IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CAREFIRST ADVANTAGE PPO, INC., Plaintiff, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Civil Action No. 26-cv-150-AHA

JOINT APPENDIX, VOLUME 1 OF 1, TABS 1-36

Tab	Description	AR Page No.
1	CMS Memo, April 20, 2023, 2023 Medicare Part D Patient Safety Reports	A.R. 1-6
2	CMS Memo, April 21, 2022, 2022 Medicare Part D Patient Safety Reports	A.R. 7-12
3	Acumen Message, July 31, 2024 Updated 2023 Reports Available (July 2024 Release)	A.R. 13–18
4	H7379 Adherence Summary YOS2023 June 2024	A.R. 19
5	CMS Memo, Plan Preview 1 2025, August 6, 2024	A.R. 48-49
6	2025 Star Ratings HPMS Preview CareFirst H7379	A.R. 61
7	Email Correspondence August 7, 2024 to August 8, 2024 H6067, H7379, and H8854 First Plan Preview	A.R. 63-66
8	CMS Memo, Plan Preview 2 2025, September 5, 2024	A.R. 67-68
9	Email Correspondence September 15, 2025 to September 18, 2025 H7379, Second Plan Preview	A.R. 69–77
10	2025 Star Ratings HPMS Preview CareFirst H7379	A.R. 90
11	Acumen Message, September 30, 2024 Patient Safety-- Updated Year of Service (YOS) 2023 Reports Available	A.R. 125–31
12	H7379 Download Activity Summary, December 22, 2025	A.R. 132
13	CMS Memo, Plan Preview 1 2026, August 5, 2025	A.R. 133-34
14	CMS Memo, Plan Preview 2 2026, September 8, 2025	A.R. 149
15	Email Correspondence September 9, 2025 Request for Calculation Sheets - H7379 and H8854	A.R. 151-52
16	H7379 2026 IM Calcs 2025	A.R. 154
17	CMS Memo, 2026 Star Ratings Marketing Template, September 11, 2025	A.R. 180

Tab	Description	AR Page No.
18	Email Correspondence September 15, 2025 to September 18, 2025 Plan Preview #2 for Contract H7379	A.R. 201-09
19	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 270
20	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 287
21	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 293-370
22	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 383
23	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 391
24	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 421
25	Medicare 2025 Part C & D Star Ratings Technical Notes	A.R. 453
26	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 485
27	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 559–60
28	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 568–70
29	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 592
30	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 600-04
31	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 606
32	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 631
33	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 633-34
34	Medicare 2026 Part C & D Star Ratings Technical Notes	A.R. 676-77
35	H7379 Adherence Summary YOS 2023 June 2024	A.R. 683–687
36	Acumen Message, July 31, 2025 Updated 2024 Reports Available (July 2025 Release)	A.R. 688-97

TAB 1

CMS Memo, April 20, 2023, 2023 Medicare Part D Patient Safety Reports

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

CENTER FOR MEDICARE

DATE: April 20, 2023

TO: All Prescription Drug Plans, Medicare Advantage-Prescription Drug Plans, Section 1876 Cost Plans, and PACE plans

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

SUBJECT: UPDATES - 2023 Medicare Part D Patient Safety Reports

The purpose of this memorandum is to announce the availability of the 2023 Patient Safety Reports on the Patient Safety Analysis Web Portal on April 28, 2023, updates to measure calculations, changes to measure specifications, new measures, and archiving of older reports. To access the Patient Safety Reports, you must be an authorized user of the Patient Safety Web Portal. The access authorization process is described later in this memo. Instructions can be found in the "Access to the Patient Safety Analysis Web Portal" section of this memorandum.

Medicare Part D Patient Safety Measures

For 2023, CMS will report and update monthly 14 patient safety measures through the Patient Safety Analysis Web Portal. Each month, Part D sponsors may download and review their measure packages. These actionable measure packages include a summary contract-level report for each measure and additional beneficiary-level files. Part D sponsors can use the Patient Safety Reports to compare their performance to overall averages and monitor their progress in improving their measure rates.

Several measures are displayed on the Medicare.gov Plan Finder as Part D Star Ratings or on CMS.gov as display measures. Medicare beneficiaries can use this information to make informed enrollment decisions about available health and prescription drug plans.

The patient safety measures include:

- Medication Adherence for Cholesterol (Statins) (ADH-Statins)
- Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)
- Medication Adherence for Diabetes Medications (ADH-Diabetes)
- Medication Adherence for HIV/AIDS (Antiretrovirals) (ADH-ARV)

- Statin Use in Persons with Diabetes (SUPD)
- Use of Opioids at High Dosage in Persons without Cancer (OHD)
- Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
- Antipsychotic Use in Persons with Dementia, Overall (APD)
- Antipsychotic Use in Persons with Dementia, for Long-Term Nursing Home Residents (APD-LTNH)
- Concurrent Use of Opioids and Benzodiazepines (COB)
- Polypharmacy: Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)
- Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)
- Initial Opioid Prescribing for Long Duration (IOP-LD)
- Persistence to Basal Insulin (PST-INS)

Sponsors may monitor their data in the reports and alert CMS if potential errors or anomalies are identified. The Patient Safety Analysis Web Portal facilitates communication between CMS, Part D contracts, and our contractor, Acumen, LLC. Sponsors can view "at-a-glance" Rate Summary and Performance Graphs for each measure and respond directly to outlier notices. CMS encourages sponsors to review the outlier notices; however, it is optional for Part D sponsors to respond.

The Patient Safety Analysis Web Portal User Guide is located under the Web Portal's navigation menu Help Documents web page link. Other information provided on the Help Documents web page includes links to each measure's Patient Safety Report User Guide, diagnosis codes, and the National Drug Code (NDC) medication lists used to calculate the measures.

The 14 year of service (YOS) 2022 measure reports will continue to be produced using YOS 2022 data submitted through July 2023.[1]

2023 Patient Safety Report Update

CMS will begin releasing monthly Patient Safety Reports using 2023 Prescription Drug Event (PDE) data with the April 2023 report release. The measures in these reports are calculated using 2023 PDE, fee-for-service claims, and encounter data processed up until one month before the release of the report. For example, the 2023 reports released on April 28, 2023 will contain PDE data for dates of service between January 1, 2023 and March 31, 2023, submitted by March 31, 2023. Each monthly report is updated as more complete 2023 data are submitted and processed.

All measures are calculated based on Pharmacy Quality Alliance (PQA) measure specifications and Value Sets, which include NDCs. The PQA updates their Value Sets biannually, usually in February and July. The April 2023 reports use the most recent updated PQA NDC lists and the ICD-10 diagnoses codes for both 2022 and 2023 data. Between NDC

[1] See HPMS memorandum, "UPDATES - 2022 Medicare Part D Patient Safety Reports, April 21, 2022."

list updates, sponsors may observe differences between their internal monitoring reports and the patient safety reports, especially if applying more real-time NDC changes or capturing PDE data not yet submitted to or processed by CMS.

The final YOS 2023 Patient Safety Reports will be released in July 2024, one month after the submission deadline for 2023 PDE records to CMS, and use the NDC list provided by the PQA in early 2024 (e.g., February). The final YOS 2023 contract rates will be used to calculate 2025 Part D Star Ratings and/or display page measures.

Patient Safety Measure Updates

Consistent with the Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies published on March 31, 2023,[2] the following changes are implemented with the release of the April 2023 reports using 2023 data unless otherwise specified.

Measure Specification Updates

APD and APD-LTNH:

- Modified APD measure description.
- Updated definition to existing numerator exclusion to reflect appropriate indication for antipsychotic use.
- Added a new numerator exclusion to remove beneficiaries with major depression diagnosis (treatment resistant) at any time during the measurement year. We will provide additional information in the APD measure user guide on how beneficiaries will be identified and excluded for major depression diagnosis based on the PQA measure manual.
- Removed the "greater than 60 days' cumulative supply" requirement from the denominator.

IOP-LD:

- Updated the timeframe to identify exclusions only during the measurement year or the 90 days prior to the index prescription start date (IPSD), the earliest date of service for an opioid medication during the measurement year, to align with the current PQA measure specifications.

Removal of Older Patient Safety Reports

As of April 30, 2023, the Patient Safety Analysis Web Portal will no longer display Performance Graphs or Rate Summary pages for 2020 Patient Safety Reports.

[2] Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

The reports will be archived and available only by request. Sponsors that currently have access to these reports may use the following Web Portal features to download this data before it is permanently archived:

- Use the Download Files feature to download 2020 contract-level and detail-level reports.
- Use the Export All Rate Measures feature on the Rate Summary page to download the final summary contract-level data for all 2020 measures.

Access to the Patient Safety Analysis Web Portal

To access the Patient Safety Reports, you will need to be an authorized user of the Patient Safety Analysis Web Portal. CMS' contractor, Acumen, LLC, currently manages the Patient Safety Analysis Web Portal. The Web Portal is accessible only to authorized participants, with each sponsor utilizing a secure space on the site that is separate from all other sponsors.

Only the Medicare Compliance Officer (MCO) for a given contract may authorize user access to Acumen's Patient Safety Web Portal for that contract. To streamline this process, Acumen has developed the User Security Web Portal – a web tool that allows MCOs to manage their users on the Acumen web portals.

To complete User Authorization, the MCO will need to:

1. Identify individuals who require access to the Patient Safety Analysis Web Portal for each contract.
    a. Contracts are limited to **five** authorized users.
    b. All authorized Web Portal users will have the ability to view all contract-specific portal content and transfer data for their designated contract and permission level.
    c. All authorized Web Portal users will also be able to discuss any data concerns with Acumen and CMS through contract-specific discussion boards.
2. Log on to the User Security Web Portal.
3. Complete the Add User steps to designate users and authorize access permissions.

Accessing the User Security Web Portal

Access to the Patient Safety Analysis Web Portal is managed by each contract's MCO through Acumen's User Security Web Portal. The latest MCO on record for each contract in HPMS has been granted access to the User Security Web Portal.

- **If your MCO already has an Acumen ProgramInfo Web Portal account**, they may log in to the User Security Web Portal using the same username and password.
- **If your MCO does not have an Acumen ProgramInfo Web Portal account**, your contract must update your MCO's contact information in HPMS to reflect the appropriate individual. Acumen will then disseminate login credentials to the updated MCO.

To access the User Security Web Portal:

1. Navigate to the Patient Safety Web Portal.
2. Agree to the Warning Notice.
3. Enter your username and login password.

Designating Users and Authorizing Access Permissions

After your organization's MCO logs in to the User Security Web Portal, they may review and/or update the current user access settings, or authorize access permissions for new users. Each contract is limited to a maximum of five users on the Patient Safety Analysis Web Portal.

- **If your contract is continuing from CY 2022**, your MCO may log in to the User Security Web Portal to review the list of individuals currently authorized to access your contract's information on the Patient Safety Analysis Web Portal. Your MCO may choose to keep the same user access settings or modify access as necessary.
- **If your contract is new in CY 2023**, your MCO may log in to the User Security Web Portal to add new users and authorize access permissions or choose to authorize existing users to access your contract's information.

To designate users and authorize access permissions, MCOs may complete the following steps through the User Security Web Portal:

1. Add an existing and/or new user.
2. Select the Web Portal and contract(s) for each user.
3. Authorize access permissions for each user.

MCOs may also designate themselves as one of the five authorized users on the Patient Safety Analysis Monitoring Web Portal.

All authorized users can log on to navigate the Web Portal and receive email notifications regarding report releases. However, access to the Patient Safety Analysis Web Portal can vary according to two possible access levels for each user:

- *Summary Report Only*: User can access a version of the Patient Safety Reports with summary information on contract-level data for each Patient Safety measure. Users will not be able to access beneficiary-level data.
- *Summary and Confidential Beneficiary Reports:* User can access confidential beneficiary-level information in the detail version of the Patient Safety Reports, in addition to the summary versions of the Patient Safety Reports.

At least one user from each contract must have access to Summary and Confidential Beneficiary Reports in order to view and respond to beneficiary-level issues.

Following the user authorization process, Acumen will send the following to each newly authorized Patient Safety Analysis Web Portal user:

- A Welcome Email with the Patient Safety Analysis Web Portal User Guide and

Web Portal URL.

- A Credential Email with a unique One-Time Password Link and login username.

Additional Resources

Part D sponsors can refer to the Part C&D Performance Data website.

Any general questions related to the Patient Safety Analysis project should be sent via email to PartCandDStarRatings@cms.hhs.gov.

For technical questions related to the user authorization process or access to the Web Portal or reports, please contact Acumen at PatientSafety@AcumenLLC.com or by phone at (650) 558-8006.

Thank you for your continued dedication to helping Medicare beneficiaries.

TAB 2

CMS Memo, April 21, 2022, 2022 Medicare Part D Patient Safety Reports

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

CENTER FOR MEDICARE

DATE: April 21, 2022

TO: All Prescription Drug Plans, Medicare Advantage-Prescription Drug Plans, Section 1876 Cost Plans, and PACE plans

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

SUBJECT: UPDATES - 2022 Medicare Part D Patient Safety Reports

The purpose of this memorandum is to announce the availability of the 2022 Patient Safety Reports on the Patient Safety Analysis Web Portal on April 29, 2022, updates to measure calculations, changes to measure specifications, new measures, and archiving of older reports.

To access the Patient Safety Reports, you must be an authorized user of the Patient Safety Web Portal. The access authorization process is described later in this memo. Instructions can be found in the "Access to the Patient Safety Analysis Web Portal" section of this memorandum.

Medicare Part D Patient Safety Measures

For 2022, CMS will report and update monthly 14 patient safety measures through the Patient Safety Analysis Web Portal. Each month, Part D sponsors may download and review their measure packages. These actionable measure packages include a summary contract-level report for each measure and additional beneficiary-level files. Part D sponsors can use the Patient Safety Reports to compare their performance to overall averages and monitor their progress in improving their measure rates.

Several measures are displayed on the Medicare.gov Plan Finder as Part D Star Ratings or on CMS.gov as display measures. Medicare beneficiaries can use this information to make informed enrollment decisions about available health and prescription drug plans.

The patient safety measures include:

- Medication Adherence for Cholesterol (Statins) (ADH-Statins)
- Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)
- Medication Adherence for Diabetes Medications (ADH-Diabetes)
- Medication Adherence for HIV/AIDS (Antiretrovirals) (ADH-ARV)
- Statin Use in Persons with Diabetes (SUPD)

- Use of Opioids at High Dosage in Persons without Cancer (OHD)
- Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
- Antipsychotic Use in Persons with Dementia, Overall (APD)
- Antipsychotic Use in Persons with Dementia, for Long-Term Nursing Home Residents (APD-LTNH)
- Concurrent Use of Opioids and Benzodiazepines (COB)
- Polypharmacy: Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)
- Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)
- Initial Opioid Prescribing for Long Duration (IOP-LD)
- Persistence to Basal Insulin (PST-INS)

Sponsors may monitor their data in the reports and alert CMS if potential errors or anomalies are identified. The Patient Safety Analysis Web Portal facilitates communication between CMS, Part D contracts, and our contractor, Acumen, LLC. Sponsors can view "at-a-glance" Rate Summary and Performance Graphs for each measure and respond directly to outlier notices. CMS encourages sponsors to review the outlier notices; however, it is optional for Part D sponsors to respond.

The Patient Safety Analysis Web Portal User Guide is located under the Web Portal's navigation menu Help Documents web page link. Other information provided on the Help Documents web page includes links to each measure's Patient Safety Report User Guide, diagnosis codes, and the National Drug Code (NDC) medication lists used to calculate the measures.

The 13 year of service (YOS) 2021 measure reports will continue to be produced using YOS 2021 data submitted through July 2022.[1]

2022 Patient Safety Report Update

CMS will begin releasing monthly Patient Safety Reports using 2022 Prescription Drug Event (PDE) data with the April 2022 report release. The measures in these reports are calculated using 2022 PDE, fee-for-service claims, and encounter data processed up until one month before the release of the report. For example, the 2022 reports released on April 29, 2022 will contain PDE data for dates of service between January 1, 2022 and March 31, 2022, submitted by March 31, 2022. Each monthly report is updated as more complete 2022 data are submitted and processed.

The 2022 Patient Safety Reports and User Guides include the following changes:

- A new user guide will be provided for the PST-INS measure once the reports are launched. We provide additional information on this measure in the "Patient Safety Measure Updates" section of this memorandum.
- "Number of enrolled beneficiaries" column will be included for all measure reports.

[1] See HPMS memorandum, "UPDATES - 2021 Medicare Part D Patient Safety Reports, April 21, 2021."

All measures are calculated based on Pharmacy Quality Alliance (PQA) measure specifications and National Drug Code (NDC) Value Sets. The PQA updates their NDC lists biannually, usually in February and July. The April 2022 reports use the most recent updated PQA NDC lists and the ICD-10 diagnoses codes for both 2021 and 2022 data. Between NDC list updates, sponsors may observe differences between their internal monitoring reports and the patient safety reports, especially if applying more real-time NDC changes or capturing PDE data not yet submitted to or processed by CMS.

The final YOS 2022 Patient Safety Reports will be released in July 2023, one month after the submission deadline for 2022 PDE records to CMS, and use the NDC list provided by the PQA in early 2023 (e.g., February). The final YOS 2022 contract rates will be used to calculate 2024 Part D Star Ratings and/or display page measures.

Patient Safety Measure Updates

Consistent with the Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies published on April 4, 2022,[2] the following changes are implemented with the release of the April 2022 reports using 2022 data unless otherwise specified:

New Measure. The PST-INS measure will be added to the Patient Safety Reports. The PST-INS measure analyzes the percentage of individuals 18 years of age or greater who were treatment persistent to basal insulin during the measurement year. A higher rate indicates better performance. As a reminder, the PST-INS measure will fully align with the PQA measure specifications and use the continuous enrollment definition, not adjusted member-years. We are still finalizing the programming for the PST-INS measure and will communicate with plans once the reports are launched for YOS 2022.

Removal of Alternative Data Source. The Risk Adjustment Processing System (RAPS) RxHCC codes are removed from all patient safety measures aligning with PQA updated 2022 measure specifications.

Measure Specification Updates

SUPD:

- Refined and narrowed the liver disease exclusion to include beneficiaries with a diagnosis of cirrhosis during the measurement year since liver disease without cirrhosis is not contraindicated. Therefore, liver disease is no longer an exclusion.

- Removed dapagliflozin and empagliflozin single ingredient medications from the NDC Medication Value Sets. The class of sodium-glucose cotransporter 2 (SGLT2) inhibitors were recently approved for use in reducing the risk of cardiovascular death and hospitalization for heart failure in adults with reduced ejection fraction (New York Heart Association class II-IV).

[2] See Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and D Payment Policies.

COB/OHD/OMP/IOP-LD:

- Beneficiaries in palliative care during the measurement period are excluded from all the opioid-related measures. Beneficiaries receiving palliative care have unique therapeutic goals and the risks and benefits associated with opioid use may be different from the broader population.

ADH-ARV:

- Added FDA-approved two-drug ARV regimens to the measure specifications.

Removal of Older Patient Safety Reports

As of April 30, 2022, the Patient Safety Analysis Web Portal will no longer display Performance Graphs or Rate Summary pages for 2019 Patient Safety Reports.

The reports will be archived and available only by request. Sponsors that currently have access to these reports may use the following Web Portal features to download this data before it is permanently archived:

- Use the Download Files feature to download 2019 contract-level and detail-level reports.
- Use the Export All Rate Measures feature on the Rate Summary page to download the final summary contract-level data for all 2019 measures.

Access to the Patient Safety Analysis Web Portal

To access the Patient Safety Reports, you will need to be an authorized user of the Patient Safety Analysis Web Portal. CMS' contractor, Acumen, LLC, currently manages the Patient Safety Analysis Web Portal. The Web Portal is accessible only to authorized participants, with each sponsor utilizing a secure space on the site that is separate from all other sponsors.

Only the Medicare Compliance Officer (MCO) for a given contract may authorize user access to Acumen's Patient Safety Web Portal for that contract. To streamline this process, Acumen has developed the User Security Web Portal – a web tool that allows MCOs to manage their users on the Acumen web portals.

To complete User Authorization, the MCO will need to:

1. Identify individuals who require access to the Patient Safety Analysis Web Portal for each contract.
    a. Contracts are limited to **five** authorized users.
    b. All authorized Web Portal users will have the ability to view all contract-specific portal content and transfer data for their designated contract and permission level.
    c. All authorized Web Portal users will also be able to discuss any data concerns with Acumen and CMS through contract-specific discussion boards.
2. Log on to the User Security Web Portal.
3. Complete the Add User steps to designate users and authorize access permissions.

