IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC.,

Plaintiffs,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES and
CENTERS FOR MEDICARE & MEDICAID SERVICES,

Defendants.

Civil Action No. 2:26-cv-00061-LGW-BWC

Hon. Lisa Godbey Wood

PLAINTIFFS' COMBINED RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REPLY IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs Elevance Health, Inc., f/k/a Anthem Inc., along with its affiliated entities Anthem Insurance Companies, Inc., Blue Cross of California, Wellpoint Health Plans, Inc., Wellpoint Insurance Company, and Wellpoint Iowa, Inc. (collectively, "Elevance" or "Elevance Health"), submit this combined Reply in Support of Their Motion for Preliminary Injunction and Response in Opposition to the Motion to Dismiss filed by Defendants the Centers for Medicare & Medicaid Services ("CMS") and the United States Department of Health and Human Services ("HHS") (collectively, "Defendants").

INTRODUCTION

Defendants' two-prong response to Elevance's motion for preliminary injunction makes one thing clear: CMS does not want to defend before this Court how the agency calculated Elevance's 2026 Star Ratings given this Court's recent ruling in the materially identical lawsuit brought by Clover Insurance Company. The Court should (i) reject Defendants' attempt to dismiss this case on venue grounds to avoid a second judgment for its unlawful conduct, and (ii) grant Elevance's motion for a preliminary injunction to ensure consistency with its decision in *Clover Insurance Co. v. U.S. Department of Health & Human Services*, No. 2:25-CV-142, 2026 WL 1483515 (S.D. Ga. May 27, 2026) ("*Clover*").

As it concerns the recalculation of Elevance's Star Ratings, this case begins and ends with the administrative record culminating in the publication on October 9, 2025, of Elevance's 2026 Star Ratings for the Medicare Advantage ("MA") contracts at issue in this lawsuit. Those Star Ratings determined Elevance's financial rebates and quality bonus payments ("QBPs") for the coming plan year. As this Court already determined in *Clover*, CMS unlawfully used 20 measures when calculating Clover's 2026 Star Ratings—and the same is true for Elevance. CMS implemented the *Clover* judgment on June 9, 2026 (11 days after final judgment), recalculating Clover's Star Rating and instructing Clover to submit a new bid at 4.5 Stars.

Elevance seeks relief consistent with *Clover*. Before filing suit, Elevance asked CMS to remove the same 20 measures from its Star Ratings, but CMS refused, insisting Elevance was limited to relief under a June 17, 2026, memorandum published through its Health Plan Management System ("HPMS") (the "June 17 HPMS Memorandum") announcing a voluntary QBP recalculation for certain contracts. Importantly, the June 17 HPMS Memorandum was not consistent with *Clover* because CMS excluded only 18 measures, retaining some unlawful

measures and excluding some not at issue in *Clover*. Because Elevance did not benefit, its only choice was to retain its original 2026 Star Ratings—ratings that were unlawfully calculated for the reasons this Court held in *Clover*. As a result, Elevance filed this lawsuit and moved for a preliminary injunction to require CMS to recalculate its 2026 Star Ratings consistent with *Clover*.

Elevance's objective is straightforward: Elevance seeks to submit new bids for its 2027 contracts offering enhanced benefits, following the *Clover* blueprint. Defendants' motion to dismiss is meritless. They argue Elevance lacks standing because contract H4036—the contract tied to this judicial district—does not improve under *Clover*. This is wrong twice over. Elevance adequately pled an injury in fact. Had the 20 unlawful measures been excluded from H4036's Star Rating, that contract would have been 4.5, ***not*** 4.0. For pleading purposes, the standing analysis requires nothing more. What Defendants *actually contest is the merits*—the correct recalculation methodology—and they are wrong there, too. Their argument relies on a post-hoc, litigation-specific recalculation that their own declarant concedes is based on "hypothetical" facts and does not reflect how Elevance's 2026 Star Ratings were calculated or would be calculated if Elevance prevails. ECF 34-1, Goldstein Decl. ¶ 21. Defendants do not deny that if CMS calculated H4036's 2026 Star Rating using the data extant on October 9, 2025—the only data within the scope of the administrative record—excluding the 20 unlawful measures, H4036 would obtain a 4.5 Star Rating. The government's gambit is based on a "hypothetical" calculation, not the administrative record, and is inconsistent with the facts. Unmasked, it is nothing more than a desperation shot to avoid answering to this Court, *again*, for its unlawful conduct.

On the preliminary injunction, Defendants do not meaningfully contest the likelihood of Elevance succeeding—the most important factor—instead simply noting their appeal of *Clover* and preserving placeholder arguments. After effectively conceding the most important factor,

Defendants argue that granting the injunction would create a lopsided balance of equities and that Elevance "waited too long" to file suit. On equities, Defendants contend without support that allowing Elevance to revise its bids would confer a competitive advantage. But CMS is currently in the phase of the bid process where plans revise their bids, and CMS allows revisions through mid-August and bid-error corrections thereafter. Throughout this entire process—extending into mid-August and even beyond—plans in the normal course of business revise their bids and identify errors that need to be fixed, making it clear that Defendants' argument is smoke and mirrors.

As for Elevance's alleged "nine-month delay," Defendants acknowledge that Elevance's claims are identical to Clover's. ECF 34, Mot. to Dismiss at 17. That Clover obtained judgment first cannot preclude Elevance from obtaining the same relief. And any operational hardship is self-inflicted: CMS published its June 17 HPMS Memorandum departing from *Clover*, creating two divergent methodologies to calculate Star Ratings for all other MAOs besides *Clover*. Elevance requested that CMS give it the same treatment as if gave Clover and, when CMS refused, Elevance filed suit two weeks later. Defendants cannot fault Elevance for seeking relief within a compressed timeline of CMS's own creation.

The Court should deny the motion to dismiss and grant the preliminary injunction. Alternatively, this Court should convert the preliminary injunction into a motion for summary judgment pursuant to Fed. R. Civ. P. 65(a)(2) and enter final judgment in favor of Elevance.

ARGUMENT

In their motion to dismiss and response to Elevance's motion for preliminary injunction, Defendants raise four objections: lack of standing, improper venue, no likelihood of success, and no irreparable harm. None holds water.

I. The motion to dismiss filed pursuant to rules 12(b)(1) and 12(b)(3) should be denied.

A. Contract H4036 has standing to challenge its 2026 Star Rating and to seek a recalculation consistent with the *Clover* decision.

Focusing on contract H4036 because of its connections to this judicial district, Defendants argue Elevance cannot show injury "because [H4036's] Star Rating remains 4.0 stars even if [the *Clover*] measures were eliminated" and "[t]here is no permutation of measures that would increase [H4036's] Star Rating to 4.5 Stars." ECF 34, Mot. to Dismiss at 8-9. This is not a standing argument. It is a disguised merits attack on the correct recalculation methodology.

Elevance's claims that CMS unlawfully calculated its Star Ratings that were published on October 9, 2025. The administrative record is cabined by that publication date. If the Court agrees with Elevance on the merits—as it should, given *Clover*—then the relief to be given to effectuate judgment is necessarily restricted to the information available to CMS and Elevance as of that date. Defendants cannot fabricate a hypothetical calculation to divest this Court of jurisdiction.

1. *Elevance properly pleads standing and Defendants' motion is really an attack on the merits disguised as a jurisdictional attack.*

Demonstrating Article III standing at the pleading stage is not a high bar. A plaintiff must show (1) a concrete, particularized, and actual or imminent injury-in-fact; (2) a causal connection between the injury and the challenged conduct; and (3) the likelihood that a favorable decision will redress the injury. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992). At the motion-to-dismiss stage, general factual allegations suffice. *See Glynn Env't Coal., Inc. v. Sea Island Acquisition, LLC*, 26 F.4th 1235, 1240 (11th Cir. 2022).

Elevance satisfies all three prongs. Had CMS not applied the 20 measures this Court held unlawful in *Clover*, H4036 would have received a 4.5 Star Rating. ECF 1, Compl. ¶ 53 & Ex. A. CMS's inclusion of those measures resulted in a lower rating, costing Elevance approximately

$115 million in smaller 2027 QBPs and rebate retention. An order directing CMS to recalculate excluding the 20 unlawful measures would fully redress that injury.

Defendants' entire argument presumes this Court would adopt their recalculation methodology—a merits question, not a jurisdictional one. When jurisdiction and the merits merge, a court should assume jurisdiction and resolve the objection on the merits. *See Morrison v. Amway Corp.*, 323 F.3d 920, 924-25 (11th Cir. 2003) (holding that where the jurisdictional attack implicates the merits of the plaintiff's claim, the court should find that jurisdiction exists and deal with the objection as a direct attack on the merits rather than under Rule 12(b)(1)). Whether H4036 would receive a higher Star Rating if the 20 unlawful measures were excluded using the correct methodology is simultaneously the redressability inquiry and the central merits question. The Court cannot resolve this dispute on a Rule 12(b)(1) motion without effectively deciding the merits, and should therefore assume jurisdiction.

2. *The administrative record closed on October 9, 2025, and Elevance's recalculation uses the correct data and methodology from that record.*

Defendants also lose on the merits. Under the APA, agency action is reviewed based on the administrative record as it existed when the agency acted. *See Camp v. Pitts*, 411 U.S. 138, 142 (1973) ("the focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court"); *Washington v. Office of Comptroller of Currency*, 856 F.2d 1507, 1511 (11th Cir. 1988) (concluding "the only matter for consideration by the trial court . . . was the administrative record"); *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 743-44 (1985) (holding review is confined to the record developed at the time of the agency action); *Clover*, 2026 WL 1483515, at *7 (citing *Camp*, 411 U.S. at 142).

Elevance's APA claim accrued upon publication of its 2026 Star Ratings on October 9, 2025. *See Corner Post, Inc. v. Bd. of Governors of Fed. Rsrv. Sys.*, 603 U.S. 799, 809 (2024)

(holding that an APA claim accrues when the plaintiff suffers an injury from final agency action). That publication marked the consummation of CMS's decisionmaking process and the date the administrative record closed. *See U.S. Steel Corp. v. Astrue*, 495 F.3d 1272, 1280 (11th Cir. 2007) ("To be considered 'final,' an agency's action: (1) 'must mark the consummation of the agency's decisionmaking process—it must not be of a merely tentative or interlocutory nature;' and (2) 'must be one by which rights or obligations have been determined, or from which legal consequences will flow.'") (quoting *Bennett v. Spear*, 520 U.S. 154, 177-78 (1997)). The only legally sound recalculation of H4036's Star Rating is therefore one that uses the inputs CMS actually employed as of that date, less the 20 measures this Court has held were unlawful.

Elevance's case is based on *that* recalculation, consistent with the CMS regulations and technical guidance in effect as of October 9, 2025. Each year, CMS provides MAOs with dynamic Excel spreadsheets detailing the Star Rating calculations for each contract, as well as spreadsheets for the Quality Improvement Measures. **Exhibit 1**, Haskins Suppl. Decl. ¶ 3. For H4036, CMS provided these spreadsheets on September 10, 2025—the very spreadsheets evidencing CMS's calculation when the Star Rating was publicly released on October 9, 2025. *Id.* ¶¶ 4-5. CMS also published the final 2026 Part C & D Star Ratings Technical Notes on September 25, 2025. *Id.* ¶¶ 6-7. In Elevance's recalculation, the original spreadsheet workbooks are kept exactly as received from CMS, and all industrywide metrics—including the cut points for the Quality Improvement Measures, the Variance Thresholds and Performance Summary Thresholds used to calculate the Reward Factor, and the CAI value—remain as CMS reported them. *See* **Exhibit 2**, Marshall Suppl. Decl. ¶ 11.

Using these administrative record inputs, Elevance conducted a straightforward recalculation. First, Elevance removed the 20 "*Clover* Measures" from H4036's overall Star Rating

calculation. Ex. 1, Haskins Suppl. Decl. ¶¶ 8, 10. Second, Elevance removed the *Clover* Measures from the Quality Improvement Measures (C30 and D04) and compared the revised scores against CMS's published cut points, resulting in a "5 Star" for both. *Id.* ¶¶ 12-15; Ex. 2, Haskins Suppl. Decl. ¶ 15. Third, Elevance calculated the Reward Factor using the Variance Thresholds and Performance Summary Thresholds from the 2026 Technical Notes, yielding a 0.3 Reward Factor. Ex. 1, Haskins Suppl. Decl. ¶ 16. Applying these calculations—all derived from the administrative record extant as of October 9, 2025—the unrounded final summary Star Rating for H4036 is 4.315685, which rounds to 4.5 Stars pursuant to CMS's own rounding rules. *Id.* ¶ 17; Ex. 2, Haskins Suppl. Decl. ¶ 12.

3. *CMS ignores the administrative record and improperly manufactures a hypothetical scenario applied only to Elevance.*

Rather than use the administrative record, Defendants premise their motion to dismiss on a recalculation that removes the *Clover* Measures but also introduces entirely hypothetical industrywide metrics that were not used by CMS in calculating the 2026 Star Rating for H4036, were not used for any other contract, and are not used in any publicly acknowledged, real-world application. Ex. 2, Haskins Suppl. Decl. ¶¶ 10, 19. CMS created hypothetical, industrywide recalculations of the necessary underlying data across all contracts and developed theoretical metrics for use solely in this litigation. *Id.* These theoretical metrics are what cause the difference between CMS's recalculated Overall Star Rating of 4.0 and Elevance's recalculation of 4.5. *Id.*

CMS's recalculation departs from the administrative record in three respects. First, CMS uses theoretical Quality Improvement Measure cut points rather than the published cut points, assigning D04 a Star Rating of 4 instead of the 5 that results from applying the published cut points. *Id.* ¶¶ 14-15. CMS does not explicitly show how it arrived at its revised cut points; instead, the Goldstein Declaration alludes to a hidden calculation that has never been produced. *Id.* ¶ 15.

Second, CMS uses theoretical Variance Thresholds and Performance Summary Thresholds to calculate the Reward Factor, rather than the thresholds published in the Technical Notes. *Id.* ¶¶ 16-17. The combination of a lower D04 Star Rating and CMS's more demanding theoretical thresholds reduces the Reward Factor from 0.3 to 0.1. *Id.* ¶ 24. Third, CMS applies a different theoretical CAI value (-0.101580) rather than the published CAI value (-0.063262). *Id.* ¶ 18. Together, these three departures reduce H4036's Overall Star Rating from 4.5 to 4.0. *Id.* ¶ 25.

CMS's simulated dataset is precisely the kind of post-hoc rationalization that *Camp* and its progeny prohibit. *See DHS v. Regents of the Univ. of California*, 591 U.S. 1, 22–23 (2020) (explaining that courts must assess agency action based on "contemporaneous explanations" and reject reasons that are "simply convenient litigating positions" (internal quotation marks omitted)); *Brisk Ins. Servs. LLC v. FCIC*, No. 26-cv-842, 2026 WL 2185700, at *9 (D.D.C. June 24, 2026) (excluding agency administrator's post-litigation declaration and instructing that "post hoc rationalizations" and "convenient litigating positions" are not properly before the court (citing Regents, 591 U.S. at 20, 23)). That dataset did not exist in the record as of October 9, 2025, was created for this litigation in July 2026, and is being advanced now solely to sustain CMS's position that Elevance was not injured. *See* Goldstein Decl. ¶ 24. As the Eleventh Circuit and this Court have repeatedly affirmed, such post-hoc materials are not a proper basis for judicial review. Moreover, CMS applied this hypothetical methodology only to Elevance. Ex. 2, Haskins Suppl. Decl. ¶ 22. CMS concedes that it recalculated the Clover contract, H5141, to a 4.5 Star Rating under a different methodology. Dkt. 34-1, Goldstein Decl. ¶¶ 11-18.

4. *CMS's justification for its hypothetical methodology is contrary to law and its own practice.*

The Goldstein Declaration submitted with CMS's motion to dismiss asserts that the Reward Factor ranking under 42 C.F.R. § 422.166(f)(1)(i) requires all contracts to have identical measures,

making a contract-specific recalculation using existing published parameters legally impossible. This does not survive scrutiny. The applicable regulation, 42 C.F.R. § 422.166(f), requires a contract's weighted mean to be assessed relative to "all rated contracts in the rating level" "for the same Star Ratings year"; it says nothing about measure-set uniformity, and CMS has never administered the program that way. Ex. 2, Haskins Suppl. Decl. ¶ 20. Moreover, each year many contracts factored into these industrywide metrics are not scored on every available measure due to a lack of data.[1] *Id.*

More problematic still, CMS itself abandoned the "identical measures" requirement when it recalculated for Clover. The Goldstein Declaration admits that CMS recalculated Clover's weighted summary mean without re-running the Reward Factor or CAI against any other contract, justifying the shortcut on the ground that Clover's 4.5 mean was comfortably above 4.25. In other words, for Clover, CMS just eyeballed it. CMS thus already departed from the very requirement it now claims is a legal mandate under § 422.166(f)(1)(i), and the only justification offered is a discretionary shortcut—not a regulatory requirement.[2] If section 422.166(f)(1)(i) truly required identical measures as a matter of law, CMS could not have waived it for Clover. CMS cannot

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[1] Elevance agrees all contracts are to be given the opportunity to be treated the same in the Star Ratings program, and it is equally true that CMS must administer the program based on real-world contracts, not hypothetical ones. In the real world, CMS has created three calculation methodologies through its implementation of the *Clover* decision and the June 17 HPMS Memorandum: (1) the original 2026 Star Ratings; (2) the recalculated Star Ratings under the June 17 HPMS Memorandum; and (3) Clover. This incongruity is of CMS's own making and demonstrates that its hypothetical scenario of calculating all contracts consistent with the *Clover* methodology simply does not align with the real world. Furthermore, to the extent there is any incongruity, CMS should bear the burden, including giving contracts the better of different potential outcomes, as it routinely does (*e.g.*, the June 17 HPMS Memorandum).

