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

PLAINTIFF'S COMBINED MEMORANDUM IN OPPOSITION TO DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT AND REPLY IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Agencies must "turn square corners" in their administration of the laws laid out by Congress. *Niz-Chavez v. Garland*, 593 U.S. 155, 172 (2021). CareFirst Advantage PPO, Inc. ("CareFirst") filed this lawsuit because, in previewing its 2025 Star Ratings for certain Medicare Advantage health plans, including CareFirst, the Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS") failed to do so, and that failure caused CareFirst injury.

In April 2023, CMS issued guidance expressly stating that "[t]he final YOS 2023 Patient Safety Reports will be released in July 2024" and that those reports "will be used to calculate 2025 Part D Star Ratings[.]" A.R. 3. That guidance aligned with past practice and CMS's annual Star Ratings schedule. CMS followed that guidance through the expiration of the plan preview period—releasing the July 2024 Report and permitting plans to review their data accordingly. Using those data, CMS then previewed the forthcoming Star Ratings based on those data. CareFirst reviewed the data and resulting Star Rating previewed for it by CMS, and determined that everything was accurate.

After the preview period closed, however, CMS discovered a "technical issue" and substituted a new data set, released in September 2024 through its contractor, Acumen. Acumen, in its notification to plans, described the impact to most contracts' Star Ratings as "marginal or unchanged." Because the technical correction was announced after the close of the preview period and, by description, appeared unremarkable, CareFirst took no action, relying on CMS to do as it said it would: use the data reported in July to calculate the 2025 Star Ratings, as had already been previewed for it.

But as CareFirst would come to discover a year later, that technical issue had a material effect on its *2026* Star Ratings. The nonchalant manner by which the "technical" correction was

communicated to CareFirst in September 2024 caused CareFirst to miss an opportunity it might otherwise have had to implement business changes to mitigate against the risk of a lower Star Rating for the following year, 2026. The result is the loss of more than $32 million in government bonus payments that would otherwise be realized in 2027. The loss of that revenue will, in turn, diminish the scope of services CareFirst will be able to offer beneficiaries in 2027.

In its own brief, CMS contends that it wears the white gloves, and points the finger at CareFirst for not paying attention to the new data set transmitted by Acumen at the end of September 2024. But in so arguing, CMS elevates substance at the expense of process. It stresses that the error correction in September 2024 was appropriate, but shrugs off the timing of that correction and the manner by which it was communicated as though CareFirst (and all affected Medicare Advantage plans) should have known to be on the lookout for changes. This, despite CMS's April 2023 Guidance stating the data reported in July 2024 would dictate the 2025 Star Ratings, and despite the second preview period closing two weeks prior, with no alert to affected plans that CMS was aware of an error that would cause the data set to change. CMS's position also blinks the reality that the calendar for 2025 Star Ratings cannot be understood in isolation. There is a cadence to the annual Medicare bid process, from which the Star Ratings calendar of events radiates, rooted in statutory and regulatory deadlines, repeated over years. The fact that the *September 2024 Report* was backdated to *July 31, 2024* shows that CMS understands that deadlines matter and are relied upon.

Indeed, CMS has no response to the attestation of CareFirst's declarant that the September 2024 switcheroo at the heart of this lawsuit is without precedent. To the contrary, in the past, when CMS has updated its data set after identifying issues, it has done so through the Health Plan Management System (HPMS) and specifically identified each corrected issue by measure. CMS's

departure from this practice in September 2024—routing a material data substitution through a contractor communication that described the impact as "marginal or unchanged," rather than through a direct HPMS communication that identified the affected measures with specificity—was inconsistent with CMS's regular order and the root cause of CareFirst's injury.

Further, the case authorities that CMS cites also do not help its argument. Most have nothing at all to do with the Medicare program, let alone the Star Ratings program applicable to Medicare Advantage plans.

As set forth below, CMS's actions were contrary to law and arbitrary and capricious, and this Court should order CMS to recalculate CareFirst's 2026 Star Rating using the data CMS itself committed to use.

ARGUMENT

I. CMS's failure to follow its own April 2023 Guidance is contrary to law.

A. CMS cannot escape the plain language of its April 2023 Guidance.

Year after year, CMS has used the patient safety reports released in July to calculate star ratings for the following year, as reflected in its April 2023 Guidance. That guidance expressly stated that "[t]he ***final*** YOS 2023 Patient Safety Reports will be released in July 2024" and that those reports "***will be used*** to calculate 2025 Part D Star Ratings[.]" A.R. 3 (emphasis added). In moving for summary judgment, however, CMS tries to subvert the explicit language in that guidance by offering a reinterpretation of the meaning of the word "final" and diminishing the significance of that word as used in its guidance.

CMS argues that the only commitment CMS made in its guidance was to "release" the relevant PDE data in July 2024, not that the data would be "final." *E.g.*, Dkt. No. 11 at 26–27. But that is not what the guidance says. In drafting its guidance, CMS chose to use the word "final" and then placed that word directly before the next words "YOS 2023 Patient Safety Reports;" it then

stated that such data "will be used" to calculate plans' Star Ratings for 2025. CMS cannot now—in the midst of litigation—indulge the fiction that the guidance says something other than what it explicitly does say. *See Siqing Wang v. USCIS*, 366 F. Supp. 3d 118, 122 (D.D.C. 2019) ("The Court will not defer to [an agency's] briefing [when] it 'appears to be nothing more than an agency's convenient litigating position.'") (quoting *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213 (1988)).

To be sure, CareFirst understands incorrect data can be corrected. CMS and CareFirst agree that this is the point of the plan preview periods. *See* Dkt. No. 11 at 23–24. But the error correction during this time (if there is anything to be corrected) is expected to come *from the plans* upon review of their data. If the error correction comes from CMS, then at the very least CMS must make it clear to Medicare Advantage plans that it will be departing from earlier guidance or statements about the "final" data set to be used in generating the Star Ratings—in this case, first and foremost, the April 2023 Guidance. After all, why would CMS, in its own words, "commit" itself to the "release" of "final" data to plans by July of every year if it does not intend plans to plan and prepare in reliance on that commitment? If CMS really intends that data released in July can be readily swapped for another data set "at any time" before plans' final Star Ratings are released to the public, *see id.* at 30, then basic principles of fair notice dictate that it must state that in advance. Yet, as CMS would have this Court understand it, the July deadline set out in the April 2023 Guidance was meaningless.