<u>Accessing the User Security Web Portal</u>

Access to the Patient Safety Analysis Web Portal is managed by each contract's MCO through Acumen's User Security Web Portal. The latest MCO on record for each contract in HPMS has been granted access to the User Security Web Portal.

- **If your MCO already has an Acumen ProgramInfo Web Portal account**, they may log in to the User Security Web Portal using the same username and password.
- **If your MCO does not have an Acumen ProgramInfo Web Portal account**, your contract must update your MCO's contact information in HPMS to reflect the appropriate individual. Acumen will then disseminate login credentials to the updated MCO.

To access the User Security Web Portal:

1. Navigate to the Patient Safety Web Portal.
2. Agree to the Warning Notice.
3. Enter your username and login password.

Designating Users and Authorizing Access Permissions

After your organization's MCO logs in to the User Security Web Portal, they may review and/or update the current user access settings, or authorize access permissions for new users. Each contract is limited to a maximum of five users on the Patient Safety Analysis Web Portal.

- **If your contract is continuing from CY 2021**, your MCO may log in to the User Security Web Portal to review the list of individuals currently authorized to access your contract's information on the Patient Safety Analysis Web Portal. Your MCO may choose to keep the same user access settings or modify access as necessary.
- **If your contract is new in CY 2022**, your MCO may log in to the User Security Web Portal to add new users and authorize access permissions or choose to authorize existing users to access your contract's information.

To designate users and authorize access permissions, MCOs may complete the following steps through the User Security Web Portal:

1. Add an existing and/or new user.
2. Select the Web Portal and contract(s) for each user.
3. Authorize access permissions for each user.

MCOs may also designate themselves as one of the five authorized users on the Patient Safety Analysis Monitoring Web Portal.

All authorized users can log on to navigate the Web Portal and receive email notifications regarding report releases. However, access to the Patient Safety Analysis Web Portal can vary according to two possible access levels for each user:

- *Summary Report Only*: User can access a version of the Patient Safety Reports with summary information on contract-level data for each Patient Safety measure. Users will not be able to access beneficiary-level data.
- *Summary and Confidential Beneficiary Reports:* User can access confidential beneficiary-level information in the detail version of the Patient Safety Reports, in addition to the summary versions of the Patient Safety Reports.

At least one user from each contract must have access to Summary and Confidential Beneficiary Reports in order to view and respond to beneficiary-level issues.

Following the user authorization process, Acumen will send the following to each newly authorized Patient Safety Analysis Web Portal user:

- A Welcome Email with the Patient Safety Analysis Web Portal User Guide and Web Portal URL.
- A Credential Email with a unique One-Time Password Link and login username.

Additional Resources

Part D sponsors can refer to the Part C&D Performance Data website.

Any general questions related to the Patient Safety Analysis project should be sent via email to PartCandDStarRatings@cms.hhs.gov.

For technical questions related to the user authorization process or access to the Web Portal or reports, please contact Acumen at PatientSafety@AcumenLLC.com or by phone at (650) 558-8006.

Thank you for your continued dedication to helping Medicare beneficiaries.

TAB 3

Acumen Message, July 31, 2024 Updated 2023 Reports Available (July 2024 Release)

From: PatientSafety
To: "Ashley.Ellerbee@carefirst.com"
Subject: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

DATE: July 31, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Ashley.Ellerbee@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2024 and June 30, 2024).

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Mike.Schulte@carefirst.com"
Subject: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

DATE: July 31, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Mike.Schulte@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2024 and June 30, 2024).

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Lauren.Roberts@carefirst.com"
Subject: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

DATE: July 31, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Lauren.Roberts@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2024 and June 30, 2024).

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Ifeoma.Atueyi@carefirst.com"
Subject: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

DATE: July 31, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Ifeoma.Atueyi@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2024 and June 30, 2024).

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "mary-paul.snapp-borleis@carefirst.com"
Subject: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

DATE: July 31, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
mary-paul.snapp-borleis@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2024 and June 30, 2024).

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Catherine.Lee@carefirst.com"
Subject: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

DATE: July 31, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Catherine.Lee@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2023 Reports Available (July 2024 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2024 and June 30, 2024).

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

TAB 4

H7379 Adherence Summary YOS2023 June 2024

Adherence (ADH) Measures Summary

Note: Beneficiaries with one or more fills for insulin are excluded from the ADH-Diabetes Rate. Beneficiaries with one or more fills for sacubitril/valsartan are excluded from the ADH-RAS Rate.

Date of Report	July 31 2024
Period Measured	Jan 2023 - Dec 2023
Contract Number	H7379
Contract Name	CAREFIRST ADVANTAGE PPO, INC.

All Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract Type	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Number of Member-Years of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)				Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)				Medication Adherence for Cholesterol (Statins) (ADH-Statins)			
			Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Diabetes Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-RAS Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Statins Rate
All Contracts	51,960,210	48,857,022.58	8,225,795	7,976,711.0	6,864,413.5	86%	21,467,187	20,909,512.1	18,596,410.8	89%	25,973,262	25,315,692.9	22,227,898.0	88%
MAPDs	29,892,494	28,329,883.17	5,122,066	4,922,811.7	4,248,246.1	86%	12,687,491	12,225,888.7	10,940,709.7	89%	15,181,656	14,675,095.4	12,959,809.0	88%
MA-PDs (non-MMP)	29,592,764	28,046,673.42	5,073,763	4,876,806.6	4,210,643.7	86%	12,563,340	12,136,355.6	10,865,489.1	90%	15,061,369	14,560,633.2	12,864,042.9	88%
H7379	3,846	3,676.75	632	618.5	560.3	91%	1,783	1,756.8	1,582.3	90%	2,133	2,105.4	1,848.8	88%

LIS Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract Type	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Number of Member-Years of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)				Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)				Medication Adherence for Cholesterol (Statins) (ADH-Statins)			
			Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Diabetes Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-RAS Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Statins Rate
All Contracts	14,180,241	13,483,598.25	2,630,414	2,498,388.0	2,152,688.9	86%	5,436,669	5,162,188.8	4,467,255.0	87%	6,613,091	6,281,050.4	5,399,745.8	86%
MAPDs	9,329,010	8,858,654.08	1,859,497	1,743,916.8	1,516,580.4	87%	3,813,911	3,578,801.9	3,131,204.5	87%	4,627,788	4,343,596.4	3,765,485.6	87%
MA-PDs (non-MMP)	9,029,250	8,575,450.08	1,811,195	1,697,912.8	1,477,979.1	87%	3,719,761	3,489,068.8	3,055,984.8	88%	4,507,496	4,229,193.2	3,669,609.5	87%
H7379	68	60.42	11	10.9	6.0	55%	26	25.0	20.0	80%	31	30.0	25.1	84%

Non-LIS Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract Type	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Number of Member-Years of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)				Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)				Medication Adherence for Cholesterol (Statins) (ADH-Statins)			
			Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Diabetes Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-RAS Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Statins Rate
All Contracts	37,824,853	36,373,424.33	5,596,350	5,478,323.0	4,711,724.6	86%	16,032,406	15,747,323.3	14,129,155.8	90%	19,362,344	19,034,642.5	16,828,152.2	88%
MAPDs	20,597,239	19,671,229.08	3,263,362	3,178,894.8	2,732,665.7	86%	8,845,052	8,647,287.8	7,809,505.3	90%	10,555,445	10,331,440.0	9,194,433.4	89%
MA-PDs (non-MMP)	20,597,232	19,671,223.33	3,263,361	3,178,893.8	2,732,664.7	86%	8,845,051	8,647,286.8	7,809,504.3	90%	10,555,445	10,331,440.0	9,194,433.4	89%
H7379	3,778	3,616.33	621	607.6	544.3	90%	1,757	1,731.8	1,562.3	90%	2,102	2,075.4	1,823.7	88%

TAB 5

CMS Memo, Plan Preview 1 2025, August 6, 2024

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

CENTER FOR MEDICARE

DATE: August 6, 2024

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Medicare-Medicaid Plans, and Section 1876 Cost Plans

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

SUBJECT: First Plan Preview of 2025 Medicare Parts C and D Star Ratings Data

The purpose of this memo is to inform Part C and D sponsors that they can preview their Star Ratings data in the Health Plan Management System (HPMS) prior to display on the Medicare Plan Finder (MPF). The first plan preview will be held from August 7-14, 2024.

During this first plan preview, CMS expects Part C and D sponsors to closely review the methodology and their posted data for each measure. Sponsors should immediately alert CMS of any suspected data issues or errors in order to allow sufficient time to investigate and process any necessary data corrections.

Star Ratings assignments will not be available for the first plan preview. A second plan preview will be conducted in September and will include any revisions made as a result of the first plan preview; in addition, preliminary Star Ratings for each measure, domain, summary score, and overall score will be displayed. Please note that any disaster adjustments will be incorporated into the Star Ratings shown in the second plan preview. Medicare beneficiaries will be able to view the final Star Ratings via the MPF on www.medicare.gov in October. Data for Medicare-Medicaid Plans (MMPs) are displayed in HPMS for informational purposes only.

Instructions for Accessing Preview Data:

- To access the Part C and D Star Ratings preview in HPMS, select: "Quality and Performance," then "Performance Metrics," then "Reports," "Star Ratings and Display Measures," then "Star Ratings," and then make sure 2025 is selected for the report period.
- The draft 2025 Part C & D Star Ratings Technical Notes are available via the "Download" link, then "Technical Notes" within the Star Ratings module.

Please email comments or questions to the following mailbox:
PartCandDStarRatings@cms.hhs.gov.

Please include "Plan Preview #1" and a Contract ID in the subject line. If you are emailing about multiple contracts with similar issues, please group your questions into a limited number of emails.

Do not submit emails requiring CMS to log in to a website to access the questions. If you need to share personally identifiable information with us, please contact us via email to discuss a safe way to transfer the data.

Comments and questions will be addressed on a rolling basis and must be received no later than 5:00 p.m. Eastern time on August 14, 2024.

Due to requests from contracts for more tools to help track upcoming changes, we have released a summary of the 2026 Star Ratings measures and their weights at https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

Thank you for your continued commitment to ensure the success of the Medicare Advantage and Prescription Drug programs.

TAB 6

2025 Star Ratings HPMS Preview CareFirst H7379

DD4: Drug Safety and Accuracy of Drug Pricing		
D08: Medication Adherence for Diabetes Medications	D09: Medication Adherence for Hypertension (RAS antagonists)	D10: Medication Adherence for Cholesterol (Statins)
01/01/2023 – 12/31/2023	01/01/2023 – 12/31/2023	01/01/2023 – 12/31/2023
89%	90%	88%

TAB 7

Email Correspondence August 7, 2024 to August 8, 2024
H6067, H7379, and H8854 First Plan Preview

From:	CMS PartC&DStarRatings
To:	Snapp-Borleis, Mary-Paul
Cc:	Adam, Rebecca; Moore, Lashawn; Modesto, Pia; Moxham, Suzanne; Larbie, Nitza; Law, Scott; CMS PartC&DStarRatings
Subject:	RE: Questions from H6067, H7379, and H8854 First Plan Preview
Date:	Thursday, August 8, 2024 6:48:00 AM
Attachments:	image003.png image004.png image005.png

Good morning,

Regarding question two, please see the final July Patient Safety reports from Acumen.

Thank you,

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

From: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Sent: Wednesday, August 7, 2024 9:42 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Adam, Rebecca <Rebecca.Adam@carefirst.com>; Moore, Lashawn <Lashawn.Moore@carefirst.com>; Modesto, Pia <Pia.Modesto@carefirst.com>; Moxham, Suzanne <Suzanne.Moxham@carefirst.com>; Larbie, Nitza <Nitza.Larbie@carefirst.com>; Law, Scott <Scott.Law@carefirst.com>
Subject: RE: Questions from H6067, H7379, and H8854 First Plan Preview

Good evening

Thank you for your response to our first question concerning the Part C Appeals data. We have downloaded the report again this evening and see the actual Part C Appeals data listed for our H6067 and H8854 contracts.

Will someone be providing a response to our second question concerning Part D Adherence Measures? Specifically, will we receive any additional information with the detail behind the rates, or should we refer to the latest Acumen reports we received?

With Care,

Mary-Paul Snapp-Borleis
Dir. Medicare & Medicaid Compliance Officer
Ethics & Compliance: Government Programs
CareFirst BlueCross BlueShield
W 410-605-2579 | F 410-720-6660

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, August 7, 2024 5:47 PM
To: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Adam, Rebecca <Rebecca.Adam@carefirst.com>; Moore, Lashawn <Lashawn.Moore@carefirst.com>; Modesto, Pia <Pia.Modesto@carefirst.com>; Moxham, Suzanne <Suzanne.Moxham@carefirst.com>; Larbie, Nitza <Nitza.Larbie@carefirst.com>; Law, Scott <Scott.Law@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Questions from H6067, H7379, and H8854 First Plan Preview

For number 1, the data for the Measure Detail – Part C Appeals page did not fully load initially. It should now be available. If you have any further issues viewing the data, please let us know.

Part C and D Star Ratings Team

From: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Sent: Wednesday, August 7, 2024 5:38 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Adam, Rebecca <Rebecca.Adam@carefirst.com>; Moore, Lashawn <Lashawn.Moore@carefirst.com>; Modesto, Pia <Pia.Modesto@carefirst.com>; Moxham, Suzanne <Suzanne.Moxham@carefirst.com>; Larbie, Nitza <Nitza.Larbie@carefirst.com>; Law, Scott <Scott.Law@carefirst.com>

Subject: Questions from H6067, H7379, and H8854 First Plan Preview

Good afternoon –

Pursuant to the 8/6/2024 HPMS Memorandum titled "First Plan Preview of 2025 Medicare Parts C and D Star Rating Data" we have identified the following issues:

1. On the SR_2025_measure data file, we received ratings for C28: Plan Makes Timely Decisions about Appeals and C29: Reviewing Appeals Decisions for H6067 and H8854. However, the SR_2025_appeals_c document states "there is no data available for this section". Can you please provide the appeals detail so that we can validate the rates?

2. For Part D measures (medication adherence, SUPD, MPF Price Accuracy), will we be receiving any additional information with the detail behind the rates, or should we refer to the latest Acumen reports we received?

Thank you in advance for your review and assistance.

With Care,

Mary-Paul Snapp-Borleis
Dir. Medicare & Medicaid Compliance Officer
Ethics & Compliance: Government Programs
CareFirst BlueCross BlueShield
W 410-605-2579 | F 410-720-6660

We work flexibly at CareFirst. I'm sending this email now because it works for me, but I don't expect that you will read, respond to, or act on it outside of your regular business hours.

-

CareFirst | 2024 WORLD'S MOST ETHICAL COMPANIES ETHISPHERE 12-TIME HONOREE

BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

TAB 8

CMS Memo, Plan Preview 2 2025, September 5, 2024

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

CENTER FOR MEDICARE

DATE: September 5, 2024

TO: All Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

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

SUBJECT: Second Plan Preview of 2025 Part C and D Star Ratings Data

The purpose of this memorandum is to inform Part C and D sponsors that they can preview their Star Ratings data in the Health Plan Management System (HPMS) prior to display on the Medicare Plan Finder (MPF). The second plan preview will be available September 6, 2024 and will end on September 13, 2024 at 5:00 p.m. ET. We have made measure data revisions and Technical Notes updates following the first plan preview. Additionally, each contract's preliminary Star Ratings for each measure, domain, summary score, and overall score will be displayed, including any applicable disaster adjustments. We have also added files in HPMS with data for sample Part C and D measures for contracts to check the CMS programming. The 2025 Star Ratings are scheduled to be released via the MPF on Medicare.gov on or about October 10, 2024.

During this second plan preview, CMS expects Part C and D sponsors to again closely review their posted data for each measure, as well as their preliminary Star Rating assignments. Sponsors should *immediately* alert CMS of any suspected data issues or errors during the plan preview in order to allow sufficient time to investigate and process any necessary data corrections. If you print or save the data displayed on the HPMS Star Rating preview pages, please double check the current values online prior to submitting emails in case any updates have been made. Prior to the release of data on the MPF, all data in HPMS will be updated with the final 2025 Star Ratings. As a reminder, we are unable to make changes to the 2025 Star Ratings methodology that has previously been codified at §§ 422.160 - 422.166 and 423.180 - 423.186.

Instructions for Accessing Preview Data:

- To access the Part C and D Star Ratings preview in HPMS, select: "Quality and Performance," then "Performance Metrics," then "Reports," then "Star Ratings and Display Measures," then "Star Ratings," and then select 2025 for the report period.
- The draft 2025 Part C & D Star Ratings Technical Notes are available by selecting the "Download" link, then "Technical Notes" within the Star Ratings module.

Please email comments or questions to the following mailbox: PartCandDStarRatings@cms.hhs.gov. Please include "Plan Preview #2" and a Contract ID in the subject line. If you are emailing about multiple contracts with similar issues, please group your questions into a limited number of emails. In this case, include "Plan Preview #2" and the organization name in the subject line, and list the affected Contract IDs in the actual email.

Do not submit emails requiring CMS to log in to a website to access the questions.

If you need to share personally identifiable information (PII) with us, please contact us via regular email to discuss a safe way to transfer the data.

Comments and questions must be received no later than 5:00 p.m. ET on September 13, 2024 and will be addressed on a rolling basis.

Thank you for your continued commitment to ensure the success of the Medicare Advantage and Prescription Drug programs.

TAB 9

Email Correspondence
September 15, 2025 to September 18, 2025
H7379, Second Plan Preview

From: CMS PartC&DStarRatings
To: Adam, Becca; Snapp-Borleis, Mary-Paul
Cc: Haynes, Liz; Williams, Krishelle; Incorvati, Laura; CMS PartC&DStarRatings; CMS PartC&DStarRatings
Subject: RE: Plan Preview #2 for Contract H7379_
Date: Thursday, September 18, 2025 12:34:33 PM
Attachments: image001.png
image002.png
image003.png

Good afternoon,

There are other instances where a contract just misses a threshold and we are unable to make changes in these situations since we need to follow the codified methodology.
The ratio of the improvement change score to the standard error is compared to 1.96, and if that exceeds 1.96 then the contract gets significant improvement on that measure. As is standard in statistical hypothesis testing, a statistically significant result is only obtained if the test-statistic exceeds the specified critical value (1.96 being the critical value corresponding to a test with significance level alpha=0.05, as specified in the technical notes). However, in this case, the contract's ratio was 1.89, which does not exceed 1.96, e.g., it does not meet the criteria for statistical significance at the alpha=0.05 level.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, September 17, 2025 2:08 PM
To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Confirming receipt.

From: Adam, Becca <Becca.Adam@carefirst.com>
Sent: Wednesday, September 17, 2025 1:59 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>
Subject: RE: Plan Preview #2 for Contract H7379_

Thank you for your response. CareFirst is aware that the methodology for statistically

identifying improvement cannot be adjusted without regulation changes. However, CareFirst is requesting that CMS reconsider situations where the improvement is well within the margin of error used for statistical significance. CareFirst respectfully requests CMS to consider this unique situation of being less than one single member from being statistically significant and statistically demonstrating improvement, as from a practical standpoint the improvement is clearly demonstrated across the whole population in the measure, not just a sample.

Thanks,
Becca

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, September 17, 2025 12:09 PM
To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

What you are requesting is a change to the methodology for calculating the improvement measures. Any changes to methodology need to be proposed and finalized through rulemaking.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 16, 2025 4:53 PM
To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Confirming receipt.

From: Adam, Becca <Becca.Adam@carefirst.com>

Sent: Tuesday, September 16, 2025 4:48 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>
Subject: RE: Plan Preview #2 for Contract H7379_

Good afternoon,

Thank you for the clarification on how the MAX function is applied.

However, the remainder of our statement was not addressed in your response. Specifically, our concern that the measure rate gap was only 0.034552 away from the threshold, equivalent to just 0.64 of a member in the numerator. We believe we demonstrated meaningful improvement that aligns with the intent of the Stars program:

- The measure rate gap of 0.034552 is equivalent to just 0.64 of a member in the numerator (SY2026 numerator: 1695; SY2026 denominator: 1863). Since fractional members cannot exist and a full member was not needed to reach statistical significance, this creates a barrier to recognizing actual improvement.
- The result is that CareFirst fell short of achieving significant improvement by a margin that does not align with the intent of the Stars program. The program's purpose is to encourage and reward meaningful quality improvement, which we believe we demonstrated such improvement.
- The stakes of this calculation are substantial. Reaching significant improvement would improve our Part D QI rate to 0.4705888 and to 4 Stars (from 3 Stars). This would then move our Overall Star Rating from a 3.5 to a 4.0 overall. The difference between receiving 3.5 Stars versus 4.0 Stars equates to only 0.64 of a single member. This outcome does not reflect the reality of our performance nor the goals of the Stars program.