[2] Nor is CMS entitled to deference on its application of its regulations. The APA commits to the courts the sole authority to resolve all relevant questions of law. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 391-92 (2024).

invoke a regulation as an absolute bar to Elevance's recalculation while simultaneously disregarding it when convenient. Regardless, CMS's reasoning is contrary to law.

5. *The improper Star Rating for H4036 causes Elevance reputational harm in this District.*

Contract H4036 has standing (as do the other contracts at issue) for the independent reason that CMS's miscalculation of its Star Rating causes reputational harm. "'[R]eputational harms,' as a general matter, are classic Article III injuries." *Bost v. Ill. State Bd. of Elections*, 607 U.S. 71, 78 (2026) (quoting *TransUnion LLC v. Ramirez*, 594 U.S. 413, 425 (2021)). Defendants claim Elevance alleged no reputational harm. But Elevance's opening brief demonstrated that, without relief, it will suffer "decreased enrollment, diminished market position, weakened provider negotiations, and diminished brand recognition among beneficiaries" that "are not readily quantifiable or compensable in dollars after the fact." ECF 7, Mot. for Prelim. Inj. at 11-12 (quoting Kurdziel Decl. ¶ 11); *see also* ECF 1, Compl. ¶¶ 2, 6 (listing evidence of reputational harm, including damage to member benefits, premiums, and quality improvements). A 2023 systematic literature review confirmed that increases in Star Ratings lead to statistically significant increases in enrollment and decreases in disenrollment. ECF 11, Marshall Decl. ¶ 30. Reputational harm is the natural consequence of an inaccurate Star Rating when it is published.

Furthermore, Star Ratings are a critical factor in Elevance's Group Medicare Advantage business in this District. Elevance offers Medicare Advantage plans under H4036 to 56 employer groups within this District. Enrollees of employer groups often view Star Ratings as an indication of a plan's quality, reliability, and ability to deliver effective care, and a lower rating may create meaningful uncertainty among members even when their personal experiences with their physicians, medications, and health plan services have been positive. *See* **Exhibit 3**, Steffens Decl. ¶ 7. Employer groups that purchase Group Medicare Advantage coverage likewise focus on Star

Ratings as indicative of plan quality, and because higher Star Ratings drive additional revenue to the plan—enabling enhanced benefits for group members—a lower-rated plan is less competitive in the market for selling Group Medicare Advantage products. *See id.* A lower Star Rating also affects the resources available to maintain or enhance benefits, care-management programs, member support, and other services that are important to this population. *See id.*

In short, Elevance's recalculation faithfully applies the data and methodology from the administrative record as it existed on October 9, 2025—removing only the 20 unlawful *Clover* Measures while holding all other inputs constant. Ex. 1, Haskins Suppl. Decl. ¶¶ 9, 15-17; Ex. 2, Haskins Suppl. Decl. ¶ 11. CMS's recalculation abandons the actual record in favor of a hypothetical simulation created in July 2026 solely for this litigation, using theoretical metrics never applied to any contract—including Clover's H5141, which CMS recalculated to 4.5 Stars without any such exercise. Ex. 2, Haskins Suppl. Decl. ¶¶ 19, 21-22; *see also* Goldstein Decl. ¶ 24. CMS's approach violates the bedrock APA principle that judicial review is confined to the pre-decision administrative record and is fatally undermined by CMS's own selective departure from the very regulatory requirements it invokes.

B. Venue is proper in this District, as a substantial part of the events giving rise to this case occurred in this District.

1. *Elevance is not required to show more than a substantial connection to this District.*

Because H4036 has standing, venue is proper in this Court. Nonetheless, rehashing arguments already rejected by this Court in *Clover*, Defendants argue that Elevance's lawsuit lacks a substantial connection to this District. The Court should reject that argument for the same reasons this Court rejected it in *Clover*.

Venue is proper in "any judicial district in which . . . a substantial part of the events or omissions giving rise to the claim occurred[.]" 28 U.S.C. § 1391(e)(1). "Plaintiffs are not required

to select the venue with the most substantial nexus to the dispute; rather, they must simply choose a venue where a substantial part of the events occurred, even if a greater part of the events occurred elsewhere." *Eakin v. Rosen*, No. CV215-42, 2015 WL 8757062, at *4 (S.D. Ga. Dec. 11, 2015) (Wood, J.). "Only the events that directly give rise to a claim are relevant." *Jenkins Brick Co. v. Bremer*, 321 F.3d 1366, 1371 (11th Cir. 2003). On a Rule 12(b)(3) motion, "the plaintiff has the burden of showing that venue in the forum is proper," *Pinson v. Rumsfeld*, 192 F. App'x 811, 817 (11th Cir. 2006), but a court "must accept the facts in the plaintiff's complaint as true," *Simbaqueba v. U.S. Dep't of Def.*, No. CV 309-066, 2010 WL 2990042, at *2 (S.D. Ga. May 28, 2010). In making that determination, this Court may consider additional evidence outside of the complaint. *See Pinson*, 192 F. App'x at 817; *Delong Equip. Co. v. Wash. Mills Abrasive Co.*, 840 F.2d 843, 845 (11th Cir. 1988) (in considering a motion to dismiss, it is "within the court's discretion" to consider the complaint "and the numerous affidavits filed by both sides"); *BW Orchards, LLC v. Spiech Farms Ga., LLC*, No. 2:19-CV-00007, 2019 WL 2635541, *2 (S.D. Ga. June 26, 2019) (Wood, J.) ("when a Rule 12(b)(3) motion is predicated upon key issues of fact, the court may consider matters outside the pleadings") (quoting *Simbaqueba*, 2010 WL 2990042, at *2).

This Court's venue decision in *Clover* provides the controlling framework. *See Clover Ins. Co. v. DHHS*, No. 2:25-cv-142 (S.D. Ga. Mar. 18, 2026), ECF No. 40. There, the Court held venue proper under 28 U.S.C. § 1391(e)(1)(B), finding two categories of conduct constituted a substantial part of the events giving rise to Clover's claims: (1) CMS collected healthcare data from thousands of Clover's Medicare Advantage beneficiaries in this District, including data factoring into the unauthorized measures; and (2) CMS published Clover's allegedly erroneous Star Rating within this District, causing reputational and business harm. The Court found these events were "practically interwoven into one sequence of allegedly unlawful activity leading directly to the

claims pursued," and that the prevalence of the South Georgia market in Clover's operations further supported the District's connection to the claims. *Id.* at 20-21, 33-35.

2. *Elevance has a substantial presence in this District that supports venue.*

H4036 is one of Elevance's largest contracts, with approximately 365,000 enrollees nationally, with approximately 81,688 enrollees in the State of Georgia and approximately 12,000 enrollees residing in this District. *See* Ex. 3, Steffens Decl. ¶ 3. These enrollees depend on Elevance for Medicare coverage, access to provider networks, home delivery of prescriptions, and outreach ensuring access to preventive screenings and services. *See id.* This is reiterated by a statement of support from one of Elevance's employer group customers in the District, the Liberty County Board of Commissioners, noting how access to the Elevance plan for their retirees and dependents in the District has benefited the health and wellness of their members. *See id.* ¶¶ 5-6. Star Ratings and associated QBPs are directly linked to Elevance's ability to support enrollees in maintaining their health, accessing timely services, consistent pharmacy delivery, and engaging with preventive services. *See id.* ¶ 15. Elevance's 2026 Star Rating is published on CMS's Medicare Plan Finder and is visible to every beneficiary entering a Southern District of Georgia zip code when shopping for Medicare Advantage coverage. *See* 83 Fed. Reg. 16,440, 16,519-20 (Apr. 16, 2018). CMS's publication of an unlawful rating that negatively impacts enrollment, provider relationships, and benefit design for thousands of District beneficiaries is a concrete, local event giving rise to an APA claim, and venue is established. *See Jenkins Brick*, 321 F.3d at 1371.

Elevance maintains a robust provider network spanning all 43 counties of the District. *See* Ex. 3, Steffens Decl. ¶ 13. In the Augusta area, Elevance's network includes 410 primary care physicians, 966 specialists, and 5 hospitals; in Savannah, 405 primary care physicians, 785 specialists, and 4 hospitals, with additional providers in the Brunswick/Coastal and Statesboro regions. *See id.* Key health systems include Piedmont Healthcare, Augusta University Health, HCA

Healthcare, and Saint Joseph's/Candler. *See id.* Elevance also has a partial ownership interest in Millennium Physician Group, which operates a clinic in Folkston, Georgia, where clinicians work directly with Elevance members on care coordination, data collection, and medication adherence. *See id.* ¶ 14. Data that is collected from members who receive services through Millennium Physician Group is used to calculate Elevance's Star Ratings. *Id.*

Defendants contend that the more than 12,000 residents of this District impacted by CMS's action are not sufficient to show "any substantial business dealings" because H4036 has enrollees across Georgia and the country. ECF 34, Mot. to Dismiss at 18. This is wrong. The statute here asks only whether "a substantial part of the events or omissions giving rise to the claim occurred" in the district. 28 U.S.C. § 1391(e)(1)(B). It imposes no minimum-percentage floor, and courts have never construed the statute to require that a proper venue must account for any particular share of a plaintiff's nationwide operations. Elevance's presence in this District, and the impact felt by its enrollees here, is substantial and supports venue. Elevance has a significant "on-the-ground" presence in the District, with its enrollees in the District receiving care from a significant number of providers and hospitals in the District, including a physician group practice that is partially owned by Elevance and operates a clinic in the District. *See* Ex. 3, Steffens Decl. ¶¶ 11, 14.

3. *CMS collected significant data from Elevance's members in this District for measures this Court ruled unlawful in Clover, and that data was used to calculate Elevance's 2026 Star Ratings for H4036.*

Specifically, CMS collected and analyzed data from thousands of H4036 enrollees in this District, including drug prescribing histories, medication adherence data, and clinical information—data that served as critical inputs for the Star Ratings measures struck down in *Clover* (*e.g.*, D08, D09, D10, D11, and D12). *See* Ex. 3, Steffens Decl. ¶¶ 8, 16. Elevance invested millions of dollars to improve these quality metrics nationally, including for District members, and

implemented its HomeWell program, which reached over 3,100 members in the District in 2025 with preventive services and distributed home lab kits to approximately 1,300 District members. *See id.* ¶¶ 9-10. This extensive in-district data collection and quality-improvement activity is precisely what this Court found supported venue in *Clover*.[3]

* * *

In sum, Elevance has demonstrated the same categories of in-District activity this Court found sufficient in *Clover*—and more—including approximately 12,000 District enrollees, a provider network spanning all 43 counties, a partially-owned physician group clinic, 56 employer groups, and extensive data collection and quality-improvement programs reaching thousands of District beneficiaries. Defendants' motion to dismiss for improper venue should be denied.

II. Elevance's motion for preliminary injunction should be granted.

A. The preliminary injunction standard is met and, alternatively, the record is sufficiently developed for this Court to rule on summary judgment.

A preliminary injunction is appropriate where the movant demonstrates (1) a "substantial likelihood of success on the merits," (2) "an irreparable injury unless the injunction is granted," (3) "the harm from the threatened injury outweighs the harm the injunction would cause the opposing party," and (4) "the injunction would not be adverse to the public interest." *Gonzalez v. Governor of Ga.*, 978 F.3d 1266, 1271 (11th Cir. 2020); *see also Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20-21 (2008). Because the opposing party is the government, the third and fourth elements merge, and the harm to the government is analyzed as part of the public interest. *See Nken v. Holder*, 556 U.S. 418, 435 (2009); *Swain v. Junior*, 958 F.3d 1081, 1091 (11th Cir. 2020).

[3] Defendants argue Elevance has not alleged that data collected in Georgia was used in CMS's 2026 Star Ratings calculation. This fact need not be separately pleaded, and, in fact this Court is not limited to the Complaint's allegations. *See, e.g.*, *Pinson*, 192 F. App'x at 817; *Delong Equip. Co*, 840 F.2d at 845 (11th Cir. 1988); *BW Orchards, LLC*, 2019 WL 2635541, at *2.

Defendants argue the Court should construe Elevance's motion as seeking a mandatory injunction subject to heightened scrutiny. This framing is wrong. An order directing CMS to recalculate Elevance's ratings using the same methodology already applied to Clover is prohibitory—it prohibits CMS from continuing to apply unlawfully calculated Star Ratings.

Even if the relief is a mandatory injunction, Elevance satisfies the heightened standard. The status quo is itself causing irreparable harm, making it "necessary to alter the situation so as to prevent the injury . . . by allowing the parties to take proposed action that the court finds will minimize the irreparable injury." *Canal Auth. of Fla. v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974). This Court has already held the 20 measures unlawful, the recalculation is executable, and Elevance has established likelihood of success and irreparable harm.

Alternatively, this Court can treat the parties' briefs as motions for summary judgment. *See* Fed. R. Civ. P. 65(a)(2); *Walmart Inc. v. King*, No. CV 623-040, 2024 WL 1258223, at *1 (S.D. Ga. Mar. 25, 2024) (reversed and vacated on other grounds by *Walmart, Inc. v. Chief Admin. Law Judge of Office of Chief Admin. Hearing Officer*, 144 F.4th 1315 (11th Cir. 2025)); *see also Albanese Enters., Inc. v. City of Jacksonville*, No. 3:13-cv-1471, 2014 WL 585425, at *1 (M.D. Fla. Feb. 14, 2014). The parties' exhibits contain all information material to the administrative record. *See Planned Parenthood of Greater N.Y. v. DHHS*, No. CV 25-2453, 2025 WL 2840318, at *16 (D.D.C. Oct. 7, 2025) (proceeding to summary judgment on an APA claim against HHS where "the administrative record makes little difference … given that the materials included are so sparse and either largely already on the docket or publicly available").

B. Elevance should prevail on the merits for the same reasons as this Court held in *Clover*.

A substantial likelihood of success "requires a showing of only *likely* or probable, rather than *certain*, success." *Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1223, 1232 (11th Cir. 2005).

"This factor is generally the most important of the four factors." *Id.*; *see also Gonzalez*, 978 F.3d at 1271. Defendants do not meaningfully dispute that Elevance has a substantial likelihood of success given this Court's underlying decision in *Clover*.

1. *This Court's decision in Clover is dispositive.*

Elevance challenges CMS's 2026 Star Ratings on the same basis as Clover did—CMS improperly included 20 measures that either violate the statutory data requirements under 42 U.S.C. § 1395w-22(e) or were promulgated without appropriate notice and comment as required by 42 U.S.C. § 1395hh(a)(2). This Court found those 20 measures unlawful and required CMS to recalculate Clover's Star Ratings, which CMS did within 11 days. CMS then voluntarily recalculated all other MAOs' 2027 QBP ratings "only using data collected under 42 U.S.C. [§] 1395w-22(e)[.]" ECF 35, Resp. at 14. Elevance did not benefit from the June 17 HPMS memorandum and thus did not resubmit its bid, but it does benefit from a recalculation consistent with the *Clover* order. Like Clover, Elevance holds MA contracts with CMS, and Elevance's largest Georgia contract directly competes with the contract at issue in *Clover*. Blue Decl. ¶ 26.

Defendants do not genuinely contest the merits. Rather than mount a substantive challenge, Defendants state that *Clover* is "currently pending appeal" and they then "preserve their disagreement" by repeating their arguments. ECF 35, Resp. at 16. Defendants then stated that they "reserve any other arguments they may make on appeal or in a subsequent cross-motion for summary judgment," *id.* at 17 n.6, and "preserve in this matter any arguments the government may make in the appeal of this Court's *Clover* decision," *id.* This is a placeholder, not a merits opposition. If this Court was correct in ruling for *Clover* on the two dispositive statutory points, then Elevance is entitled to the same relief.

2. *Elevance should also succeed on its independent claim that it is entitled to be treated the same as Clover under the APA.*

In Count I of its Complaint, Elevance alleges that the well-established administrative law principle that "like cases must receive like treatment" is violated by CMS giving Clover—a similarly situated MAO—a recalculated Star Rating while refusing to extend the same recalculation to Elevance. ECF 1, Compl. ¶ 66 (quoting *Grayscale Invs., LLC v. SEC*, 82 F.4th 1239, 1245 (D.C. Cir. 2023)). This principle carries particular force in the context of Medicare Advantage Star Ratings, where contracts are not graded against an absolute standard but rather on a curve relative to one another. Because Star Ratings are derived from a relative ranking methodology—in which each contract's performance is measured against the distribution of all other contracts' scores—applying a different set of measures to one plan necessarily distorts the competitive standing of every other plan graded under the original methodology. Where CMS has excluded the 20 unlawful measures for Clover but continues to include them for Elevance, the two entities are being evaluated under fundamentally different grading criteria within the same relative system. To allow plans to be compared on an apples to apples basis, they must at least have the opportunity to be graded using the same methodology as a structural prerequisite to the integrity of Star Ratings.