CMS's position also cannot be reconciled with the carefully constructed calendar of key events that CMS established to govern the Star Rating process so that plans can meet the statutory bid submission deadline, CMS can determine payments to plans, and plans can determine the scope of services they can offer to their plan members in the coming year. The final patient safety report

is released in July—after plans' deadline for submitting final Prescription Drug Event (PDE) data at the end of June—precisely because that July release is meant to reflect final data. If the July 2024 report was not intended to be "final," there would have been no reason to time its release after the PDE submission deadline, and the next timed event in the Star Ratings calendar would serve little purpose.

CMS is required by its own regulations to offer plans a preview period, the entire point of which is to allow plans an opportunity to preview their Star Ratings prior to release to the public so as to make any adjustments before release. 42 C.F.R. §§ 422.166(h)(2); 423.186(h)(2). CMS chose to establish two relatively short "plan preview" periods. Plan Preview 1 begins in August, shortly after release of its final patient safety reports in July. Plan Preview 2 begins in September. *See generally* Dkt. No. 10-1 at 8–9. Each plan preview period serves a distinct purpose. Plan Preview 1 affords plans an opportunity to review CMS's methodology and data and raise questions with CMS. Then, during Plan Preview 2, CMS makes any necessary revisions to its calculations before its public release of final Star Ratings. This has been CMS's practice for years, as evidenced by its statements during 2018 rulemaking:

> During the first plan preview, we expect Part C and D sponsors to closely review the methodology and their posted numeric data for each measure. The second plan preview includes any revisions made as a result of the first plan preview.

83 Fed. Reg. 16440, 16588 (Apr. 16, 2018) (Final Rule).

CMS's claim that the patient safety data report released in July 2024 was never intended to be "final" would render this entire plan preview process a fruitless exercise. Again, why would CMS require plans to "closely review" the data and raise questions in the first plan period so as to allow CMS sufficient time to incorporate any revisions in the second period if that data could afterward be swapped for another set of data without adequate notice to plans? CMS's contention

that the plan preview does not "close" at the end of the second preview period also does nothing to help CMS's argument, as CMS concedes (at 23–25) that there is a deadline *for plans* to submit questions and comments that they wish CMS to consider during these periods. CMS's replacement of data in the final July 2024 report with new data *after* the plan preview deadline had passed deprived plans of their opportunity to raise any questions and comments during the first plan preview to be addressed by CMS in its calculations during the second plan preview.[1]

B. CMS's failure to follow its own established practice of communicating data corrections through HPMS further confirms its departure from the norms on which plans rely.

CMS's HPMS is the platform through which CMS communicates all important messages about Medicare Advantage, including matters relating to Star Ratings. *See* April 3, 2026, Declaration of Elizabeth Haynes ¶ 7; *see also* https://hpms.cms.gov/app/ng/home/. Medicare Advantage plans—including CareFirst—are required by CMS to maintain a process for reviewing and responding to every HPMS memorandum that CMS releases. *Id.* That obligation creates a corollary responsibility on CMS's part: when it makes changes that plans are expected to act upon, it must use that channel.

CMS honored that responsibility in the past. For example, during the first plan preview period for the 2017 Star Ratings, CMS issued an HPMS communication on August 12, 2016, notifying plans that it had updated the Star Ratings data set and detailing each of the specific issues that had been corrected. Less than a week later, CMS issued a second HPMS communication,

[1] CMS also refers to various memorandum that use the term "preliminary" in an attempt to buttress its argument that the July 2024 data was not "final." However, CMS mischaracterizes the memoranda's use of the word and removes it from its context. For example, its first cite is to an August 6, 2024 memorandum, but that memorandum does not refer to the July 2024 final patient safety report as "preliminary"; rather, the memorandum refers to "preliminary Star Ratings" that are released in the first plan preview period. *See* Defs.' Br. at 24; A.R. 48. The same is true of the September 5, 2024, September 11, 2025 memorandum and CMS's September 16, 2025 email.

again updating the data set and again identifying, with specificity, each additional issue that had been corrected since the prior update. And at the opening of the second plan preview period in September 2016, CMS issued yet another HPMS communication confirming that it had made "measure data revisions and Technical Note updates as a result of issues found during the first plan preview," and directing plans to "*immediately* alert CMS of any suspected data issues or errors in order to allow sufficient time to investigate and process any necessary data corrections." And finally, CMS issued another HPMS communication on September 28, 2016 confirming it had made contract-specific data corrections as a result of issues found during the second plan preview period. *See* April 3, 2026 Declaration of Elizabeth Haynes.

In 2024, as part of the 2025 Star Ratings process, CMS did none of this. If CMS had communicated the details of the corrected data set announced by Acumen in September 2024 in the same manner it had done for the data corrected in 2016—through a direct HPMS memorandum identifying the affected measures with specificity—CareFirst would have reviewed that notification and taken appropriate action in response. *See, e.g.*, Dkt. No. 10-2 ¶ 2 (March 4, 2026 Declaration of Elizabeth Haynes). Instead, CMS routed a material post-preview data substitution through its contractor, Acumen, which minimized the change as a "minor technical issue" with effects that were "marginal or unchanged" for most contracts. That was not notice; it was obscurity. CMS's failure to use its own established communication channel, and its failure to provide the measure-specific detail that has characterized its prior error-correction communications, deprived CareFirst of fair notice and the opportunity to respond.

C. CMS is wrong that the Medicare statute required it to sacrifice procedural fairness in correcting its error.

In its brief (at 18–20), CMS insists that the Medicare statute requires it to correct data errors and (at 30) contends that CareFirst is estopped from arguing otherwise. As explained below, that

is not quite right, but ultimately it does not matter because error correction is not the linchpin of this lawsuit. The central issue is CMS's failure of process in announcing the error correction. To the extent CMS decides to depart from the deadlines and protocol that it dictated in the first instance, CMS must provide meaningful, timely notice—which it failed to do. CareFirst is surely not estopped from seeking relief under the APA for CMS's unlawful or arbitrary conduct.