We are committee to quality improvement and to working collaboratively with CMS to ensure program goals are met.

Thank you for your consideration.

Thanks,
Becca

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 16, 2025 3:55 PM

To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Hello,

When you tried to remove the MAX function during your exploration, you removed too many parentheses and inadvertently changed the equation of the standard error calculation. Removing the MAX function if done correctly does not change the standard error:

CORRECT EQUATION WITHOUT MAX:

SQRT((E11*(100-E11)/K11+F11*(100-F11)/M11)-2*R11*SQRT(E11*(100-E11)/K11)*SQRT(F11*(100-F11)/M11)) = 0.482249752 (No Significant Difference) CORRECT

YOUR INCORRECT EQUATION:

SQRT(E11*(100-E11)/K11+F11*(100-F11)/M11)-2*R11*SQRT(E11*(100-E11)/K11)*SQRT(F11*(100-F11)/M11) = 0.257553228 (Significant Improvement) INCORRECT

These contract-specific calculation spreadsheets emulate the actual SAS calculation and are a tool to help contract(s) understand the calculations. The official calculations are located in HPMS. Contracts should focus on reviewing their Star Ratings data in HPMS during the preview period since these are the preliminary data that we anticipate posting on Medicare Plan Finder.

Thank you,

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

From: Adam, Becca <Becca.Adam@carefirst.com>
Sent: Tuesday, September 16, 2025 11:03 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>
Subject: RE: Plan Preview #2 for Contract H7379_

Good morning,

Thank you for the clarification on the updated Patient Safety Reports. We still respectfully request that CMS reconsider the calculation of the Part D improvement measure for H7379, specifically for the Medication Adherence for Hypertension measure.

We continue to believe that the current calculation method does not accurately reflect the true improvement that was demonstrated:

- The maximum standard error (MAX) is not applied consistently across measures, and the technical specifications do not explicitly reference its use in this calculation. Applying MAX creates a larger, more conservative threshold which makes achieving improvement much more difficult.
- Without the use of MAX, CareFirst would have achieved statistically significant improvement in Medication Adherence for Hypertension (See attached example). With MAX applied, the improvement calculation fell just short. Specifically, the difference between SY2025 and SY2026 was 0.910659, but the threshold with MAX applied was 0.945210, meaning the gap to achieve significant improvement was just 0.034552.
- The measure rate gap of 0.034552 is equivalent to just 0.64 of a member in the numerator (SY2026 numerator: 1695; SY2026 denominator: 1863). Since fractional members cannot exist and a full member was not needed to reach statistical significance, this strict calculation creates a barrier to recognizing actual improvement.

The result is that CareFirst fell short of achieving significant improvement by a margin that does not align with the intent of the Stars program. The program's purpose is to encourage and reward meaningful quality improvement, which we believe we demonstrated such improvement.

The stakes of this calculation are substantial. Reaching significant improvement would improve our Part D QI rate to 0.4705888 and to 4 Stars. This would then move our Overall Star Rating from a 3.5 to a 4.0 overall. With the current calculation for statistical significance, the difference between receiving 3.5 Stars versus 4.0 Stars equates to only 0.64 of a single member. This outcome does not reflect the reality of our performance nor the goals of the Stars program.

CareFirst respectfully urges CMS to reconsider this outcome. CareFirst is deeply committed to continuous improvement and has consistently demonstrated progress across measures for H7379, including Medication Adherence for Hypertension.

Thanks,
Becca

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, September 15, 2025 2:08 PM
To: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Adam, Becca <Becca.Adam@carefirst.com>; Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Hi Mary-Paul,

Thank you for reaching out. As a reminder, last year we notified all Part D contracts that the final YOS 2023 July Patient Safety Report Package zip files were re-uploaded to replace the zip files that were originally uploaded on July 31, 2024 due to minor technical issues in the process that assigns and links Prescription Drug Event (PDE) and the Common Working File (CWF) claims to beneficiaries, which impacted a small fraction of beneficiaries. The rates in these reports were calculated using the PDE data with dates of service between January 1, 2023, and December 31, 2023 (submitted between January 1, 2023- June 28, 2024). We explained in the email notification to all Part D contracts that the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged.

For the Medication Adherence measures for H7379 remained unchanged for Diabetes and Cholesterol (Statin) and marginally improved for Hypertension (RAS) to 0.90071628. Note, this revised rate of 0.90071628 was used in last year's Part D Improvement Measure calculation for

the CY 2025 measure score.

Please review the re-uploaded final monthly report which was uploaded to the Web Portal last year in September 2024 for measurement year 2023 using the PDE data with dates of service between January 1, 2023, and December 31, 2023 (submitted between January 1, 2023- June 28, 2024).

Best,
Part C & D Star Ratings

From: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Sent: Monday, September 15, 2025 8:42 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Adam, Becca <Becca.Adam@carefirst.com>; Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Subject: Plan Preview #2 for Contract H7379_

Good morning –

CareFirst Advantage PPO, Inc., Contract H7379, has identified a data error in the Star Ratings calculation in Plan Preview #2. We would like to request that CMS review the calculation of the Part D improvement measure for this contract. The rates for Star Year 2025 that are included in the improvement calculation for the medication adherence measures do not match the rates in the final Acumen reports distributed in July 2024. The full details are in the attached letter titled "202-09-15_Starts Recalculation_H7379_PlanReview2" and the attached Acumen report that includes the final Star Year 2025 adherence rates.

Please feel free to contact me if you have any questions.

Mary-Paul Snapp-Borleis (She/her/hers)
Dir. Medicare & Medicaid Compliance Officer
Ethics & Compliance: Government Programs
CareFirst BlueCross BlueShield
1501 S. Clinton Street, Baltimore, MD 21224
W 410-605-2579 | F 410-720-6660

-

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates

comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

TAB 10

2025 Star Ratings HPMS Preview CareFirst H7379

		DD4: Drug Safety and Accuracy of Drug Pricing	
D07: MPF Price Accuracy	D08: Medication Adherence for Diabetes Medications	D09: Medication Adherence for Hypertension (RAS antagonists)	D10: Medication Adherence for Cholesterol (Statins)
01/01/2023 – 9/30/2023	01/01/2023 – 12/31/2023	01/01/2023 – 12/31/2023	01/01/2023 – 12/31/2023
Not enough data available	89%	90%	88%

TAB 11

Acumen Message, September 30, 2024 Patient Safety-- Updated Year of Service (YOS) 2023 Reports Available

From: PatientSafety
To: "Mary-Paul.Snapp-Borleis@Carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Mary-Paul.Snapp-Borleis@Carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Ashley.Ellerbee@carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Ashley.Ellerbee@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Catherine.Lee@carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Catherine.Lee@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Ifeoma.Atueyi@carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Ifeoma.Atueyi@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Sara.M.Barekzai@carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Sara.M.Barekzai@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Mike.Schulte@carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Mike.Schulte@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

From: PatientSafety
To: "Lauren.Roberts@carefirst.com"
Subject: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

DATE: September 30, 2024

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Lauren.Roberts@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated Year of Service (YOS) 2023 Reports Available

---

Notice Regarding Update to the YOS 2023 Reports

Updated final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2023 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024. The rates in these reports were calculated using PDE data with dates of service between January 1, 2023 and December 31, 2023 (submitted between January 1, 2023 and June 28, 2024).

We identified and corrected a minor technical issue in the process that assigns and links PDE and Common Working File (CWF) claims to beneficiaries that impacted a small fraction of beneficiaries. The impact to the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged. The updated 2025 Part C and D Star Ratings data will be available from CMS in HPMS in early October.

Web Portal User Authorization Reminder

As a reminder, only Patient Safety Web Portal users with authorized access will be able to download the Patient Safety Reports. MCOs must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

TAB 12

H7379 Download Activity Summary, December 22, 2025

Contract H7379 Activity Summary Report

First Published: 12/22/2025
Last Updated: 12/22/2025

Overview

The table below presents an Activity Summary Report for the re-run final July 2024 YOS 2023 reports, including the report month, YOS, file name, download date, authorized user, report version, and delete status for contract H7379.

Activity Summary Report

Contract	Contract Report Month	YOS	File Name	Download Date	Authorized User	Report Version	Delete Date
H7379	24-Jul	2023	H7379_Detail_PtSafety_YOS2023_06-2024.zip	9/15/2025 13:15	programinfo\Ifeoma.Atueyi	UPDATED	
H7379	24-Jul	2023	H7379_Summary_PtSafety_YOS2023_06-2024.zip	9/15/2025 13:15	programinfo\Ifeoma.Atueyi	UPDATED	
H7379	24-Jul	2023	H7379_Summary_PtSafety_YOS2024_06-2024.zip	9/15/2025 13:13	programinfo\Ifeoma.Atueyi	UPDATED	
H7379	24-Jul	2023	H7379_Summary_PtSafety_YOS2023_06-2024.zip	9/15/2025 13:10	programinfo\Ifeoma.Atueyi	UPDATED	
H7379	24-Jul	2024	H7379_Detail_PtSafety_YOS2024_06-2024.zip	7/31/2024 18:08	programinfo\Catherine.Lee	ORIGINAL	
H7379	24-Jul	2024	H7379_Summary_PtSafety_YOS2024_06-2024.zip	7/31/2024 18:08	programinfo\Catherine.Lee	ORIGINAL	
H7379	24-Jul	2023	H7379_Detail_PtSafety_YOS2023_06-2024.zip	7/31/2024 18:08	programinfo\Catherine.Lee	ORIGINAL	9/30/2024 9:06
H7379	24-Jul	2023	H7379_Summary_PtSafety_YOS2023_06-2024.zip	7/31/2024 18:08	programinfo\Catherine.Lee	ORIGINAL	9/30/2024 9:06

TAB 13

CMS Memo, Plan Preview 1 2026, August 5, 2025

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

CENTER FOR MEDICARE

DATE: August 5, 2025

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Medicare-Medicaid Plans, and Section 1876 Cost Plans

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

SUBJECT: First Plan Preview of 2026 Medicare Parts C and D Star Ratings Data

The purpose of this memo is to inform Part C and D sponsors that they can preview their Star Ratings data in the Health Plan Management System (HPMS) prior to display on the Medicare Plan Finder (MPF). The first plan preview will be held from August 6-13, 2025.

During this first plan preview, CMS expects Part C and D sponsors to closely review the methodology and their posted data for each measure. Sponsors should immediately alert CMS of any suspected data issues or errors in order to allow sufficient time to investigate and process any necessary data corrections.

Star Ratings assignments will not be available for the first plan preview. A second plan preview will be conducted in September and will include any revisions made as a result of the first plan preview; in addition, preliminary Star Ratings for each measure, domain, summary score, and overall score will be displayed. Please note that any disaster adjustments will be incorporated into the Star Ratings shown in the second plan preview. Medicare beneficiaries will be able to view the final Star Ratings via the MPF on www.medicare.gov in October. Data for Medicare-Medicaid Plans (MMPs) are displayed in HPMS for informational purposes only.

Instructions for Accessing Preview Data:

- To access the Part C and D Star Ratings preview in HPMS, select: "Quality and Performance," then "Performance Metrics," then "Reports," "Star Ratings and Display Measures," then "Star Ratings," and then make sure 2026 is selected for the report period.
- The draft 2026 Part C & D Star Ratings Technical Notes are available via the "Download" link, then "Technical Notes" within the Star Ratings module.

Please email comments or questions to the following mailbox: PartCandDStarRatings@cms.hhs.gov. Also, copy the CallCenterMonitoring@cms.hhs.gov mailbox for call center monitoring questions.

Please include "Plan Preview #1" and a Contract ID in the subject line. If you are emailing about multiple contracts with similar issues, please group your questions into a limited number of emails.

Do not submit emails requiring CMS to log in to a website to access the questions. If you need to share personally identifiable information with us, please contact us via email to discuss a safe way to transfer the data.

Comments and questions will be addressed on a rolling basis and must be received no later than 5:00 p.m. Eastern time on August 13, 2025.

Due to requests from contracts for more tools to help track upcoming changes, we have released a summary of the 2027 Star Ratings measures and their weights at https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

Thank you for your continued commitment to ensure the success of the Medicare Advantage and Prescription Drug programs.

TAB 14

CMS Memo, Plan Preview 2 2026, September 8, 2025

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

CENTER FOR MEDICARE

DATE: September 8, 2025

TO: All Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

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

SUBJECT: Second Plan Preview of 2026 Part C and D Star Ratings Data

The purpose of this memorandum is to inform Part C and D sponsors that they can preview their Star Ratings data in the Health Plan Management System (HPMS) prior to display on the Medicare Plan Finder (MPF). The second plan preview will be available September 9, 2025 and will end on September 16, 2025 at 5:00 p.m. ET. We have made measure data revisions and Technical Notes updates following the first plan preview. Additionally, each contract's preliminary Star Ratings for each measure, domain, summary score, and overall score will be displayed, including any applicable disaster adjustments. We have also added files in HPMS with data for sample Part C and D measures for contracts to check the CMS programming. Sample data are provided for one of each type of measure needed to replicate cut points; the same cut point programming is used for all other measures as the sample measures. The 2026 Star Ratings are scheduled to be released via the MPF on Medicare.gov on or about October 9, 2025.

During this second plan preview, CMS expects Part C and D sponsors to again closely review their posted data for each measure, as well as their preliminary Star Rating assignments. Sponsors should *immediately* alert CMS of any suspected data issues or errors during the plan preview in order to allow sufficient time to investigate and process any necessary data corrections. If you print or save the data displayed on the HPMS Star Rating preview pages, please double check the current values online prior to submitting emails in case any updates have been made. Prior to the release of data on the MPF, all data in HPMS will be updated with the final 2026 Star Ratings. Finalized Star Ratings will be available for all contracts, including withdrawn and terminated contracts, in HPMS in early October. As a reminder, we are unable to make changes to the 2026 Star Ratings methodology that has previously been codified at §§ 422.160 - 422.166 and 423.180 - 423.186.

Instructions for Accessing Preview Data:

- To access the Part C and D Star Ratings preview in HPMS, select: "Quality and Performance," then "Performance Metrics," then "Reports," then "Star Ratings and Display Measures," then "Star Ratings," and then select 2026 for the report period.

TAB 15

Email Correspondence September 9, 2025 Request for Calculation Sheets - H7379 and H8854

From: CMS PartC&DStarRatings
To: Adam, Becca
Cc: Moore, Lashawn; CMS PartC&DStarRatings
Subject: RE: Request for calculation sheets - H7379 and H8854
Date: Tuesday, September 9, 2025 1:41:00 PM
Attachments: image002.png
image003.png
H7379_2026_IM_Calcs_2025_09_09.xlsx
H7379_2026_SR_Calculations_2025_09_09.xlsx
H8854_2026_IM_Calcs_2025_09_09.xlsx
H8854_2026_SR_Calculations_2025_09_09.xlsx

Hi Becca,

Please see attached.

Thank you and regards,

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

From: Adam, Becca <Becca.Adam@carefirst.com>
Sent: Tuesday, September 9, 2025 10:47 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Moore, Lashawn <Lashawn.Moore@carefirst.com>
Subject: Request for calculation sheets - H7379 and H8854

Good morning,

I would like to request to receive the calculation sheets for improvement and overall rating for H7379 and H8854 (CareFirst).

Thanks,
Becca

Becca Adam
she/her/hers
Manager | Stars, Quality, and Risk Adjustment
CareFirst BlueCross BlueShield
1501 S. Clinton St
Baltimore, MD 21224
w 410-469-2325
carefirst.com

TAB 16

H7379 2026 IM Calcs 2025

Contract: H7379	Contract Type: Local & Regional CCP w/o SNP	Part D Improvement Measure Eligibility: Eligible

Part D Measures

Measure Label	Measure Weight	Eligibility	Eligible for Measure	CY2025 Measure Score	CY2026 Measure Score	CY2025-CY2026 Difference	CY2025 Measure Star	CY2026 Measure Star	CY2025 Numerator	CY2025 Denominator	CY2026 Numerator	CY2026 Denominator	CY2025 SE	CY2026 SE	Days for 2025 (2023)	Days for 2026 (2024)	Correlation	CY2026-CY2025 Difference Standard Error	Improve	Decline	Improvement, Decline, or No Change	Held Harmless	Weighted Score	Weighted Eligibility	Lower is Better
D01: Call Center - Foreign Language Interpreter and TTY Availability	2	0	Not Eligible		96.875	96.875	Not enough data	4				64					0.514133	Not Applicable	N/A	N/A	Not Applicable	Not Applicable	0	0	
D02: Complaints about the Drug Plan	2	1	Eligible	0.071058	0.081405	-0.010347	5	5	5	5783	5	6041			365	366	0.723507	0.024211779	0	0	No Significant Change	Not Applicable	0	2	1
D03: Members Choosing to Leave the Plan	2	0	Not Eligible			0	Not enough data	Not enough data available									0.79 540	Not Applicable	N/A	N/A	Not Applicable	Not Applicable	0	0	1
D05: Rating of Drug Plan	2	1	Eligible	85.572194	87.644881	2.072687	2	4					1.107411	0.751501			0.784401	0.6967533	1	0	Significant Improvement	Not Applicable	2	2	
D06: Getting Needed Prescription Drugs	2	1	Eligible	88.757279	90.02768	1.270401	3	4					1.039991	0.783301			0.68 827	0.764113336	0	0	No Significant Change	Not Applicable	0	2	
D07: MPF Price Accuracy	1	0	Not Eligible			0	Not enough data	Not enough data available									0.833917	Not Applicable	N/A	N/A	Not Applicable	Not Applicable	0	0	
D08: Part D Medication Adherence for Diabetes Medications	3	1	Eligible	88.995238	89.640884	0.675646	4	4		618		724					0.609524	1.0688721 1	0	0	No Significant Change	Not Applicable	0	3	
D09: Part D Medication Adherence for Hypertension (RAS antagonists)	3	1	Eligible	90.071628	90.982287	0.910659	4	4		1757		1863					0.757009	0.482249752	0	0	No Significant Change	Not Applicable	0	3	
D10: Part D Medication Adherence for Cholesterol (Statins)	3	1	Eligible	87.809222	89.756098	1.946876	3	4		2105		2255					0.754967	0.478822567	1	0	Significant Improvement	Not Applicable	3	3	
D11: MTM Program Completion Rate for CMR	1	1	Eligible	88.12095	88.475836	0.354886	3	3		463		538					0.779423	0.964002305	0	0	No Significant Change	Not Applicable	0	1	
D12: Statin Use in Persons with Diabetes (SUPD)	1	1	Eligible	84.136086	84.008529	-0.127557	2	2		436		469					0.836138	0.989778074	0	0	No Significant Change	Not Applicable	0	1	

MA-PD or PDP	MA-PD
Part D Improvement Measure Score	0.294118
D04: Part D Improvement Measure Star	3

D04: Cut Points	Type	1 Star	2 Star	3 Star	4 Star	5 Star
	MA-PD	< -0.233766	≥ -0.233766 to < 0	≥ 0 to < 0.320439	≥ 0.320439 to < 0.615909	≥ 0.615909
	PDP	< -0.183824	≥ -0.183824 to < 0	≥ 0 to < 0.330927	≥ 0.330927 to < 0.672727	≥ 0.672727

Year1	2025
Year2	2026

D04 Thresholds	MA-PD	PDP
2 Star Threshold	-0.233766	-0.183824
3 Star Threshold	0.000000	0.000000
4 Star Threshold	0.320439	0.330927
5 Star Threshold	0.615909	0.672727

TAB 17

CMS Memo, 2026 Star Ratings Marketing Template, September 11, 2025

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

CENTER FOR MEDICARE

DATE: September 11, 2025

TO: All Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

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

SUBJECT: 2026 Star Ratings Marketing Template and Data Disclosure

The purpose of this memorandum is to alert Medicare Advantage Organizations, Cost Plans, and Part D Prescription Drug Plans that the 2026 Medicare Star Ratings marketing template will be available in the Health Plan Management System (HPMS) around October 9, 2025. As in previous years, the template highlights the contract's Star Ratings in a box at the top of the page, and to the right, inside the box, there is room for an optional plan logo.

Additionally, we remind all contracts that **Star Ratings data shared prior to the release of Final Star Ratings in October are preliminary and subject to change**. Thus, plans and related entities should not release information on 2026 Star Ratings through any means until the ratings have been released publicly and are live on the Medicare Plan Finder. Further, CMS prohibits prospective plan year marketing until October 1 of each year for the following contract year.