CMS contends, however, that Clover obtained a judgment and, therefore, it is differently situated. To be sure, this Court's judgment in *Clover* only applied to Clover. *See Trump v. CASA, Inc.*, 606 U.S. 831 (2025). But Elevance did not come to this Court to enforce *Clover*; it came to this Court for its own judgment, *for the identical reasons* presented in *Clover*. Elevance does not seek a universal injunction anymore than Clover did. Elevance seeks only party-specific relief. The fact that Elevance seeks identical relief is an incidental but permissible advantage. *See id.* at

851. Should other MAOs believe they are entitled to the same treatment, they may file their own lawsuits. The only MAO at issue in this case is Elevance.

Defendants further argue that "a party that has obtained a judgment is unlike a party that has not in one dispositive way: it may ask the district court that issued the judgment to enforce it." Dkt. 35, Resp. at 15. This misses the point. The relevant principle is not whether a court order compelled CMS's disparate treatment; it is whether CMS provided a reasoned explanation for it. *See Georgia v. Wheeler*, 418 F. Supp. 3d 1336, 1379 (S.D. Ga. 2019) (Wood, J.). CMS has not.[4]

C. Elevance will suffer irreparable harm absent immediate injunctive relief.

The harm CMS's action causes Elevance is immediate and irreparable. Because CMS refused to exclude the 20 unlawful measures, Elevance is losing $115 million in additional 2027 rebates and QBPs—revenue that is permanently lost without relief. This financial loss compounds into competitive and reputational harm. Competitors whose recalculated QBP ratings produced increases have redesigned and resubmitted bids funding richer supplemental benefits, lower premiums, and reduced cost-sharing. Kurdziel Decl. ¶ 7. Elevance cannot do the same absent immediate injunctive relief. Enrollment choices made during the Annual Enrollment Period ("AEP") lock beneficiaries into their selected plan for the entire following plan year; if Elevance enters the AEP with inferior benefits driven by an uncorrected Star Rating, it will lose enrollees and market position it cannot recover. *Id.* ¶ 10. Studies confirm that increases in Star Ratings lead to statistically significant increases in enrollment and decreases in disenrollment. Marshall Decl. ¶ 30. These injuries—decreased enrollment, diminished market position, and weakened

[4] The timing of Defendants' appeal of *Clover* is likely not coincidental. The government never sought a stay of the *Clover* judgment and waited 53 days to file its appeal, two days before court-ordered mediation in this case. Regardless, the pending appeal does not change the analysis. The arguments Defendants raise here were already considered and rejected by this Court.

competitive standing—are not readily quantifiable or compensable after the fact and will compound year over year.

Defendants argue that "Elevance's nearly nine-month delay in bringing this action undermines its allegation of irreparable harm." ECF 35, Resp. at 19. Relying on *Wreal, LLC v. Amazon.com, Inc.*, 840 F.3d 1244 (11th Cir. 2016), Defendants assert that "a *preliminary* injunction is premised on the need for speedy and urgent action to protect a plaintiff's rights[.]" *Id.* at 1248. Elevance agrees—which is precisely why it filed its motion.

It is irrelevant that Elevance could have filed when Clover did. Following *Clover*, CMS chose not to implement the decision upon Elevance's request and did not implement it across the board as it did following the SCAN and Elevance decisions in 2024[5]—but instead issued the June 17 HPMS memorandum creating disparity among plans. Indeed, CMS created three methodologies for calculating 2026 Star Ratings among plans: (1) the original 2026 Star Ratings; (2) recalculated Star Ratings consistent with the June 17 HPMS Memorandum; and (3) the *Clover* methodology. Elevance acted within days—requesting the same treatment seven days after the memorandum issued and filing suit five days after CMS's refusal. *See* Blue Decl. Exs. 1-4. Under *Wreal*, even a delay of "a few months" may not be fatal to a finding of irreparable harm. 840 F.3d at 1248.

Defendants also allege that because Elevance submitted its 2027 bids incorporating the October 9, 2025, Star Ratings without objection, it cannot claim irreparable harm. ECF 35, Resp. at 18-20. But "[p]laintiffs are not required to demonstrate the complete and imminent destruction of the business to obtain a preliminary injunction." *ABC Charters, Inc. v. Bronson*, 591 F. Supp. 2d 1272, 1309 (S.D. Fla. 2008). Elevance is required by regulation to submit annual bids by the

[5] *See Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1 (D.D.C. 2024); *Scan Health Plan v. DHHS*, No. 23-CV-03910, 2024 WL 2815789 (D.D.C. June 3, 2024).

first Monday of June, 42 C.F.R. § 423.265(b)(1), and failure to do so would have forfeited participation in MA for the entirety of Contract Year 2027. Submitting bids as required by regulation while simultaneously pursuing legal relief is not an election or waiver of remedies—it shows Elevance was compelled to price its 2027 plans based on Star Ratings this Court has already held unlawfully calculated while Elevance then sought relief in this Court.

D. The balance of equities and public interest favor Elevance.

Defendants argue the balance of equities weighs against a preliminary injunction because recalculating Elevance's 2026 Star Ratings in August 2026 would impose an undue administrative burden and irreparably harm CMS's ability to open the AEP on October 15, 2026. This claimed hardship is overstated, contrary to the normal bidding process, and entirely of CMS's own making.

1. CMS has created the problem and cannot hide behind that conduct.

As an initial matter, a party that creates the conditions it now claims make equitable relief impossible cannot invoke those conditions to deny relief. CMS created the conditions necessitating this lawsuit by refusing to apply the *Clover* methodology to Elevance. On May 29, 2026, this Court entered final judgment requiring CMS to recalculate Clover's Star Rating. *Clover*, No. 2:25-cv-00142, ECF Nos. 64 and 65. On June 9, 2026—11 days later—CMS informed Clover it had recalculated consistent with the order. *See* Clover Health Investments, Corp., Current Report (Form 8-K) (June 10, 2026).[6] Shortly thereafter, on June 22, 2026, Elevance requested the same treatment. ECF 1, Compl. at 17-18. CMS refused, necessitating this lawsuit. *Id.* at 18.

The clean-hands doctrine provides that a court will not deny equitable relief when the opposing party's own inequitable conduct produced the very hardship it asserts. *See Precision Instrument Mfg. Co. v. Auto. Maint. Mach. Co.*, 324 U.S. 806, 814-15 (1945). "Any willful act

[6] https://www.sec.gov/Archives/edgar/data/1801170/000180117026000137/clov-20260609.htm.

concerning the cause of action which rightfully can be said to transgress equitable standards of conduct" is sufficient to invoke the clean-hands doctrine. *Id.* Simply put, CMS cannot create the urgency and then hide behind it to resist the equitable remedy its conduct necessitated. *See, e.g.*, *Hi-Tech Pharm., Inc. v. Nutrition Res. Services, Inc.*, No. 24-10564, 2024 WL 4973107, at *4 (11th Cir. Dec. 4, 2024) (upholding a preliminary injunction because the opposing party's claimed hardship "was caused by its own actions" after it chose not to change its behavior despite notice).

CMS cannot credibly characterize the recalculation as an overwhelming undertaking that would irreparably harm the public interest or prevent it from publishing the Medicare & You handbook. CMS already possesses everything it needs to provide the relief requested, including the measure scores for each Elevance contract at issue, the 20 measures to be excluded, and the recalculation methodology it has already developed and applied to Clover's H5141. Extending that process to five additional contracts—H0544, H0907, H1423, H4036, and H8849—is of negligible hardship and can be done within days. CMS completed Clover's recalculation in 11 days; it could have done the same for Elevance in late June. By refusing to act then, however, it deliberately created the compressed timeline it now uses to argue that relief is operationally impossible.

2. *CMS's claims that allowing Elevance to resubmit its bid would cause a competitive advantage and delayed Annual Enrollment Period are, at best, exaggerated.*

CMS asserts that the publication of the National Average Monthly Bid Amount ("NAMBA") on July 28, 2026 would provide Elevance with a competitive advantage if the Court grants relief. *See* ECF 35-1, Lazio Decl. ¶¶ 7-8. CMS provides no support beyond vague assertion, fails to identify any competitively sensitive information, and does not explain how Elevance could gain an advantage. CMS's innuendos of competitive advantage do not hold up for two reasons.

First, the NAMBA publication does not close the bid process—it initiates a new phase. After the NAMBA is released, CMS conducts a rebate reallocation process during which MA-PD

plans update their Bid Pricing Tools to reflect the published NAMBA and Base Beneficiary Premium values. *See* **Exhibit 4**, Chervenska Suppl. Decl. ¶¶ 5-8. This process is expressly authorized by 42 C.F.R. § 422.256(c), which provides that the rebate reallocation process may include resubmission of information to account for CMS's calculation of the NAMBA. *Id.* ¶¶ 6, 7. CMS's own HPMS memo of July 30, 2026 establishes that the final actuarial certification deadline is August 12, 2026—meaning bids are not finalized until at least that date. *Id.* ¶ 10. Even after final certification, CMS permits plans to correct bid errors through its Plan Correction Module, which has historically remained open through September. *Id.* ¶ 11. Allowing Elevance to revise its impacted bids would fall squarely within the ordinary bid-processing timeline.

Second, the NAMBA does not reveal competitively actionable information. The NAMBA is a single, enrollment-weighted national average of applicable standardized Part D bids. *Id.* ¶ 12. It does not disclose underlying bids, does not identify submitting plans, and does not reveal bids specific to any geographic market. *Id.* Many different combinations of plan bids can produce the same weighted average, and the aggregate equation cannot be solved backward into plan-specific bids. *Id.* The NAMBA likewise does not disclose any element of Part C competitive strategy—including a competitor's basic bid, rebate amount, premiums, cost-sharing, supplemental-benefit designs, or network strategy—nor does it reveal Part D benefit design such as formulary, tier structure, or final premium. *Id.* ¶¶ 13-14. Moreover, Elevance develops its Part D strategy through centralized national guiding principles applied uniformly across its MA-PD contracts; a corrected Star Rating would not cause Elevance to selectively depart from that strategy. *Id.* ¶ 15. The release of the NAMBA provides no competitively actionable advantage. *Id.* ¶ 16.

Defendants further contend that revised bids in mid-August would not provide sufficient time to incorporate changes into the Medicare & You handbook—statutorily required to be mailed

in September—and that discrepancies between the printed handbook and online Plan Finder would confuse beneficiaries. *See* ECF 35, Resp. at 25; ECF 35-2, Goldstein Decl. ¶¶ 2, 5. Elevance agrees that beneficiary access to accurate information is paramount—which is precisely why the current Star Ratings, corrupted by 20 unlawful measures, must be corrected. But Defendants' argument rests on bare assertion. The Goldstein Declaration offers no specific timeline showing that incorporation of revised bid information is infeasible; it merely speculates without support that discrepancies "could" arise. This is precisely the sort of generalized, unsupported claim of administrative inconvenience that cannot overcome a movant's demonstrated entitlement to relief.

Moreover, Defendants' own bidding process refutes their argument. The rebate reallocation process is currently underway following the July 28 NAMBA release. Ex. 4, Chervenska Suppl. Decl. ¶¶ 5-8. CMS's own HPMS memo establishes that the final actuarial certification deadline is August 12, 2026, *id.* ¶ 10, and the Plan Correction Module has historically remained open through September, *id.* ¶ 11. If CMS's standard timeline already contemplates material changes to bids through mid-August and corrections into September, Defendants cannot credibly maintain that allowing Elevance to resubmit revised bids within that window would disrupt the AEP.

CONCLUSION

This Court has already decided this case in *Clover*. Plaintiffs respectfully request that the Court deny the motion to dismiss and grant the preliminary injunction or, alternatively, convert this into a motion for summary judgment pursuant to Fed. R. Civ. P. 65 and enter judgment in Elevance's favor.

Dated: August 4, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system and service will be perfected upon the following this 4th day of August, 2026:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

SUPPLEMENTAL DECLARATION OF JAMES HASKINS

I, James Haskins, declare as follows:

1. I am the Director, Advanced Analytics for Elevance Health, Inc. ("Elevance"). I submit this declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case. The statements contained herein are based on my own personal knowledge and professional experience.

2. As explained in my declaration dated July 3, 2026, Contract H4036, held by Anthem Insurance Companies, Inc., has a membership of 365,764 and serves enrollees in Georgia, Ohio, Wisconsin, and Kentucky. Its 2026 Star Rating was 4.0. If the Star Rating had been calculated without regard to the 20 measures that the U.S. District Court for the Southern District of Georgia found unlawful in a lawsuit brought by Clover Insurance Company ("Clover") against

CMS (the "Clover Litigation"), the 2026 Star Rating for H4036 would be 4.5 Stars. In turn, Contract H4036's rebate and Quality Bonus Payment ("QBP") for 2027 would increase by approximately $65,800,000. The 20 measures that were determined to be unlawful in the Clover Litigation were C03, C04, C05, C15, C16, C22, C23, C24, C25, C27, C32, C33, D01, D05, D06, D08, D09, D10, D11, and D12 (the "the *Clover* Measures").

3. Each year, when CMS calculates Star Ratings, it provides dynamic spreadsheets that detail the Star Rating calculations for each contract. Those spreadsheets are dynamic in the sense that if you adjust the inputs, the spreadsheet will automatically update the remainder of the data in the spreadsheet. In addition, CMS publishes detailed spreadsheets for the contract improvement measures, which are designed to provide data relating to the contract's quality improvement measures for Star Ratings. For H4036, Elevance received those Star Rating spreadsheets from CMS on September 10, 2025.

4. A true and correct copy of the overall Star Rating spreadsheet that Elevance received from CMS for H4036 on or about September 10, 2025 is attached hereto as **Exhibit 1** (the "CMS Overall Star Rating Spreadsheet") (file labeled "H4036_2026_SR_Calculations_2025_09_10"). This is the spreadsheet evidencing CMS's calculation of Elevance's Star Rating for H4036 when the Star Rating for that contract was publicly released on October 9, 2025.

5. A true and correct copy of the Star Rating Quality Improvement Measures spreadsheet that Elevance received from CMS for H4036 on or about September 10, 2025 is attached hereto as **Exhibit 2** ("CMS Quality Improvement Measure Spreadsheet") (file labeled "H4036_2026_IM_Calcs_2025_09_10". This is the spreadsheet evidencing CMS's calculation of

Elevance's Star Rating Quality Improvement Measure scores for H4036 when the Star Rating for that contract was publicly released on October 9, 2025.

6. In addition, CMS publishes Medicare Part C and D Star Rating Technical Notes each year to explain how CMS calculated the Star Ratings for that particular year. For CY2026, CMS published the final Part C & D Star Ratings Technical Notes on September 25, 2025.

7. A true and correct copy of the Part C & D Star Ratings Technical Notes is attached hereto as **Exhibit 3**. These technical notes are publicly-available on CMS's website at https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data. These are the Technical Notes that CMS used to calculate the Star Rating for H4036 when the Star Rating for that contract was publicly released on October 9, 2025.

8. The purpose of this declaration is to explain how the Star Rating for H4036 would be calculated if the *Clover* Measures are excluded from the Star Rating calculation for H4036.

9. Elevance's lawsuit challenges the correctness of the Star Rating as published by CMS on Medicare Plan Finder on October 9, 2025. I calculated the Star Rating for H4036 (and the other contracts at issue in this litigation) by removing the *Clover* Measures from the overall Star Rating calculation and Quality Improvement Measures, while maintaining as stable all other variables and inputs related to the published 2026 Star Ratings. In other words, I ran the calculation as though it would have been published on October 9, 2025, the only difference being the removal of the *Clover* Measures. In the following paragraphs, I explain the methodology to conduct that calculation.

10. Attached hereto are two Excel spreadsheets detailing my calculations as to how H4036 would be calculated based upon the information available as of October 9, 2025. **Exhibit 4** shows what H4036's overall Star Rating would be by removing the *Clover* Measures. As part

of that calculation, as explained more fully below, **Exhibit 5** shows what H4036's Quality Improvement Measure Star rating scores would be by removing the *Clover* Measures. I created these files by taking the CMS Overall Star Rating Spreadsheet and the CMS Quality Improvement Measure Spreadsheet. Because these files are dynamic, they are automatically updated based upon the adjustments I made.

11. First, I removed the 20 *Clover* Measures from the calculation for the overall Star Rating for H4036. Specifically, I removed C03, C04, C05, C15, C16, C22, C23, C24, C25, C27, C32, C33, D01, D05, D06, D08, D09, D10, D11, D12 from the calculation. *See generally* Exhibit 4 (removing the 20 *Clover* Measures).

12. Second, I accounted for impacts to the Quality Improvement Measures as a result of removing the *Clover* Measures. Star Ratings have one Part C Quality Improvement Measure (C30) and one Part D Quality Improvement Measure (D04). These measures are derived by comparing certain measure scores, including many of the 20 *Clover* Measures, to see if there was significant improvement from the current year compared to the prior year. The Part C Quality Improvement Measure (C30) includes only Part C measure scores, and the Part D Quality Improvement Measure (D04) includes only Part D measure scores.

