 80%	80% to less than 82%	82% to less than 84%	84% to less than 86%	greater than or equal to 86%

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-9 and K-10 contain the rules applied to determine the final CAHPS measure star value.

Table K-9: 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-10: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
less than 15th percentile by greater than 1 SE	1	1	1	2	2	2	2
less than 15th percentile by less than or equal to 1 SE		2	1	2	2	2	2
greater than or equal to 15th to less than 30th percentile	2	2	2	3	2	3	2
greater than or equal to 30th to less than 60th percentile	3	2	2	3	3	4	4
greater than or equal to 60th to less than 80th percentile	4	3	4	3	4	4	4
greater than or equal to 80th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
greater than or equal to 80th percentile by greater than 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (<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-11 contains the 12% reliability cutoffs.

Table K-11: CAHPS Measure 12% Reliability Cutoffs

Measure	12% Reliability Cutoff
Annual Flu Vaccine	0.853836*
Getting Needed Care	0.751402*
Getting Appointments and Care Quickly	0.722606
Customer Service	0.634544
Rating of Health Care Quality	0.655488
Rating of Health Plan	0.828638*
Care Coordination	0.636025
Rating of Drug Plan (MA-PD)	0.787018*
Getting Needed Prescription Drugs (MA-PD)	0.628637
Rating of Drug Plan (PDP)	0.950305*
Getting Needed Prescription Drugs (PDP)	0.833025*

*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	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
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	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
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	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022
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	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
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	
	1/1/2022	1/16/2022	2/1/2022	2/16/2022	3/1/2022	3/16/2022	4/1/2022	4/16/2022
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. 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 2019 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries. 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 cover a beneficiary's entire enrollment episode that meets the inclusion criteria, the associated proportion of member-years is not included in the rate calculation. Consequently, if SNF and IP stays span all of the beneficiary's enrollment episode(s) within the measurement period, the beneficiary is excluded from the measurement year.

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 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 prescription drug event (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:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

[4] MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is $10.237, then it is rounded to $10.24. MPF unit costs are not rounded.

[5] 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_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i and TC_{iMPF} is the ingredient cost plus dispensing fee calculated from MPF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{iPDE>PF}}{\sum_i \text{Claims}_{iTotal}}$$

where

$\text{Claims}_{iPDE>PF}$ is the total number of claims where the PDE price is greater than the rounded MPF price

Claims_{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 Medicare.gov on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength, and dosage form. Using the reference NDC, the following MPF data are obtained: brand/generic dispensing fee (as assigned by the pharmacy cost file) and unit cost (as assigned by the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The MPF cost is computed as the quantity dispensed from PDE multiplied by the MPF unit cost plus the MPF brand/generic dispensing fee (brand or generic status is assigned based on the NDC), and then rounded to the nearest cent. The last column shows the amount by which the PDE cost is higher than the rounded MPF cost. When PDE cost is less than or equal to the rounded MPF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table M-1: Example of Price Accuracy Index Calculation

NDC	Pharmacy Number	PDE Data DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PDE Days of Supply	MPF Data Biweekly Posting Period	MPF Data Unit Cost	MPF Data Dispensing Fee Brand	MPF Data Dispensing Fee Generic	Calculated Value Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost MPF	Calculated Value Amount that PDE is higher than MPF
A	111	01/08/2022	3.82	2	60	60	01/06/22 - 01/19/22	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2022	0.98	2	30	60	01/20/22 - 02/02/22	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2022	10.48	1.5	24	28	02/03/22 - 02/16/22	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2022	47	1.5	90	30	02/17/22 - 03/01/22	0.48	1.5	2.25	G	48.50	45.45	3.05
											Totals	69.28		5.78
											Price Accuracy Index			1.08343
											Claim Percentage Index			0.5
											MPF Composite Price Accuracy Score			71

PDE = Prescription Drug Event
MPF = Medicare Plan Finder

Attachment N: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2022. 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 2022.
Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 30, 2023), or that were not required to participate in data validation.
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 2022 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 2022 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 2022 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 2024 Star Ratings are developed using the following sources of information:

- The 2021 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2021 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 2022 provided for beneficiaries who were alive at least through December 2022, 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 2021 1-year data from ACS (https://www.census.gov/content/dam/Census/library/publications/2022/acs/acsbr22-014.pdf, see Table 1). *The states identified are: Alabama, Arkansas, District of Columbia, Kentucky, Louisiana, Mississippi, New Mexico, 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 2024 Star Ratings adjustment, the data used for the model development included a total of 92 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 2021 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 2021. 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 0.930021.