Additional guidance on the use of Star Ratings in marketing materials may be found at 42 CFR Parts 422 and 423 Subpart V.

Thank you for your continued commitment to the Medicare Advantage and Prescription Drug programs. Please direct questions about the use of Star Ratings in marketing materials to marketing@cms.hhs.gov.

TAB 18

Email Correspondence
September 15, 2025 to September 18, 2025
Plan Preview #2 for Contract H7379

From: CMS PartC&DStarRatings
To: Adam, Becca; Snapp-Borleis, Mary-Paul
Cc: Haynes, Liz; Williams, Krishelle; Incorvati, Laura; CMS PartC&DStarRatings; CMS PartC&DStarRatings
Subject: RE: Plan Preview #2 for Contract H7379_
Date: Thursday, September 18, 2025 12:34:00 PM
Attachments: image001.png
image002.png
image003.png

Good afternoon,

There are other instances where a contract just misses a threshold and we are unable to make changes in these situations since we need to follow the codified methodology.
The ratio of the improvement change score to the standard error is compared to 1.96, and if that exceeds 1.96 then the contract gets significant improvement on that measure. As is standard in statistical hypothesis testing, a statistically significant result is only obtained if the test-statistic exceeds the specified critical value (1.96 being the critical value corresponding to a test with significance level alpha=0.05, as specified in the technical notes). However, in this case, the contract's ratio was 1.89, which does not exceed 1.96, e.g., it does not meet the criteria for statistical significance at the alpha=0.05 level.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, September 17, 2025 2:08 PM
To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Confirming receipt.

From: Adam, Becca <Becca.Adam@carefirst.com>
Sent: Wednesday, September 17, 2025 1:59 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>
Subject: RE: Plan Preview #2 for Contract H7379_

Thank you for your response. CareFirst is aware that the methodology for statistically

identifying improvement cannot be adjusted without regulation changes. However, CareFirst is requesting that CMS reconsider situations where the improvement is well within the margin of error used for statistical significance. CareFirst respectfully requests CMS to consider this unique situation of being less than one single member from being statistically significant and statistically demonstrating improvement, as from a practical standpoint the improvement is clearly demonstrated across the whole population in the measure, not just a sample.

Thanks,
Becca

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Wednesday, September 17, 2025 12:09 PM
To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

What you are requesting is a change to the methodology for calculating the improvement measures. Any changes to methodology need to be proposed and finalized through rulemaking.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 16, 2025 4:53 PM
To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Confirming receipt.

From: Adam, Becca <Becca.Adam@carefirst.com>

Sent: Tuesday, September 16, 2025 4:48 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>
Subject: RE: Plan Preview #2 for Contract H7379_

Good afternoon,

Thank you for the clarification on how the MAX function is applied.

However, the remainder of our statement was not addressed in your response. Specifically, our concern that the measure rate gap was only 0.034552 away from the threshold, equivalent to just 0.64 of a member in the numerator. We believe we demonstrated meaningful improvement that aligns with the intent of the Stars program:

- The measure rate gap of 0.034552 is equivalent to just 0.64 of a member in the numerator (SY2026 numerator: 1695; SY2026 denominator: 1863). Since fractional members cannot exist and a full member was not needed to reach statistical significance, this creates a barrier to recognizing actual improvement.
- The result is that CareFirst fell short of achieving significant improvement by a margin that does not align with the intent of the Stars program. The program's purpose is to encourage and reward meaningful quality improvement, which we believe we demonstrated such improvement.
- The stakes of this calculation are substantial. Reaching significant improvement would improve our Part D QI rate to 0.4705888 and to 4 Stars (from 3 Stars). This would then move our Overall Star Rating from a 3.5 to a 4.0 overall. The difference between receiving 3.5 Stars versus 4.0 Stars equates to only 0.64 of a single member. This outcome does not reflect the reality of our performance nor the goals of the Stars program.

We are committee to quality improvement and to working collaboratively with CMS to ensure program goals are met.

Thank you for your consideration.

Thanks,
Becca

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Tuesday, September 16, 2025 3:55 PM

To: Adam, Becca <Becca.Adam@carefirst.com>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Hello,

When you tried to remove the MAX function during your exploration, you removed too many parentheses and inadvertently changed the equation of the standard error calculation. Removing the MAX function if done correctly does not change the standard error:

CORRECT EQUATION WITHOUT MAX:

SQRT((E11*(100-E11)/K11+F11*(100-F11)/M11)-2*R11*SQRT(E11*(100-E11)/K11)*SQRT(F11*(100-F11)/M11)) = 0.482249752 (No Significant Difference) CORRECT

YOUR INCORRECT EQUATION:

SQRT(E11*(100-E11)/K11+F11*(100-F11)/M11)-2*R11*SQRT(E11*(100-E11)/K11)*SQRT(F11*(100-F11)/M11) = 0.257553228 (Significant Improvement) INCORRECT

These contract-specific calculation spreadsheets emulate the actual SAS calculation and are a tool to help contract(s) understand the calculations. The official calculations are located in HPMS. Contracts should focus on reviewing their Star Ratings data in HPMS during the preview period since these are the preliminary data that we anticipate posting on Medicare Plan Finder.

Thank you,

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

From: Adam, Becca <Becca.Adam@carefirst.com>
Sent: Tuesday, September 16, 2025 11:03 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>
Subject: RE: Plan Preview #2 for Contract H7379_

Good morning,

Thank you for the clarification on the updated Patient Safety Reports. We still respectfully request that CMS reconsider the calculation of the Part D improvement measure for H7379, specifically for the Medication Adherence for Hypertension measure.

We continue to believe that the current calculation method does not accurately reflect the true improvement that was demonstrated:

- The maximum standard error (MAX) is not applied consistently across measures, and the technical specifications do not explicitly reference its use in this calculation. Applying MAX creates a larger, more conservative threshold which makes achieving improvement much more difficult.
- Without the use of MAX, CareFirst would have achieved statistically significant improvement in Medication Adherence for Hypertension (See attached example). With MAX applied, the improvement calculation fell just short. Specifically, the difference between SY2025 and SY2026 was 0.910659, but the threshold with MAX applied was 0.945210, meaning the gap to achieve significant improvement was just 0.034552.
- The measure rate gap of 0.034552 is equivalent to just 0.64 of a member in the numerator (SY2026 numerator: 1695; SY2026 denominator: 1863). Since fractional members cannot exist and a full member was not needed to reach statistical significance, this strict calculation creates a barrier to recognizing actual improvement.

The result is that CareFirst fell short of achieving significant improvement by a margin that does not align with the intent of the Stars program. The program's purpose is to encourage and reward meaningful quality improvement, which we believe we demonstrated such improvement.

The stakes of this calculation are substantial. Reaching significant improvement would improve our Part D QI rate to 0.4705888 and to 4 Stars. This would then move our Overall Star Rating from a 3.5 to a 4.0 overall. With the current calculation for statistical significance, the difference between receiving 3.5 Stars versus 4.0 Stars equates to only 0.64 of a single member. This outcome does not reflect the reality of our performance nor the goals of the Stars program.

CareFirst respectfully urges CMS to reconsider this outcome. CareFirst is deeply committed to continuous improvement and has consistently demonstrated progress across measures for H7379, including Medication Adherence for Hypertension.

Thanks,
Becca

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, September 15, 2025 2:08 PM
To: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Cc: Adam, Becca <Becca.Adam@carefirst.com>; Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 for Contract H7379_

Hi Mary-Paul,

Thank you for reaching out. As a reminder, last year we notified all Part D contracts that the final YOS 2023 July Patient Safety Report Package zip files were re-uploaded to replace the zip files that were originally uploaded on July 31, 2024 due to minor technical issues in the process that assigns and links Prescription Drug Event (PDE) and the Common Working File (CWF) claims to beneficiaries, which impacted a small fraction of beneficiaries. The rates in these reports were calculated using the PDE data with dates of service between January 1, 2023, and December 31, 2023 (submitted between January 1, 2023- June 28, 2024). We explained in the email notification to all Part D contracts that the YOS 2023 Patient Safety measure rates for most contracts was marginal or unchanged.

For the Medication Adherence measures for H7379 remained unchanged for Diabetes and Cholesterol (Statin) and marginally improved for Hypertension (RAS) to 0.90071628. Note, this revised rate of 0.90071628 was used in last year's Part D Improvement Measure calculation for

the CY 2025 measure score.

Please review the re-uploaded final monthly report which was uploaded to the Web Portal last year in September 2024 for measurement year 2023 using the PDE data with dates of service between January 1, 2023, and December 31, 2023 (submitted between January 1, 2023- June 28, 2024).

Best,
Part C & D Star Ratings

From: Snapp-Borleis, Mary-Paul <Mary-Paul.Snapp-Borleis@carefirst.com>
Sent: Monday, September 15, 2025 8:42 AM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Adam, Becca <Becca.Adam@carefirst.com>; Haynes, Liz <Liz.Haynes@carefirst.com>; Williams, Krishelle <Krishelle.Williams@carefirst.com>; Incorvati, Laura <Laura.Incorvati@carefirst.com>; CMS CallCenterMonitoring <CallCenterMonitoring@cms.hhs.gov>
Subject: Plan Preview #2 for Contract H7379_

Good morning –

CareFirst Advantage PPO, Inc., Contract H7379, has identified a data error in the Star Ratings calculation in Plan Preview #2. We would like to request that CMS review the calculation of the Part D improvement measure for this contract. The rates for Star Year 2025 that are included in the improvement calculation for the medication adherence measures do not match the rates in the final Acumen reports distributed in July 2024. The full details are in the attached letter titled "202-09-15_Starts Recalculation_H7379_PlanReview2" and the attached Acumen report that includes the final Star Year 2025 adherence rates.

Please feel free to contact me if you have any questions.

With Care,

Mary-Paul Snapp-Borleis (She/her/hers)
Dir. Medicare & Medicaid Compliance Officer
Ethics & Compliance: Government Programs
CareFirst BlueCross BlueShield
1501 S. Clinton Street, Baltimore, MD 21224
W 410-605-2579 | F 410-720-6660

CareFirst | 2025 World's Most Ethical Companies® Ethisphere 13 Time Honoree

-

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates

comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

****

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518 CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

****

TAB 19

Medicare 2025 Part C & D Star Ratings Technical Notes

Sources of the Star Ratings Measure Data

The 2025 Star Ratings include a maximum of 9 domains comprised of a maximum of 42 measures.

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

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

Figure 2: The Four Categories of Data Sources

Improvement Measures

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

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

TAB 20

Medicare 2025 Part C & D Star Ratings Technical Notes

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

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

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

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

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

Calculation Precision

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

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

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

Rounding Rules for Measure Scores

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

TAB 21

Medicare 2025 Part C & D Star Ratings Technical Notes

Framework and Definitions for the Domain and Measure Details Section

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

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

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

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

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

Part C Domain and Measure Details

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

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

Measure: C01 - Breast Cancer Screening

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C02 - Colorectal Cancer Screening

Title	Description

Label for Stars: Colorectal Cancer Screening

Label for Data: Colorectal Cancer Screening

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

HEDIS Label: Colorectal Cancer Screening (COL)

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

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

Primary Data Source: HEDIS Patient-level Data

Data Source Category: Health and Drug Plans

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

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

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

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

Reporting Requirements:

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

Cut Points:

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

Measure: C03 - Annual Flu Vaccine

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

Title	Description

Reporting Requirements:

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

Base Group Cut Points:

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

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

Measure: C04 - Monitoring Physical Activity

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

Title	Description
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00450-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Domain: 2 - Managing Chronic (Long Term) Conditions

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

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

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

Title	Description
CMIT #:	00685-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C06 - Care for Older Adults – Medication Review

Title	Description
Label for Stars:	Yearly Review of All Medications and Supplements Being Taken
Label for Data:	Yearly Review of All Medications and Supplements Being Taken
Description:	Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
HEDIS Label:	Care for Older Adults (COA) – Medication Review
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 115
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	SNP benefit packages whose enrollment was less than 30 as of February 2023 SNP Comprehensive Report were excluded from this measure. Exclude members in hospice or using hospice services or who died any time during the measurement year.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2023 – 12/31/2023

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

Reporting Requirements:

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

Cut Points:

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

Measure: C07 - Care for Older Adults – Pain Assessment

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

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

Reporting Requirements:

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

Cut Points:

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

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

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

Title	Description

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

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: C09 - Diabetes Care – Eye Exam

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

Title	Description
	– Members who died any time during the measurement year. – Members receiving palliative care any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00203-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 57 %	>= 57 % to < 70 %	>= 70 % to < 77 %	>= 77 % to < 83 %	>= 83 %

Measure: C10 - Diabetes Care – Blood Sugar Controlled

Title	Description
Label for Stars:	Plan Members with Diabetes whose Blood Sugar is Under Control
Label for Data:	Plan Members with Diabetes whose Blood Sugar is Under Control
Description:	Percent of plan members with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control.
HEDIS Label:	Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c poor control (>9.0%)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 184
Metric:	The percentage of diabetic MA enrollees age 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator). (This measure for public reporting is reverse scored so higher scores are better.) To calculate this measure, subtract the submitted rate from 100.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. • Members 66 years of age and older as of December 31 of the measurement year with both frailty and advanced illness during the measurement year. Members must meet both the following frailty and advanced illness criteria to be excluded: • At least two indications of frailty with different dates of service during the measurement year. • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): ○ At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. ○ At least one acute inpatient encounter with an advanced illness diagnosis. ○ At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. ○ A dispensed dementia medication. • (Required) Exclude members who meet any of the following criteria: – Members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Title	Description

– Members in hospice or using hospice services any time during the measurement year.
– Members who died any time during the measurement year.
– Members receiving palliative care any time during the measurement year.

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00204-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 49 %	>= 49 % to < 72 %	>= 72 % to < 84 %	>= 84 % to < 90 %	>= 90 %

Measure: C11 - Controlling Blood Pressure

Title	Description
Label for Stars:	Controlling Blood Pressure
Label for Data:	Controlling Blood Pressure
Description:	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
HEDIS Label:	Controlling High Blood Pressure (CBP)
Measure Reference:	NCQA HEDIS MY 2023 Technical Specifications Volume 2, page 152
Metric:	The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year. • Members 66–80 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded: • At least two indications of frailty with different dates of service during the measurement year. • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. • At least one acute inpatient encounter with an advanced illness diagnosis. • At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. • A dispensed dementia medication. • (Required) Exclude members who meet any of the following criteria: – • Members with evidence of end-stage renal

Title	Description

disease (ESRD), dialysis, nephrectomy, or kidney transplant any time during the member's history on or prior to December 31 of the measurement year.
- • Members receiving palliative care during the measurement year.
- • Members with a diagnosis of pregnancy

during the measurement year.
- • Members in hospice or using hospice services any time during the measurement year.
- • Members who died any time during the measurement year.

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcomes Measure

Weighting Value: 3

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00167-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 69 %	>= 69 % to < 74 %	>= 74 % to < 80 %	>= 80 % to < 85 %	>= 85 %

Measure: C12 - Reducing the Risk of Falling

Title	Description
Label for Stars:	Reducing the Risk of Falling
Label for Data:	Reducing the Risk of Falling
Description:	Percent of plan members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Specifications for the Medicare Health Outcomes Survey Volume 6, page 38
Metric:	The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 24 Follow-up Data collection (2023) and Cohort 26 Baseline data collection (2023). HOS Survey Question 44: A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? HOS Survey Question 45: Did you fall in the past 12 months? HOS Survey Question 46: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 47: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.
Data Source Category:	Survey of Enrollees
Exclusions:	Members who responded "I had no visits in the past 12 months" to Question 44 or Question 47 are excluded from results calculations. Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/17/2023 – 11/01/2023
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Safety
CMIT #:	00646-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 50 %	>= 50 % to < 56 %	>= 56 % to < 63 %	>= 63 % to < 73 %	>= 73 %

Measure: C13 - Improving Bladder Control

Title	Description
Label for Stars:	Improving Bladder Control
Label for Data:	Improving Bladder Control
Description:	Percent of plan members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.
HEDIS Label:	Management of Urinary Incontinence in Older Adults (MUI)
Measure Reference:	NCQA HEDIS Measurement Year 2022 Specifications for the Medicare Health Outcomes Survey Volume 6, page 33
Metric:	The percentage of Medicare members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).
Primary Data Source:	HEDIS-HOS
Data Source Description:	Cohort 24 Follow-up Data collection (2023) and Cohort 26 Baseline data collection (2023).

Title	Description
	HOS Survey Question 38: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 41: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? Member choices must be as follows to be included in the denominator: • Q38 = "Yes." • Q41 = "Yes" or "No." The numerator contains the number of members in the denominator who indicated they discussed treatment options for their urinary incontinence with a health care provider. Member choice must be as follows to be included in the numerator: • Q41 = "Yes."
Data Source Category:	Survey of Enrollees
Exclusions:	Contracts must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, the measure result will be "Not enough data available." Members with evidence from CMS administrative records of a hospice start date are excluded.
Data Time Frame:	07/17/2023 – 11/01/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2022 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00378-01-C-PARTC
Data Display:	Percentage with no decimal place

Title	Description

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 39 %	>= 39 % to < 44 %	>= 44 % to < 48 %	>= 48 % to < 52 %	>= 52 %

Measure: C14 - Medication Reconciliation Post-Discharge

Title	Description
Label for Stars:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Label for Data:	The Plan Makes Sure Member Medication Records Are Up-to-Date After Hospital Discharge
Description:	This shows the percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.
HEDIS Label:	Medication Reconciliation Post-Discharge (MRP)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 330
Metric:	The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Members in hospice or using hospice services any time during the measurement year. Members who died any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included

Title	Description
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00441-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 42 %	>= 42 % to < 57 %	>= 57 % to < 73 %	>= 73 % to < 87 %	>= 87 %

Measure: C15 - Plan All-Cause Readmissions

Title	Description
Label for Stars:	Readmission to a Hospital within 30 Days of Being Discharged (more stars are better because it means fewer members are being readmitted)
Label for Data:	Readmission to a Hospital within 30 Days of Being Discharged (lower percentages are better because it means fewer members are being readmitted)
Description:	Percent of plan members aged 18 and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This “risk-adjustment” helps make the comparisons between plans fair and meaningful.)
HEDIS Label:	Plan All-Cause Readmissions (PCR)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 498
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average

Title	Description
	is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment F: Calculating Measure C15: Plan All-Cause Readmissions (18+) for the complete formula, example calculation and National Average Observation value used to complete this measure.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude hospital stays for the following reasons: • The member died during the stay. • Members with a principal diagnosis of pregnancy on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period on the discharge claim. (Required) Exclude members in hospice or using hospice services any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure. As listed in the HEDIS Technical Specifications. CMS has excluded contracts whose denominator was less than 150.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	Yes
Weighting Category:	Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Admissions and Readmissions to Hospitals

Title	Description
CMIT #:	00561-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 14 %	> 12 % to <= 14 %	> 10 % to <= 12 %	> 8 % to <= 10 %	<= 8 %

Measure: C16 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description
Label for Stars:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Description:	This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs. Health plans can help make sure their members are prescribed medications that are more effective for them.
HEDIS Label:	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 168
Metric:	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Pregnancy during the measurement year or year prior to the measurement year. • In vitro fertilization in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year. • ESRD or dialysis during the measurement year or the year prior to the measurement year. • Cirrhosis during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year. • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. • Members receiving palliative care any time during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

Title	Description

– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
• Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  – At least two indications of frailty with different dates of service during the measurement year.
  – Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
    1. At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits, virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
    2. At least one acute inpatient encounter with an advanced illness diagnosis.
    3. At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim.
    4. A dispensed dementia medication.

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00700-01-C-PARTC

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 81 %	>= 81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %

Measure: C17 - Transitions of Care

Title	Description
Label for Stars:	After hospital stay, members receive information and care they need
Label for Data:	After hospital stay, members receive information and care they need
Description:	This rating is based on the percent of plan members who got follow-up care after a hospital stay. Follow-up care includes: getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 330
Metric:	The average of the rates for Transitions of Care - Medication Reconciliation Post-Discharge, Transitions of Care - Notification of Inpatient Admission, Transitions of Care - Patient Engagement After Inpatient Discharge, and Transitions of Care - Receipt of Discharge Information.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). If the admission dates and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. Required exclusions: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.