13. To determine a revised Part C Quality Improvement Measure (C30) and Part D Quality Improvement Measure (D04), I used the CMS Quality Improvement Measure Spreadsheet and removed any of the 20 *Clover* Measures from factoring into C30 and D04 for H4036's 2026 Star Rating. Specifically, I removed C03, C15, C16, C22, C23, C24, C25, C27, C32, C33, D01, D05, D06, D08, D09, D10, D11, and D12, all of which are normally accounted for in the Part C and Part D Quality Improvement Measures but which are part of the 20 *Clover* Measures. *See* Exhibit 5. I then followed the methodology described in the CMS 2026 Medicare Part C and D

Star Ratings and Technical Notes guidance document, attached hereto as Exhibit 3, to determine the numerical improvement measure score for the 2026 Part C and D Quality Improvement Measures (C30 and D04). *See* Exhibit 5.

14. I then compared the resulting revised numerical scores against the C30 and D04 cut points released by CMS in the original CMS Quality Improvement Measure Spreadsheets and used in the calculation of the H4036 2026 Star Rating (those cut points were re-released publicly again on July 22, 2026, in an updated Report Card Master Table). *See* Exhibit 1 at Part C, Line 36 & Part D, Lines 19-20. A "cut point" is an industrywide threshold value that CMS establishes to determine whether each contract's performance for that measure receives a 1, 2, 3, 4, or 5-star rating. Comparing the revised numerical score for C30 with the *Clover* Measures removed against the cut points CMS used when calculating the 2026 Star Rating for H4036 results in a "5 Star" for the C30 measure, and not the "4" originally reported in October 2025 by CMS. This is because Elevance experienced on balance more improvement for the measures that remained after the removal of the 20 *Clover* Measures.

15. After removing the *Clover* Measures from the calculation for the Part D Quality Improvement Measure (D04), that measure did not change because it would also receive a "5" but was already a "5" in October 2025. I then incorporated the updated measure score for C30 (and kept the same measure score for D04 because there was no change) into the overall Star Ratings calculation. *See* Exhibit 4.

16. Third, I took into account the Reward Factor as required by 42 C.F.R. § 422.166(f)(1). The Reward Factor is a "bonus" that high performing contracts receive that incentivizes high performance across measures. I calculated the impact to the Reward Factor for H4036 as a result of the *Clover* Measures being removed and the change to the Part C Quality

Improvement Measure, which resulted in a revised summary rating of 4.078947 and variance of 1.018370 with the Quality Improvement Measures. Applying this to the summary rating and variance thresholds applied by CMS when it calculated the 2026 Star Rating for H4036 and as published in the 2026 Part C and D Star Rating Technical Notes. *See* Exhibit 3 at pp. 15-16. Doing this, H4036's revised summary rating of 4.078947 and variance of 1.018370 with the Improvement Measures results in a 0.3 Reward Factor, due to a combination of "high" mean with "medium" variance when comparing to the thresholds. *See* Exhibit 4.

17. Doing all this, pursuant to the methodology prescribed by CMS, the unrounded final summary Star Rating for H4036 is 4.315685, which rounds up to 4.5 pursuant to the Star Rating rounding rules. *See* Exhibit 4

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

Executed this 4th day of August, 2026.

/s/ *James Haskins*

Exhibit 1

to Declaration of James Haskins

Placeholder for native file entitled Haskins Declaration - Exhibit 1 (H4036_2026_SR_Calculations_2025_09_10), which was e-mailed to the Court and to opposing counsel at the time of filing on 08/04/2026.

Exhibit 2

to Declaration of James Haskins

Placeholder for native file entitled Haskins Declaration - Exhibit 2 (H4036_2026_IM_Calcs_2025_09_10), which was e-mailed to the Court and to opposing counsel at the time of filing on 08/04/2026.

Exhibit 3

to Declaration of James Haskins

Medicare 2026 Part C & D Star Ratings Technical Notes

Updated – 09/25/2025

Document Change Log

Previous Version	Description of Change	Revision Date
Draft 09/04/2025	The reporting requirements for the Kidney Health Evaluation for Patients with Diabetes (C13) measure were updated to reflect CCP with Only I-SNP contracts are required to report this measure. The cut points for this measure were also updated consistent with this change.	09/25/2025

OMB Approved Data Sources

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

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

Table of Contents

Introduction

CMS created the Part C & D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period. We refer to them as the '2026 Medicare Part C & D Star Ratings' because they are posted prior to the 2026 open enrollment period.

This document describes the methodology for creating the Part C & D Star Ratings displayed on the Medicare Plan Finder (MPF) at http://www.medicare.gov/ and posted on the CMS website at http://go.cms.gov/partcanddstarratings. A Glossary of Terms used in this document can be found in Attachment R.

The Star Ratings data are also displayed in the Health Plan Management System (HPMS). In HPMS, the data can be found by selecting: "Quality and Performance," then "Performance Metrics," then "Reports," then "Star Ratings and Display Measures," then "Star Ratings" for the report type, and "2026" for the report period. See Attachment S: Health Plan Management System Module Reference for descriptions of the HPMS pages.

The Star Ratings Program is consistent with the "Meaningful Measures" framework which focuses on measures related to person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. With Meaningful Measures 2.0, CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives of care. The Star Ratings include measures applying to the following five broad categories:

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

Differences between the 2025 Star Ratings and 2026 Star Ratings

There have been several changes between the 2025 Star Ratings and the 2026 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2026 Star Ratings. A table with the complete history of measures used in the Star Ratings can be found in Attachment J.

- Changes
    a. The weight of the patient experience, complaints, and access measures was decreased from 4 to 2.
    b. Since the respecified Part C Controlling Blood Pressure measure is no longer treated as a new measure, guardrails are now applied after mean resampling.

c. Re-specified Part C Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health measures moved into the 2026 Star Ratings as new measures with a weight of 1 for the first year.
d. Part C Kidney Health Evaluation for Patients with Diabetes measure moved into the 2026 Star Ratings as a new measure with a weight of 1.
e. Removed the 60 percent rule for non-CAHPS measures such that the numeric score values for affected contracts with 60 percent or more of their enrollees in Federal Emergency Management Agency (FEMA) designated Individual Assistance areas at the time of an extreme and uncontrollable circumstance are no longer excluded from the clustering algorithm or from the reward factor calculations.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. None
- Retired measures
  a. None

Health/Drug Organization Types Included in the Star Ratings

All health and drug plan quality and performance measure data described in this document are reported at the contract/sponsor level. Table 1 lists the contract year 2026 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2026 Organization Types Reported in the 2026 Star Ratings

Organization Type	Technical Notes Abbreviation	Medicare Advantage (MA)	Can Offer SNPs	Part C Ratings	Part D Ratings
1876 Cost	*1876 Cost*	*No*	*No*	*Yes*	*Yes (if drugs offered)*
Demonstration (Medicare-Medicaid Plan) †	*MMP*	*No*	*No*	*No*	*No*
Employer/Union Only Direct Contract Local Coordinated Care Plan (CCP)	*CCP*	*Yes*	*No*	*Yes*	*Yes*
Employer/Union Only Direct Contract Prescription Drug Plan (PDP)	*PDP*	*No*	*No*	*No*	*Yes*
Employer/Union Only Direct Contract Private Fee-for-Service (PFFS)	*PFFS*	*Yes*	*No*	*Yes*	*Yes (if drugs offered)*
HCPP 1833 Cost	*HCPP*	*No*	*No*	*No*	*No*
Local Coordinated Care Plan (CCP)	*CCP*	*Yes*	*Yes*	*Yes*	*Yes*
Medical Savings Account (MSA)	*MSA*	*Yes*	*No*	*Yes*	*No*
National PACE	*PACE*	*No*	*No*	*No*	*No*
Medicare Prescription Drug Plan (PDP)	*PDP*	*No*	*No*	*No*	*Yes*
Private Fee-for-Service (PFFS)	*PFFS*	*Yes*	*No*	*Yes*	*Yes (if drugs offered)*
Regional Coordinated Care Plan (CCP)	*CCP*	*Yes*	*Yes*	*Yes*	*Yes*
Religious Fraternal Benefit Private Fee-for-Service (RFB PFFS)	*PFFS*	*Yes*	*No*	*Yes*	*Yes (if drugs offered)*

† Note: The measure scores from these organizations are displayed in HPMS only during the first plan preview. Data from these organizations are not used in calculating the Part C & D Star Ratings.

The Star Ratings Framework

The Star Ratings are based on health and drug plan quality and performance measures. Each measure is reported in two ways:

Score: A score is either a numeric value or an assigned 'missing data' message.

Star: The measure numeric value is converted to a Star Rating.

The measure Star Ratings are combined into three groups and each group is assigned 1 to 5 stars. The three groups are:

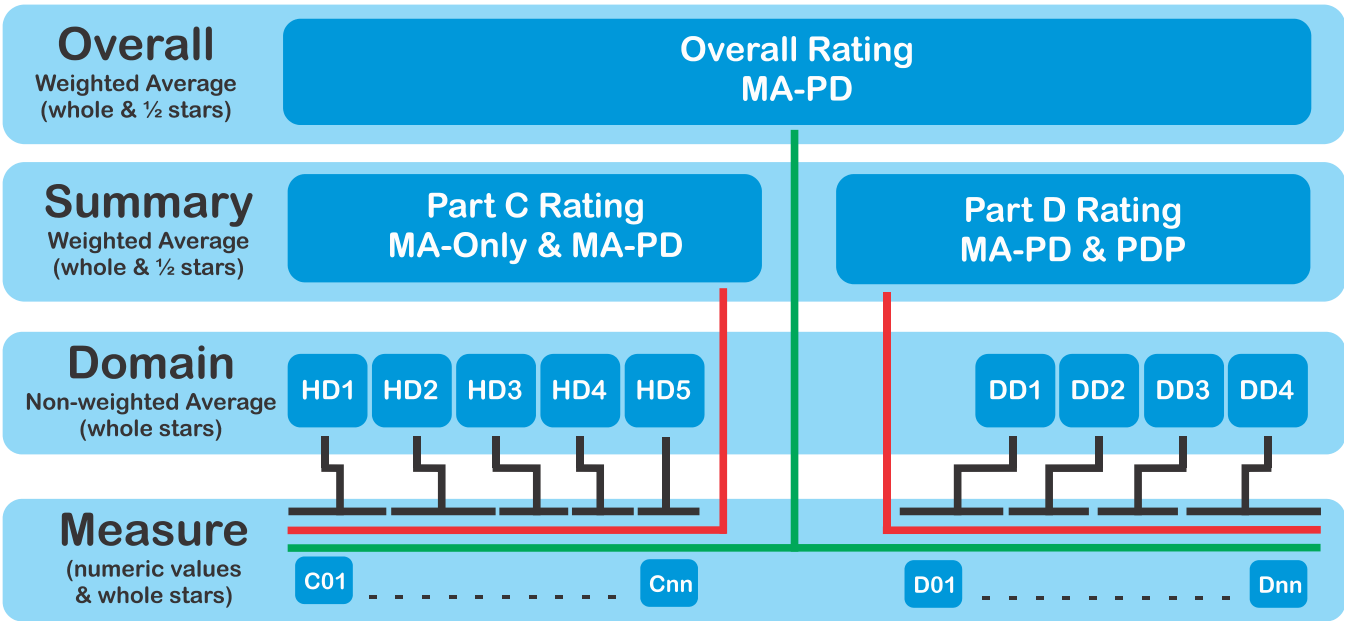
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

Summary: Part C measures are grouped to calculate a Part C Rating; Part D measures are grouped to calculate a Part D Rating. Summary ratings are calculated from the weighted average Star Ratings of the included measures.

Overall: For MA-PDs, all unique Part C and Part D measures are grouped to create an overall rating. The overall rating is calculated from the weighted average Star Ratings of the included measures.

Figure 1 shows the four levels of Star Ratings that are calculated and reported publicly.

Figure 1: The Four Levels of Star Ratings



The whole star scale used at the measure and domain levels is shown in Table 2.

Table 2: 5-Star Scale

Numeric	Graphic	Description
5	★★★★★	*Excellent*
4	★★★★	*Above Average*
3	★★★	*Average*
2	★★	*Below Average*
1	★	*Poor*

To allow for more variation across contracts, CMS assigns half stars to the summary and overall ratings. As different organization types offer different benefits, CMS classifies contracts into three contract types. The highest level Star Rating differs among the contract types because the set of required measures differs by contract type. Table 3 clarifies how CMS classifies contracts for purposes of the Star Ratings and indicates the highest rating available for each organization type.

Table 3: Relation of 2026 Organization Types to Contract Types and Highest Rating in the 2026 Star Ratings

Organization Type	1876 Cost (no drugs) †	1876 Cost (offers drugs) †	CCP	MSA	PDP	PFFS (no drugs)	PFFS (offers drugs)
Rated As	*MA-Only*	*MA-PD*	*MA-PD*	*MA-Only*	*PDP*	*MA-Only*	*MA-PD*
Highest Rating	*Part C rating*	*Overall Rating*	*Overall Rating*	*Part C Rating*	*Part D Rating*	*Part C Rating*	*Overall Rating*

† Note: While 1876 contracts are not MA contracts, for the purposes of determining the highest rating they are considered to be rated as either "MA-only" or "MA-PD" depending on whether they offer drugs.

Sources of the Star Ratings Measure Data

The 2026 Star Ratings include a maximum of 9 domains comprised of a maximum of 45 measures.

- 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.

Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type

Part	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	11 of 22	13 of 26	15 of 29	9 of 17	13 of 25	N/A	13 of 26
D	5 of 10*	6 of 11	6 of 11	5 of 9	N/A	6 of 11	6 of 11*

** Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.*

For a detailed description of all Part C and Part D measures, see the section entitled "Framework and Definitions for the Domain and Measure Details."

Contract Enrollment Data

The enrollment data used in the Part C and Part D "Complaints about the Health/Drug Plan" measures are pulled from HPMS. These data may also be accessed on the Monthly Enrollment by Contract page on CMS.gov. These enrollment files represent the number of enrolled beneficiaries the contract was paid for in a specific month. For these measures, twelve months of enrollment files are pulled (January 2024 through December 2024) and the average enrollment across those months is used in the calculations.

Enrollment data are also used when combining the plan-level data into contract-level data in the two Part C "Care for Older Adults" Healthcare Effectiveness Data and Information Set (HEDIS) measures. (The "Care for Older Adults – Functional Status Assessment" measure is currently on the display page). When there is a reported rate, the eligible population in the plan benefit package (PBP) submitted with the HEDIS data is used. If the audit designation for the PBP level HEDIS data is set to "Not Reported" (NR) or "Biased Rate" (BR) by the auditor (see following section), there is no value in the eligible population field. In these instances, twelve months of PBP-level enrollment files are pulled (January 2024 through December 2024), and the average enrollment in the plan across those months is used in calculating the combined rate.

Handling of Biased, Erroneous, and/or Not Reportable (NR) Data

The data used for CMS's Star Ratings must be accurate and reliable. CMS has identified issues with some contracts' data and has taken steps to protect the integrity of the data. For any measure scores CMS identifies to be based on inaccurate or biased data, CMS's policy is to reduce a contract's measure rating to 1 star and set the measure score to "CMS identified issues with this plan's data."

Inaccurate or biased data result from the mishandling of data, inappropriate processing, or implementation of incorrect practices. Examples include, but are not limited to: a contract's failure to adhere to HEDIS, Health Outcomes Survey (HOS), or CAHPS reporting requirements; a contract's failure to adhere to Medicare Plan Finder data requirements; a contract's errors in processing organization determinations and appeals; compliance actions taken against the contract due to errors in operational areas that impact the data reported or processed for specific measures; or a contract's failure to pass validation of the data reported for specific measures.
For HEDIS data, CMS uses the audit designation information assigned by the HEDIS auditor. An audit designation of 'NR' (Not reported) is assigned when the contract chooses not to report the measure. An audit designation of 'BR' (Biased rate) is assigned when the individual measure score is materially biased (e.g., the auditor informs the contract the data cannot be reported to the National Committee for Quality Assurance (NCQA) or to CMS). When either a 'BR' or 'NR' designation is assigned to a HEDIS measure audit designation, the contract receives 1 star for the measure and the measure score is set to "CMS identified issues with this plan's data." In addition, CMS reduces contracts' HEDIS measure ratings to 1 star if the patient-level data files are not successfully submitted and validated by the submission deadline. Also, if the HEDIS summary-level data value varies substantially from the value in the patient-level data, the measure is reduced to

a rating of 1 star. If an approved CAHPS or HOS vendor does not submit a contract's CAHPS or HOS data by the data submission deadline, the contract automatically receives a rating of 1 star for the CAHPS or HOS measures and the measure scores are set to "CMS identified issues with this plan's data."

Data Handling of Measures for Contracts Affected by a Major Disaster

CMS has a policy for making adjustments in the Star Ratings to take into account major disasters. That policy was described in the 2026 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.) This is also codified in regulation at §422.166(i) and §423.186(i).

This section describes how the policy is implemented for measures from each of the different data sources in the 2026 Star Ratings. The methodology used by CMS to identify the major disaster geographic areas, determine which contracts were affected, and how much of their geographic service area and percent of enrollment resided in an affected area can be found in Attachment P.

The disaster policy specifies a threshold of "25% or more" of the contract's membership at the time of the disaster resided in a FEMA-designated Individual Assistance area. CMS calculated the percentage of enrollment affected for every contract being rated and applied the following rules to the data from those contracts that meet or exceed the threshold.