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + (\text{intercept})$$

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 (29.200398%) 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	59.500000%
Percent of residents in the 10 poorest US states below 150% of FPL	26.539801%
Observed average LIS/DE percentage in the 10 poorest US states	39.159485%
Observed average DE percentage in Puerto Rico contracts	29.200398%

The product thus becomes $\left(39.159485 \times \frac{59.500000}{26.539801}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 25%, the value of 25.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.930021 \times \text{contract's DE percentage}) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The contracts percentage of 25.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.930021 \times 25.000000) + \left(39.159485 \times \frac{59.500000}{26.539801}\right) - (0.930021 \times 29.200398)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 25.000000% is 83.885811%.

The final adjustment category for the CAI adjustment is identified using the DE percentage of 25.000000% and the LIS/DE percentage 83.885811%.

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 2024 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 2024 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
5/9/2022	New Mexico Wildfires and Straight-line Winds	Wildfires	New Mexico	**4/5/2022**
8/2/2022	Kentucky Severe Storms, Flooding, Landslides, and Mudslides	Severe Storms, Flooding, Landslides, and Mudslides	Kentucky	**7/26/2022**
9/20/2022	Tropical Storm/Hurricane Fiona	Hurricane	Puerto Rico	**9/17/2022**
9/26/2022	Hurricane Ian	Hurricane	Florida	**9/23/2022**
9/30/2022	**Hurricane Ian**	**Hurricane**	**South Carolina**	**9/25/2022**

- 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-4652- NM	New Mexico	Colfax, Lincoln, Mora, San Miguel, Valencia
DR-4663-KY	Kentucky	Breathitt, Clay, Floyd, Knott, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley
DR-4671-PR	Puerto Rico	Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamon, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guanica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Diaz, Juncos, Lajas, Lares, Las Marias, Las Piedras, Loiza, Luquillo, Manati, Maricao, Maunabo, Mayaguez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Penuelas, Ponce, Quebradillas, Rincon, Rio Grande, Sabana Grande, Salinas, San German, San Juan, San Lorenzo, San Sebastian, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco
DR-4673-FL	Florida	Brevard, Charlotte, Collier, DeSoto, Flagler, Glades, Hardee, Hendry, Highlands, Hillsborough, Lake, Lee, Manatee, Monroe, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, Volusia
DR-4677-SC	South Carolina	Charleston, Georgetown, Horry

- 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-4652-NM	New Mexico	4/5/2022	May 2022	April 8, 2022
DR-4663-KY	Kentucky	7/26/2022	September 2022	August 5, 2022
DR-4671-PR	Puerto Rico	9/17/2022	October 2022	September 9, 2022
DR-4673-FL	Florida	9/23/2022	November 2022	October 7, 2022
DR-4677-SC	South Carolina	9/25/2022	November 2022	October 7, 2022

- 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

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48163	Frio	TX	Yes	FALSE	43	-	42	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	17
48175	Goliad	TX	Yes	TRUE	18	-	18	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	41
48237	Jack	TX	Yes	FALSE	35	-	34	34
48239	Jackson	TX	Yes	TRUE	30	-	30	30
48255	Karnes	TX	Yes	TRUE	19	-	19	19
48265	Kerr	TX	Yes	FALSE	85	-	86	86
48283	La Salle	TX	Yes	FALSE	25	-	25	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	24
48301	Loving	TX	Yes	FALSE	0	-	0	0
48311	McMullen	TX	Yes	FALSE	4	-	4	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	142
48323	Maverick	TX	Yes	FALSE	160	-	156	158
48371	Pecos	TX	Yes	FALSE	20	-	21	20
48377	Presidio	TX	Yes	FALSE	50	-	49	50
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 > 01/01/2022?
    - 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 > 07/01/2022?
  - 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 > 01/01/2023?
    - 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 > 01/01/2022?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2022?
  - 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 2022?
  - 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 > 01/01/2022?
  - 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 2022?
  - 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 > 01/01/2022?
  - 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 2022?
  - 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 > 01/01/2022?
  - 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 2024?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date > 01/01/2022?
  - 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 > 01/01/2021?
  - Yes: Display message: Plan too new to be measured
  - No: Is the February 2022 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 > 01/01/2022?
  - 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 2024?
- 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 > 01/01/2022?
      - 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 > 01/01/2022?
  - 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 > 07/01/2022?
  - 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 > 01/01/2023?
    - 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 > 01/01/2022?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment < 800 in 2022?
  - 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 > 01/01/2022?
  - 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 > 01/01/2022?
  - 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 > 9/30/2022?
- 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 > 12/31/2022?
- 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 > 12/31/2022?
- 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 all plans terminate by validation deadline	No data available
Contract had no MTM enrollees to report	No data available
Contract has 0 Part D enrollees	No data available
Contract had 30 or fewer beneficiaries meeting denominator criteria	Not enough data available
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 > 01/01/2022?
  - 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 > 01/01/2022?
  - 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 > 01/01/2022?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2024 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 > 1/1/2022?
- 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 2024 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

				HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	01/01/2022 - 12/31/2022	01/01/2022 - 12/31/2022	03/2023 - 06/2023
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 less than 800, No = average enrollment greater than or equal to 800

3. Measure Detail – Part C Appeals page

The Measure Detail – Part C Appeals page contains the case-level data of the non-excluded cases used in producing the Part C Appeals measures Plan Makes Timely Decisions about Appeals (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 2024 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 – HEDISpage 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 2022 (see section Contract Enrollment Data)

Table S-6: HEDIS 2022 Audit Designations and 2024 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 1/1/2022 and 12/31/2022. 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 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
greater than 25% 2022	Flag that indicates if the contract has met the 25% threshold for 2022 disasters (Yes: greater than or equal to 25%, No: less than 25%)
greater than 60% 2022	Flag that indicates if the contract has met the 60% threshold for 2022 disasters (Yes: greater than or equal to 60%, No: less than 60%)
Disaster Flag 2021	Indicates if the contract was affected by a 2021 disaster or not (valid values “Affected”, “Not Affected” or “Too New“)
Total Cnty in SA 2021	The total number of counties in the contract’s 2021 service area (SA)
Num Cnty IA 2021	The number of counties from the contract’s total SA designated as FEMA Individual Assistance (IA) counties in a 2021 disaster
IA Enrolled 2021	The number of members residing in the contract SA designated FEMA IA counties in a 2021 disaster
Total Enrolled 2021	The total number of members residing in the contract’s 2021 SA
IA % 2021	The percent of members living in IA areas in a 2021 disaster (IA Enrolled)/(Total Enrolled)
IA % Rounded 2021	The percent of members living in IA areas in a 2021 disaster rounded to an integer
greater than or equal to 25% 2021	Flag that indicates if the contract has met the 25% threshold for 2021 disasters (Yes: greater than or equal to 25%, No: less than 25%)

12. Calculation Detail – CAI

The Calculation Detail – CAI page contains the enrollment data used to calculate the percentages for use in the Categorical Adjustment Index (CAI) to determine the Final Adjustment Categories for each of the summary and overall rating calculations. This page is available during the first plan preview. Table S-13 below explains the columns displayed on this page.

Table S-13: Measure Detail – CAI page fields

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Puerto Rico Only	Does the contract's non-employer service area only cover Puerto Rico? Yes or No
Contract Type	The contract plan type used to compute the ratings
Part D Offered	Is Part D offered by the contract? Yes or No
Enrolled	The total number enrolled in the contract used to determine the % LIS/DE and % Disabled
Num LIS/DE	The number of LIS/DE enrolled in the contract
Num Disabled	The number of Disabled enrolled in the contract
% LIS/DE	The percent of LIS/DE in the contract
% Disabled	The percent Disabled in the contract
Part C LIS/DE Initial Group	The Part C LIS/DE initial group this contract is in
Part C Disabled Quintile	The Part C Disabled Quintile group this contract is in
Part C FAC	The Part C Final adjustment category this contract is in
Part C CAI Value	The CAI value that will be combined with the final Part C summary score prior to rounding to half stars
Part D MA-PD LIS/DE Initial Group	The Part D MA-PD LIS/DE initial group this contract is in
Part D MA-PD Disabled Quintile	The Part D MA-PD Disabled Quintile group this contract is in
Part D MA-PD FAC	The Part D MA-PD Final adjustment category this contract is in
Part D MA-PD CAI Value	The CAI value that will be combined with the final Part D MA-PD summary score prior to rounding to half stars
Part D PDP LIS/DE Quartile	The Part D PDP LIS/DE Quartile group this contract is in
Part D PDP Disabled Quartile	The Part D PDP Disabled Quartile group this contract is in
Part D PDP FAC	The Part D PDP Final adjustment category this contract is in
Part D PDP CAI Value	The CAI value that will be combined with the final Part D PDP summary score prior to rounding to half stars
Overall LIS/DE Initial Group	The overall LIS/DE initial group this contract is in
Overall Disabled Quintile	The overall disabled Quintile group this contract is in
Overall FAC	The overall final adjustment category this contract is in
Overall CAI Value	The CAI value that will be combined with the final overall score prior to rounding to half stars