Title	Description

Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

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

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

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00729-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 44 %	>= 44 % to < 52 %	>= 52 % to < 63 %	>= 63 % to < 77 %	>= 77 %

Measure: C18 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Title	Description
Label for Stars:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Label for Data:	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
Description:	This rating is based on the percent of plan members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.
HEDIS Label:	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
Measure Reference:	NCQA HEDIS Measurement Year 2023 Technical Specifications Volume 2, page 340
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays. 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place Required exclusions: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2023 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2023 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00263-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 39 %	>= 39 % to < 53 %	>= 53 % to < 60 %	>= 60 % to < 69 %	>= 69 %

Domain: 3 - Member Experience with Health Plan

Measure: C19 - Getting Needed Care

Title	Description
Label for Stars:	Ease of Getting Needed Care and Seeing Specialists
Label for Data:	Ease of Getting Needed Care and Seeing Specialists (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? • In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.

Title	Description
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00293-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 77	>= 77 to < 79	>= 79 to < 82	>= 82 to < 83	>= 83

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

Measure: C20 - Getting Appointments and Care Quickly

Title	Description
Label for Stars:	Getting Appointments & Care Quickly
Label for Data:	Getting Appointments & Care Quickly (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how quickly members get appointments and care.
Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00292-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 80	>= 80 to < 82	>= 82 to < 84	>= 84 to < 86	>= 86

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

Measure: C21 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your health plan's customer service give you the

Title	Description
	information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00181-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 88	>= 88 to < 89	>= 89 to < 91	>= 91 to < 92	>= 92

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

Measure: C22 - Rating of Health Care Quality

Title	Description
Label for Stars:	Members' Rating of Health Care Quality
Label for Data:	Members' Rating of Health Care Quality (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Metric:	This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00642-01-C-PARTC

Title	Description
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 84	>= 84 to < 85	>= 85 to < 87	>= 87 to < 88	>= 88

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

Measure: C23 - Rating of Health Plan

Title	Description
Label for Stars:	Members' Rating of Health Plan
Label for Data:	Members' Rating of Health Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the health plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes

Title	Description
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters. Person-Centered Care
CMIT #:	00643-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 84	>= 84 to < 86	>= 86 to < 88	>= 88 to < 89	>= 89

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

Measure: C24 - Care Coordination

Title	Description
Label for Stars:	Coordination of Members' Health Care Services
Label for Data:	Coordination of Members' Health Care Services (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)
Metric:	This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

Title	Description
	• In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00106-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
< 84	>= 84 to < 85	>= 85 to < 87	>= 87 to < 88	>= 88

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

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

Measure: C25 - Complaints about the Health Plan

Title	Description
Label for Stars:	Complaints about the Health Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of complaints filed with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2023 complaints made by the June 28, 2024 deadline are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTC
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 1.39	> 0.76 to <= 1.39	> 0.37 to <= 0.76	> 0.12 to <= 0.37	<= 0.12

Measure: C26 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2023–December 31, 2023 (numerator) divided by all members enrolled in the contract at any time during 2023 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data

Title	Description
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2023 and 12/31/2023 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4

Title	Description
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
> 36 %	> 24 % to <= 36 %	> 17 % to <= 24 %	> 8 % to <= 17 %	<= 8 %

Measure: C27 - Health Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Health Plan's Performance
Label for Data:	Improvement (if any) in the Health Plan's Performance
Description:	This shows how much the health plan's performance improved or declined from one year to the next. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2024 and 2025 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2024 and 2025 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment H contains the formulas used to calculate the improvement measure and lists indicating which measures were used.

Title	Description
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00300-01-C-PARTC
Data Display:	Not Applicable

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< -0.179809	>= -0.179809 to < 0	>= 0 to < 0.174445	>= 0.174445 to < 0.421057	>= 0.421057

Domain: 5 - Health Plan Customer Service

Measure: C28 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Stars:	Health Plan Makes Timely Decisions about Appeals
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	This rating shows how fast a plan sends information for an independent review.
Metric:	Percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and appeals not evaluated by the IRE because plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Not Evaluated by the IRE Because Plan Agreed to Cover])) * 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is "Not enough data available." Dismissed appeals (except appeals not evaluated by the IRE because plan agreed to cover) and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) + [Appeals Not Evaluated by the IRE Because Plan Agreed to Cover]) - [Late] Note: Appeals Not Evaluated by the IRE Because Plan Agreed to Cover were formerly called Dismissed Because Plan Agreed to Cover. When reviewing IRE data from the Maximus appeals website found at http://www.medicareappeal.com/AppealSearch and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

Title	Description

Previous Field Name	Current Field Name
Upheld	Unfavorable
Overturn	Favorable
Partially Overturn	Partially favorable

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 4

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

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00562-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 69 %	>= 69 % to < 85 %	>= 85 % to < 95 %	>= 95 % to < 99 %	>= 99 %

Measure: C29 - Reviewing Appeals Decisions

Title	Description

Label for Stars: Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer

Label for Data: Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer

Description: This rating shows how often an independent reviewer found the health plan's decision to deny coverage to be reasonable.

Title	Description
Metric:	Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: ([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2024, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2024 are not reflected in these data and the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00652-01-C-PARTC

Title	Description
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 78 %	>= 78 % to < 92 %	>= 92 % to < 96 %	>= 96 % to < 99 %	>= 99 %

Measure: C30 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Health Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the health plan's prospective enrollee customer service phone line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part C benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MAOs, MA-PDs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to CallCenterMonitoring@cms.hhs.gov.
Data Time Frame:	02/2024 – 05/2024
General Trend:	Higher is better
Statistical Method:	Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	4
Major Disaster:	No adjustment for 2022 or 2023 disasters.
Meaningful Measure Area:	Person-centered Care
CMIT #:	00096-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
< 46 %	>= 46 % to < 69 %	>= 69 % to < 93 %	>= 93 % to < 100 %	100 %

Part D Domain and Measure Details

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

Domain: 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MA-PDs, PDPs, and MMPs under sanction.
General Notes:	Specific questions about Call Center Monitoring and requests for detail data should be directed to CallCenterMonitoring@cms.hhs.gov.
Data Time Frame:	02/2024 – 05/2024
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access

Title	Description

Weighting Value: 4

Major Disaster: No adjustment for 2022 or 2023 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 40 %	>= 40 % to < 74 %	>= 74 % to < 90 %	>= 90 % to < 100 %	100 %
PDP	< 70 %	>= 70 % to < 85 %	>= 85 % to < 98 %	>= 98 % to < 100 %	100 %

Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance

Measure: D02 - Complaints about the Drug Plan

Title	Description
Label for Stars:	Complaints about the Drug Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Drug Plan (number of complaints for every 1,000 members). (Lower numbers are better because it means fewer complaints.)
Description:	Rate of complaints filed with Medicare about the drug plan.
Metric:	Rate of complaints about the drug plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2023 complaints made by the June 28, 2024 deadline are captured. Complaint rates per 1,000 enrollees are adjusted to a 30-day basis. Monthly enrollment files from HPMS were used to calculate the average enrollment for the contract for the measurement period.
Data Source Category:	CMS Administrative Data
Exclusions:	On May 10, 2019, CMS released an HPMS memo on the Complaints Tracking Module (CTM) Updated Standard Operating Procedures (SOP). Plans should review all complaints at intake and verify the contract assignment and issue level. The APPENDIX A - Category and Subcategory Listing in the SOP lists the subcategories that are excluded. Complaint rates are not calculated for contracts with average enrollment of less than 800 enrollees during the measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00142-02-C-PARTD
Data Display:	Numeric with 2 decimal places

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 1.39	> 0.76 to <= 1.39	> 0.37 to <= 0.76	> 0.12 to <= 0.37	<= 0.12
PDP	> 0.32	> 0.2 to <= 0.32	> 0.11 to <= 0.2	> 0.04 to <= 0.11	<= 0.04

Measure: D03 - Members Choosing to Leave the Plan

Title	Description
Label for Stars:	Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)
Label for Data:	Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)
Description:	Percent of plan members who chose to leave the plan.
Metric:	The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2023–December 31, 2023 (numerator) divided by all members enrolled in the contract at any time during 2023 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)

Title	Description
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
General Notes:	This measure includes members with a disenrollment effective date between 1/1/2023 and 12/31/2023 who disenrolled from the contract with any one of the following disenrollment reason codes: 11 - Voluntary Disenrollment through plan 13 - Disenrollment because of enrollment in another Plan 14 - Retroactive 99 - Other (not supplied by beneficiary). If all potential members in the numerator meet one or more of the exclusion criteria, the measure result will be "Not enough data available". The Disenrollment Reasons Survey (DRS) data available in the HPMS plan preview and in the CMS downloadable Master Table, are not used in the calculation of this measure. The DRS data are presented in each of the systems for information purposes only.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure

Title	Description
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	> 36 %	> 24 % to <= 36 %	> 17 % to <= 24 %	> 8 % to <= 17 %	<= 8 %
PDP	> 22 %	> 16 % to <= 22 %	> 9 % to <= 16 %	> 5 % to <= 9 %	<= 5 %

Measure: D04 - Drug Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Drug Plan's Performance
Label for Data:	Improvement (If any) in the Drug Plan's Performance
Description:	This shows how much the drug plan's performance has improved or declined from one year to the next year. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2024 and 2025 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2024 and 2025 Star Ratings
Data Source Category:	Star Ratings

Title	Description
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< -0.218869	>= -0.218869 to < 0	>= 0 to < 0.242468	>= 0.242468 to < 0.496603	>= 0.496603
PDP	< -0.282500	>= -0.282500 to < 0	>= 0 to < 0.273334	>= 0.273334 to < 0.576667	>= 0.576667

Domain: 3 - Member Experience with the Drug Plan

Measure: D05 - Rating of Drug Plan

Title	Description
Label for Stars:	Members' Rating of Drug Plan
Label for Data:	Members' Rating of Drug Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned from members who rated the prescription drug plan.
Metric:	This case-mix adjusted measure is used to assess members' overall view of their prescription drug plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Question (question numbers vary depending on survey type): • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care

Title	Description
CMIT #:	00641-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	< 84	>= 84 to < 86	>= 86 to < 87	>= 87 to < 89	>= 89
PDP	< 79	>= 79 to < 82	>= 82 to < 85	>= 85 to < 87	>= 87

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

Measure: D06 - Getting Needed Prescription Drugs

Title	Description
Label for Stars:	Ease of Getting Prescriptions Filled When Using the Plan
Label for Data:	Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.
Metric:	This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? • In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2024. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2024 – 06/2024
General Trend:	Higher is better

Title	Description
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	4
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00294-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	< 87	>= 87 to < 88	>= 88 to < 90	>= 90 to < 91	>= 91
PDP	< 86	>= 86 to < 87	>= 87 to < 89	>= 89 to < 90	>= 90

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

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder (MPF) website. Higher scores are better because they mean the plan provided more accurate prices.
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than MPF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than MPF) / (Total number of PDEs). The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index and claim percentage index as: 0.5 x (100 – ((accuracy index – 1) x 100)) + 0.5 x ((1 – claim percentage index) x 100).
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data used in this measure are obtained from a number of sources: MPF Pricing Files and PDE data are the primary data sources. The PDE data were submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023- September 30, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the measure. If the PDE edit is informational, and therefore does not result in the PDE being rejected, then the PDE is used. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. The HPMS-approved formulary extracts, and data from First DataBank and Medi-span are also used.
Data Source Category:	Data Collected by CMS Contractors

Title	Description
Exclusions:	A contract with less than 30 PDE claims over the measurement period. PDEs must also meet the following criteria: • If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. • Drug must appear in formulary file and in MPF pricing file • PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug
General Notes:	Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2023 – 09/30/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Affordability and Efficiency
CMIT #:	00452-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	100
PDP	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	100

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description
Label for Stars:	Taking Diabetes Medication as Directed
Label for Data:	Taking Diabetes Medication as Directed
Description:	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with diabetes can manage their health is by taking their medication as directed. The plan, the doctor, and the member can work together to find ways to do this. ("Diabetes medication" means a *biguanide drug,* a *sulfonylurea drug,* a *thiazolidinedione drug*, a *DPP-4 inhibitor,* a *GIP/GLP-1 receptor agonist*, a *meglitinide drug,* or an *SGLT2 inhibitor*. Plan members who take insulin are not included.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DiPeptidyl Peptidase (DPP)-4 Inhibitors, GIP/GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then

Title	Description
	the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the Common Medicare Environment (CME), the Medicare Enrollment Database (EDB), the Common Working File (CWF), and the Encounter Data Systems (EDS). The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient (IP) and skilled nursing facility (SNF) stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • In hospice • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode,

Title	Description
	reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by the active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings, and stays in SNFs. The discharge date is included as an adjustment for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00436-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 87 %	>= 87 % to < 91 %	>= 91 %
PDP	< 85 %	>= 85 % to < 87 %	>= 87 % to < 89 %	>= 89 % to < 93 %	>= 93 %

Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)

Title	Description
Label for Stars:	Taking Blood Pressure Medication as Directed
Label for Data:	Taking Blood Pressure Medication as Directed
Description:	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACEI (angiotensin converting enzyme inhibitor)*, an *ARB (angiotensin receptor blocker),* or a *direct renin inhibitor drug*.)
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first. The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the PQA. See the medication list for this measure. The Part D Medication Adherence rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted to the CMS DDPS and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two

Title	Description
	prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the CME, the EDB, and the CWF, and the EDS. The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient and SNF stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • In hospice • ESRD diagnosis or dialysis coverage dates • One or more prescriptions for sacubitril/valsartan
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings, and stays in SNFs. The discharge date is included as an adjustment day for IP/SNF stays.

Title	Description
	Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00437-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 83 %	>= 83 % to < 87 %	>= 87 % to < 90 %	>= 90 % to < 92 %	>= 92 %
PDP	< 87 %	>= 87 % to < 89 %	>= 89 % to < 90 %	>= 90 % to < 92 %	>= 92 %

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title	Description
Label for Stars:	Taking Cholesterol Medication as Directed
Label for Data:	Taking Cholesterol Medication as Directed
Description:	Percent of plan members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period (denominator). The PDC is the percent of days in the measurement period "covered" by prescription claims for the same medication or another in the therapeutic category. Beneficiaries are only included in the measure calculation if the first fill of their statin medication occurs at least 91 days before the end of the enrollment period, end of measurement period, or death, whichever comes first. The Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the PQA. See the medication list for this measure. The Medication Adherence rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from PDE data submitted by drug plans to the CMS DDPS and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023-December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.

Title	Description
	Additional data sources include the CME, the EDB, the CWF, and the EDS. The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, IP and SNF stays for PDPs and MA-PDs (if available). • EDS is used to identify diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period: • In hospice • ESRD diagnosis or dialysis coverage dates
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member-years for each enrollment episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12). The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings, and stays in SNFs. The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments. When available, beneficiary death date from the CME is the end date of a beneficiary's measurement period.

Title	Description
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00435-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 80 %	>= 80 % to < 85 %	>= 85 % to < 89 %	>= 89 % to < 93 %	>= 93 %
PDP	< 86 %	>= 86 % to < 88 %	>= 88 % to < 89 %	>= 89 % to < 92 %	>= 92 %

Measure: D11 - MTM Program Completion Rate for CMR

Title	Description
Label for Stars:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Label for Data:	Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications
Description:	Some plan members are in a program (called a *Medication Therapy Management* program) to help them manage their drugs. The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.

Title	Description
Metric:	This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period. Numerator = Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period. Denominator = Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. Only those beneficiaries who meet the contracts' specified targeting criteria per CMS – Part D requirements pursuant to §423.153(d) of the regulations at any time in the reporting period are included in this measure. Beneficiaries who were in hospice at any point during the reporting period are excluded. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are only included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. The date of enrollment is counted towards the 60 days but the opt-out date is not. A beneficiary's MTM eligibility, receipt of CMRs, etc., is determined for each contract he/she was enrolled in during the measurement period. Similarly, a contract's CMR completion rate is calculated based on each of its eligible MTM enrolled beneficiaries. For example, a beneficiary must meet the inclusion criteria for the contract to be included in the contract's CMR rate. A beneficiary who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates. The beneficiary is only included in the measure calculation for the contract(s) where they were enrolled at least 60 days or received a CMR if enrolled for less than 60 days. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract. Beneficiaries may be enrolled in MTM based on the contracts' specified targeting criteria per CMS – Part D requirements and/or based on expanded, other plan-specific targeting criteria. Beneficiaries who were initially enrolled in MTM due to other plan-specific (expanded) criteria and then later met the contracts' specified targeting criteria per CMS – Part D requirements at any time in the reporting period are included in this measure. In these cases, a CMR received after the date of MTM enrollment but before the date the beneficiary met the specified targeting criteria per CMS – Part D requirements are included.
Primary Data Source:	Part D Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2023 Part D Reporting Requirements (data pulled June 2024). Validation of these data was performed retrospectively during the 2024 data validation cycle (deadline June 15, 2024 and data validation results pulled July 2024). Additionally, the Medicare Enrollment Database (EDB) from the Integrated Data Repository (CME IDRC) is used to identify beneficiaries in hospice (data pulled June 2024).
Data Source Category:	Health and Drug Plans

Title	Description
Exclusions:	Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as “Not required to report.” MTM CMR rates are not provided for contracts that did not score at least 95% on data validation for the Medication Therapy Management Program reporting section or were not compliant with data validation standards/sub-standards for any of the following Medication Therapy Management Program data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation. • MBI Number (Element B) • Date of MTM program enrollment (Element H) • Met the specified targeting criteria per CMS – Part D requirements (Element I) • Date met the specified targeting criteria per CMS – Part D requirements (Element J) • Date of MTM program opt-out, if applicable (Element K) • Received annual CMR with written summary in CMS standardized format (Element O) • Date(s) of CMR(s) (Element P) MTM CMR rates are also not provided for contracts that failed to submit their MTM file and pass system validation by the reporting deadline or who had a missing data validation score for MTM. Contracts excluded from the MTM CMR Rates due to data validation issues are shown as “CMS identified issues with this plan's data.” See Attachment N for more details on the MTM CMR completion rate measure scoring methodology. Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select “Monitoring,” then “Plan Reporting Data Validation.” Select the appropriate contract year. Select the PRDVM Reports. Select “Score Detail Report.” Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMS at HPMS_Access@cms.hhs.gov. Additionally, contracts must have 31 or more enrollees in the denominator in order to have a calculated rate. Contracts with fewer than 31 eligible enrollees are listed as "Not enough data available".
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure

Title	Description
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	00454-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 57 %	>= 57 % to < 77 %	>= 77 % to < 89 %	>= 89 % to < 93 %	>= 93 %
PDP	< 30 %	>= 30 % to < 55 %	>= 55 % to < 68 %	>= 68 % to < 80 %	>= 80 %

Measure: D12 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Stars:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The percentage is calculated as the number of member-years of enrolled beneficiaries 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of member-years of enrolled beneficiaries 40-75 years old with at least two diabetes medication fills on unique dates of service during the measurement period (denominator). Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year or end of the enrollment episode. The SUPD measure is adapted from the measure concept that was developed and endorsed by the PQA. See the medication list for this measure. The SUPD measure is calculated using the NDC lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.

Title	Description
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS DDPS and accepted by the 2023 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2023 – December 31, 2023. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore, does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2023 PDE submission deadline are used to calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure. Additional data sources include the CME, the EDB, the CWF, and the EDS. The data cut off date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation. • CME is used for enrollment information. • EDB is used to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period). Due to CMS's migration of the beneficiary database, including the EDB and CME, to the Amazon Web Services (AWS Cloud), equivalent EDB information to identify beneficiaries in hospice and with ESRD status is pulled from the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes. • EDS is used to identify diagnoses based on ICD-10-CM codes.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 30 or fewer enrolled member-years (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • Hospice enrollment • ESRD diagnosis or dialysis coverage dates • Rhabdomyolysis and myopathy • Pregnancy, Lactation, and fertility • Cirrhosis • Pre-Diabetes • Polycystic Ovary Syndrome
General Notes:	Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses. Also, the member-years of enrollment adjustment is made by CMS to account for partial enrollment within the benefit year. Enrollment is measured at the episode level, and inclusion in the measure is determined separately for each episode – i.e., to be included for a given

Title	Description
	episode, the beneficiary must meet the initial inclusion criteria for the measure during that episode. The measure is weighted based on the total number of member years for each episode in which the beneficiary meets the measure criteria. For instance, if a beneficiary is enrolled for a three-month episode, disenrolled for a six-month episode, reenrolled for a three-month episode, and meets the measure criteria during each enrollment episode, s/he will count as 0.5 member years in the rate calculation (3/12 + 3/12 = 6/12).
Data Time Frame:	01/01/2023 – 12/31/2023
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2024-2025) for contracts with 25% or more enrolled affected by 2023 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00702-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	< 81 %	>= 81 % to < 86 %	>= 86 % to < 89 %	>= 89 % to < 93 %	>= 93 %
PDP	< 80 %	>= 80 % to < 83 %	>= 83 % to < 85 %	>= 85 % to < 87 %	>= 87 %

TAB 22

Medicare 2025 Part C & D Star Ratings Technical Notes

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2024 – 05/2024
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2023 – 12/31/2023
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2023 – 12/31/2023
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2024 – 06/2024
D06	Getting Needed Prescription Drugs	CAHPS	03/2024 – 06/2024
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2023 – 09/30/2023
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2023 – 12/31/2023
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2023 – 12/31/2023

TAB 23

Medicare 2025 Part C & D Star Ratings Technical Notes

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

Contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measure to be eligible to receive a rating in that improvement measure.