Given the nature of this lawsuit, CMS's reliance (at 19–20) on *Methodist Hospital of Sacramento v. Shalala*, 38 F.3d 1225 (D.C. Cir. 1994), to support its authority to correct errors is out of place. *Methodist Hospital* addressed how hospital reimbursements under a different provision of Medicare are to be calculated. The case arose from a mistake by a large Sacramento-area hospital, which supplied inaccurate wage data to the California state authorities relevant to the transition period. As a result of that erroneous data, the Sacramento wage index understated the actual labor costs faced by Sacramento hospitals relative to the national average in 1984. That in turn affected the economics of other Sacramento hospitals and a legal battle ensued over whether the wage index should be recalculated retrospectively. Ultimately, the D.C. Circuit held that although retroactive adjustment would result in more accurate payments to the affected hospitals, "[i]t was not arbitrary and capricious of the Secretary to decide that the administrative burden of recalculating the reimbursement rate for every hospital in a metropolitan area every time any hospital in that area makes an error in reporting wage data *outweighs the increase in accuracy* that would result." 38 F.3d at 1233 (emphasis added). It concluded that "the Secretary's prospective-only policy was a reasonable choice between the competing values of finality and accuracy." *Id.* at 1235.

Again, because CareFirst does not contest CMS's general authority to correct errors, *Methodist Hospital* is inapposite for the point on which CMS relies on it. That said, the reasoning

of *Methodist Hospital* as it concerns how the agency exercised its discretion lends support to the relief CareFirst seeks here. CareFirst had no role in the error that CMS corrected. The mistake was that of CMS or its contractor Acumen. CMS could have thus exercised its discretion differently, so as not to penalize CareFirst.

CMS has adopted a similar approach in its Medicare Advantage reopening regulation. CMS's regulation provides that if CMS discovers a "systemic calculation" error that impacts more than the Medicare Advantage organization that submitted an appeal to challenge its Quality Bonus Payment (QBP) status, CMS may reopen that determination and adjust the QBP ratings for all Medicare Advantage organizations impacted by that calculation error. 42 C.F.R. § 422.260(d). However, in doing so, it will *only* adjust a Medicare Advantage organization's QBP rating if CMS's correction results in a *higher* QBP rating. If CMS's recalculation results in a *lower* QBP rating, CMS will leave the plan's initial rating intact, even if it is no longer accurate. 42 C.F.R. § 422.260(d) states:

> CMS may, on its own initiative, revise an MA organization's QBP status at any time after the initial release of the QBP determinations through April 1 of each year. CMS may take this action on the basis of any credible information, including the information provided during the administrative review process by a different MA organization, that demonstrates that the initial QBP determination was incorrect. If a contract's QBP determination is reopened as a result of a systemic calculation issue that impacts more than the MA organization that submitted an appeal, the QBP rating for MA organizations that did not appeal will only be updated if it results in a higher QBP rating.

The circumstances that prompted CMS to promulgate this regulation are directly analogous to the circumstances presented in this case. CMS obviously determined that it had made a systematic mistake that impacted more than one Medicare Advantage plan's QBP rating. There is no question that CMS made a mistake that was systematic and affected its *calculation* of plans'

Star Ratings. In these instances, CMS's regulation explicitly authorizes CMS to conduct a reopening and recalculation "*at any time* after the initial release of the QBP determinations through April 1 of each year." *Id.* (emphasis added). And in performing that calculation, CMS has committed to not "correct" its mistake for a plan if doing so would result in a *lower* QBP rating for that year. *Id.* CMS also commits to rectifying a plan's QBP rating if the recalculation would result in a higher rating *irrespective of* whether the plan itself filed an appeal. *Id.* Furthermore, while this regulatory language was finalized in 2024, CMS also noted during rulemaking that "[t]his is how we have historically noted how we would handle this type of systemic calculation error as described in our annual HPMS memo released in November each year." 89 Fed. Reg. 30448, 30648 (Apr. 23, 2024). In other words, in those instances where CMS is responsible for a systematic error, it will forgo accuracy for fairness, which is precisely what CareFirst is seeking here.

While the reopening regulation does not apply on all fours to this case, what it and *Methodist Hospital* demonstrate is that CMS's argument that it is beholden to correct all errors at all costs, and regardless of circumstances, is wrong. CMS makes decisions all the time, as the cases CMS cites show, as to which errors to correct, the administrative burden of correcting each and every error, and the impact and fairness of its corrections. CareFirst submits that this case should be no different, particularly when it played no role in CMS/Acumen's error and the bungled communication of that error was CMS's doing alone.[2]

[2] As to the line of cases CMS cites to regarding the "ministerial error doctrine," those cases only apply if CMS's error was merely "**typographical**, not substantive[.]" *Voyageur Outward Bound Sch. v. United States*, 444 F. Supp. 3d 182, 191 (D.D.C. 2020), *vacated as moot,* No. 20-5097, 2022 WL 829754 (emphasis added). CMS has not attempted to show that swapping data that had a material impact on CareFirst was a typo—nor could it.

CMS (at 20) also cites *Cape Cod Hospital v. Sebelius*, 630 F.3d 203 (D.C. Cir. 2011). In that case, plaintiff hospitals argued that CMS had made computational errors in calculating certain adjustments. As in *Methodist Hospital*, CMS refused to correct its calculations for past years, *id.* at 209, invoking the need for finality, even if such finality came at the cost of accuracy. CMS said "[a]lthough errors in ratesetting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered." *Id.* at 209, 214 (citation omitted). The D.C. Circuit disagreed, holding that retroactive adjustments were required by the governing statute. *Id.* at 213.

CMS is also mistaken about what the Medicare statute requires. Relying on the authorities noted above for support, CMS asserts that it was required by 42 U.S.C. § 1395w-22(e) to correct its error, but that is not what the statute says. The cited provision states that "each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality." *Id.* § 1395w-22(e)(3)(A)(i). There is no dispute that CareFirst did that. CMS then turns to its regulation at 42 C.F.R. § 423.182(c)(2) for the proposition that "Part D sponsors must provide unbiased, accurate, and complete quality data . . . to CMS on a timely basis as requested by CMS." Again, there is no question that CareFirst did that as well.