13. Measure Detail – HEDIS LE page

The Measure Detail – HEDIS LE page contains the data used to calculate the reliability of the HEDIS measures (C01, C02, C08 – C11, C14 – C18) data for contracts with ≥ 500 and < 1,000 members enrolled in July of the measurement year (July 01, 2022). 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 2022
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 2024 Star Ratings Part C measure ID
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
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
Final Value	The measure value to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final From	The Star Ratings year where the final data for the measure came from

15. Measure Detail – D MD Results

The Part D Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-16 below explains the columns displayed on this page.

Table S-16: Measure Detail – D MD Results

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Measure ID	The 2024 Star Ratings Part D measure ID
2023 Value	The numeric measure value for the contract from the 2023 Star Ratings
2023 Star	The measure star for the contract from the 2023 Star Ratings
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
Final Value	The measure value to be used in the 2024 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2024 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

					HD1: Staying Healthy: Screenings, Tests and Vaccines		
					C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
Contract Number	Organization Marketing Name	Contract Name	Parent Organization		01/01/2022 - 12/31/2022	01/01/2022 - 12/31/2022	03/2023 - 06/2023
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 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 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

HPMS Field Label	Field Description
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)
2024 Part C Summary Rating	The final rounded 2024 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 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 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)
2024 Part D Summary Rating	The final rounded 2024 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 2021	The percentage of members living in an Individual Assistance area in 2021 rounded to an integer
Major Disaster Percentage 2022	The percentage of members living in an Individual Assistance area in 2022 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
2024 Part C Summary Rating	The 2024 Part C Summary Rating
2024 Part D Summary Rating	The 2024 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)
2024 Overall Rating	The final 2024 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”
2022 C Summary	The 2022 Part C Summary Rating earned by the contract
2022 D Summary	The 2022 Part D Summary Rating earned by the contract
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
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 2024 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 2024 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, and the Complaints about the Plan Part D 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, 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 Part C measure file to identify HEDIS low enrollment contracts. There is also a flag in the Part D measure files identifying contracts as MAPD or PDP. This downloadable is in Zip format and contains three Excel files.

EXHIBIT 9

Data Sources (/healthypeople/objectives-and-data/data-sources-and-methods/data-sources)

Healthcare Effectiveness Data and Information Set (HEDIS)

Supplier: NCQA

Years Available: 2001 to present

Periodicity: Annual

Mode of Collection: Abstraction of administrative claims data or data from other records.

Description: The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service. More than 190 million people are enrolled in health plans that report quality results using HEDIS. Since 2008, HEDIS has also been available for use by medical providers and practices. Because so many health plans use HEDIS and because the measures are so specifically defined, HEDIS can be used to make comparisons among plans. To ensure that HEDIS stays current, the National Committee for Quality Assurance (NCQA) has established a process to evolve the measurement set each year through its Committee on Performance Measurement.

Selected Content: HEDIS measures address a range of health issues including: asthma medication use; persistence of beta-blocker treatment after a heart attack; controlling high blood pressure; comprehensive diabetes care; breast cancer screening; chlamydia screening; antidepressant medication management; immunization status; and advising smokers to quit.

Population Covered: Persons enrolled in health plans that report quality results using HEDIS.

Methodology: NCQA collects HEDIS survey results directly from health plans and Preferred Provider Organizations (PPOs) through the Healthcare Organization Questionnaire and collects non-survey data through the Interactive Data Submission System. Submission formats are defined for each type of health plan (e.g., commercial, Medicare, Medicaid) and data provider group. Schedules for data submission, analysis, and health plan ratings release are available on the HEDIS website.