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2024 and 2025.

For measures where a higher score is better:

$$\text{Improvement Change Score} = \text{Score in 2025} - \text{Score in 2024}$$

For measures where a lower score is better:

$$\text{Improvement Change Score} = \text{Score in 2024} - \text{Score in 2025}$$

An eligible measure was defined as a measure for which a contract was scored in both the 2024 and 2025 Star Ratings, and there were no significant measure specification changes or a regional contract reconfiguration for which only contract data is available from the original contract in one or both years.

For each measure, significant improvement or decline between Star Ratings years 2024 and 2025 was determined by a two-sided t-test at the 0.05 significance level:

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} > 1.96, \text{ then YES = significant improvement}$$

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} < -1.96, \text{ then YES = significant decline}$$

Hold Harmless Provision for Individual Measures: If a contract demonstrated statistically significant decline (at the 0.05 significance level) on an attainment measure for which they received five stars during both the current contract year and the prior contract year, then this measure will be counted as showing no significant change. Measures that are held harmless as described here will be considered eligible for the improvement measure. Net improvement is calculated for each class of measures (e.g., outcome, access, and process) by subtracting the number of significantly declined measures from the number of significantly improved measures.

$$\text{Net Improvement} = \text{Number of significantly improved measures} - \text{Number of significantly declined measures}$$

The improvement measure score is calculated for Parts C and D separately by taking a weighted sum of net improvement divided by the weighted sum of the number of eligible measures.

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 4

Process measure: Weight of 1

Specific weights for each measure, which may deviate from the general scheme above are described in Attachment G. When the weight of an individual measure changes over the two years of data used, the newer weight value is used in the improvement calculation.

$$\text{Improvement Measure Score} = \frac{\text{Net\_Imp\_Process} + 3 * \text{Net\_Imp\_Outcome} + 4 * \text{Net\_Imp\_PtExp}}{\text{Elig\_Process} + 3 * \text{Elig\_Outcome} + 4 * \text{Elig\_PtExp}}$$

TAB 24

Medicare 2025 Part C & D Star Ratings Technical Notes

Attachment L: Medication Adherence Measure Calculations

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the measurement period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Calculating the PDC Adjustment for IP Stays and SNF Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

In this example, a beneficiary fills Benazepril and Captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the Captopril prescription after the days' supply for the Benazepril medication ended.

Table L-1: No Adjustment

	January		February		March	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX
Benazepril	15	16	15	13		
Captopril					15	16

PDC Calculation
Covered Days: 90
Measurement Period: 90
PDC: 90/90 = 100%

Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products

In this example, a beneficiary fills a drug with the same target generic ingredient prior to the end of the days' supply of the first fill. In rows one and two, there is an overlap between a single and combination drug product, both containing Lisinopril. For this scenario, the overlapping days are shifted because the combination drug product includes the targeted generic ingredient. An adjustment is made to the PDC to account for the overlap in days covered.

In rows two and three, there is an overlap between two combination drug products, both containing Hydrochlorothiazide. However, Hydrochlorothiazide is not a RAS antagonist or targeted generic ingredient, so this overlap is not shifted.

TAB 25

Medicare 2025 Part C & D Star Ratings Technical Notes

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.

TAB 26

Medicare 2026 Part C & D Star Ratings Technical Notes

- MA-Only contracts are measured on 5 domains with a maximum of 33 measures.
- PDPs are measured on 4 domains with a maximum of 12 measures.
- MA-PD contracts are measured on all 9 domains with a maximum of 45 measures, 43 of which are unique measures. Two of the measures are shown in both Part C and Part D so that the results for a MA-PD contract can be compared to an MA-Only contract or a PDP contract. Only one instance of those two measures is used in calculating the overall rating. The two duplicated measures are Complaints about the Health/Drug Plan (CTM) and Members Choosing to Leave the Plan (MCLP).

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

Figure 2: The Four Categories of Data Sources

Improvement Measures

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

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

TAB 27

Medicare 2026 Part C & D Star Ratings Technical Notes

Measure: D04 - Drug Plan Quality Improvement

Title	Description
Label for Stars:	Improvement (if any) in the Drug Plan's Performance
Label for Data:	Improvement (If any) in the Drug Plan's Performance
Description:	This shows how much the drug plan's performance has improved or declined from one year to the next year. If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse). If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**. If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**. Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.
Metric:	The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2025 and 2026 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2025 and 2026 Star Ratings
Data Source Category:	Star Ratings
Exclusions:	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
General Notes:	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
Data Time Frame:	Not Applicable
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Improvement Measure
Weighting Value:	5
Major Disaster:	Includes only measures which have data from both years.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00224-01-C-PARTD
Data Display:	Not Applicable

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than -0.233766	Greater than or equal to -0.233766 to less than 0	Greater than or equal to 0 to less than 0.320439	Greater than or equal to 0.320439 to less than 0.579545	Greater than or equal to 0.579545
PDP	Less than -0.183824	Greater than or equal to -0.183824 to less than 0	Greater than or equal to 0 to less than 0.330927	Greater than or equal to 0.330927 to less than 0.672727	Greater than or equal to 0.672727

TAB 28

Medicare 2026 Part C & D Star Ratings Technical Notes

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 83%	Greater than or equal to 83% to less than 86%	Greater than or equal to 86% to less than 89%	Greater than or equal to 89% to less than 92%	Greater than or equal to 92%
PDP	Less than 85%	Greater than or equal to 85% to less than 87%	Greater than or equal to 87% to less than 89%	Greater than or equal to 89% to less than 92%	Greater than or equal to 92%

Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)

Title **Description**

Label for Stars: Taking Blood Pressure Medication

Label for Data: Taking Blood Pressure Medication

Description: The percentage of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are taking the medication.

One of the most important ways people with high blood pressure can manage their health is by their taking medication. The plan, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACEI (angiotensin converting enzyme inhibitor)*, an *ARB (angiotensin receptor blocker),* or a *direct renin inhibitor drug*.)

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: ACEI, ARB, or direct renin inhibitor medications. The proportion of days covered (PDC) is the percentage of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for the target medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period.

This percentage is calculated as the number of continuously enrolled beneficiaries, 18 years and older, with a PDC of 80 percent or higher for RAS antagonist medications during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two RAS antagonist medication fills on unique dates of service during the measurement period, and a treatment period that is at least 91 days during the measurement year (denominator).

The Part D Medication Adherence measure is adapted from the Medication Adherence-Proportion of Days Covered measure that was developed and endorsed by the PQA.

See the medication list for this measure. The Part D Medication Adherence rate is calculated using the NDC list maintained by the PQA. The complete NDC list, including diagnosis codes, is posted along with these technical notes.

Primary Data Source: Prescription Drug Event (PDE) data

Data Source Description: The data for this measure come from PDE data submitted to the CMS DDPS and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024-December 31, 2024. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the Patient Safety measure calculations. If the PDE edit is informational and therefore does not result in the PDE being rejected, then the PDE is used in the Patient Safety measure calculations. Reminder, CMS uses the term "final action" PDE to describe the most recently accepted original, adjustment, or deleted PDE record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2024 PDE submission deadline are used to calculate this measure. PDE claims are limited to members who received at least two prescriptions on unique dates of service for RAS antagonist medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.

Additional data sources include the CME, the CWF, and the EDS. The data cutoff date for all the additional data sources listed below such as the CME, CWF, and EDS is determined by the same PDE submission deadline for the annual Part D payment reconciliation.

- CME is used for enrollment information and to identify beneficiaries who elected to receive hospice care or with ESRD status (dialysis start and end dates within the measurement period).
- CWF is used to identify exclusion diagnoses based on ICD-10-CM codes, inpatient
- and SNF stays for PDPs and MA-PDs (if available).
- EDS is used to identify exclusion diagnoses based on ICD-10-CM codes, and SNF/IP stays for MA-PD beneficiaries.

Data Source Category: Health and Drug Plans

Exclusions: Contracts with 30 or fewer continuously enrolled beneficiaries (in the denominator). The following beneficiaries are also excluded from the denominator if at any time during the measurement period unless otherwise specified:

- In hospice
- ESRD diagnosis or dialysis coverage dates
- One or more prescriptions for sacubitril/valsartan during the treatment period

General Notes: Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents. As such, these drugs, which may be included in the PQA medication or NDC lists, are excluded from CMS analyses.

The PDC calculation is adjusted for overlapping prescriptions for the same drug which is defined by active ingredient at the generic name level using the NDC list maintained by PQA. The calculation also adjusts for Part D beneficiaries' stays in IP settings and stays in SNFs. The discharge date is included as an adjustment day for IP/SNF stays. Please see Attachment L: Medication Adherence Measure Calculations for more information about these calculation adjustments.

When available, beneficiary death date from the CME is the end date of a beneficiary's treatment period.

Data Time Frame: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Intermediate Outcome Measure

Weighting Value: 3

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00437-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 84%	Greater than or equal to 84% to less than 88%	Greater than or equal to 88% to less than 91%	Greater than or equal to 91% to less than 93%	Greater than or equal to 93%
PDP	Less than 88%	Greater than or equal to 88% to less than 90%	Greater than or equal to 90% to less than 91%	Greater than or equal to 91% to less than 93%	Greater than or equal to 93%

Measure: D10 - Medication Adherence for Cholesterol (Statins)

Title **Description**

Label for Stars: Taking Cholesterol Medication

Label for Data: Taking Cholesterol Medication

Description: The percentage of plan members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are taking the medication.

One of the most important ways people with high cholesterol can manage their health is by taking their medication. The plan, the doctor, and the member can work together to do this.

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for statin cholesterol medications. The proportion of days covered (PDC) is the percentage of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category. The index prescription start date (IPSD) is the earliest date of service for a statin medication during the measurement year. The treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period must be at least 91 days during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the treatment period with no enrollment gaps allowed during the treatment period.

TAB 29

Medicare 2026 Part C & D Star Ratings Technical Notes

Table D-2: Part D Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2025 – 05/2025
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2024 – 12/31/2024
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2024 – 12/31/2024
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2025 – 05/2025
D06	Getting Needed Prescription Drugs	CAHPS	03/2025 – 05/2025
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2024 – 09/30/2024
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024
D11	MTM Program Completion Rate for CMR	Part D Plan Reporting	01/01/2024 – 12/31/2024
D12	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2024 – 12/31/2024

TAB 30

Medicare 2026 Part C & D Star Ratings Technical Notes

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

Contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measure to be eligible to receive a rating in that improvement measure.

The improvement change score was determined for each measure for which a contract was eligible by calculating the difference in measure scores between Star Rating years 2025 and 2026.

For measures where a higher score is better:

Improvement Change Score equals Score in 2026 minus Score in 2025

For measures where a lower score is better:

Improvement Change Score equals Score in 2025 minus Score in 2026

An eligible measure was defined as a measure for which a contract was scored in both the 2025 and 2026 Star Ratings, and there were no significant measure specification changes or a regional contract reconfiguration for which only contract data is available from the original contract in one or both years.

For each measure, significant improvement or decline between Star Ratings years 2025 and 2026 was determined by a two-sided t-test at the 0.05 significance level:

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} > 1.96, \text{ then YES = significant improvement}$$

$$\text{If } \frac{\text{Improvement Change Score}}{\text{Standard Error of Improvement Change Score}} < -1.96, \text{ then YES = significant decline}$$

Hold Harmless Provision for Individual Measures: If a contract demonstrated statistically significant decline (at the 0.05 significance level) on an attainment measure for which they received five stars during both the current contract year and the prior contract year, then this measure will be counted as showing no significant change. Measures that are held harmless as described here will be considered eligible for the improvement measure. Net improvement is calculated for each class of measures (e.g., outcome, access, and process) by subtracting the number of significantly declined measures from the number of significantly improved measures.

Net Improvement equals Number of significantly improved measures minus Number of significantly declined measures

The improvement measure score is calculated for Parts C and D separately by taking a weighted sum of net improvement divided by the weighted sum of the number of eligible measures.

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 2

Process measure: Weight of 1

Specific weights for each measure, which may deviate from the general scheme above, are described in Attachment G. When the weight of an individual measure changes over the two years of data used, the newer weight value is used in the improvement calculation.

$$\text{Improvement Measure Score} = \frac{\text{Net\_Imp\_Process} + 3 * \text{Net\_Imp\_Outcome} + 2 * \text{Net\_Imp\_PtExp}}{\text{Elig\_Process} + 3 * \text{Elig\_Outcome} + 2 * \text{Elig\_PtExp}}$$

Net_Imp_Process equals Net improvement for process measures
Net_Imp_Outcome equals Net improvement for outcome and intermediate outcome measures
Net_Imp_PtExp equals Net improvement for patient experience/complaints and access measures
Elig_Process equals Number of eligible process measures
Elig_Outcome equals Number of eligible outcome and intermediate outcome measures
Elig_PtExp equals Number of eligible patient experience/complaints and access measures

The improvement measure score is converted into a Star Rating using the clustering method. Conceptually, the clustering algorithm identifies the "gaps" in the data and creates cut points that result in the creation of five categories (one for each Star Rating) such that scores of contracts in the same score category (Star Rating) are as similar as possible, and scores of contracts in different categories are as different as possible. Improvement scores of 0 (equivalent to no net change on the attainment measures included in the improvement measure calculation) will be centered at 3 stars when assigning the improvement measure Star Rating. Then, the remaining contracts are split into two groups and clustered: 1) improvement scores less than zero receive one or two stars on the improvement measure and 2) improvement scores greater than or equal to zero receive 3, 4, or 5 stars.

General Standard Error Formula

Because a contract's score on a given measure in one year is not independent of its score in the next year, the standard error for the improvement change score for each measure is calculated using the standard approach for estimating the variance of the difference between two variables that may not be independent. In particular, the standard error of the improvement change score is calculated using the formula:

$$\sqrt{se(Y_{i2})^2 + se(Y_{i1})^2 - 2 * Cov(Y_{i2}, Y_{i1})}$$

Using measure C01 as an example, the change score standard error is:

$se(Y_{i2})$ Represents the 2026 standard error for contract i on measure C01

$se(Y_{i1})$ Represents the 2025 standard error for contract i on measure C01

Y_{i2} Represents the 2026 rate for contract i on measure C01

Y_{i1} Represents the 2025 rate for contract i on measure C01

cov Represents the covariance between Y_{i2} and Y_{i1} computed using the correlation across all contracts observed at both time points (2026 and 2025). In other words:

$$cov(Y_{i2}, Y_{i1}) = se(Y_{i2}) * se(Y_{i1}) * Corr(Y_{i2}, Y_{i1})$$

where the correlation $Corr(Y_{i2}, Y_{i1})$ is assumed to be the same for all contracts and is computed using data for all contracts for which both years' measure scores are available and not excluded by the disaster policy. This assumption is needed because only one score is observed for each contract in each year; therefore, it is not possible to compute a contract-specific correlation.

Improvement Change Score Standard Error Numerical Example

For measure C03, contract A:

$se(Y_{i2}) =$ 2.805

$se(Y_{i1}) =$ 3.000

$Corr(Y_{i2}, Y_{i1}) = 0.901$

Improvement change score standard error for measure C03 for contract

A = sqrt ($2.805^2 + 3.000^2 - 2 * 0.901 * 2.805 * 3.000$) = 1.305

Standard Error Formulas (SEF) for Specific Measures

The following formulas are used for calculating the contract-specific standard errors for specific measures in the 2026 Star Ratings. These standard errors are used in calculating the improvement change score standard error.

1. **SEF for Measures: C01, C02, C06, C07, C10 – C12, C14 – C17, C19, C21, C29, C31 – C33, D01, D03, D08 – D12**

$$SE_y = \sqrt{\frac{Score_y * (100 - Score_y)}{Denominator_y}}$$

for y equals 2025 and 2026, and

$Denominator_y$ is as defined in the Measure Details section for each measure.

2. **SEF for Measures: C08, C09**

These measures are rolled up from the plan level to the contract level following the formula outlined in Attachment E: NCQA HEDIS Measures. The standard error at the contract level is calculated as shown below. The specifications are written for two PBP submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

The plan level standard error is calculated as:

$$SE_{yj} = \sqrt{\frac{Score_{yj} * (100 - Score_{yj})}{Denominator_{yj}}}$$

for y equals 2025 and 2026 and j equals Plan 1 and 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 equals 2025, 2026. This result is estimated by the formula $W_{y1} = N_{y1} / (N_{y1} + N_{y2})$

Let W_{y2} = The weight assigned to the second PBP results (estimated, auditable) for year y, where y equals 2025, 2026. This result is estimated by the formula

$$W_{y2} = N_{y2} / (N_{y1} + N_{y2})$$

$$SE_{yi} = \sqrt{(W_{y1})^2 * (SE_{y1})^2 + (W_{y2})^2 * (SE_{y2})^2}$$

for y equals Contract Year 2025, Contract Year 2026 and i equals Contract i

3. **SEF for Measure C18**

$$SE_y = 100 * \text{National Observed Rate}_y * \sqrt{\frac{\text{Oberved Count}_y}{\text{Expected Count}_y^2}}$$

for y equals 2025 and 2026

National Observed Rate, Observed Count, and Expected Count as defined in Attachment F.

4. SEF for Measure C20

Let T_{1y}, T_{2y}, T_{3y}, and T_{4y} be the four Transitions of Care component measures.

Let Z_y be the Transitions of Care measure, which is calculated as an average of the four component measures.

$$\mathrm{Var}(Z_y) = \frac{1}{16} * [\mathrm{Var}(T_{1y}) + \mathrm{Var}(T_{2y}) + \mathrm{Var}(T_{3y}) + \mathrm{Var}(T_{4y}) + 2\mathrm{Cov}(T_{1y}, T_{2y})$$

$$+2\mathrm{Cov}(T_{1y}, T_{3y}) + 2\mathrm{Cov}(T_{1y}, T_{4y}) + 2\mathrm{Cov}(T_{2y}, T_{3y}) + 2\mathrm{Cov}(T_{2y}, T_{4y}) + 2\mathrm{Cov}(T_{3y}, T_{4y})]$$

$$\mathrm{SE}_y = \sqrt{\mathrm{Var}(Z_y)}$$

for y equals 2025 and 2026

In the above formula, $Var(T_{1y}) = (100 * \frac{n_{1y}}{d_{1y}}) * \frac{(100 - (100 * \frac{n_{1y}}{d_{1y}})}{d_{1y}}$ where n_{1y} is the numerator for T_{1y} and d_{1y} the denominator, and so on for each of the four component measures.

$Cov(T_{1y}, T_{2y}) = Corr(T_{1y}, T_{2y}) * \sqrt{Var(T_{1y})} * \sqrt{Var(T_{2y})}$ and so on for each pair of component measures.

We estimate the correlations between pairs of component measures by calculating the sample correlation across all contract scores. These correlations are shown in the table below.

Measures		*2025 Correlation*	*2026 Correlation*
Patient Engagement After Inpatient Discharge	*Receipt of Discharge Information*	*0.556274*	*0.535619*
Patient Engagement After Inpatient Discharge	*Notification of Inpatient Admission*	*0.526902*	*0.489659*
Patient Engagement After Inpatient Discharge	*Medication Reconciliation Post-Discharge*	*0.544586*	*0.499420*
Receipt of Discharge Information	*Notification of Inpatient Admission*	*0.762500*	*0.771564*
Receipt of Discharge Information	*Medication Reconciliation Post-Discharge*	*0.408025*	*0.460944*
Notification of Inpatient Admission	*Medication Reconciliation Post-Discharge*	*0.540088*	*0.596070*

5. SEF for Measures: C03, C22 – C27, and D05, D06

The CAHPS measure standard errors for 2025 and 2026 were provided to CMS by the CAHPS contractor following the formulas documented in the CAHPS Macro Manual. The actual values used for each contract are included on the Measure Detail CAHPS page in the HPMS preview area.