- CAHPS adjustments:
    - All contracts were required to administer the 2025 CAHPS survey unless the contract requested and CMS approved an exemption based on having greater than 25% of beneficiaries in Individual Assistance areas at the time of the 2025 Los Angeles County wildfires. If a contract received an exemption, CAHPS measure scores and ratings from the 2025 Star Ratings were used.
    - All affected contracts with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster receive the higher of the 2025 or the 2026 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure). The CAHPS data used in the 2026 Star Ratings are adjusted for 2024 disasters and 2025 Los Angeles County wildfires.
    - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated individual Assistance areas that were affected by disasters that began in 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2023 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected). For example, if a doubly-affected contract reverted back to the 2024 Star Rating on a given measure in the 2025 Star Ratings, the 2024 Star Rating is *not* used in determining the 2026 Star Rating. Rather the 2026 Star Rating is compared to what the 2025 Star Rating would have been absent any disaster adjustments.
- HOS adjustments:
    - The HOS data used in the 2026 Star Ratings are adjusted for 2023 disasters (see Attachment P of the 2025 Star Ratings Technical Notes for the identification of contracts affected by 2023 disasters).
    - All affected contracts (i.e., contracts affected by 2023 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the

2025 or the 2026 Star Rating (and corresponding measure score) for each HOS and HEDIS-HOS measure.

  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2023 were also affected by disasters in 2022. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2022 disaster for each HOS and HEDIS-HOS measure (we use the corresponding measure score for the Star Ratings year selected).

- HEDIS adjustments:
  - All contracts were required to report HEDIS measurement year 2024 unless the contract requested and CMS approved an exemption. Contracts were able to work with NCQA to adjust samples if necessary.
  - Contracts with 25% or more affected members received the higher of the 2025 or 2026 Star Rating (and corresponding measure scores) for each HEDIS measure.
  - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2023 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- Part C and D Call Center:
  - For all contracts, no adjustments were made.
- New measures:
  - Contracts with 25% or more affected members have a hold harmless provision applied which compares the result of a contract's overall rating "with" and "without" including all of the applicable new measure(s) and/or respecified measure(s). If the "with" result is lower than the "without" result, then we use the "without" result as the final highest level rating. For the 2026 Star Ratings, two new measures are HOS measures and one is a HEDIS measure. As noted above, HOS measures are adjusted for disasters occurring in 2023 whereas HEDIS measures are adjusted for disasters occurring in 2024. Therefore, the hold harmless provision is conditionally applied for a given contract according to the new measures' available data. Contracts with data for both the new HEDIS measure and at least one of the new HOS measures are eligible for the new measure hold harmless provision if the percentage of beneficiaries affected by a disaster is at least 25 percent in either 2023 or 2024. Contracts with only available data for the new HEDIS measure are eligible for the new measure hold harmless provision if the percentage of beneficiaries affected by a disaster is at least 25 percent in 2024. Contracts with only data for one or both of the new HOS measures are eligible for the new measure hold harmless provision if the percentage of beneficiaries affected by a disaster is at least 25 percent in 2023.
  - A similar hold harmless provision is applied for the Part C and D summary ratings, when applicable. If a contract has 25% or more affected members, the Part C and D summary ratings are calculated "with" and "without" including all of the applicable new measure(s) and/or respecified measure(s), and if the "with" result is lower than the "without" result, then we use the "without" result for the final summary ratings. For the 2026 Star Ratings, all new measures are Part C measures with differing disaster year adjustments, and a similar conditional hold harmless provision as described above for the overall rating is applied based on new measures' available data.

- All other measures:
    - Contracts with 25% or more affected members receive the higher of the 2025 or 2026 measure stars (and corresponding measure scores).
    - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2026 Star Rating or what the 2025 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2023 disaster for each measure (we use the corresponding measure score for the Star Ratings year selected).
- All adjustments:
    - For all adjustments, if the Star Rating is the same in both years, the Star Rating and the measure score from the most recent year are used.
- Improvement measures:
    - For affected contracts that reverted back to the data underlying the previous year's Star Rating for a particular measure for either 2025 or 2026 Star Ratings, that measure is excluded from both the count of measures (used to determine whether the contract has at least half of the measures needed to calculate the relevant improvement measure) and the improvement measures' calculation. Affected contracts do not have the option of reverting to the prior year's improvement rating.
- Affected contracts with missing data:
    - If an affected contract has missing data in either the current or previous year (e.g., because of a data integrity issue, it is too new, or it is too small), the final measure rating comes from the current year. Missing data includes data where there is a data integrity issue.

Methodology for Assigning Stars to the Part C and Part D Measures

CMS assigns stars for each numeric measure score by applying one of two methods: clustering, or relative distribution and significance testing. Each method is described below. Attachment K explains the clustering and relative distribution and significance testing (used for CAHPS measures) methods in greater detail.

A. Clustering

This method is applied to the majority of the Star Ratings measures, ranging from operational and process-based measures, to HEDIS and other clinical care measures. Using this method, the Star Rating for each measure is determined by applying a clustering algorithm to the measure's numeric value scores from all contracts. Conceptually, the clustering algorithm identifies the "gaps" among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). The scores in the same Star Rating level are as similar as possible; the scores in different Star Rating levels are as different as possible. Star Rating levels 1 through 5 are assigned with 1 being the worst and 5 being the best.

Technically, the variance in measure scores is separated into within-cluster and between-cluster sum of squares components. The clusters reflect the groupings of numeric value scores that minimize the variance of scores within the clusters. The Star Ratings levels are assigned to the clusters that minimize the within-cluster sum of

squares. The cut points for star assignments are derived from the range of measure scores per cluster, and the star levels associated with each cluster are determined by ordering the means of the clusters.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling within the hierarchical clustering algorithm.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are randomly separated into 10 equal-sized groups. The hierarchal clustering algorithm is then applied 10 times, each time leaving one of the 10 groups out of the clustered data. The method results in 10 sets of measure-specific cut points. The mean for each 1 through 5 star level cut point is taken across the 10 sets for each measure to produce the final cut points. For the improvement measures, mean resampling is done separately for contracts with negative improvement scores and for contracts with improvement scores greater than or equal to zero.

Guardrails are used to cap the amount of increase or decrease in measure cut point values from one year to the next. Specifically, each 1 to 5 star level cut point is compared to the prior year's value and capped at an increase or decrease of at most 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or at most 5 percent of the prior year's restricted score range for measures not having a 0 to 100 scale (restricted range cap). The final capped cut points after comparing each 1 through 5 star level cut point to the prior year's values are used for assigning measure stars.

B. Relative Distribution and Significance Testing (CAHPS)

This method is applied to determine valid star cut points for CAHPS measures. In order to account for the reliability of scores produced from the CAHPS survey, the method combines evaluating the relative percentile distribution with significance testing. For example, to obtain 5 stars, a contract's CAHPS measure score needs to be ranked at least at the 80th percentile and be statistically significantly higher than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error above the 80th percentile. To obtain 1 star, a contract's CAHPS measure score needs to be ranked below the 15th percentile and be statistically significantly lower than the national average CAHPS measure score, as well as either have not low reliability or have a measure score more than one standard error below the 15th percentile.

Methodology for Calculating Stars at the Domain Level

A domain rating is the average, unweighted mean, of the domain's measure stars. To receive a domain rating, a contract must meet or exceed the minimum number of rated measures required for the domain. The minimum number of rated measures required for a domain is determined based on whether the total number of measures in the domain for a contract type is odd or even:

- If the total number of measures that comprise the domain for a contract type is odd, divide the number of measures in the domain by two and round the quotient to the next whole number.
    - Example: If the total number of measures required in a domain for a contract type is 3, the value 3 is divided by 2. The quotient, in this case 1.5, is then rounded to the next whole number. To receive a domain rating, the contract must have a Star Rating for at least 2 of the 3 required measures.

- If the total number of measures that comprise the domain for a contract type is even, divide the number of measures in the domain by two and add one to the quotient.
    - Example: If the total number of measures required in a domain for a contract type is 6, the value 6 is divided by 2. In this example, 1 is then added to the quotient of 3. To receive a domain rating, the contract must have a Star Rating for at least 4 of the 6 required measures.

Table 5 details the minimum number of rated measures required for a domain rating by contract type.

Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type

Part	Domain Name (Identifier)	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	*Staying Healthy: Screenings, Tests and Vaccines (HD1)*	*4 of 6*	*4 of 6*	*4 of 6*	*2 of 2*	*4 of 6*	*N/A*	*4 of 6*
C	*Managing Chronic (Long Term) Conditions (HD2)*	*5 of 9*	*7 of 12*	*8 of 15*	*6 of 11*	*7 of 12*	*N/A*	*7 of 12*
C	*Member Experience with Health Plan (HD3)*	*4 of 6*	*4 of 6*	*4 of 6*	*N/A*	*4 of 6*	*N/A*	*4 of 6*
C	*Member Complaints and Changes in the Health Plan's Performance (HD4)*	*2 of 3*	*2 of 3*	*2 of 3*	*2 of 3*	*2 of 3*	*N/A*	*2 of 3*
C	*Health Plan Customer Service (HD5)*	*2 of 2*	*2 of 3*	*2 of 3*	*2 of 3*	*2 of 2*	*N/A*	*2 of 3*
D	*Drug Plan Customer Service (DD1)*	*N/A**	*1 of 1*	*1 of 1*	*1 of 1*	*N/A*	*1 of 1*	*1 of 1**
D	*Member Complaints and Changes in the Drug Plan's Performance (DD2)*	*2 of 3**	*2 of 3*	*2 of 3*	*2 of 3*	*N/A*	*2 of 3*	*2 of 3**
D	*Member Experience with the Drug Plan (DD3)*	*2 of 2**	*2 of 2*	*2 of 2*	*N/A*	*N/A*	*2 of 2*	*2 of 2**
D	*Drug Safety and Accuracy of Drug Pricing (DD4)*	*4 of 6**	*4 of 6*	*4 of 6*	*4 of 6*	*N/A*	*4 of 6*	*4 of 6**

** Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.*
† Note: 1876 Cost contracts that offer drug benefits and which do not submit data for the MPF measure must have a rating in 3 out of 5 Drug Safety and Accuracy of Drug Pricing (DD4) measures to receive a rating in that domain.

Summary and Overall Ratings: Weighting of Measures

The summary and overall ratings are calculated as weighted averages of the measure stars. For the 2026 Star Ratings, CMS assigns the highest weight to the improvement measures, followed by outcome and intermediate outcome measures, then by patient experience/complaints and access measures, and finally process measures. New measures included in the Star Ratings are given a weight of 1 for their first year of inclusion in the ratings; in subsequent years the weight associated with the measure weighting category is used. The weights assigned to each measure and their weighting category are shown in Attachment G.

In calculating the summary and overall ratings, a measure given a weight of 3 counts three times as much as a measure given a weight of 1. For any given contract, any measure without a rating is not included in the calculation. The first step in the calculation is to multiply each measure's weight by the measure's rating and sum these results. The second step is to divide this sum by the sum of the weights of the contract's rated measures. For the summary and overall ratings, half stars are assigned to allow for more variation across contracts.

Methodology for Calculating Part C and Part D Summary Ratings

The Part C and Part D summary ratings are calculated by taking a weighted average of the measure stars for Parts C and D, respectively. To receive a Part C and/or Part D summary rating, a contract must meet the minimum number of rated measures. The Parts C and D improvement measures are not included in the count of the minimum number of rated measures. The minimum number of rated measures required is determined as follows:

- If the total number of measures required for the organization type is odd, divide the number by two and round it to a whole number.
    - Example: if there are 13 required Part D measures for the organization, 13 divided by 2 equals 6.5, when rounded the result is 7. The contract needs at least 7 measures with ratings out of the 13 total measures to receive a Part D summary rating.
- If the total number of measures required for the organization type is even, divide the number of measures by two.
    - Example: if there are 30 required Part C measures for the organization, 30 divided by 2 equals 15. The contract needs at least 15 measures with ratings out of the 30 total measures to receive a Part C summary rating.

Table 6 shows the minimum number of rated measures required by each contract type to receive a summary rating.

Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Part C summary	*13 of 25*	*15 of 29*	*16 of 32*	*9 of 18*	*14 of 28*	*N/A*	*15 of 29*
Part D summary	*5 of 10**	*6 of 11*	*6 of 11*	*5 of 9*	*N/A*	*6 of 11*	*6 of 11**

** Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.*
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 5 out of 9 measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

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

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

There are a total of 45 measures (33 in Part C, 12 in Part D) in the 2026 Star Ratings. The following two measures are contained in both the Part C and D measure lists:

- Complaints about the Health/Drug Plan (CTM)
- Members Choosing to Leave the Plan (MCLP)

These measures share the same data source, so CMS includes only one instance of each of these two measures in the calculation of the overall rating. In addition, the Part C and D improvement measures are not included in the count for the minimum number of measures. Therefore, a total of 41 distinct measures plus the two improvement measures are used in the calculation of the overall rating.

The minimum number of rated measures required for an overall MA-PD rating is determined using the same methodology as for the Part C and D summary ratings. Table 7 provides the minimum number of rated measures required for an overall Star Rating by contract type.

Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Overall Rating	*17 of 33**	*19 of 38*	*21 of 41*	*13 of 25*	*N/A*	*N/A*	*19 of 38**

** Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.*
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 16 out of 32 measures to receive an overall rating.

The overall and summary Star Ratings are calculated based on the measures required to be collected and reported for the contract type being offered for the Star Ratings year. For example, the 2026 Star Ratings are calculated for the 2026 contract year using data primarily from measurement year 2024. If a contract offered a SNP PBP in measurement year 2024, but is no longer offering a SNP PBP for the 2026 contract year, the 2026 Star Ratings exclude the SNP-only measures and the contract is rated as ‘‘Coordinated Care Plan without SNP.’’

Completing the Summary and Overall Rating Calculations

There are two adjustments made to the results of the summary and overall calculations described above. First, to reward consistently high performance, CMS utilizes both the mean and the variance of the measure stars to differentiate contracts for the summary and overall ratings. If a contract has both high and stable relative performance, a reward factor is added to the contract’s ratings. Details about the reward factor can be found in the section entitled “Applying the Reward Factor.” Second, the summary and overall ratings include a Categorical Adjustment Index (CAI) factor, which is added to or subtracted from a contract’s summary and overall ratings. Details about the CAI can be found in the section entitled “Categorical Adjustment Index (CAI).”

The summary and overall rating calculations are run twice, once including the improvement measures and once without including the improvement measures. Based on a comparison of the results of these two calculations a decision is made as to whether the improvement measures are to be included in calculating a contract’s final summary and overall ratings. Details about the application of the improvement measures can be found in the section entitled “Applying the Improvement Measure(s).”

Lastly, standard rounding rules are applied to convert the results of the final summary and overall ratings calculations into the publicly reported Star Ratings. Details about the rounding rules are presented in the section “Rounding Rules for Summary and Overall Ratings.”

Applying the Improvement Measure(s)

The Part C Improvement Measure - Health Plan Quality Improvement (C30) and the Part D Improvement Measure - Drug Plan Quality Improvement (D04) were introduced earlier in this document in the section entitled “Improvement Measures.” The measures and formulas for the improvement measures can be found in Attachment I. This section discusses whether and how to apply the improvement measures in calculating a contract’s final summary and overall ratings.

Since high performing contracts have less room for improvement and consequently may have lower ratings on these measure(s), CMS has developed the following rules to not penalize contracts receiving 4 or more stars for their highest rating.

MA-PD Contracts

1. There are separate Part C and Part D improvement measures (C30 & D04) for MA-PD contracts.
   a. C30 is used in calculating the Part C summary rating of an MA-PD contract.
   b. D04 is used in calculating the Part D summary rating for an MA-PD contract.
   c. Both improvement measures will be used when calculating the overall rating in step 3.
2. Calculate the overall rating for MA-PD contracts without including either improvement measure.
3. Calculate the overall rating for MA-PD contracts with both improvement measures included.
4. If an MA-PD contract in step 2 has 4 or more stars, compare the two overall ratings. If the rating in step 3 is less than the value in step 2, use the overall rating from step 2; otherwise use the result from step 3.
5. For all other MA-PD contracts, use the overall rating from step 3.

MA-Only Contracts

1. Only the Part C improvement measure (C30) is used for MA-Only contracts.
2. Calculate the Part C summary rating for MA-Only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-Only contracts with the Part C improvement measure.
4. If an MA-Only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2; otherwise use the result from step 3.
5. For all other MA-Only contracts, use the Part C summary rating from step 3.

PDP Contracts

1. Only the Part D improvement measure (D04) is used for PDP contracts.
2. Calculate the Part D summary rating for PDP contracts without including the improvement measure.
3. Calculate the Part D summary rating for PDP contracts with the Part D improvement measure.
4. If a PDP contract in step 2 has 4 or more stars, compare the two Part D summary ratings. If the rating in step 3 is less than the value in step 2, use the Part D summary rating from step 2; otherwise use the result from step 3.
5. For all other PDP contracts, use the Part D summary rating from step 3.

Applying the Reward Factor

The following represents the steps taken to calculate and include the reward factor (r-Factor) in the Star Ratings summary and overall ratings. These calculations are performed both with and without the improvement measures included.