Response Rates and Sample Size: HEDIS is used by more than 90% of America's health plans.

References: HEDIS Measures and Technical Resources. https://www.ncqa.org/hedis/measures/ (https://www.ncqa.org/hedis/measures/)

Objectives using data from this source (1)

Increase the proportion of sexually active female adolescents and young women who get screened for chlamydia — STI-01 (/healthypeople/objectives-and-data/browse-objectives/sexually-transmitted-infections/increase-proportion-sexually-active-female-adolescents-and-young-women-who-get-screened-chlamydia-sti-01)

This microsite is coordinated by the Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services.

EXHIBIT 10

Q&A

Clarifications to Questions and Answers During the Webinar

Question: If the state relay operator [for TTY] is not available or accidentally drops the call, the call is still considered incomplete. Is that a correct statement?

Clarified Answer: The majority of the 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. During the call, the 711 relay operator narrates what is happening via the TTY device for the contractor's test caller 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, and instances when a failure *is* or is *not* counted against the contract.

The test caller uses a TTY device 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 turn the machine off, and turn it back on, 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 for a third attempt. If the test caller 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, the test caller 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 one unsuccessful call 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 contractor connects on its TTY device 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 the "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 device, e.g., he or she may 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 7-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 test caller 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 test caller will state again, "No, please hold for a live CSR." The test caller will hold until a live CSR answers, or the 7-minute TTY hold timer expires.

If the call successfully connects with a live customer service representative who can respond "yes" to the introductory question ("Can you answer questions about Medicare Part C (or Part D) benefits?") before the 7-minute TTY HOLD timer expires, the survey continues and each of the randomly generated three accuracy questions is asked. A time stamp is set on exiting the test caller'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 7-minute timer.

If the relay operator stops responding via the TTY device at any point, this counts against the contract. Here is an example. Our test caller is communicating and types "GA" for "go ahead" on our TTY device 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 for TTY functionality because we have not had true communication in the process and are still awaiting an answer to our question. Rationale: Plans needs to 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.

Webinar Answer: I may have to defer the answer on that one. Let me touch base with the contractor. If the person who asked that question could send it to the Call Center Monitoring mailbox, I would appreciate it.

[Linda] I was just going to say exactly the same thing. Send it to the mailbox and we will give it careful thought, but in general we try not to hold you accountable for things outside of your control, so if it was obvious that it was dropped by the relay and that was a knowable event, we would strive not to count that against you.

[Chris] Let me say too that if the Call Center Monitoring contractor is placing a call and anything goes awry – they make the wrong IVR selection or whatever – they have the option to do what they call a redo, so it will stop that call and invalidate it. If they make an error, it does not count against you. It would just allow an opportunity for them to redo that call. So, please know that we try not to hold you accountable for anything that is not your fault

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

Clarified Answer: Upon research, we clarify that the accuracy measure results previously were 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. It was then moved to a display measure rather than a Star Ratings measure.

Webinar Answer: This is a very deep question and probably beyond the scope of today's call. There are lots of reasons why things wind up in the call ratings. The only piece of the call center monitoring has been is the accessibility [of TTY and interpreter availability]. I think that it's a more objective study, perhaps, or it just happens to be historically that it was not included. If you really need to know, send us an email and we will go hunt down the powers that be on the Star Ratings team.

Q&A

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?

Clarified Answer: One of the goals of the Accuracy & 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. In this scenario, 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 this 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.

Webinar Answer: Our goal is not to test language translation's ability to translate language. That is a different test. Our hope and dream is that you are able to provide answers to them [callers]. If it is obvious that the interpreter on the line is not successfully interpreting – which means, I think, a native speaker often knows when something doesn't make sense in their language -- I don't think that we would count against you. I don't know if it gets documented, so I would have to look to Chris for that answer.

[Chris] Well, I would say too that the questions we are asking are more plan-specific questions so the real emphasis is that customer service representative be able to answer plan-specific questions, and that might be something on your formulary [for example]. It should be pretty straightforward. I wouldn't anticipate too many problems, but if you experience that and you need to come to us to say we don't think this is fair the way this was counted, reach out to me. We do have mechanisms where if you have the recorded conversation we can listen to it to see if there is a problem and check our own finish notes from our contractor's records and make a judgment call on that. If it is due to the failure strictly of the interpreter, I wouldn't hold that against you.

[Linda] I've never heard of that happening.