Without statutory or regulatory language to support its position, CMS turns to preamble language in which CMS states that the data used in the ratings must be "complete, accurate, reliable, and valid." Dkt. No. 11 at 19 (citation omitted). However, CMS fails to include the proper context for that statement, which is included in this sentence: "it is important that the data underlying the ratings are unbiased, accurate, and complete *so that the ratings themselves are reliable*." 83 Fed. Reg. at 16532 (emphasis added). Here, there is no question that inclusion of the July 2024 data would result in a "reliable" rating for CareFirst.

This is demonstrated by the simple and undisputed fact that it would take the mere addition of a fraction of a plan member in CMS's calculations to raise CareFirst from a 3.5 rating to a 4 rating. Dkt. No. 10-1 at 24. The Medication Adherence for Hypertension measure (D09) feeds into the Part D Quality Improvement Measure (D04)—a measure that carries five times the standard weighting. Using the September 2024 Report data, CareFirst missed the threshold for "Significant Improvement" in that measure by a gap of just 0.034552. To have closed that gap, CareFirst would have needed 0.64 of an additional member. Since members are whole people only, that 0.64 of a member is a physical impossibility that CareFirst would not have been able to achieve. It is therefore inescapable that CareFirst's current rating cannot be an accurate reflection of its performance. CMS's contrary claim that *but for* its use of the September 2024 Report it would not be presenting an "accurate" depiction of CareFirst's performance for the benefit of the public rings hollow.

Again, though, the central question for the Court is not whether CMS was within its right to correct for erroneous data, but whether it did so in a lawful and procedurally fair manner. It did not. Changing the rules of the game quietly, without notice, and after the close of the plan preview periods is not lawful, and certainly not reasonable. It is noteworthy that CMS does not dispute the Declaration of CareFirst's Elizabeth Haynes, who stated in support of CareFirst's motion for summary judgment that she "cannot recall CMS or its vendor Acumen issuing such material revisions to finalized reports in a manner similar to the way they did with the September 2024 Report." Dkt. No. 10-2 ¶ 37.

Remarkably, CMS contends it "has no statutory obligation to preview the data underlying its Star Ratings calculation." Dkt. No. 11 at 23. But that can hardly matter here because, as discussed above, CMS by regulation plainly does commit to the preview periods, *see* 42 C.F.R. §§

422.166(h)(2); 423.186(h)(2), and it is fundamental that an agency is obligated to adhere to its own regulations. *See United States v. Nixon*, 418 U.S. 683, 695-96 (1974). CMS is the architect of the preview process. The April 2023 Guidance that created the expectation that the PDE data released in July 2024 would be "final" fit neatly and consistently within this architecture. CareFirst understood the architecture for what it was, on the terms set by CMS.

Thus, when it received the notice from Acumen transmitting the September 2024 Report identifying a "minor technical issue" that would result in "marginal or unchanged" Star Ratings scores for most contracts, CareFirst was given no reason by CMS to be curious. The preview periods were over and CMS made no announcement of its own that its April 2023 Guidance did not still apply. It would have been easy enough for CMS, in September 2024, part and parcel to Acumen's transmission of the September 2024 Report, to issue superseding guidance to affected Medicare Advantage plans expressly withdrawing the April 2023 Guidance and making it clear that the new "final" data set is contained in the September 2024 Report.

CMS did not do that. In fact, it did the opposite. If there were any doubt as to the intended finality and significance of the July 2024 Final Patient Safety Report, CMS's own post-hoc conduct—principally, backdating the September 2024 Report to July 31, 2024 (which CMS notably does not dispute doing)—shows that CMS itself understood the norm created by its guidance and past practice that it would use the data contained in its July 2024 Report to calculate plans' Star Ratings, which is precisely what its guidance states. If CMS's contrary argument were correct, it would have been completely unnecessary to backdate the report to July 31, 2024. CMS's backdating lays bare its argument that the July 2024 date was merely a commitment to release the data at that time, as CMS indisputably "released" the data replacement set in September.

D. CMS misconstrues *Accardi*.

At bottom, *Accardi* promotes stability. The norm of administrative law that the *Accardi* doctrine expresses is that agencies should be held accountable to do as they say they will do. Agencies can of course change course, but they must announce in reasonably clear terms when they are doing so. The April 2023 Guidance was consistent with CMS's practice of using final patient safety reports issued in July to calculate plans' Star Ratings. CMS contends *Accardi* is inapposite because, with the April 2023 Guidance, "CMS did not create a norm that patient safety data would not be revised if errors were identified." Dkt. No. 11 at 31. Here again, CMS misses the point. CareFirst understands that the April 2023 Guidance did not lock in the July patient safety data, errors notwithstanding. But what it did do is lead Medicare Advantage plans to expect CMS to use the July patient safety data absent *a plan* identifying a data error during the plan preview periods. That was *the point* of the April 2023 Guidance. That is *the point* of CMS staging the rollout of data and resulting Star Ratings in advance of open enrollment the same way, year after year.

Here, there can be no doubt that "the rights of individuals are affected[.]" *Morton v. Ruiz*, 415 U.S. 199, 235 (1974). By downplaying the significance of the substitute data set transmitted by Acumen with the September 2024 Report, weeks after the plan preview period had closed, CMS denied CareFirst the opportunity to modify its business plans in a way that would have allowed it to mitigate against the downside implications for the following (2026) Star Ratings year. *See, e.g.*, Dkt. No. 10-2 ¶ 2.

Despite CMS's attempt to recast the doctrine to limit its import, both prongs of *Accardi* are met: (i) CMS "fell substantially short" of the norm it devised, as reflected in its April 2023 Guidance; and (ii) that failure then prejudiced CareFirst, resulting in a 3.5-Star Rating instead of 4.0 and an estimated $32 million loss to CareFirst, limiting the services it can offer its plan

members for the 2027 benefit year. *Sheble v. Huerta*, 755 F.3d 954, 957 (D.C. Cir. 2014) (quoting *Lopez v. FAA*, 318 F.3d 242, 248 (D.C. Cir. 2003)); *see also Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 25 (D.D.C. 2024) (applying the *Accardi* doctrine in a Stars Ratings challenge).