- Calculate the mean and the variance of all of the individual quality and performance measure stars at the contract level.
    - The mean is equal to the summary or overall rating before the reward factor is applied, which is calculated as described in the section entitled “Weighting of Measures.”
    - Using weights in the variance calculation accounts for the relative importance of measures in the reward factor calculation. To incorporate the weights shown in Attachment G into the variance

calculation of the available individual performance measures for a given contract, the steps are as follows:

- Subtract the summary or overall star from each performance measure's star; square the results; and multiply each squared result by the corresponding individual performance measure weight.
- Sum these results; call this 'SUMWX.'
- Set n equal to the number of individual performance measures available for the given contract.
- Set W equal to the sum of the weights assigned to the n individual performance measures available for the given contract.
- The weighted variance for the given contract is calculated as: $n * SUMWX / (W * (n-1))$. For the complete formula, please see Attachment H: Calculation of Weighted Star Rating and Variance Estimates.

- Categorize the variance into three categories:
  - low (0 to less than 30th percentile),
  - medium (greater than or equal to 30th to less than 70th percentile) and
  - high (greater than or equal to 70th percentile)
- Develop the reward factor as follows:
  - r-Factor equals 0.4 (for contract with low variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor equals 0.3 (for contract with medium variance & high mean (mean greater than or equal to 85th percentile))
  - r-Factor equals 0.2 (for contract with low variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor equals 0.1 (for contract with medium variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
  - r-Factor equals 0.0 (for all other contracts)

Tables 8 and 9 show the final threshold values used in reward factor calculations for the 2026 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	*With*	*65th*	*3.695652*	*3.740741*	*3.385522*	*3.649351*
With	*With*	*85th*	*4.000000*	*4.000000*	*3.913300*	*3.932432*
With	*Without*	*65th*	*3.708333*	*3.740741*	*3.385522*	*3.656716*
With	*Without*	*85th*	*4.019608*	*4.000000*	*3.913300*	*3.943662*
Without	*With*	*65th*	*3.717391*	*3.769231*	*3.318182*	*3.686567*
Without	*With*	*85th*	*4.020408*	*4.136364*	*4.117647*	*3.953125*
Without	*Without*	*65th*	*3.736842*	*3.769231*	*3.318182*	*3.700000*
Without	*Without*	*85th*	*4.023810*	*4.136364*	*4.117647*	*3.966667*

Table 9: Variance Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	*With*	*30th*	*0.918435*	*0.754209*	*0.869005*	*0.914850*
With	*With*	*70th*	*1.285170*	*1.268986*	*1.747939*	*1.263462*
With	*Without*	*30th*	*0.909844*	*0.754209*	*0.869005*	*0.905154*
With	*Without*	*70th*	*1.281071*	*1.268986*	*1.747939*	*1.272639*
Without	*With*	*30th*	*0.914326*	*0.736111*	*0.749180*	*0.908919*
Without	*With*	*70th*	*1.328432*	*1.318182*	*1.814773*	*1.269610*
Without	*Without*	*30th*	*0.908942*	*0.736111*	*0.749180*	*0.915156*
Without	*Without*	*70th*	*1.310167*	*1.318182*	*1.814773*	*1.289063*

Categorical Adjustment Index (CAI)

The Categorical Adjustment Index (CAI) is an analytical adjustment factor that is added to or subtracted from a contract's Overall and/or Summary Star Ratings to adjust for the average within-contract disparity in performance for Low Income Subsidy/Dual Eligible (LIS/DE) beneficiaries and disabled beneficiaries. The CAI value (factor) depends on the contract's percentage of beneficiaries with LIS/DE and the contract's percentage of beneficiaries with disabled status. These adjustments are performed both with and without the improvement measures included. The value of the CAI varies by the contract's percentage of beneficiaries with LIS/DE and disability status.

The CAI values use data collected for the 2025 Star Ratings. To calculate the CAI, case-mix adjustment is applied to clinical Star Rating measure scores (see below) that are not adjusted for SES using a beneficiary-level logistic regression model with contract fixed effects and beneficiary-level indicators of LIS/DE and disability status, similar to the approach currently used to adjust CAHPS patient experience measures. However, unlike CAHPS case-mix adjustment, the only adjusters are LIS/DE and disability status. Adjusted measure scores are then converted to measure stars using the 2025 rating year measure cutoffs and used to calculate Adjusted Overall and Summary Star Ratings. Unadjusted Overall and Summary Star Ratings are also determined for each contract.

The 2025 measures used in the 2026 CAI adjustment calculations are:

- Breast Cancer Screening (Part C)
- Colorectal Cancer Screening (Part C)
- Annual Flu Vaccine (Part C)
- Monitoring Physical Activity (Part C)
- Osteoporosis Management in Women who had a Fracture (Part C)
- Diabetes Care – Eye Exam (Part C)
- Diabetes Care – Blood Sugar Controlled (Part C)
- Controlling Blood Pressure (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (Part C)
- Medication Reconciliation Post-Discharge (Part C)
- Plan All-Cause Readmissions (Part C)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)
- Transitions of Care (Part C)

- Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (Part C)
- Medication Adherence for Diabetes Medication (Part D)
- Medication Adherence for Hypertension (RAS antagonists) (Part D)
- Medication Adherence for Cholesterol (Statins) (Part D)
- MTM Program Completion Rate for CMR (Part D)
- Statin Use in Patients with Diabetes (SUPD) (Part D)

To determine the value of the CAI, contracts are first divided into an initial set of categories based on the combination of a contract's LIS/DE and disability percentages. For the adjustment for the overall and summary ratings for MA-Only and MA-PD contracts, the initial groups are formed by the ten groups of LIS/DE and quintiles of disability, thus resulting in 50 initial categories. For PDPs, the initial groups are formed using quartiles for both LIS/DE and disability. The mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts in each initial category are determined and examined. The initial categories are collapsed to form final adjustment groups. The CAI values are the mean differences between the Adjusted Overall or Summary Star Rating and the corresponding Unadjusted Star Rating for contracts within each final adjustment group. Separate CAI values are computed for the overall and summary ratings, and the rating-specific CAI value is the same for all contracts that fall within the same final adjustment category.

The categorization of contracts into final adjustment categories for the CAI relies on both the use of a contract's percentages of LIS/DE and disabled beneficiaries. Categories were chosen to enforce monotonicity. Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI. Details regarding the methodology for the Puerto Rico model are provided in Attachment O.

Tables 10 and 11 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the determination of the CAI values for the Overall Rating. For example, if a contract's percentage of LIS/DE beneficiaries is 13.60%, the contract's LIS/DE initial group would be L4. The upper limit for each initial category is only included for the highest categories (L10 and D5), and the upper limit is equal to 100% for both of these categories.

Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating

LIS/DE Initial Group	*Percentage of Contract's Beneficiaries who are LIS/DE*
1	*0.000000 to less than 6.092755*
2	*6.092755 to less than 9.274484*
3	*9.274484 to less than 13.191153*
4	*13.191153 to less than 18.339007*
5	*18.339007 to less than 26.699929*
6	*26.699929 to less than 38.938694*
7	*38.938694 to less than 55.108425*
8	*55.108425 to less than 78.990228*
9	*78.990228 to less than 100.000000*
10	*100.000000*

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

Disability Quintile	*Percentage of Contract's Beneficiaries who are Disabled*
1	*0.000000 to less than 14.248145*
2	*14.248145 to less than 20.849011*
3	*20.849011 to less than 29.981129*
4	*29.981129 to less than 43.027888*
5	*43.027888 to 100.000000*

Table 12 provides the description of each of the final adjustment categories and the associated value of the CAI per category for the overall rating.

Table 12: Final Adjustment Categories and CAI Values for the Overall Rating

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.063262
2	L2-L3 L1-L3 L1-L2	D1 D2 D3	-0.040422
3	L4-L5 L4	D1 D2	-0.017803
4	L6-L8 L5-L6 L3-L5 L1-L3	D1 D2 D3 D4-D5	0.003256
5	L9-L10 L7-L10 L6-L8 L4-L6	D1 D2 D3 D4-D5	0.018790
6	L7	D4	0.045683
7	L8 L7-L8	D4 D5	0.058145
8	L9-L10 L9	D3-D4 D5	0.101257
9	L10	D5	0.145515

Tables 13 and 14 provide the range of the percentages that correspond to the LIS/DE initial groups and disability quintiles for the initial categories for the determination of the CAI values for the Part C summary.

Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 5.954454
2	5.954454 to less than 9.130047
3	9.130047 to less than 12.937535
4	12.937535 to less than 18.051788
5	18.051788 to less than 26.285153
6	26.285153 to less than 38.318544
7	38.318544 to less than 54.171489
8	54.171489 to less than 78.912575
9	78.912575 to less than 100.000000
10	100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.052399
2	14.052399 to less than 20.586681
3	20.586681 to less than 29.918328
4	29.918328 to less than 42.948173
5	42.948173 to 100.000000

Table 15 provides the description of each of the final adjustment categories for the Part C summary and the associated value of the CAI for each final adjustment category.

Table 15: Final Adjustment Categories and CAI Values for the Part C Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.058259
2	L2-L3 L1-L2	D1 D2	-0.036927
3	L4 L3-L4 L1-L3	D1 D2 D3	-0.013699
4	L5-L8 L5-L7 L4-L7 L1-L5	D1 D2 D3 D4-D5	0.004022
5	L6-L7	D4-D5	0.032302
6	L9-L10 L8	D1-D3 D2-D5	0.059788
7	L9-L10 L9	D4 D5	0.080451
8	L10	D5	0.102370

Tables 16 and 17 provide the range of the percentages that correspond to the LIS/DE initial groups and the disability quintiles for the initial categories for the determination of the CAI values for the Part D summary rating for MA-PDs.

Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.444755
2	6.444755 to less than 10.035143
3	10.035143 to less than 14.606291
4	14.606291 to less than 20.303651
5	20.303651 to less than 30.231295
6	30.231295 to less than 42.953664
7	42.953664 to less than 61.465546
8	61.465546 to less than 95.305544
9	95.305544 to less than 100.000000
10	100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.421553
2	14.421553 to less than 21.736420
3	21.736420 to less than 31.819192
4	31.819192 to less than 45.115107
5	45.115107 to 100.000000

Table 18 provides the description of each of the final adjustment categories for the MA-PD Part D summary and the associated values of the CAI for each final adjustment category.

Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.033144
2	L2-L8 L1-L4 L1	D1 D2 D3	-0.014987
3	L5-L8 L2-L8 L1-L3	D2 D3 D4-D5	-0.002688
4	L4-L8 L4-L7	D4 D5	0.046282
5	L9-L10 L8-L9	D1-D4 D5	0.072332
6	L10	D5	0.128476

Tables 19 and 20 provide the range of the percentages that correspond to the LIS/DE and disability quartiles for the initial categories for the determination of the CAI values for the PDP Part D summary. Quartiles are used for both dimensions due to the limited number of PDPs as compared to MA-PD contracts.

Table 19: Categorization of Contract's Members into Quartiles of LIS/DE for the PDP Part D Summary

LIS/DE Quartile	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 1.351684
2	1.351684 to less than 2.907975
3	2.907975 to less than 4.682845
4	4.682845 to 100.000000

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

Disability Quartile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 6.315789
2	6.315789 to less than 8.540366
3	8.540366 to less than 12.638758
4	12.638758 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	-0.227881
2	L3-L4 L1-L2	D1-D3 D3-D4	-0.082454
3	L3-L4	D4	0.025549

Calculation Precision

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

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

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

Rounding Rules for Measure Scores

Measure scores are rounded to the precision indicated next to the label "Data Display" within the detailed description of each measure. Measure scores are rounded using traditional rounding rules. These are standard "round to nearest" rules prior to cut point analysis. To obtain a value with the specified level of precision, the single digit following the level of precision will be rounded. If the digit to be rounded is 0, 1, 2, 3 or 4, the value is rounded down, with no adjustment to the preceding digit. If the digit to be rounded is 5, 6, 7, 8 or 9, the value is rounded up, and a value of one is added to the preceding digit. After rounding, all digits after the specified level of precision are removed. If rounding to a whole number, the digit to be rounded is in the first decimal place. If the digit in the first decimal place is below 5, then after rounding the whole number remains unchanged and fractional parts of the number are deleted. If the digit in the first decimal place is 5 or greater, then the whole number is rounded up by adding a value of 1 and fractional parts of the number are deleted. For example, a measure listed with a Data Display of "Percentage with no decimal point" that has a value of 83.499999 rounds down to 83, while a value of 83.500000 rounds up to 84.

Rounding Rules for Summary and Overall Ratings

The results of the summary and overall calculations are rounded to the nearest half star (i.e., 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0). Table 22 summarizes the rounding rules for converting the Part C and D summary and overall ratings into the publicly reported Star Ratings.

Table 22: Rounding Rules for Summary and Overall Ratings

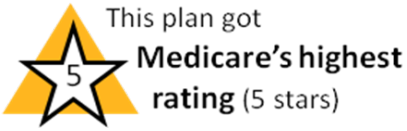
Raw Summary / Overall Score	Final Summary / Overall Rating
Greater than or equal to 0.000000 and less than 0.250000	*0*
Greater than or equal to 0.250000 and less than 0.750000	*0.5*
Greater than or equal to 0.750000 and less than 1.250000	*1.0*
Greater than or equal to 1.250000 and less than 1.750000	*1.5*
Greater than or equal to 1.750000 and less than 2.250000	*2.0*
Greater than or equal to 2.250000 and less than 2.750000	*2.5*
Greater than or equal to 2.750000 and less than 3.250000	*3.0*
Greater than or equal to 3.250000 and less than 3.750000	*3.5*
Greater than or equal to 3.750000 and less than 4.250000	*4.0*
Greater than or equal to 4.250000 and less than 4.750000	*4.5*
Greater than or equal to 4.750000 and less than or equal to 5.000000	*5.0*

For example, a summary or overall rating of 3.749999 rounds down to a rating of 3.5, and a rating of 3.750000 rounds up to rating of 4. That is, a score would need to be at least halfway between 3.5 and 4 (having a minimum value of 3.750000) in order to obtain the higher rating of 4.

Methodology for Calculating the High Performing Icon

A contract may receive a high performing icon as a result of its performance on the Parts C and/or D measures. The high performing icon is assigned to an MA-Only contract for achieving a 5-star Part C summary rating, a PDP contract for a 5-star Part D summary rating, and an MA-PD contract for a 5-star overall rating. Figure 3 shows the high performing icon used in the MPF:

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past two years (i.e., the 2024, 2025, and 2026 Star Ratings). If the contract had any combination of Part C and/or Part D summary ratings of 2.5 or lower in all three years of data, it is marked with a low performing icon (LPI). A contract must have a rating in either Part C and/or Part D for all three years to be considered for this icon.

Figure 4 shows the low performing contract icon used in the MPF:

Figure 4: The Low Performing Icon

Table 23 shows example contracts which would receive an LPI.

Table 23: Example LPI Contracts

Contract/Rating	Rated As	2024 C	2025 C	2026 C	2024 D	2025 D	2026 D	LPI Awarded	LPI Reason
HAAAA	*MA-PD*	*2*	*2.5*	*2.5*	*3*	*3*	*3*	*Yes*	*Part C*
HBBBB	*MA-PD*	*3*	*3*	*3*	*2.5*	*2*	*2.5*	*Yes*	*Part D*
HCCCC	*MA-PD*	*2.5*	*3*	*3*	*3*	*2.5*	*2.5*	*Yes*	*Part C or D*
HDDDD	*MA-PD*	*3*	*2.5*	*3*	*2.5*	*3*	*2.5*	*Yes*	*Part C or D*
HEEEE	*MA-PD*	*2.5*	*2*	*2.5*	*2*	*2.5*	*2.5*	*Yes*	*Part C and D*
HFFFF	*MA-Only*	*2.5*	*2*	*2.5*	*-*	*-*	*-*	*Yes*	*Part C*
SAAAA	*PDP*	*-*	*-*	*-*	*2.5*	*2.5*	*2*	*Yes*	*Part D*

Mergers, Novations, and Consolidations

This section covers how the Star Ratings are affected by mergers, novation and consolidations. To ensure a common understanding, we begin by defining each of the terms.

- Merger: when two (or more) companies join together to become a single business. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to Medicare beneficiaries. After the merger, all of those individual contracts with CMS are still intact, only the ownership changes in each of the contracts to the name of the new single business. Mergers can occur at any time during a contract year.
- Novation: when one company acquires another company. Each of these separate businesses had one or more contracts with CMS for offering health and/or drug services to beneficiaries. After the novation, all of those individual contracts with CMS are still intact. The owner's names of the contracts acquired are changed to the new owner's name. Novations can occur at any time during the contract year.

- Consolidation: when an organization/sponsor that has at least two contracts with CMS for offering health and/or drug services to beneficiaries combines multiple contracts into a single contract with CMS. Consolidations occur only at the change of the contract year. The one or more contracts that will no longer exist at contract year's end are known as the consumed contracts. The contract that will still exist is known as the surviving contract and all of the beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract.

Mergers and novations do not change the ratings earned by an individual contract in any way.

For a merger or novation, the only change is the company listed as owning the contract; there is no change in contract structure, so the Star Ratings earned by the contract remains with them until the next rating cycle. This includes any High Performing or Low Performing icons earned by any of the contracts.

Consolidations become effective the first day of the calendar year. The Star Ratings are released the previous October so they are available when open enrollment begins. In the first year following a consolidation, the measure values used in calculating the Star Ratings of the surviving contract will be based on the enrollment-weighted mean of all contracts in the consolidation (see Attachment B). The surviving contract's ratings are posted publicly, used in determining QBP ratings, and included in the Past Performance Analysis.