Q&A

Questions Asked of the Call Center Monitoring Mailbox after the Webinar

Q: Would you be able to 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 (7) minute limit. Does this count as untimely? Please let me know if you would like further clarification to the inquiry posed.

A: I believe the best way to answer your question is to explain that the timers in place are all the same for the LEP HOLD timer used when waiting for an interpreter to assist the CSR with the introductory question, the TTY HOLD timer used when connecting via a TTY device, or for any of the three accuracy questions that each utilize a 7-minute timer. The test caller has a screen that has a timer on it that counts backward from 420 seconds (7 minutes x 60 seconds). When that timer goes off, the test caller does not have the ability to change the outcome of the call being ended, so 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 the call is ended.

So, 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 untimely call for the interpreter availability measure.

When we have moved to the accuracy question, 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, so that would count in a good way for the plan if that portion of the test was over, and the timer going off during the accuracy questions does not negatively impact the plan because at that stage we are determining the accuracy of the answer only, so not having enough time to reply is not normally a problem for accuracy questions 1-3, but if the timer goes off, it is neutral to the plan. There is no correct answer and no incorrect answer, in other words.

Q: Are the [Accuracy] questions that were used as part of the 2015 accuracy study published and available? I would like to pass them along to the Member Services staff to be used in training.

A: No, they are not published or available. To explain, we did not ask accuracy questions of traditional Medicare Advantage Plans and Prescription Drug Plans in 2015. Instead, we asked Medicare-Medicaid Plans (MMPs) accuracy questions that are specific to MMPS. So, at the conclusion of that study, the MMPs received their results and the informational notices they received at the end of the study shared the questions that were asked of their plans. So, those would not be helpful to traditional MAs or PDPs because they are separate questions based upon MMP benefits.
While I do not have the list of questions asked in the past to share, I can tell you that you will receive a listing of the questions asked following the 2016 study. Additionally, we emphasize 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 2016 version of Medicare & You, which is available here: https://www.medicare.gov/medicare-and-you/different-formats/m-and-y-different-formats.html

Q: I just want to confirm my understanding of how menu choices are handled when monitoring calls are made. When the menu includes an option for member services, this is the option that will be chosen for the monitoring - I am understanding that the caller would not choose options such as Behavioral Health crisis lines, provider lines or nurse lines.

Q&A

A: Your understanding is correct. Our telephone interviewers will make an IVR/menu selection for member services whenever that is an available choice and we are testing either an enrollee Part C or Part D phone lines. 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.

I separated out the enrollee Part C and Part D lines above so that I could emphasize that we also call your pharmacy technical assistance help line as part of our Timeliness Study to measure average hold time and disconnect percentage rates. This line is intended for pharmacists or providers who need technical assistance, so in that case, we call the toll-free number you designate in HPMS and make appropriate IVR selections to direct us toward the goal of receiving an answer to this question: "Can you help me with questions about processing a Medicare Part D pharmacy claim?" This is slightly different than when we call enrollee lines for the Timeliness Study, or when we call prospective beneficiary customer service lines for the Accuracy & Accessibility Study.

Q: During the Q &A session after the webinar when the phone lines were unmuted, it was hard to hear the questions/answers. Could you please share your answer again for the question that pertained to what can be said by the answering service when the benefit department has closed for the evening (and what time frame is that permissible).

A: We did not specifically address what can or cannot be said by the answering service when the benefit department has closed, but I believe you are referring to what Linda said, which was a general comment in response to slide 70 on inclement weather. At that point, we were discussing plans/sponsors having back-up measures in place in case they needed to close a center, meaning maybe a call center in the East has to "shut down" due to weather by passing the baton to a call center in the West, or something like that. Linda stated that she has also heard of plans who contract with their pharmacy benefit manager (PBM) to answer calls after hours. She postulated that the PBM may be able to respond to any Part D/prescription drug questions that comes in but would most likely just answer the phone and say that center was closed at this time and take a message. I do not recall anything more being said about center closures and the messages that are left, as we on the Call Center Monitoring team do not oversee that sort of process or react to any sort of message, unless there was an instance where a call center message says they are closed at an inappropriate time. In that case, the contractor informs me and I reach out to the compliance officer to ask why it was closed during the required hours of operation. Ultimately, we can take compliance actions for inappropriate closures. Our experience shows that most often, the sponsors' and plans' Medicare call centers are open as required.