CMS's argument that the April 2023 Guidance invited correction because it asked plans to "monitor data and alert CMS if errors are identified" merely confirms that *plans* had the ability to identify errors during the preview period; it said nothing about CMS unilaterally substituting data *post-preview* without meaningful notice. There is not a single communication in the administrative record from CMS notifying Medicare Advantage plans to be alert to post-preview data substitutions by CMS.

CMS asserts (at 30) that it did not intend to "transform" its announcement of the "release schedule" for patient safety data into a "norm that the released data would not be later corrected[.]" But as discussed above, that argument is belied by the language in the April 2023 Guidance, which tracked the carefully developed and iterative schedule CMS has developed and adhered to over the years: routine means plans know when they will be expected to engage in the two plan preview periods; routine means beneficiaries know when to compare plans during the enrollment period; and routine means plans know when to expect CMS to determine a plan's QBP for the coming year and when to develop bids for the following year.

CMS's reliance on *Sierra Club* and *Syncor* is misplaced. *Sierra Club* was a petition to the D.C. Circuit challenging agency guidance; the D.C. Circuit dismissed the case for lack of final agency action, *inter alia*. *Sierra Club v. EPA*, 873 F.3d 946, 951–53 (D.C. Cir. 2017). *Syncor* also does not help CMS, as that case involved the distinction between a substantive and interpretative rule. *Syncor Int'l Corp. v. Shalala*, 127 F.3d 90, 94 (D.C. Cir. 1997). Application of the *Accardi* doctrine does not turn on the "finality" *vel non* of the agency standard from which the agency has

departed. The premise of *Accardi* is that agencies must be held accountable for departures from agency norms—be they in the form of regulations or guidance or other pronouncements, including policy statements—that unsettle reliance interests. *See, e.g.*, *Battle v. FAA*, 393 F.3d 1330, 1336 (D.C. Cir. 2005). There is no question the *Accardi* doctrine "can be applied to internal agency guidance" (such as the April 2023 Guidance). *Damus v. Nielsen*, 313 F. Supp. 3d 317, 336 (D.D.C. 2018) (citing *Montilla v. I.N.S.*, 926 F.2d 162, 167 (2d Cir. 1991) ("The *Accardi* doctrine is premised on fundamental notions of fair play underlying the concept of due process. . . . Its ambit is not limited to rules attaining the status of formal regulations.")). CMS acted contrary to that principle by relying on data outside the scope of its April 2023 Guidance without clearly notifying affected plans that it was doing so, and thereby depriving stakeholders, including CareFirst, of the opportunity to make business adjustments to mitigate against the risk of a lower 2026 Star Rating.

This is why it is irrelevant whether the April 2023 Guidance was a mere "policy statement," Dkt. No. 11 at 27, or something else. The key, as CMS concedes (and as controlling precedent requires), is whether CMS's departure from that guidance affected the legal norms on which CareFirst relied. *See Syncor*, 127 F.3d at 94. As explained, it did. CMS's argument is unbounded, and undercuts a central tenet of the APA, to wit, that agencies be held accountable for their actions. *See generally Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 156 (2012) (recognizing "the principle that agencies should provide regulated parties 'fair warning of the conduct'" required of them to avoid the type of "'unfair surprise' against which our cases have long warned") (citations omitted); *FCC v. Fox Television Stations, Inc.*, 567 U.S. 239, 258 (2012) (setting aside agency action because the agency failed to provide fair notice); *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (holding "[i]t would be arbitrary or capricious" to permit agency action that contradicts earlier agency action that "engendered serious reliance interests").

The complexity of the Star Ratings program evidences the need for health plans to rely on CMS's guidance—and CMS knows this because it puts out guidance relating to the meticulously timed Star Ratings year. When it strays from that guidance, it must be held accountable.

II. CMS's actions are arbitrary and capricious.

A. Acumen's downplaying of the September 2024 Report is arbitrary and capricious because it induced CareFirst's reliance.

Even if not unlawful per se, CMS's actions (and inaction) were arbitrary and capricious. Acumen downplayed the significance of the updated data in the September 2024 Report. In its email to plans, Acumen noted that "[t]he YOS 2023 Patient Safety Report Package zip files have been re-uploaded to replace the zip files that were uploaded on July 31, 2024." A.R. 125–31. The communication stated that Acumen had "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," and that the changes would have a "*marginal or unchanged*" impact. A.R. 125–31 (emphasis added).

Unlike CMS's prior practice of issuing direct HPMS memoranda—through the official platform that plans are required to monitor—that identified corrected measures with specificity and directed plans to take action, *see supra* Section I.B, CMS did nothing of the sort here. No HPMS communication accompanied the September 2024 data substitution. No measure-specific impact was disclosed. CMS did nothing to clarify the potential significance to individual plans.

That so-called "marginal or unchanged" impact will cause CareFirst to lose approximately $32 million in Quality Bonus Payments for 2027. And the failure to properly communicate the significance of the impact at the time caused CareFirst to miss out on an opportunity to initiate business plans to mitigate against the risk of a lower 2026 Star Rating, meaning CareFirst is stuck with a 3.5 Star Rating instead of the 4.0 Star Rating it would have received had CMS adhered to

its April 2023 Guidance or at least given CareFirst sufficient information to allow it to make operational changes to adjust for the updated data in planning for the 2026 Star Ratings. This "marginal or unchanged" impact, moreover, was not from a clerical error, *see supra* Section I.C, but from CMS relying on a completely different data set released in September, rather than the data set it told plans it would rely on from July.

CMS now argues (at 38) Acumen's message was "accurate" because most contracts were unaffected. That *most* contracts may not have suffered harm is irrelevant to the injury CMS caused *CareFirst*. CMS had an obligation to ensure CareFirst, among its regulated entities, had a fair opportunity to understand the material impact of CMS's departure from its April 2023 Guidance. CMS did not follow its own guidance in replacing the July 2024 Report with the September 2024 Report after the close of the second plan preview period and did nothing to clarify the significance of the new data, even though it appreciated the departure as evidenced by Acumen backdating the September report. That failure—even if it impacted only CareFirst—may not be explained away just because it may not affect other regulated entities. (This is, after all, an as-applied challenge to discrete final agency action; not a facial challenge to some broader policy pronouncement or regulation.)