Reliability Requirement for Low-enrollment Contracts

HEDIS measures for contracts whose enrollment as of July 2024 was at least 500 but less than 1,000 will be included in the Star Ratings in 2026 when the contract-specific measure score reliability is equal to or greater than 0.7. The reliability calculations are implemented using SAS PROC MIXED as documented on pages 31-32 of the report "The Reliability of Provider Profiling – A Tutorial," available at https://www.rand.org/pubs/technical_reports/TR653.html.

The within-contract variance for the Transitions of Care composite measure utilizes a different formula than other HEDIS pass/fail measures because it is an average of four component measures. First, the binomial variances and standard deviations (i.e., the square root of a variance term), as discussed in the report "The Reliability of Provider Profiling – A Tutorial", are calculated for each of the four component measures. Next, pairwise correlations are computed among the four component measures. Pairwise covariance terms among the four component measures are calculated by multiplying the respective pairwise correlation and two items' standard deviations together. The final within-contract variance for the Transitions of Care composite measure is computed by summing the four variance terms and each pairwise covariance term multiplied by 2.0 and dividing by 16. This assumes that all contracts have the same correlation between pairs of measures.

Special Needs Plan (SNP) Data

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP). Further details on SNP plans can be found in the glossary, Attachment R.

CMS has included three SNP-specific measures in the 2026 Star Ratings. The Part C 'Special Needs Plan Care Management' measure is based on data reported by contracts through the Medicare Part C Reporting Requirements. The two Part C 'Care for Older Adults' measures are based on HEDIS data. The data for all of these measures are reported at the plan benefit package (PBP) level, while the Star Ratings are reported at the contract level.

The methodology used to combine the PBP data to the contract level is different between the two data sources. The Part C Reporting Requirements data are summed into a contract-level rate after excluding PBPs that do not map to any PBP offered by the contract in the calendar year for which the Reporting Requirements data underwent data validation. The HEDIS data are summed into a contract-level rate as long as the contract will be offering a SNP PBP in the Star Ratings year.

The two methodologies used to combine the PBP data within a contract for these measures are described further in Attachment E.

Star Ratings and Marketing

Plan sponsors must ensure the Star Ratings document and all marketing of Star Ratings information is compliant with CMS's Medicare Marketing Guidelines. Failure to follow CMS's guidance may result in compliance action against the contract. The Medicare Marketing Guidelines were issued as Chapters 2 and 3 of the Prescription Drug Benefit Manual and the Medicare Managed Care Manual, respectively. Please direct questions about marketing Star Ratings information to your Account Manager.

Contact Information

The contact below can assist you with various aspects of the Star Ratings.

- Part C & D Star Ratings: PartCandDStarRatings@cms.hhs.gov

If you have questions or require information about the specific subject areas associated with the Star Ratings please write to those contacts directly and cc the Part C & D Star Ratings mailbox.

- CAHPS (MA & Part D): MP-CAHPS@cms.hhs.gov
- Call Center Monitoring: CallCenterMonitoring@cms.hhs.gov
- Compliance Activity Module issues (Part C): PartCCompliance@cms.hhs.gov
- Compliance Activity Module issues (Part D): PartD_Monitoring@cms.hhs.gov
- Disenrollment Reasons Survey: DisenrollSurvey@cms.hhs.gov
- HEDIS: HEDISquestions@cms.hhs.gov
- HOS: HOS@cms.hhs.gov
- HPMS Access issues: HPMS_Access@cms.hhs.gov
- HPMS Help Desk (all other HPMS issues): HPMS@cms.hhs.gov
- Marketing: marketing@cms.hhs.gov
- Part C Compliance Activity issues: PartCCompliance@cms.hhs.gov
- Part D Compliance Activity issues: PartD_Monitoring@cms.hhs.gov
- Plan Reporting and Data Validation (Part C & D): PartsCDPlanReportingandDV@cms.hhs.gov
- QBP Ratings and Appeals questions: QBPAppeals@cms.hhs.gov
- QBP Payment or Risk Analysis questions: riskadjustment@cms.hhs.gov

Framework and Definitions for the Domain and Measure Details Section

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

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

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

Title	Description
Label for Stars:	The label that appears with the stars for this measure on Medicare.gov.
Label for Data:	The label that appears with the numeric data for this measure on HPMS and CMS.gov.
Description:	The English language description shown for the measure on Medicare.gov. The text in this sub-section has been prepared to aid beneficiaries' understanding of the nature and the purpose of the measure. We strongly encourage any public-facing explanation of the measure to use this description.
HEDIS Label:	Optional – contains the full NCQA HEDIS measure name.
Measure Reference:	Optional – this sub-section contains the location of the detailed measure specification in the NCQA documentation for all HEDIS and HEDIS-HOS measures.
Metric:	Defines how the measure is calculated.
Primary Data Source:	The primary source of the data used in the measure.
Data Source Description:	Optional – contains information about additional data sources needed for calculating the measure.
Data Source Category:	The category of this data source.
Exclusions:	Optional – lists any exclusions applied to the data used for the measure.
General Notes:	Optional – contains additional information about the measure and the data used.
Data Time Frame:	The time frame of data used from the data source. In some HEDIS measures this date range may appear to conflict with the specific data time frame defined in the NCQA Technical Specifications. In those cases, the data used by CMS are unchanged from what was submitted to NCQA. CMS uses the data time frame of the overall HEDIS submission which is the HEDIS measurement year.
General Trend:	Indicates whether high values are better or low values are better for the measure.
Statistical Method:	The methodology used for assigning stars in this measure; see the section entitled "Methodology for Assigning Part C and Part D Measure Star Ratings" for an explanation of each of the possible entries in this sub-section.
Improvement Measure:	Indicates whether this measure is included in the improvement measure.
CAI Usage:	Indicates if the measure is used in the Categorical Adjustment Index calculation.
Case-Mix Adjusted:	Indicates if the data are case mix adjusted prior to being used for the Star Ratings.
Weighting Category:	The weighting category of this measure.
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 50-74 who had a mammogram.
HEDIS Label:	Breast Cancer Screening (BCS)
Measure Reference:	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 558
Metric:	The percentage of women MA enrollees 52 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 who died any time during the measurement period. • 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 the criteria for bilateral mastectomy: – Bilateral mastectomy. – Unilateral mastectomy with a bilateral modifier (same procedure). – Unilateral mastectomy found in clinical data with a bilateral qualifier value (same procedure). – 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). – Unilateral mastectomy found in clinical data with a right-side qualifier value (same procedure). – Unilateral mastectomy found in clinical data with a left-side qualifier value procedure (same procedure). – Absence of the left breast. – Absence of the right breast. – Left unilateral mastectomy. – Right unilateral mastectomy. • Medicare members 66 years of age and older by the end of the measurement period 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. • Members 66 years of age and older by the end of the measurement period with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:

  - **Frailty.** At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims.
  - **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period:
    - Advanced illness on at least two different dates of service. Do not include laboratory claims.
    - Dispensed dementia medication.
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Wellness and Prevention

CMIT #: *00093-02-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 58%	Greater than or equal to 58% to less than 71%	Greater than or equal to 71% to less than 76%	Greater than or equal to 76% to less than 84%	Greater than or equal to 84%

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 colorectal cancer.

HEDIS Label: Colorectal Cancer Screening (COL)

Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 578

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:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who died any time during the measurement period.
- Members who had colorectal cancer any time during the member's history through December 31 of the measurement year. Do not include laboratory claims.
- Members who had a total colectomy any time during the member's history through December 31 of the measurement period.
- Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
  - Living long-term in an institution any time during the measurement period.
- Members 66 years of age and older by the end of the measurement period with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:
  - **Frailty.** At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims.
  - **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period:
    - Advanced illness on at least two different dates of service. Do not include laboratory claims.
    - Dispensed dementia medication.
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

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 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Wellness and Prevention

CMIT #: *00139-02-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 48%	Greater than or equal to 48% to less than 60%	Greater than or equal to 60% to less than 70%	Greater than or equal to 70% to less than 78%	Greater than or equal to 78%

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, 2024?

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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2025 – 05/2025

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles Wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Meaningful Measure Area: Wellness and Prevention

CMIT #: *00259-01-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*
less than 57	*Greater than or equal to 57 to less than 61*	*Greater than or equal to 61 to less than 68*	*Greater than or equal to 68 to less than 73*	*Greater than or equal to 73*

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 - Improving or Maintaining Physical Health

Title Description

Label for Stars: Improving or Maintaining Physical Health

Label for Data: Improving or Maintaining Physical Health

Description: Percent of plan members whose physical health was the same or better than expected after two years.

Metric: The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose physical health status was the same or better than expected (numerator).

Primary Data Source: HOS

Data Source Description: 2022-2024 Cohort 25 Performance Measurement Results (2022 Baseline data collection, 2024 Follow-up data collection)

2-year PCS change – Questions: 1, 2a-b, 3a-b & 5

Data Source Category: Survey of Enrollees

Exclusions Contracts with less than 100 responses are suppressed.

Data Time Frame: 07/17/2024 – 11/01/2024

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Outcome Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Patient's Reported Functional Outcomes

CMIT #: Not Applicable.

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 66%	Greater than or equal to 66% to less than 70%	Greater than or equal to 70% to less than 72%	Greater than or equal to 72% to less than 75%	Greater than or equal to 75%

Measure: C05 - Improving or Maintaining Mental Health

Title Description

Label for Stars: Improving or Maintaining Mental Health

Label for Data: Improving or Maintaining Mental Health

Description: Percent of plan members whose mental health was the same or better than expected after two years.

Metric: The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose mental health status was the same or better than expected (numerator).

Primary Data Source: HOS

Data Source Description: 2022-2024 Cohort 25 Performance Measurement Results (2022 Baseline data collection, 2024 Follow-up data collection)

2-year MCS change – Questions: 4a-b, 6a-c, & 7.

Data Source Category: Survey of Enrollees

Exclusions: Contracts with less than 100 responses are suppressed.

Data Time Frame: 07/17/2024 – 11/01/2024

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Outcome Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

CMIT #: Not Applicable.

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 81%	Greater than or equal to 81% to less than 83%	Greater than or equal to 83% to less than 85%	Greater than or equal to 85% to less than 88%	Greater than or equal to 88%

Measure: C06 - 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 2023 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 25 Follow-up Data collection (2024) and Cohort 27 Baseline data collection (2024).

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: 07/17/2024 – 11/01/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2023 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***
	Less than 41%	*Greater than or equal to 41% to less than 47%*	*Greater than or equal to 47% to less than 53%*	*Greater than or equal to 53% to less than 59%*	*Greater than or equal to 59%*

Domain: 2 - Managing Chronic (Long Term) Conditions

Measure: C07 - 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) plus Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)] divided by [Number of new enrollees due for an Initial HRA (Element A) plus Number of enrollees eligible for an annual reassessment HRA (Element B)]
Primary Data Source:	Part C Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2024 Part C Reporting Requirements (data pulled June 2025). Validation of these data was performed retrospectively during the 2025 data validation cycle (deadline June 15, 2025 and data validation results pulled July 2025).
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, 2025) 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) • Number of annual reassessments performed on enrollees eligible for reassessment (Element F)

General Notes:

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) plus Number of enrollees eligible for an annual HRA (Element B) greater than or equal to 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available." 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: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: *00685-01-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 42%	Greater than or equal to 42% to less than 60%	Greater than or equal to 60% to less than 73%	Greater than or equal to 73% to less than 88%	Greater than or equal to 88%

Measure: C08 - 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 medications, OTC medications, herbal or supplemental remedies) 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 2024 Technical Specifications Volume 2, page 101
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 2024 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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.
Meaningful Measure Area:	Seamless Care Coordination
CMIT #:	*00110-01-C-PARTC*
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 58%	Greater than or equal to 58% to less than 85%	Greater than or equal to 85% to less than 93%	Greater than or equal to 93% to less than 98%	Greater than or equal to 98%

Measure: C09 - 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 2024 Technical Specifications Volume 2, page 101
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 2024 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. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: *00111-01-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 65%	Greater than or equal to 65% to less than 86%	Greater than or equal to 86% to less than 95%	Greater than or equal to 95% to less than 99%	Greater than or equal to 99%

Measure: C10 - 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 2024 Technical Specifications Volume 2, page 208

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.
- 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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 32%	Greater than or equal to 32% to less than 41%	Greater than or equal to 41% to less than 53%	Greater than or equal to 53% to less than 68%	Greater than or equal to 68%

Measure: C11 - 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 2024 Technical Specifications Volume 2, page 179

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.
  - Members who died any time during the measurement year.
  - Members receiving palliative care any time during the measurement year.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: *00203-02-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 60%	Greater than or equal to 60% to less than 72%	Greater than or equal to 72% to less than 80%	Greater than or equal to 80% to less than 86%	Greater than or equal to 86%

Measure: C12 - 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: Glycemic Status Assessment for Patients With Diabetes (GSD) – HbA1c poor control (greater than 9.0%)

Measure Reference: NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 162

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.
  - 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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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 #: *00204-02-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 54%	Greater than or equal to 54% to less than 77%	Greater than or equal to 77% to less than 87%	Greater than or equal to 87% to less than 91%	Greater than or equal to 91%

Measure: C13 - Kidney Health Evaluation for Patients with Diabetes

Title	Description
Label for Stars:	Kidney Health Evaluation for Patients with Diabetes
Label for Data:	Kidney Health Evaluation for Patients with Diabetes
Description:	Percent of plan members with diabetes who received a kidney health evaluation during the year.
HEDIS Label:	Kidney Health Evaluation for Patients with Diabetes (KED)
Measure Reference:	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 189
Metric:	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Required exclusions for 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 with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of 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. Exclude members who meet any of the following criteria: • 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 66-80 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. Visit type need not be the same for the two visits. • 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. • A dispensed 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 measurement year.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: *00204-02-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 34%	Greater than or equal to 34% to less than 51%	Greater than or equal to 51% to less than 62%	Greater than or equal to 62% to less than 74%	Greater than or equal to 74%

Measure: C14 - 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 Measurement Year 2024 Technical Specifications Volume 2, page 132

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 (less than 140/90 mm Hg) (numerator).

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: (Required) Exclude members who meet any of the following criteria:

- Members in hospice or using hospice services any time during the measurement period.
- Members who die any time during the measurement period.
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims.
- Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims.
- Members with a diagnosis of pregnancy any time during the measurement year. Do not include laboratory claims
- Members 66 years of age and older by the end of the measurement period 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.
- 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:
  - **Frailty.** At least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims.
  - **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period:
    - Advanced illness on at least two different dates of service. Do not include laboratory claims.
    - Dispensed 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 measurement year. Do not include laboratory claims.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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 Outcomes 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 #: *00167-02-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 67%	Greater than or equal to 67% to less than 75%	Greater than or equal to 75% to less than 80%	Greater than or equal to 80% to less than 86%	Greater than or equal to 86%

Measure: C15 - 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 2023 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 25 Follow-up Data collection (2024) and Cohort 27 Baseline data collection (2024).

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: 07/17/2024 – 11/01/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2023 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
Less than 51%	Greater than or equal to 51% to less than 57%	Greater than or equal to 57% to less than 62%	Greater than or equal to 62% to less than 71%	Greater than or equal to 71%

Measure: C16 - 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 2023 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 25 Follow-up Data collection (2024) and Cohort 27 Baseline data collection (2024).

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 equals "Yes."
- Q41 equals "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 equals "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: 07/17/2024 – 11/01/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2023 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: *00378-01-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 41%	Greater than or equal to 41% to less than 45%	Greater than or equal to 45% to less than 49%	Greater than or equal to 49% to less than 53%	Greater than or equal to 53%

Measure: C17 - 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 2024 Technical Specifications Volume 2, page 294

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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 40%	Greater than or equal to 40% to less than 60%	Greater than or equal to 60% to less than 74%	Greater than or equal to 74% to less than 87%	Greater than or equal to 87%

Measure: C18 - 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 2024 Technical Specifications Volume 2, page 448
Metric:	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older using the following formula to control for differences in the case mix of patients across different contracts. For contract A, their case-mix adjusted readmission rate relative to the national average is the observed readmission rate for contract A divided by the expected readmission rate for contract A. This ratio is then multiplied by the national average observed rate. See Attachment F: Calculating Measure C18: 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 2024 enrollment report and having measure score reliability less than 0.7 are excluded. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2. Contracts whose enrollment was less than 500 as of the July 2024 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:	01/01/2024 – 12/31/2024
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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.

Meaningful Measure Area: Admissions and Readmissions to Hospitals

CMIT #: 00561-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Greater than 12%	Greater than 10% to less than or equal to 12%	Greater than 9% to less than or equal to 10%	Greater than 7% to less than or equal to 9%	Less than or equal to 7%

Measure: C19 - 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 2024 Technical Specifications Volume 2, page 148

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.
  - 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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: *00700-01-C-PARTC*

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 81%	Greater than or equal to 81% to less than 85%	Greater than or equal to 85% to less than 88%	Greater than or equal to 88% to less than 91%	Greater than or equal to 91%

Measure: C20 - 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 2024 Technical Specifications Volume 2, page 294

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.

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

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 44%	Greater than or equal to 44% to less than 56%	Greater than or equal to 56% to less than 69%	Greater than or equal to 69% to less than 79%	Greater than or equal to 79%

Measure: C21 - 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 2024 Technical Specifications Volume 2, page 304

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.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2024 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2024 enrollment report are excluded from this measure.