Q: Slide 35 & 36 are a bit confusing. Where is the 2 minute Average Speed of Answer (ASA/AHT)? The ASA would be calculated from the time the caller has left the IVR and waiting for the agent to pick up the line, is that correct? Or, does it also include the 30 second to answer the initial call?
Also, want to clarify, we believe the ASA should be after the 30 second for the line to connect and should be after the beneficiary has navigated through the IVR and is now in the hold queue waiting for agent to pick up. Is that correct (ASA, 2 min is while the beneficiary is in the hold queue (after moving through the IVR))?

A: Slides 35-36 may have been confusing because I used those to discuss the Accuracy & Accessibility Study (Survey II) where we measure interpreter and TTY availability as well as the accuracy of questions. The slide generally does apply to the average hold time of 2 minutes or less as well, which is measured during

the quarterly Timeliness Study (Survey I). We covered that during the start of the call when we had the most audio problems, so you may not have heard me say this.

Just to clarify, we do not measure anything specifically called the Average Speed of Answer. Our study measures the average hold time, which is likely the same, but wanted to point that out in case it is difference in your call center. The text below, provided during our presentation, should answer your question.

> Let's take a minute to discuss the **Average Hold Time**. The average hold time is defined as the 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. Please be aware that time spent navigating the IVR system or touch tone response system does **not** count toward the average hold time. For calls in which our caller terminates the call due to being on hold greater than 10 minutes prior to reaching a live person, the hold time applied is 10 minutes. Contracts with an average hold time for each measure greater than 2 minutes are out of compliance with CMS standards.

Q: How can I receive the audio recording from the 2/3/2015 Webinar on Call Center Monitoring? I would like to share with staff that were unable to attend the live session.

A: We will post it in the same location where the slides are currently posted. The slide deck is available on CMS's webpage, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html. Following the presentation, we will attach a list of FAQ's to an updated version of the slide deck so that all can benefit from questions sent to the Call Center Monitoring mailbox after the call. This updated slide deck will also include clarifications to several questions asked during the webinar. We will post the recording with the updated slide deck.

I do want to point out that we had some audio difficulties in the beginning of the webinar, so the first 13 minutes of the original recording were not audible and were edited out of the recording. Therefore, I am sharing the script that accompanied the first 13 slides so that all can benefit from the section they may not have been able to hear.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN, *Plaintiff*, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 1:23-cv-3910-CJN

[PROPOSED] ORDER

UPON CONSIDERATION of Plaintiff SCAN Health Plan's Motion for Expedited Summary Judgment, Defendants Department of Health and Human Services, the Centers for Medicare and Medicaid Services ("CMS"), Xavier Becerra, and Chiquita Brooks-LaSure's ("Defendants'") Cross-Motion for Expedited Summary Judgment, and the parties' submissions on these motions, it is **HEREBY ORDERED** that:

1. Plaintiffs' Motion For Expedited Summary Judgment is **GRANTED**;
2. Defendants' Cross-Motion For Expedited Summary Judgment is **DENIED**;
3. CMS's calculation of SCAN Health Plan's 3.5-star 2024 Star Rating is **SET ASIDE** and **VACATED**;
4. Defendants are **ORDERED** not to utilize SCAN Health Plan's vacated 3.5-star 2024 Star Rating in connection with any quality bonus payment eligibility decisions;

5. Defendants are **ORDERED** to recalculate, prior to June 3, 2024, SCAN Health Plan's 2024 Star Rating consistent with the Court's Memorandum Opinion On Plaintiff's Motion For Expedited Summary Judgment, namely:
    a. Defendants shall apply the required 5 percentage point regulatory guardrail relative to prior-year actual measure-specific cut points in determining SCAN Health Plan's 2024 Star Rating, and
    b. Defendants shall exclude the February 9, 2023 secret-shopper call from Defendants' determination of SCAN Health Plan's Star Rating (or, alternatively, shall deem that call "completed"); and
6. Defendants are **ORDERED** to utilize SCAN Health Plan's recalculated 2024 Star Rating for purposes of determining SCAN Health Plan's eligibility for quality bonus payments for the 2025 Medicare Advantage plan year; and
7. This matter is **REMANDED** to CMS for further proceedings consistent with the Court's Opinion.

IT IS SO ORDERED.

SO ORDERED this ____ day of _____, 2024.

HONORABLE CARL J. NICHOLS
United States District Judge