The adequacy of notice should be measured by whether a regulated entity in CareFirst's position—reasonably relying on the April 2023 Guidance and the back-drop of the regular annual cadence of the Medicare bid submission process—would have understood the full import of the correction for its future Star Ratings. *See Nat'l Conservative Pol. Action Comm. v. Fed. Election Comm'n*, 626 F.2d 953, 959 (D.C. Cir. 1980) ("[P]rior notice is required where a private party justifiably relies upon an agency's past practice and is substantially affected by a change in that practice."). Here, the notification came from a contractor—Acumen—not from CMS directly

through HPMS. Furthermore, Acumen described the impact as affecting "a small fraction of beneficiaries" with "marginal or unchanged" effects—there was no individualized notification of whose contracts were affected, no notice that at least some would have their Star Rating impacted, and no explanation of what change CMS undertook. CMS did not state it was departing from its April 2023 Guidance. It provided no contract-specific impact information, and the substitute data set was transmitted after the closing of the plan preview period, at a time plans had no expectation of receiving material notifications based on years of CMS practice and CMS's own guidance. The substitute data set did not change our 2025 Star Ratings preview as made available by CMS in the HPMS. In this circumstance, CMS plainly failed to consider and communicate all relevant information. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) ("Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, *entirely failed to consider an important aspect of the problem*, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.") (emphasis added).

At the very least, if CMS is correct that the "plan preview" period does not establish a presumptive deadline for data correction, *see* Dkt. No. 11 at 25, then the corollary must also be true: CMS is duty-bound under basic principles of administrative law to identify and provide sufficient notice of whatever changes it makes after the plan preview period. After all, it cannot possibly be reasonable for an agency that identifies and corrects errors during the preview period, and then appropriately communicates to Medicare Advantage plans about those errors through the HPMS, to say absolutely nothing to Medicare Advantage plans about errors found only after the close of preview period. CMS cannot have it both ways—expecting plans to be alert to potential

post-preview errors yet not taking its own action to notify plans of such. CMS must turn square corners. It did not do so here.

CMS's lack of transparency about the impact of the replacement of the July 2024 Report with the September 2024 Report further deprived CareFirst of adequate notice and an opportunity to adjust its performance targets for the final quarter of 2024. Had the magnitude of the change been identified to CareFirst by either CMS or Acumen, rather than obscured by them, then CareFirst could have adjusted its performance objectives for 2024. *See, e.g.*, Dkt. No. 10-2 ¶ 2.

B. CMS's "harmless error" argument fails.

CMS's argument (at 38) that CareFirst "waived" objection to CMS and Acumen's error, by not downloading the data, inverts the burden: CMS ***created*** the conditions that made it reasonable for CareFirst to rely on CMS following its April 2023 Guidance, and acted arbitrarily and capriciously when it strayed from that guidance. On its own, CMS's failure to adhere to its April 2023 Guidance that the YOS 2023 patient safety reports released in the July 2024 Report would contain the data CMS would use to generate Medicare Advantage plans' 2025 Star Ratings was arbitrary and capricious. *See, e.g.*, *UnitedHealthcare Benefits of Tex., Inc. v. CMS*, No. 24-cv-357, 2024 WL 4870771, at *4 (E.D. Tex. Nov. 22, 2024) (vacating a Star Rating and ordering CMS to recalculate that rating where it failed in the first instance to follow its guidance, stating "[a]gency action that is contrary to the agency's guidelines may be arbitrary and capricious").

In a different vein, CMS argues any error was harmless in that the new data increased CareFirst's 2025 D09 score, so CareFirst would not have objected. But this statement is untrue and misleading. When the final 2025 Star Ratings were released in October 2024, CareFirst's Star Rating *did not change* so CareFirst had no reason in that time period to think the technical error identified by Acumen in its September 2024 report impacted CareFirst's data at all. *See* Dkt. No. 10-1 at 16–17. CareFirst accepted at face value Acumen's statements that the impact of the

"minor," "technical issue" on measure rates for "most contracts was marginal or unchanged." In other words, CareFirst did not download the report *precisely because* CMS and Acumen downplayed its significance, and it did not object at the time because it was unaware of the impact of CMS's change until that impact was manifested with the calculation of the 2026 Star Ratings.

If CareFirst had been given fair notice of the impact of CMS's change, it would have made operational adjustments to the remainder of its 2024 performance to improve its position for the 2026 D04 measure calculation. *See* Dkt. No. 10-2 ¶¶ 32–37. CareFirst's injury derives directly from CMS's inadequate notice of its departure from the April 2023 Guidance. Any opportunity CareFirst might otherwise have had to improve its 2024 performance in order to demonstrate significant improvement for the 2026 D04 calculation was foreclosed by CMS's failure to give CareFirst fair notice of its departure from its guidance. CareFirst cannot act on something it does not know.

For similar reasons, any conjecture CMS floats on CareFirst acting with the benefit of hindsight twists the narrative. It is not that CareFirst is acting because it discovered an outcome it did not like—it is that CareFirst discovered a negative outcome in 2025 (for the 2026 Star Ratings) *because* CMS broke from its April 2023 Guidance *sub silentio* one year earlier, in 2024. The ability to take corrective action in real time, before data is "baked," is the whole point of CMS's plan preview framework. When CMS strayed from its own regulations and guidance, it denied CareFirst that opportunity.

C. CMS's inclusion of a fraction of an individual renders its Star Rating unreasonable.

Aside from abandoning its own guidance on which CareFirst relied, to its detriment, CMS acted arbitrarily and capriciously in a different way—one that illustrates just how razor-thin, and how arbitrary, the margin against CareFirst truly is: Even using the September 2024 Report data,

CareFirst missed the "significant improvement" cut-off by just 0.034552—an insignificant gap equivalent to 0.64 of a member. *See* Dkt. No. 10-1 at 31 (citing A.R. 69–77, 201–09). Since fractions of individuals do not exist, CMS's determination unreasonably created a barrier to recognizing actual improvement.

The story starts with a single heavily weighted measure: Medication Adherence for Hypertension (D09). That measure feeds directly into the Part D Quality Improvement Measure (D04), which carries five times the weight of a standard measure—meaning errors in D09 ripple through CareFirst's overall rating with outsized force. The September 2024 data update altered the baseline year-over-year comparison for D09, and the consequences were decisive.