6. SEF for Measures: C28, D02

$$\mathrm{SE}_y = \sqrt{\frac{\text{Total Number of Complaints}_y}{(\text{Average Contract Enrollment}_y)^2}} * \frac{1000*30}{\text{NumDays}}$$

NumDays: 2025 equals 365, 2026 equals 366

7. SEF for Measure D07

The standard error of the MPF Composite Price Accuracy Score for each contract is calculated by using binomial approximations for each of the component scores (Price Accuracy Score and Claim Percentage Score, as described in Attachment M). Since the MPF Composite Price Accuracy Score is equal to (0.5 multiplied by

Price Accuracy Score) + (0.5 multiplied by Claim Percentage Score), the composite measure's variance (and standard error) is a function of the variance of the Price Accuracy Score, the variance of the Claim Percentage Score, and the covariance between them. We assume that the product of the total PDE cost and the Price Accuracy Score (on a 0-1 scale) follows a binomial distribution, and likewise that the product of the number of PDE claims and the Claims Percentage Score (on a 0-1 scale) also follows a binomial distribution. With these assumptions in place, the standard error of the MPF Composite Accuracy Score is calculated as follows:

1. The contract's component scores, on their original 0-100 scale, have variances calculable using formulas based on the binomial variance assumptions described above, separately for each year y equals 2025, 2026.

    a. For the Price Accuracy Score, the variance in year y is represented by

$$Var(Price\ Acc.Score_y) = \frac{\left(Price\ Acc.Score_y \times (100 - Price\ Acc.Score_y)\right)}{Total\ PDE\ Cost_y}$$

    b. For the Claim Percentage Score, the variance in year y is represented by

$$Var(Claims\ Pct.Score_y) = \frac{\left(Claims\ Pct.Score_y \times (100 - Claims\ Pct.Score_y)\right)}{Number\ of\ PDE\ Claims_y}$$

2. The contract-specific covariance between the component scores, shown as $Cov(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y)$ in step 3 below, is calculated as the product of:
    a. the contract-specific standard errors of the two component scores, which are the square roots of the two variance estimates shown above in step 1, and
    b. the correlation between the two component scores estimated based on all contracts. The correlations for the two measurement years are shown below.

2025 Correlation	2026 Correlation
0.599486	0.653381

3. The standard error of the MPF Composite Price Accuracy Score is calculated from the components calculated in steps 1 and 2 as shown below:

$$SE_y = \sqrt{\frac{Var(Price\ Acc.\ Score_y)}{4} + \frac{Var(Claim\ Pct.\ Score_y)}{4} + \frac{Cov(Price\ Acc.\ Score_y, Claim\ Pct.\ Score_y)}{2}}$$

for y equals 2025, 2026

TAB 31

Medicare 2026 Part C & D Star Ratings Technical Notes

Table I-2: Part D Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
D01	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.518133
D02	Complaints about the Drug Plan	Included	0.723507
D03	Members Choosing to Leave the Plan	Included	0.791540
D04	Drug Plan Quality Improvement	Not Included	-
D05	Rating of Drug Plan	Included	0.784401
D06	Getting Needed Prescription Drugs	Included	0.681827
D07	MPF Price Accuracy	Included	0.832817
D08	Medication Adherence for Diabetes Medications	Included	0.605524
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.757009
D10	Medication Adherence for Cholesterol (Statins)	Included	0.754567
D11	MTM Program Completion Rate for CMR	Included	0.779423
D12	Statin Use in Persons with Diabetes (SUPD)	Included	0.835138

TAB 32

Medicare 2026 Part C & D Star Ratings Technical Notes

Attachment L: Medication Adherence Measure Calculations

NOTE: The examples below provide a snapshot of how to calculate PDC adjustments for overlapping fill and for inpatients and skilled nursing facility stays. These examples are not intended to represent the calculation of the measures for the entire treatment period. Reminder, the treatment period should be at least 91 days.

Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Web Portal to compare their performance to overall rates and monitor their progress in improving the Part D patient safety measures over time. Sponsors may use the website to view and download the reports for performance monitoring.

Report User Guides are available on the Patient Safety Analysis Web Portal under Help Documents and provide detailed information about the measure calculations and reports. The following information is an excerpt from the Adherence Measures Report Guide (Appendices A and B) and illustrates the days covered calculation and the modification for inpatient stays and skilled nursing facility stays.

Proportion of Days Covered Calculation

In calculating the Proportion of Days Covered (PDC), we first count the number of days the patient was "covered" by at least one drug in the target drug class. The number of days is based on the prescription fill date and days' supply. PDC is calculated by dividing the number of covered days by the number of days in the treatment period. Both of these numbers may be adjusted for IP/SNF stays, as described in the 'Calculating the PDC Adjustment for IP Stays and SNF Stays' section that follows.

Example 1: Non-Overlapping Fills of Two Different Drugs

In this example, a beneficiary fills benazepril and captopril, two drugs in the RAS antagonist hypertension target drug class. The covered days do not overlap, meaning the beneficiary filled the Captopril prescription after the days' supply for the Benazepril medication ended.

Table L-1: No Adjustment

	January		February		March		April
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX
Benazepril	15	16	15	13			
Captopril					15	16	30

PDC Calculation
Covered Days: 120
Treatment Period: 120
PDC: 120 out of 120 equals 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.

TAB 33

Medicare 2026 Part C & D Star Ratings Technical Notes

Table L-5: After Overlap Adjustment

	January		February		March		April	
	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Lisinopril	15	16						
Lisinopril & HCTZ			15	13	3			
Captopril					15	16		
Lisinopril						16	15	

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105 out of 120 equals 88%

PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples

In response to Part D sponsor feedback, CMS modified the PDC calculation, starting with the 2013 Star Ratings (using 2011 PDE data) to adjust for beneficiary stays in inpatient (IP) facilities, and with the 2015 Star Ratings (using 2013 PDE data) to also adjust for hospice enrollments and beneficiary stays in skilled nursing facilities (SNF). These adjustments account for periods that the Part D sponsor would not be responsible for providing prescription fills for targeted medications or more accurately reflect drugs covered under the hospice benefit or waived through the beneficiary's hospice election; thus, their medication fills during an IP or SNF stay or during hospice enrollment would not be included in the PDE claims used to calculate the Patient Safety adherence measures.

The PDC modification for IP stays, hospice enrollments, and SNF stays reflects this situation. Please note that while this modification will enhance the adherence measure calculation, extensive testing indicates that most Part D contracts will experience a negligible impact on their adherence rates. On average, the 2011 adherence rates increased 0.4 to 0.6 percentage points due to the inpatient stay adjustment, and the adjustment may impact the rates positively or negatively.

The hospice and SNF adjustments were tested on 2013 PDE data and overall increased the rates by 0.13 to 0.15 percentage points and 0.29 to 0.35 percentage points, respectively. Hospice information and inpatient claims from the Common Working File (CWF) are available for both PDPs and MA-PDs.

SNF claims from the CWF have been used to adjust the SNF PDC adjustments for PDPs. Starting in the 2019 measurement year, when available for MA-PDs in the CWF, adjust the SNF PDC adjustments. Additionally, starting in 2020 measurement year, when available for MA-PDs in the encounter data, adjust for SNF/IP stays for MA-PD beneficiaries.

Note: Hospice enrollment is no longer a PDC adjustment but rather an exclusion starting with the 2020 Star Ratings (2018 YOS).

Calculating the PDC Adjustment for IP Stays and SNF Stays

The PDC modification for IP stays and SNF stays is based on two assumptions: 1) a beneficiary receives their medications through the facility during the IP or SNF stay, and 2) if a beneficiary accumulates an extra supply of their Part D medication during an IP stay or SNF stay, that supply can be used once he/she returns home. The modification is applied using the steps below:

- Identify start and end dates of relevant types of stays for beneficiaries included in adherence measures. The discharge date is included in the PDC adjustment.
  - Use IP claims from the CWF to identify IP stays, and when available for MA-PDs.
  - Use SNF claims from the CWF for PDPs, and when available for MA-PD beneficiaries, for SNF PDC adjustments. (1) Use SNF claims from the CWF with either a positive or negative paid amount with Medicare utilization days to identify Medicare Part A covered SNF stays. (2) Use SNF claims from the CWF with a condition code 04 (Beneficiary enrolled in a MA-PD) not associated with a condition code 21 and/or a no payment reason code.
  - Use IP and SNF stay encounter data when available for MA-PD beneficiaries. Additionally, if IP and SNF stay claims for MA-PD enrolled beneficiaries are reported in the CWF, the CWF will remain as an additional data source.
- Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion of days covered calculation.
- Shift days' supply from Part D prescription fills that overlap with the stay or subsequent fills for the same drug class to uncovered days after the end of the relevant stay, if applicable. This assumes the beneficiary receives the relevant medication from a different source during the stay and accumulates the Part D prescription fills for later use.

If SNF and/or IP stays span a beneficiary's entire treatment period within the measurement period, the beneficiary is excluded from the denominator.

The following examples provide illustrations of the implementation of these assumptions when calculating PDC.

NOTE: The examples below provide a snapshot of how to calculate the PDC adjustments for IP and SNF stays. These examples are not intended to represent the calculation of the measures for the entire treatment period. Reminder, the treatment period should be at least 91 days.

Example 1: Gap in Coverage after IP Stay

In this example, the treatment period is 15 days and the beneficiary meets eligibility criteria for the measure by receiving at least two fills on different dates of service. This beneficiary had drug coverage on days 1-8 and 12-15 and an IP stay on days 5 and 6, as illustrated in Table L-6.

Table L-6: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1	X1	X1	X1	X1	X1				X2	X2	X2	X2
Inpatient Stay					+	+									

PDC Calculation:
Covered Days: 12
Treatment Period: 15

TAB 34

Medicare 2026 Part C & D Star Ratings Technical Notes

Table S-16: Measure Detail – D MD Results

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Measure ID	*The 2026 Star Ratings Part D measure ID*
2025 Value	*The numeric measure value for the contract from the 2025 Star Ratings*
2025 Star	*The measure star for the contract from the 2025 Star Ratings*
2026 Value	*The numeric measure value for the contract from the 2026 Star Ratings*
2026 Star	*The measure star for the contract from the 2026 Star Ratings*
Final Value	*The measure value to be used in the 2026 Star Ratings after the data handling policy for disasters was applied*
Final Star	*The measure star to be used in the 2026 Star Ratings after the data handling policy for disasters was applied*
Final From	*The Star Ratings year where the final data for the measure came from*

16. Measure Detail – C Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part C measures. There is one column for each Part C measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part C measure columns which contains the final numeric Part C improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part C measure calculations are shown in Table S-17 below.

Table S-17: Part C Measure Improvement Results

Improvement Measure Result	Description
No significant change	*There was no significant change in the values between the two years*
Significant improvement	*There was a significant improvement from last year to this year*
Significant decline	*There was a significant decline from last year to this year*
Not included in calculation	*There was only one year of data available so the calculation could not be completed*
Not Applicable	*The measure is not an improvement measure*
Not Eligible	*The contract did not have data in more than half of the improvement measures or was too new*
Held Harmless	*The contract had 5 stars in this measure last year and this year*
Low reliability and low enrollment	*The low-enrollment contract measure score did not have sufficiently high reliability*

17. Measure Detail – D Improvement page

The Improvement page is constructed in a similar manner as the Measure Data page. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the results of the improvement calculation for the specific Part D measures. There is one column for each Part D measure. The measure columns are identified by measure id and measure name. There is an additional column to the right of the Part D measure columns which contains the final numeric Part D improvement score. This numeric result is described in Attachment I: "Calculating the Improvement Measure and the Measures Used."

The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains a flag (Included or Not Included) to show if the measure was used to calculate the final improvement measure. All subsequent rows contain the data associated with an individual contract. The possible results for Part D measure calculations are shown in Table S-18 below.

Table S-18: Part D Measure Improvement Results

Improvement Measure Result	Description
No significant change	*There was no significant change in the values between the two years*
Significant improvement	*There was a significant improvement from last year to this year*
Significant decline	*There was a significant decline from last year to this year*
Not included in calculation	*There was only one year of data available so the calculation could not be completed*
Not Applicable	*The measure is not an improvement measure*
Not Eligible	*The contract did not have data in more than half of the improvement measures or was too new*
Held Harmless	*The contract had 5 stars in this measure last year and this year*

18. Measure Stars page

The Measure Stars page displays the Star Rating for each Part C and Part D measure. This page is available during the second plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measure stars which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain id and domain name. The row immediately below the measure information contains the data time frame. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-19 below shows a sample of the left hand most columns shown in HPMS.

Table S-19: Measure Stars page sample

Medicare Star Ratings Report Card Master Table						
				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*	*01/01/2024 - 12/31/2024*	*01/01/2024 - 12/31/2024*	*03/2025 - 06/2025*
HAAAA	*Market A*	*Contract A*	*PO A*	*Plan too new to be measured*	*Plan too new to be measured*	*Not enough data available*
HBBBB	*Market B*	*Contract B*	*PO B*	*Not enough data available*	*4*	*5*
HCCCC	*Market C*	*Contract C*	*PO C*	*3*	*4*	*5*

19. Domain Stars page

The Domain Stars page displays the Star Rating for each Part C and Part D domain. This page is available during the second plan preview.

TAB 35

H7379 Adherence Summary YOS 2023 June 2024

Adherence (ADH) Measures Summary

Note: Beneficiaries with one or more fills for insulin are excluded from the ADH-Diabetes Rate. Beneficiaries with one or more fills for sacubitril/valsartan are excluded from the ADH-RAS Rate.

Date of Report	July 31 2024
Period Measured	Jan 2023 - Dec 2023
Contract Number	H7379
Contract Name	CAREFIRST ADVANTAGE PPO, INC.

All Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract Type	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Number of Member-Years of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)				Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)				Medication Adherence for Cholesterol (Statins) (ADH-Statins)			
			Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Diabetes Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-RAS Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Statins Rate
All Contracts	51,960,233	49,857,044.75	8,225,406	7,976,341.5	6,862,366.0	86%	21,466,099	20,908,500.6	18,587,910.2	89%	25,971,597	25,314,126.3	22,216,597.9	88%
MAPDs	29,892,495	28,329,883.25	5,121,867	4,922,628.4	4,248,282.2	86%	12,655,956	12,225,408.7	10,936,968.7	89%	15,180,865	14,674,305.7	12,954,951.2	88%
MA-PDs (non-HMP)	29,592,755	28,046,673.50	5,073,566	4,876,626.8	4,209,683.2	86%	12,562,809	12,135,878.1	10,861,741.2	90%	15,060,679	14,559,907.6	12,859,100.2	88%
H7379	3,846	3,676.75	632	618.5	550.3	89%	1,783	1,756.8	1,581.3	90%	2,133	2,105.4	1,848.8	88%

LIS Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract Type	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Number of Member-Years of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)				Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)				Medication Adherence for Cholesterol (Statins) (ADH-Statins)			
			Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Diabetes Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-RAS Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Statins Rate
All Contracts	14,180,246	13,483,602.42	2,630,335	2,498,306.8	2,152,507.1	86%	5,436,506	5,162,035.7	4,466,796.2	87%	6,612,883	6,280,855.7	5,399,185.5	86%
MAPDs	9,329,011	8,658,654.17	1,859,450	1,743,870.2	1,516,473.1	87%	3,813,812	3,578,511.4	3,130,929.9	87%	4,627,658	4,343,482.1	3,765,107.2	87%
MA-PDs (non-HMP)	9,029,361	8,376,460.17	1,811,160	1,697,966.5	1,477,876.2	87%	3,719,666	3,488,991.9	3,066,713.3	88%	4,507,373	4,229,082.0	3,669,366.3	87%
H7379	58	50.42	11	10.9	5.0	55%	26	25.0	20.0	80%	31	30.0	25.1	84%

Non-LIS Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract Type	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Number of Member-Years of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)				Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)				Medication Adherence for Cholesterol (Statins) (ADH-Statins)			
			Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Diabetes Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-RAS Rate	Number of Enrolled Beneficiaries	Number of Member-Years of Enrolled Beneficiaries	Number of Member-Years of Adherent Beneficiaries	ADH-Statins Rate
All Contracts	37,824,871	36,373,442.33	5,596,039	5,478,034.7	4,709,858.9	86%	16,031,481	15,746,464.9	14,121,113.9	90%	19,360,886	19,033,270.7	16,817,412.4	88%
MAPDs	20,597,239	19,671,229.08	3,263,209	3,178,758.2	2,731,809.1	86%	8,844,616	8,646,897.3	7,806,028.8	90%	10,554,780	10,330,824.6	9,189,844.0	89%
MA-PDs (non-HMP)	20,597,232	19,671,223.33	3,263,208	3,178,757.2	2,731,808.1	86%	8,844,615	8,646,896.3	7,806,027.8	90%	10,554,780	10,330,824.6	9,189,844.0	89%
H7379	3,778	3,616.33	621	607.5	544.3	90%	1,757	1,731.8	1,561.3	90%	2,102	2,075.4	1,823.7	88%

Adherence (ADH) Measures Demographic Rates

Note: Beneficiaries with one or more fills for insulin are excluded from the ADH-Diabetes Rate. Beneficiaries with one or more fills for sacubitril/valsartan are excluded from the ADH-RAS Rate.

Date of Report	July 31 2024
Period Measured	Jan 2023 - Dec 2023
Contract Number	H7379
Contract Name	CAREFIRST ADVANTAGE PPO, INC.

ADH-Diabetes - Demographics Of All Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Diabetes Medications (ADH-Diabetes)													
		Adherence Rate, By Gender		Adherence Rate, By LIS Status		Adherence Rate, by Dual Eligibility		Adherence Rate, by Disability Status		Adherence Rate, By Age Groups					
		Female	Male	LIS	Non-LIS	Dual Eligibility	Non-Dual Eligibility	Disability	Non-Disability	18-54	55-64	65-69	70-74	75-79	80+
All Contracts	51,960,233	85%	87%	86%	86%	86%	86%	84%	87%	80%	83%	86%	87%	87%	87%
MAPDs	29,892,495	86%	87%	87%	86%	87%	86%	84%	87%	80%	84%	86%	87%	88%	87%
MA-PDs (non-MMP)	29,592,755	86%	87%	87%	86%	87%	86%	84%	87%	80%	84%	86%	87%	88%	87%
H7379	3,846	87%	92%	55%	90%	26%	89%	82%	89%		72%	91%	88%	92%	84%

ADH-RAS - Demographics Of All Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

Contract	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Hypertension (RAS Antagonists) (ADH-RAS)													
		Adherence Rate, By Gender		Adherence Rate, By LIS Status		Adherence Rate, by Dual Eligibility		Adherence Rate, by Disability Status		Adherence Rate, By Age Groups					
		Female	Male	LIS	Non-LIS	Dual Eligibility	Non-Dual Eligibility	Disability	Non-Disability	18-54	55-64	65-69	70-74	75-79	80+
All Contracts	51,960,233	89%	89%	87%	90%	87%	90%	86%	90%	82%	86%	89%	90%	90%	89%
MAPDs	29,892,495	90%	89%	87%	90%	87%	90%	87%	90%	83%	86%	90%	90%	90%	90%
MA-PDs (non-MMP)	29,592,755	90%	89%	88%	90%	88%	90%	87%	90%	83%	86%	90%	90%	90%	90%
H7379	3,846	90%	91%	80%	90%	78%	90%	83%	90%	100%	92%	91%	91%	89%	88%

ADH-Statins - Demographics Of All Beneficiaries Age 18 Or Older, Excluding Beneficiaries Enrolled In Hospice, With An ESRD Diagnosis, Or In IP/SNF During the Entire Measurement Period (ESRD is not excluded in ADH-ARV)

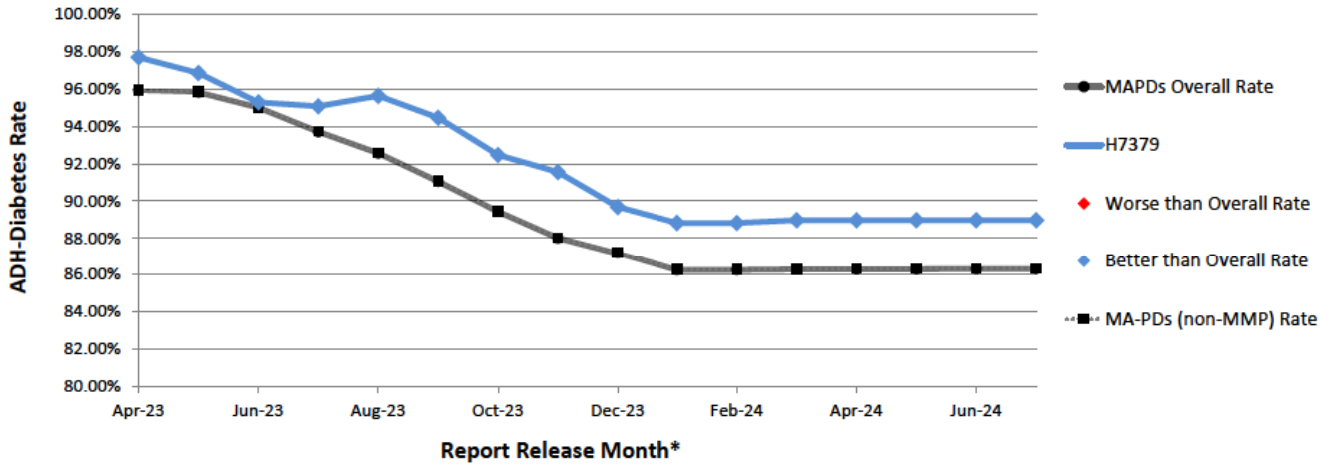
Contract	Number of Enrolled Beneficiaries from Jan 2023 - Dec 2023	Medication Adherence for Cholesterol (Statins) (ADH-Statins)													
		Adherence Rate, By Gender		Adherence Rate, By LIS Status		Adherence Rate, by Dual Eligibility		Adherence Rate, by Disability Status		Adherence Rate, By Age Groups					
		Female	Male	LIS	Non-LIS	Dual Eligibility	Non-Dual Eligibility	Disability	Non-Disability	18-54	55-64	65-69	70-74	75-79	80+
All Contracts	51,960,233	87%	88%	86%	88%	86%	88%	86%	88%	83%	85%	87%	88%	89%	88%
MAPDs	29,892,495	88%	89%	87%	89%	87%	89%	88%	89%	83%	86%	88%	89%	89%	89%
MA-PDs (non-MMP)	29,592,755	88%	89%	87%	89%	87%	89%	87%	89%	83%	86%	88%	89%	89%	89%
H7379	3,846	88%	88%	84%	88%	80%	88%	84%	88%	100%	88%	88%	87%	90%	88%

Medication Adherence for Diabetes Medications (ADH-Diabetes) Measure Performance

Note: The chart below compares the contract's monthly measure rate to its contract type overall rate.
Red data points highlight the month(s) the contract performed worse than its contract type overall rate.