Under the updated data, CareFirst's improvement rate for D09 came in just shy of the "Significant Improvement" threshold by a gap of 0.034552. To have cleared that gap, CareFirst would have needed just 0.64 of an additional adherent member in the D09 numerator. CareFirst had 1,695 adherent members. If that number had been 1,695.64, CareFirst would have achieved Significant Improvement and, with it, a 4-Star overall rating. Of course, members are whole people. Fractional members do not exist. CMS's determination thus created an insurmountable barrier—denying CareFirst a 4-Star rating on the basis of a gap that, as a matter of arithmetic reality, no plan could ever close by so small a margin.

CMS responds that no statute, regulation, or guidance ***requires*** rounding up to the next whole member. Dkt. No. 11 at 34. But that fumbles the claim here—CareFirst's claim is one of arbitrary and capricious agency action. CareFirst understands that, in some instances, plans may "fall a hair's breadth short of the next-highest rating." *See id.* at 36. But here, as previously noted, the arbitrary and capricious nature of CMS's position is that the gap between a 3.5 and a 4 Star Rating for CareFirst can be closed if CareFirst were to insert a *fraction* of a member into the

numerator of CMS's formula, and a fraction of an individual is an impossibility. Given the objective of the Star Rating program to create a level playing field, it was arbitrary and capricious for CMS to deny CareFirst a 4-Star D04 rating on so thin a reed—particularly when the thin reed is itself the product of CMS's departure from its guidance.

III. Remand to CMS with instructions to recalculate CareFirst's 2026 Star Rating is the appropriate remedy.

CMS argues remand would be improper because CMS can easily cure any defects in CareFirst's Star Rating. CMS is wrong on the law and wrong on the facts. The cases do not support CMS.

The appropriate remedy for CMS's unlawful action is remand for recalculation of CareFirst's Star Rating. *See, e.g.*, *Elevance Health, Inc.*, 736 F. Supp. 3d at 25–26 (instructing CMS to recalculate plaintiff's Star Rating because when an agency acts contrary to its own regulations, the resulting agency action is arbitrary and capricious). This Court should order CMS to recalculate CareFirst's 2026 Star Rating for contract H7379 by either excluding the Medication Adherence for Hypertension Measure (D09) from the calculation of the Drug Plan Quality Improvement Measure (D04) rating, or by using the data contained in the July 2024 Report to calculate the D04 score.

Moreover, CMS's "parade of horribles" argument cuts the other way: if CMS were able to promulgate guidance establishing a timeline and announcing the data it will use to calculate Star Ratings, induce every single health plan to shape its business year around CMS's announced timeline, submit data according to CMS's announcement, and then abdicate that guidance without notice or reason to the detriment of some plans, there would be no point to the guidance in the first instance. The APA militates against unaccountable agency action, and this Court should hold CMS to that congressional command. Furthermore, any argument that CMS's doors would be whipped

"open" to a flood of lawsuits only presumes that CMS will continue to promulgate—then abandon—guidance on which plans rely. Thus, the culprit is *not* the entities asking for accountability and judicial relief, but the agency which is acting contrary to law and arbitrarily and capriciously.

CONCLUSION

For all the foregoing reasons, the Court should grant CareFirst's motion for summary judgment, deny CMS's cross-motion for summary judgment, and order CMS to recalculate CareFirst's 2026 Star Rating using the July 2024 patient safety data as specified in the April 2023 Guidance, or on whatever alternative basis the Court deems appropriate.

Dated: April 3, 2026

Respectfully submitted,

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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

DECLARATION OF ELIZABETH HAYNES

I, Elizabeth Haynes, declare as follows:

1. I am the Vice President of Quality, Stars, and Risk Adjustment of CareFirst Advantage PPO, Inc. ("CareFirst"). I submit this declaration in support of CareFirst's opposition to the motion for summary judgment filed by the Department of Health and Human Services and its Center for Medicare and Medicaid Services (CMS) in the captioned case.

2. During the 2017 Star Ratings year, CMS updated its initial data set after identifying several issues. In a memorandum issued during the first plan preview period through its Health Plan Management System (HPMS) portal, CMS stated that it "has updated the dataset in HPMS for the first 2017 Star Ratings Plan Preview today, 8/12/16."

3. CMS's HPMS Memorandum identified the specific issues it had addressed via the update as follows:

- Part C & D measures C28 & D06: The original data used the CMP report issued date from CAMS, not the Date Action Taken for the CMPs shown on the enforcement actions page of the CMS.gov website. The CMP data used in the BAPP measure have been updated to align with the CMS website dates.

- Part C measure C30: The number of late appeals were off for some contracts since it did not include the Corrected Appeal Date field shown on the Measure Detail -Part C Appeals page. This field and the measure scores have been updated.

- Part C measure C31: The original data did not include reopenings that were decided prior to May 1, 2016. The revised data include this change.

A true and correct copy of CMS's August 12, 2016 HPMS Email is attached hereto as Exhibit A.

4. Then on August 18th, 2016, during the first plan preview period, CMS updated the data set again, and explained this second update in another HPMS Email, in which CMS advised plans that it had "updated the dataset for the first 2017 Star Ratings plan preview today, 8/18/16." CMS further explains plans should "However, continue to review your data. You will have another opportunity during the second plan preview in September."

5. The HPMS Emails identified all the issues that CMS had corrected since the last update on August 12, 2016. These issues included the following:

- Part C measure C08: Some contracts were not displaying anything in this measure. These contracts are now showing the correct "CMS identified issues with this plan's data" message.

- Part C & D measures C27 & D05: The original data was from an earlier run which missed pulling out some excluded members for some contracts. The correct data is now being displayed and all detail data files contain the correct data.

- Part C measure C30: Approximately 300 reopenings in 2015 were recorded in MAS as Dismiss. This did not mean the appeal was being dismissed, it meant the reopening was dismissed. This was an incorrect way to enter the reopening decision. The source data has been corrected to contain the original decision (Uphold, Overturn or Partly Overturned).

- Part D measure D03: The original data included duplicate cases. The correct data is now being displayed and the detail data has been corrected as well.

A true and correct copy of CMS's August 18, 2016 HPMS Memorandum is attached hereto as Exhibit B.

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6. During the second plan preview period, CMS again referred to its data set updates in an HPMS Memorandum dated September 8, 2016, stating "we have made measure data revisions and Technical Note updates as a result of issues found during the first plan preview." A true and correct copy of CMS's September 8, 2016 HPMS Memorandum is attached hereto as Exhibit C.

7. And on September 28, 2016, CMS issued yet another HPMS email confirming it had made contract-specific data corrections as a result of issues found during the second plan preview period. A true and correct copy of CMS's September 28, 2016 email is attached hereto as Exhibit D.

8. We understand HPMS to be the platform through which CMS communicates all important messages about Medicare Advantage and the Medicare Prescription Drug Program, including Star Ratings. Our plan has a process (required by CMS) for reviewing and responding to every HPMS memorandum that is released. If CMS had sent a communication about details of the corrected data set announced by its contractor Acumen in September 2024 in the same manner it had done so in 2016, CareFirst would have reviewed that notification and taken appropriate action in response.

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Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 3rd day of April, 2026.

/s/ Elizabeth Haynes
Elizabeth Haynes
Vice President, Quality, Stars, and Risk Adjustment
of CareFirst Advantage PPO, Inc.

From: HPMS
Sent: Friday, August 12, 2016
Subject: Updated 2017 Star Ratings dataset for Plan Preview #1

CMS has updated the dataset in HPMS for the first 2017 Star Ratings Plan Preview today, 8/12/16.

The following issues have been corrected in the original data posted on 8/8/16:

* Part C & D measures C28 & D06: The original data used the CMP report issued date from CAMS, not the Date Action Taken for the CMPs shown on the enforcement actions page of the CMS.gov website. The CMP data used in the BAPP measure have been updated to align with the CMS website dates.

* Part C measure C30: The number of late appeals were off for some contracts since it did not include the Corrected Appeal Date field shown on the Measure Detail - Part C Appeals page. This field and the measure scores have been updated.

* Part C measure C31: The original data did not include reopenings that were decided prior to May 1, 2016. The revised data include this change.

The first plan preview comment period will still end on 8/18/16 as announced. Please send questions about Part C and D Star Ratings to PartCandDStarRatings@cms.hhs.gov.

HPMS E-Mail

Date: August 18, 2016

Subject: 2nd Update to 2017 Star Ratings dataset for Plan Preview #1

E-mail text:

CMS has updated the dataset for the first 2017 Star Ratings plan preview today, 8/18/16.

The following issues have been corrected since the last update posted on 8/12/16:

- Part C measure C08: Some contracts were not displaying anything in this measure. These contracts are now showing the correct "CMS identified issues with this plan's data" message.
- Part C & D measures C27 & D05: The original data was from an earlier run which missed pulling out some excluded members for some contracts. The correct data is now being displayed and all detail data files contain the correct data.
- Part C measure C30: Approximately 300 reopenings in 2015 were recorded in MAS as Dismiss. This did not mean the appeal was being dismissed, it meant the reopening was dismissed. This was an incorrect way to enter the reopening decision. The source data has been corrected to contain the original decision (Uphold, Overturn or Partly Overturned).
- Part D measure D03: The original data included duplicate cases. The correct data is now being displayed and the detail data has been corrected as well.

The first plan preview comment period will still end on 8/18/16 at 5:00 p.m. Eastern time as announced. However, continue to review your data. You will have another opportunity during the second plan preview in September to preview your data and star assignments in HPMS and alert CMS of any questions or data issues. Please send questions about Part C and D Star Ratings to PartCandDStarRatings@cms.hhs.gov.

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

MEDICARE DRUG BENEFIT AND C & D DATA GROUP

DATE: September 8, 2016

TO: Medicare Compliance Officers, Part C and D Sponsors

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

SUBJECT: Second Plan Preview of 2017 Star Ratings Data

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 second plan preview will begin on September 9, 2016 and will end on September 19, 2016 at 5pm ET. We have made measure data revisions and Technical Note updates as a result of issues found during the first plan preview. Additionally, each contract's preliminary Star Ratings for each measure, domain, summary score, and overall score will be displayed. Medicare beneficiaries will be able to view the final Star Ratings via the MPF on Medicare.gov in October.

During this second plan preview, CMS expects Part C and D sponsors to again closely review the methodology and 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 in order to allow sufficient time to investigate and process any necessary data corrections. If issues are found during the plan preview, we will update the plan preview data in HPMS on a rolling basis. If you print the information from HPMS, please double check values online prior to submitting emails.

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 "Star Ratings and Display Measures," then "Star Ratings," and then select 2017 for the report period.
- The Technical Notes for Part C and D are available via the "Technical Notes" link found within the Star Ratings module.

Changes from 2016 Star Ratings and 1st plan preview:

- As described on the August 3rd User Group Call, changes made since last year's Star Ratings include the addition of the Categorical Adjustment Index and adjustment for Puerto Rico contracts, and several small measure specification updates.
- CAHPS data are included with the 2nd plan preview.

- The disability values and percentages for the CAI have been updated for the 2nd plan preview.

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. Do not submit emails requiring CMS to login to a website to access the questions. If you need to share personally identifying information (PII) with us, please contact us via regular 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 September 19, 2016.

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

HPMS E-Mail

Date: September 28, 2016

Subject: Updated 2017 Star Ratings Data

This message is to inform Part C and D sponsors that they can view their updated 2017 Star Ratings data in the Health Plan Management System (HPMS). CMS has reviewed all of the feedback from the second plan preview and has made the necessary data corrections as a result of issues found during the second plan preview. We thank all sponsors for their careful review during both plan previews.

- To access the Part C and D Star Ratings data in HPMS, select: "Quality and Performance," then "Performance Metrics," then "Star Ratings and Display Measures," then "Star Ratings," and then select 2017 for the report period.
- The Technical Notes for Part C and D Star Ratings are available via the "Technical Notes" link found on each page in the Master Table modules.

Changes from the 2nd plan preview:

- We have revised the cut points for Plan All-Cause Readmissions.
- Revisions for contract-specific issues.

If you have any questions, please email us at PartCandDStarRatings@cms.hhs.gov.