Date of Report	July 31 2024
Period Measured	Jan 2023 - Dec 2023
Contract Number	H7379
Contract Name	CAREFIRST ADVANTAGE PPO, INC.

Back to Adherence Measure Summary



* The ADH-Diabetes Rate Report contains PDE data with 2023 dates of service that were submitted up to one month prior to the report release date. Therefore, the ADH-Diabetes Rate of a report released in April 2024 continues to analyze the YOS 2023 measurement period. The YOS 2023 report released in April 2024 contains PDE data with dates of service from January 2023 through December 2023 that were submitted to Medicare, received and accepted by March 2024. Please refer to Section 4 *Measure Reporting* and Section 5 *Patient Safety Report Naming Conventions* of the Patient Safety Measures General User Guide for more information regarding the contents and schedule of the Patient Safety Reports.

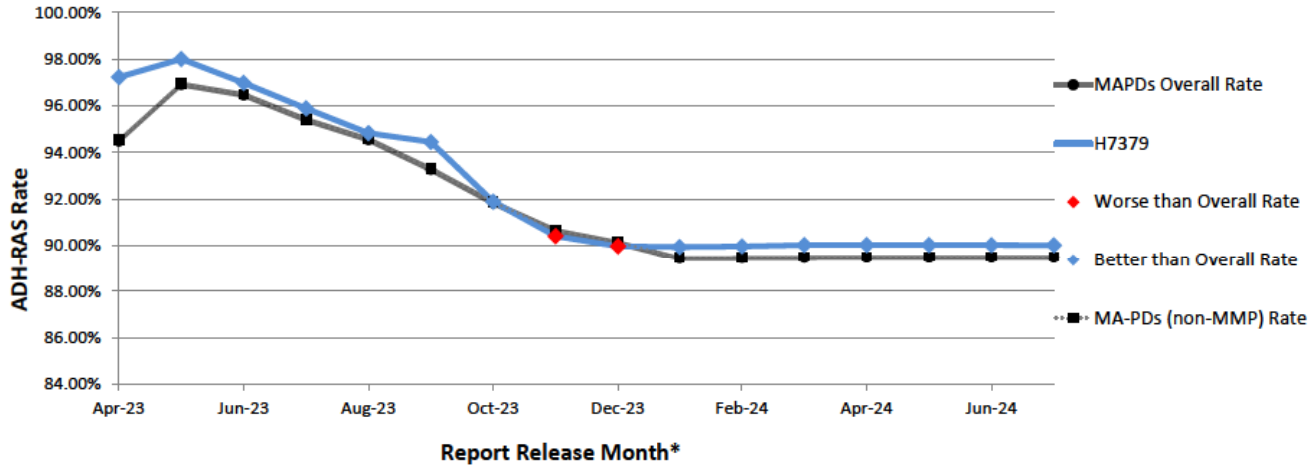
Please note that fluctuation of rates during the first few reports is expected due to the 91 day restriction of the measurement period. Please refer to Section 2.3.1 *91 Day Restriction* of the ADH Measures User Guide for more information regarding this restriction.

Medication Adherence for Hypertension (RAS Antagonists) Medications (ADH-RAS) Measure Performance

Note: The chart below compares the contract's monthly measure rate to its contract type overall rate.
Red data points highlight the month(s) the contract performed worse than its contract type overall rate.

Date of Report	July 31 2024
Period Measured	Jan 2023 - Dec 2023
Contract Number	H7379
Contract Name	CAREFIRST ADVANTAGE PPO, INC.

Back to Adherence Measure Summary



* The ADH-RAS Rate Report contains PDE data with 2023 dates of service that were submitted up to one month prior to the report release date. Therefore, the ADH-RAS Rate of a report released in April 2024 continues to analyze the YOS 2023 measurement period. The YOS 2023 report released in April 2024 contains PDE data with dates of service from January 2023 through December 2023 that were submitted to Medicare, received and accepted by March 2024. Please refer to Section 4 *Measure Reporting* and Section 5 *Patient Safety Report Naming Conventions* of the Patient Safety Measures General User Guide for more information regarding the contents and schedule of the Patient Safety Reports.

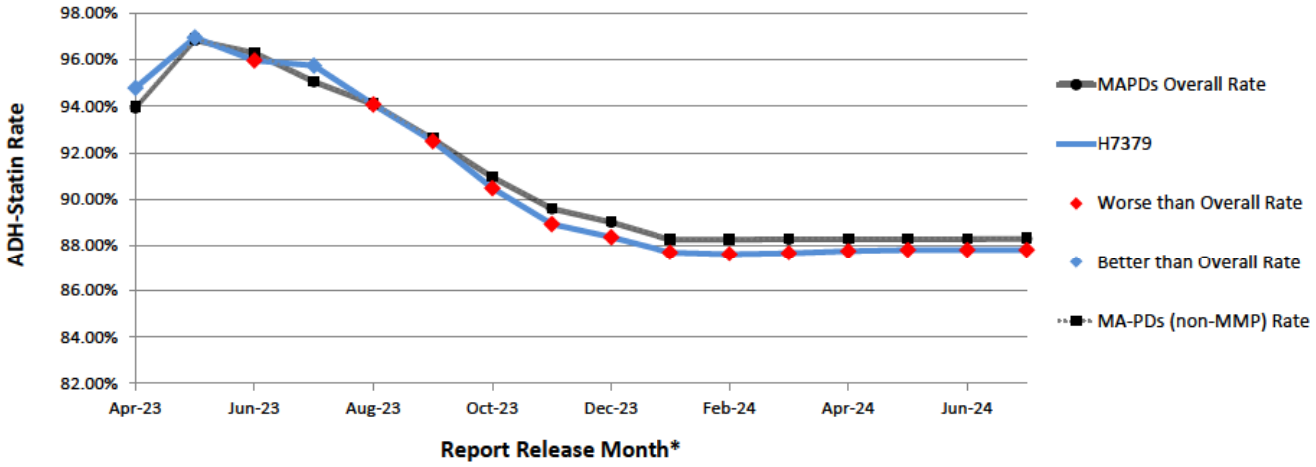
Please note that fluctuation of rates during the first few reports is expected due to the 91 day restriction of the measurement period. Please refer to Section 2.3.1 *91 Day Restriction* of the ADH Measures User Guide for more information regarding this restriction.

Medication Adherence for Cholesterol (Statins) Medications (ADH-Statins) Measure Performance

Note: The chart below compares the contract's monthly measure rate to its contract type overall rate.
Red data points highlight the month(s) the contract performed worse than its contract type overall rate.

Date of Report	July 31 2024
Period Measured	Jan 2023 - Dec 2023
Contract Number	H7379
Contract Name	CAREFIRST ADVANTAGE PPO, INC.

Back to Adherence Measure Summary



* The ADH-Statins Rate Report contains PDE data with 2023 dates of service that were submitted up to one month prior to the report release date. Therefore, the ADH-Statins Rate of a report released in April 2024 continues to analyze the YOS 2023 measurement period. The YOS 2023 report released in April 2024 contains PDE data with dates of service from January 2023 through December 2023 that were submitted to Medicare, received and accepted by March 2024. Please refer to Section 4 *Measure Reporting* and Section 5 *Patient Safety Report Naming Conventions* of the Patient Safety Measures General User Guide for more information regarding the contents and schedule of the Patient Safety Reports.

Please note that fluctuation of rates during the first few reports is expected due to the 91 day restriction of the measurement period. Please refer to Section 2.3.1 *91 Day Restriction* of the ADH Measures User Guide for more information regarding this restriction.

TAB 36

Acumen Message, July 31, 2025 Updated 2024 Reports Available (July 2025 Release)

Outlook

Patient Safety – Updated 2024 Reports Available (July 2025 Release)

From PatientSafety <PatientSafety@acumenllc.com>
Date Wed 3/4/2026 2:22 PM
To Catherine.Lee@carefirst.com <Catherine.Lee@carefirst.com>

DATE: July 31, 2025

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Catherine.Lee@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2024 Reports Available (July 2025 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2024 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2024 and December 31, 2024 by the annual PDE submission deadline.

New Display Page Adherence 'Risk Adjusted Rate'

The final Patient Safety Reports' YOS 2024 Display page Adherence (ADH) Contract-Level Report includes the 'Risk Adjusted Rate' worksheet. The 'Risk Adjusted Rate' worksheet presents the risk adjusted rates for your contract, broken out by ADH measure.

In addition to accessing the 'Risk Adjusted Rate' worksheet within the Contract-Level Report, you can also view these rates on the Patient Safety Analysis Web Portal. From the left-hand navigation pane, select the 'Rate Summary' page. Within the 'Rate Summary' page, navigate to the respective Display page Adherence measure tab (i.e., ADH-Diabetes RA Rate Summary, ADH-RAS RA Rate Summary, or ADH-Statins RA Rate Summary), then open the benefit year '2024' tab. The risk adjusted rate will be displayed as the column on the far right (e.g., "Your Contract - [Display page ADH Measure] RA Rate (adjusted)").

For additional information, please refer to Section 2.3.3 'RA' and Section 3.1.2 'Risk Adjusted Rates Worksheet' of the YOS 2024 Display page Adherence Measures User Guide (PS-DPM-ADH-YOS2024-Report-Guide-Apr-2024) available within the contract report packages and in the 'Help Documents' section of the Patient Safety Analysis Web Portal.

Web Portal User Authorization Reminder

Only Patient Safety Web Portal users with authorized access can download the Patient Safety Reports. Medicare Compliance Officers (MCOs) must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

Outlook

Patient Safety – Updated 2024 Reports Available (July 2025 Release)

From PatientSafety <PatientSafety@acumenllc.com>
Date Wed 3/4/2026 2:24 PM
To Leona.Garber@carefirst.com <Leona.Garber@carefirst.com>

DATE: July 31, 2025

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Leona.Garber@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2024 Reports Available (July 2025 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2024 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2024 and December 31, 2024 by the annual PDE submission deadline.

New Display Page Adherence 'Risk Adjusted Rate'

The final Patient Safety Reports' YOS 2024 Display page Adherence (ADH) Contract-Level Report includes the 'Risk Adjusted Rate' worksheet. The 'Risk Adjusted Rate' worksheet presents the risk adjusted rates for your contract, broken out by ADH measure.

In addition to accessing the 'Risk Adjusted Rate' worksheet within the Contract-Level Report, you can also view these rates on the Patient Safety Analysis Web Portal. From the left-hand navigation pane, select the 'Rate Summary' page. Within the 'Rate Summary' page, navigate to the respective Display page Adherence measure tab (i.e., ADH-Diabetes RA Rate Summary, ADH-RAS RA Rate Summary, or ADH-Statins RA Rate Summary), then open the benefit year '2024' tab. The risk adjusted rate will be displayed as the column on the far right (e.g., "Your Contract - [Display page ADH Measure] RA Rate (adjusted)").

For additional information, please refer to Section 2.3.3 'RA' and Section 3.1.2 'Risk Adjusted Rates Worksheet' of the YOS 2024 Display page Adherence Measures User Guide (PS-DPM-ADH-YOS2024-Report-Guide-Apr-2024) available within the contract report packages and in the 'Help Documents' section of the Patient Safety Analysis Web Portal.

Web Portal User Authorization Reminder

Only Patient Safety Web Portal users with authorized access can download the Patient Safety Reports. Medicare Compliance Officers (MCOs) must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

Outlook

Patient Safety – Updated 2024 Reports Available (July 2025 Release)

From PatientSafety <PatientSafety@acumenllc.com>
Date Wed 3/4/2026 2:24 PM
To mary-paul.snapp-borleis@carefirst.com <mary-paul.snapp-borleis@carefirst.com>

DATE: July 31, 2025

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
mary-paul.snapp-borleis@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2024 Reports Available (July 2025 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2024 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2024 and December 31, 2024 by the annual PDE submission deadline.

New Display Page Adherence 'Risk Adjusted Rate'

The final Patient Safety Reports' YOS 2024 Display page Adherence (ADH) Contract-Level Report includes the 'Risk Adjusted Rate' worksheet. The 'Risk Adjusted Rate' worksheet presents the risk adjusted rates for your contract, broken out by ADH measure.

In addition to accessing the 'Risk Adjusted Rate' worksheet within the Contract-Level Report, you can also view these rates on the Patient Safety Analysis Web Portal. From the left-hand navigation pane, select the 'Rate Summary' page. Within the 'Rate Summary' page, navigate to the respective Display page Adherence measure tab (i.e., ADH-Diabetes RA Rate Summary, ADH-RAS RA Rate Summary, or ADH-Statins RA Rate Summary), then open the benefit year '2024' tab. The risk adjusted rate will be displayed as the column on the far right (e.g., "Your Contract - [Display page ADH Measure] RA Rate (adjusted)").

For additional information, please refer to Section 2.3.3 'RA' and Section 3.1.2 'Risk Adjusted Rates Worksheet' of the YOS 2024 Display page Adherence Measures User Guide (PS-DPM-ADH-YOS2024-Report-Guide-Apr-2024) available within the contract report packages and in the 'Help Documents' section of the Patient Safety Analysis Web Portal.

Web Portal User Authorization Reminder

Only Patient Safety Web Portal users with authorized access can download the Patient Safety Reports. Medicare Compliance Officers (MCOs) must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

Outlook

Patient Safety – Updated 2024 Reports Available (July 2025 Release)

From PatientSafety <PatientSafety@acumenllc.com>
Date Wed 3/4/2026 2:24 PM
To Ifeoma.Atueyi@carefirst.com <Ifeoma.Atueyi@carefirst.com>

DATE: July 31, 2025

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Ifeoma.Atueyi@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2024 Reports Available (July 2025 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2024 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2024 and December 31, 2024 by the annual PDE submission deadline.

New Display Page Adherence 'Risk Adjusted Rate'

The final Patient Safety Reports' YOS 2024 Display page Adherence (ADH) Contract-Level Report includes the 'Risk Adjusted Rate' worksheet. The 'Risk Adjusted Rate' worksheet presents the risk adjusted rates for your contract, broken out by ADH measure.

In addition to accessing the 'Risk Adjusted Rate' worksheet within the Contract-Level Report, you can also view these rates on the Patient Safety Analysis Web Portal. From the left-hand navigation pane, select the 'Rate Summary' page. Within the 'Rate Summary' page, navigate to the respective Display page Adherence measure tab (i.e., ADH-Diabetes RA Rate Summary, ADH-RAS RA Rate Summary, or ADH-Statins RA Rate Summary), then open the benefit year '2024' tab. The risk adjusted rate will be displayed as the column on the far right (e.g., "Your Contract - [Display page ADH Measure] RA Rate (adjusted)").

For additional information, please refer to Section 2.3.3 'RA' and Section 3.1.2 'Risk Adjusted Rates Worksheet' of the YOS 2024 Display page Adherence Measures User Guide (PS-DPM-ADH-YOS2024-Report-Guide-Apr-2024) available within the contract report packages and in the 'Help Documents' section of the Patient Safety Analysis Web Portal.

Web Portal User Authorization Reminder

Only Patient Safety Web Portal users with authorized access can download the Patient Safety Reports. Medicare Compliance Officers (MCOs) must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.

Outlook

Patient Safety – Updated 2024 Reports Available (July 2025 Release)

From PatientSafety <PatientSafety@acumenllc.com>
Date Wed 3/4/2026 2:25 PM
To Sara.M.Barekzai@carefirst.com <Sara.M.Barekzai@carefirst.com>

DATE: July 31, 2025

TO: Authorized Patient Safety Analysis Web Portal User
Or Medicare Compliance Officer
Sara.M.Barekzai@carefirst.com

FROM: Acumen, LLC
PatientSafety@AcumenLLC.com

RE: Patient Safety – Updated 2024 Reports Available (July 2025 Release)

The final Patient Safety Reports based on Prescription Drug Event (PDE) data from year of service (YOS) 2024 are now available for download through the Patient Safety Analysis Web Portal (https://partd.programinfo.us/PatientSafety). The rates in these reports were calculated using PDE data with dates of service between January 1, 2024 and December 31, 2024 by the annual PDE submission deadline.

New Display Page Adherence 'Risk Adjusted Rate'

The final Patient Safety Reports' YOS 2024 Display page Adherence (ADH) Contract-Level Report includes the 'Risk Adjusted Rate' worksheet. The 'Risk Adjusted Rate' worksheet presents the risk adjusted rates for your contract, broken out by ADH measure.

In addition to accessing the 'Risk Adjusted Rate' worksheet within the Contract-Level Report, you can also view these rates on the Patient Safety Analysis Web Portal. From the left-hand navigation pane, select the 'Rate Summary' page. Within the 'Rate Summary' page, navigate to the respective Display page Adherence measure tab (i.e., ADH-Diabetes RA Rate Summary, ADH-RAS RA Rate Summary, or ADH-Statins RA Rate Summary), then open the benefit year '2024' tab. The risk adjusted rate will be displayed as the column on the far right (e.g., "Your Contract - [Display page ADH Measure] RA Rate (adjusted)").

For additional information, please refer to Section 2.3.3 'RA' and Section 3.1.2 'Risk Adjusted Rates Worksheet' of the YOS 2024 Display page Adherence Measures User Guide (PS-DPM-ADH-YOS2024-Report-Guide-Apr-2024) available within the contract report packages and in the 'Help Documents' section of the Patient Safety Analysis Web Portal.

Web Portal User Authorization Reminder

Only Patient Safety Web Portal users with authorized access can download the Patient Safety Reports. Medicare Compliance Officers (MCOs) must periodically monitor user authorization status by updating existing user access or adding/deleting new users when necessary. Modifications can be made by the MCO using the User Security Web Portal. Each contract is limited to a maximum of five users on the Web Portal. MCOs may also designate themselves as one of the five authorized users.

If you have any questions or need help accessing the Web Portal, contact Website Support at servicedesk@skyshaper.us.

If you have any questions or need help accessing the reports, contact Acumen at PatientSafety@acumenllc.com or by phone at (650) 558-8006.

If you have any questions or concerns about CMS policies regarding Part D performance and quality measures, contact CMS at PartCandDStarRatings@cms.hhs.gov.

Thank you,
Acumen, LLC.