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: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Less than 50%	Greater than or equal to 50% to less than 59%	Greater than or equal to 59% to less than 67%	Greater than or equal to 67% to less than 78%	Greater than or equal to 78%

Domain: 3 - Member Experience with Health Plan

Measure: C22 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	*00293-02-C-PARTC*
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*

Less than 78	Greater than or equal to 78 to less than 80	Greater than or equal to 80 to less than 82	Greater than or equal to 82 to less than 84	Greater than or equal to 84

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 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00292-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

1876 Cost	*CCP w/o SNP*	*CCP with SNP*	*CCP with Only I-SNP*	*MSA*	*PDP*	*PFFS*

Yes	*Yes*	*Yes*	*No*	*Yes*	*No*	*Yes*

Base Group Cut Points:

Base Group 1	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*
Less than 80	*Greater than or equal to 80 to less than 82*	*Greater than or equal to 82 to less than 84*	*Greater than or equal to 84 to less than 86*	*Greater than or equal to 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: C24 - Customer Service

Title	Description
Label for Stars:	Health Plan Provides Information or Help When Members Need It
Label for Data:	Health Plan Provides Information or Help When Members Need It (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Metric:	This case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Primary Data Source:	CAHPS
Data Source Description:	CAHPS Survey Questions (question numbers vary depending on survey type): • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms from your health plan easy to fill out?
Data Source Category:	Survey of Enrollees
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00181-01-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 88	Greater than or equal to 88 to less than 89	Greater than or equal to 89 to less than 91	Greater than or equal to 91 to less than 92	Greater than or equal to 92

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

Measure: C25 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2025 – 05/2025

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00642-01-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*
Less than 84	*Greater than or equal to 84 to less than 86*	*Greater than or equal to 86 to less than 87*	*Greater than or equal to 87 to less than 88*	*Greater than or equal to 88*

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

Measure: C26 - 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2025 – 05/2025

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Person-Centered Care

CMIT #: 00643-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*
Less than 84	*Greater than or equal to 84 to 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*

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: C27 - 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?
- 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2025 – 05/2025

General Trend: Higher is better

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00106-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*
Less than 85	*Greater than or equal to 85 to less than 86*	*Greater than or equal to 86 to less than 88*	*Greater than or equal to 88 to less than 89*	*Greater than or equal to 89*

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

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

Measure: C28 - 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 equals 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 2024 complaints made by the May 30, 2025 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 January 6, 2025, 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:	01/01/2024 – 12/31/2024
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included

Case-Mix Adjusted: No

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Greater than 1.34	Greater than 0.71 to less than or equal to 1.34	Greater than 0.32 to less than or equal to 0.71	Greater than 0.11 to less than or equal to 0.32	Less than or equal to 0.11

Measure: C29 - 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, 2024–December 31, 2024 (numerator) divided by all members enrolled in the contract at any time during 2024 (denominator).

Primary Data Source: MBDSS

Data Source Description: Medicare Beneficiary Database Suite of Systems (MBDSS)

Data Source Category: CMS Administrative Data

Exclusions: Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically:

- Members affected by a contract service area reduction
- Members affected by PBP termination
- Members in PBPs that were granted special enrollment exceptions
- Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into
- Members affected by LIS reassignments
- Members who are enrolled in employer group plans
- Members who were passively enrolled into a Demonstration (MMP)
- Contracts with less than 1,000 enrollees
  1876 Cost contract disenrollments into the transition MA contract (H contract)
- Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address

submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
- Members that enrolled into an Applicable Integrated Plan where the contract the member disenrolled from is not an Applicable Integrated Plan. D-SNPs in Florida are not included in this exclusion.

General Notes: This measure includes members with a disenrollment effective date between 1/1/2024 and 12/31/2024 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: 01/01/2024 – 12/31/2024

General Trend: Lower is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Patients’ Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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
Greater than 39%	Greater than 28% to less than or equal to 39%	Greater than 17% to less than or equal to 28%	Greater than 8% to less than or equal to 17%	Less than or equal to 8%

Measure: C30 - 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 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 #: 00300-01-C-PARTC

Data Display: Not Applicable

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than -0.121368	Greater than or equal to -0.121368 to less than 0	Greater than or equal to 0 to less than 0.202884	Greater than or equal to 0.202884 to less than 0.391253	Greater than or equal to 0.391253

Domain: 5 - Health Plan Customer Service

Measure: C31 - 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 less than or equal to 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: "Upheld" was updated to "Unfavorable" "Overturn" was updated to 'Favorable" "Partially Overturn" was updated to "Partially favorable"
Data Time Frame:	01/01/2024 – 12/31/2024
General Trend:	Higher is better
Statistical Method:	Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 2

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

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00562-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 74%	Greater than or equal to 74% to less than 90%	Greater than or equal to 90% to less than 99%	Greater than or equal to 99% to less than 100%	Greater than or equal to 100%

Measure: C32 - Reviewing Appeals Decisions

Title Description

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

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

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

Metric: Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as:

([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, 2025, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2025 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 plus overturned plus partially overturned) is less than or equal to 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: 01/01/2024 – 12/31/2024

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 2

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

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00652-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 83%	Greater than or equal to 83% to less than 96%	Greater than or equal to 96% to less than 98%	Greater than or equal to 98% to less than 100%	Greater than or equal to 100%

Measure: C33 - 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: 02/2025 – 05/2025

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Measures Capturing Access

Weighting Value: 2

Major Disaster: No adjustment for 2023 or 2024 disasters.

Meaningful Measure Area: Person-centered Care

CMIT #: 00096-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 51%	Greater than or equal to 51% to less than 74%	Greater than or equal to 74% to less than 97%	Greater than or equal to 97% to less than 100%	Greater than or equal to 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:	02/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access
Weighting Value:	2
Major Disaster:	No adjustment for 2023 or 2024 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 45%	Greater than or equal to 45% to less than 79%	Greater than or equal to 79% to less than 95%	Greater than or equal to 95% to less than 100%	Greater than or equal to 100%
PDP	Less than 75%	Greater than or equal to 75% to less than 90%	Greater than or equal to 90% to less than 98%	Greater than or equal to 98% to less than 100%	Greater than or equal to 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 equals 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 2024 complaints made by the May 30, 2025 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 January 6, 2025, 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:	01/01/2024 – 12/31/2024
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Greater than 1.34	Greater than 0.71 to less than or equal to 1.34	Greater than 0.32 to less than or equal to 0.71	Greater than 0.11 to less than or equal to 0.32	Less than or equal to 0.11
PDP	Greater than 0.31	Greater than 0.19 to less than or equal to 0.31	Greater than 0.1 to less than or equal to 0.19	Greater than 0.03 to less than or equal to 0.1	Less than or equal to 0.03

Measure: D03 - Members Choosing to Leave the Plan

Title Description

Label for Stars: Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan)

Label for Data: Members Choosing to Leave the Plan (lower percentages are better because that indicates fewer members choose to leave the plan)

Description: Percent of plan members who chose to leave the plan.

Metric: The percent of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percent is calculated as the number of members who chose to leave the contract between January 1, 2024–December 31, 2024 (numerator) divided by all members enrolled in the contract at any time during 2024 (denominator).

Primary Data Source: MBDSS

Data Source Description: Medicare Beneficiary Database Suite of Systems (MBDSS)

Data Source Category: CMS Administrative Data

Exclusions:

- Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically:
- Members affected by a contract service area reduction
- Members affected by PBP termination
- Members in PBPs that were granted special enrollment exceptions
- Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into
- Members affected by LIS reassignments
- Members who are enrolled in employer group plans
- Members who were passively enrolled into a Demonstration (MMP)
- Contracts with less than 1,000 enrollees
- 1876 Cost contract disenrollments into the transition MA contract (H contract)

- Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled.
- Members that enrolled into an Applicable Integrated Plan where the contract the member disenrolled from is not an Applicable Integrated Plan. D-SNPs in Florida are not included in this exclusion.

General Notes: This measure includes members with a disenrollment effective date between 1/1/2024 and 12/31/2024 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: 01/01/2024 – 12/31/2024

General Trend: Lower is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

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

Meaningful Measure Area: Person-Centered Care

CMIT #: 00446-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Greater than 39%	Greater than 28% to less than or equal to 39%	Greater than 17% to less than or equal to 28%	Greater than 8% to less than or equal to 17%	Less than or equal to 8%
PDP	Greater than 17%	Greater than 11% to less than or equal to 17%	Greater than 5% to less than or equal to 11%	Greater than 3% to less than or equal to 5%	Less than or equal to 3%

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

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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00641-01-C-PARTD
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Type	*Base Group 1*	*Base Group 2*	*Base Group 3*	*Base Group 4*	*Base Group 5*
MA-PD	*less than 85*	*Greater than or equal to 85 to less than 86*	*Greater than or equal to 86 to less than 88*	*Greater than or equal to 88 to less than 89*	*Greater than or equal to 89*

PDP	*less than 82*	*Greater than or equal to 82 to less than 83*	*Greater than or equal to 83 to less than 86*	*Greater than or equal to 86 to less than 88*	*Greater than or equal to 88*

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

Measure: 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 2025. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.
Data Time Frame:	03/2025 – 05/2025
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters and 2025 Los Angeles wildfires. 2025 measure star for contracts exempt from survey fielding because of 2025 Los Angeles Wildfires.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00294-01-C-PARTD

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Type	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
MA-PD	less than 87	Greater than or equal to 87 to 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
PDP	less than 88	Greater than or equal to 88 to less than 89	Greater than or equal to 89 to less than 90	Greater than or equal to 90 to less than 91	Greater than or equal to 91

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

Domain: 4 - Drug Safety and Accuracy of Drug Pricing

Measure: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder (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—that is, the reported price is higher than the actual price—will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than MPF plus Total PDE cost) divided by (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than MPF) divided by (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 PDE data and MPF Pricing Files. Reference data sources include HPMS approved formulary extracts, Formulary Reference File, RxNorm, FDA NSDE data, and data from First DataBank and Medi-span. The PDE data for this measure are from the data submitted by drug plans to CMS Drug Data Processing Systems (DDPS) and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2024- September 30, 2024. If the PDE edit results in the PDE being rejected by DDPS, then the PDE is not used in the MPF 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 MPF 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 adjustments made post-reconciliation were not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors

Exclusions: A contract with less than 30 PDE claims over the measurement period will not have the measure calculated. 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
- The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

General Notes: Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.

Data Time Frame: 01/01/2024 – 09/30/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 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	Less than 92	Greater than or equal to 92 to less than 93	Greater than or equal to 93 to less than 94	Greater than or equal to 94 to less than 99	Greater than or equal to 99
PDP	Less than 92	Greater than or equal to 92 to less than 93	Greater than or equal to 93 to less than 94	Greater than or equal to 94 to less than 99	Greater than or equal to 99

Measure: D08 - Medication Adherence for Diabetes Medications

Title	Description
Label for Stars:	Taking Diabetes Medication
Label for Data:	Taking Diabetes Medication
Description:	The percentage 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 taking the medication. One of the most important ways people with diabetes can manage their health is by taking their medication. 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 *dipeptidyl peptidase 4 (DPP-4) inhibitor,* a glucose-dependent insulinotropic *polypeptide/glucagon-like peptide 1 (GIP/GLP-1) receptor agonist*, a *meglitinide drug,* or a *sodium glucose cotransporter 2* (*SGLT2) inhibitor*.)
Metric:	This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, DPP-4 inhibitors, GIP/GLP-1 receptor agonists, meglitinides, and SGLT2 inhibitors. 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 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 Medicare Part D beneficiaries, 18 years and older, with a PDC of 80 percent or higher across the classes of diabetes medications during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two fills of diabetes medication(s) 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 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 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 diabetes medication(s). PDE adjustments made post-reconciliation were not reflected in this measure.

Additional data sources include the Common Medicare Environment (CME), the Common Working File (CWF), and the Encounter Data Systems (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 (IP) and skilled nursing facility (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 insulin in 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 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 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 #: 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.

This percentage is calculated as the number of continuously enrolled beneficiaries, 18 years and older, with a PDC of 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 18 years and older, with at least two statin cholesterol 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 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 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 statin medication. PDE adjustments made post-reconciliation were not reflected in this measure.

Additional data sources include the CME, 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 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, IP 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:

- 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.

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 #: 00435-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 84%	Greater than or equal to 84% to less than 88%	Greater than or equal to 88% to less than 90%	Greater than or equal to 90% to less than 93%	Greater than or equal to 93%
PDP	Less than 87%	Greater than or equal to 87% to less than 89%	Greater than or equal to 89% to less than 90%	Greater than or equal to 90% to less than 92%	Greater than or equal to 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.

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 equals Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period.

Denominator equals 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 2024 Part D Reporting Requirements (data pulled June 2025). Validation of these data was performed retrospectively during the 2025 data validation cycle (deadline June 15, 2025 and data validation results pulled July 2025). Additionally, the Common Medicare Environment (CME) is used to identify beneficiaries in hospice (data pulled June 2025).

Data Source Category: Health and Drug Plans

Exclusions: Contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2025) 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: 01/01/2024 – 12/31/2024

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 (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00454-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 62%	Greater than or equal to 62% to less than 82%	Greater than or equal to 82% to less than 91%	Greater than or equal to 91% to less than 96%	Greater than or equal to 96%
PDP	Less than 2%	Greater than or equal to 27% to less than 51%	Greater than or equal to 51% to less than 70%	Greater than or equal to 70% to less than 83%	Greater than or equal to 83%

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 percentage 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 index prescription start date (IPSD) is the earliest date of service for a diabetes medication during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month. Beneficiaries are only included in the measure calculation if the IPSD occurs at least 90 days before the end of the measurement period. The percentage is calculated as the number of continuously enrolled beneficiaries, 40-75 years old, who received a statin medication fill during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 40-75 years old, with at least two diabetes medication fills on unique dates of service during the measurement period and an IPSD that occurs at least 90 days prior to the end of the measurement period (denominator). 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.
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 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 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.
- EDS is used to identify exclusion diagnoses based on ICD-10-CM codes.

Data Source Category: Health and Drug Plans

Exclusions: Contracts with 30 or fewer continuously enrolled beneficiaries (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.

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: Process Measure

Weighting Value: 1

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

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 81%	Greater than or equal to 81% to less than 85%	Greater than or equal to 85% to less than 89%	Greater than or equal to 89% to less than 93%	Greater than or equal to 93%
PDP	Less than 82%	Greater than or equal to 82% to less than 83%	Greater than or equal to 83% to less than 84%	Greater than or equal to 84% to less than 86%	Greater than or equal to 86%

Attachment A: CAHPS and HOS Case-Mix Adjustment

CAHPS Case-Mix Adjustment

The CAHPS measures are case-mix adjusted to take into account the mix of enrollees. Case-mix variables include administrative age, dual eligibility status, low-income subsidy (LIS) indicator, and use of Asian language survey, and self-reported education, general health status, mental health status, and proxy usage status. The tables below include the case-mix variables and show the case-mix coefficients for each of the CAHPS measures included in the Star Ratings. The coefficients indicate how much higher or lower people with a given characteristic tend to respond compared to otherwise similar people with the baseline value for that characteristic (e.g., reference group), on the original scale of the item or composite, as presented in plan reports. The reference group for each characteristic will have a coefficient value of zero.

For example, for the Part C measure "Rating of Health Plan," the model coefficient for "age 75-79" is 0.0587, indicating that respondents in that age range tend to score their plans 0.0587 points higher than otherwise similar people in the 70-74 age range (the baseline or reference category). Similarly, respondents who had a proxy help aside from answering for them tend to respond 0.0834 points lower on this item than otherwise similar respondents without proxy help. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who had proxy help will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

The composites consist of multiple items, each of which is adjusted separately before combining the adjusted scores into a composite score. Item-level coefficients are presented below separately for each composite. For more detailed information on the application of CAHPS case-mix adjustment, please review the materials at https://ma-pdpcahps.org/en/scoring-and-star-ratings/.

Table A-1: Coefficients of Part C Getting Needed Care (C22) CAHPS Measure Composite Items

Predictor	Get appointment with specialist	Easy to get care
Age: 64 or under	0.0553	-0.0093
Age: 65 – 69	0.0148	-0.0206
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0042	0.0130
Age: 80 – 84	0.0173	0.0069
Age: 85 and older	0.0220	-0.0217
Education: Less than an 8th grade education	0.0105	-0.0030
Education: Some high school	0.0035	-0.0106
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.0532	-0.0593
Education: College graduate	-0.0824	-0.0731
Education: More than a bachelor's degree	-0.1388	-0.0994
General health rating: excellent	0.0992	0.0707
General health rating: very good	0.0522	0.0516
General health rating: good	0.0000	0.0000
General health rating: fair	-0.0523	-0.0404
General health rating: poor	-0.0921	-0.1499
Mental health rating: excellent	0.1935	0.1776
Mental health rating: very good	0.1088	0.1000
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.0580	-0.0327
Mental health rating: poor	-0.1554	-0.1819
Proxy helped	-0.0169	-0.0204
Proxy answered	0.0657	0.0714
Medicaid dual eligible	0.0187	0.0248
Low-income subsidy (LIS)	-0.0255	0.0218
Asian survey language	-0.2197	-0.1702

Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C23) CAHPS Measure Composite Items

Predictor	*Getting Needed Care as Soon as Wanted*	*Getting Routine Care as Soon as Wanted*
Age: 64 or under	*-0.0353*	*0.0789*
Age: 65 – 69	*0.0000**	*0.0069*
Age: 70 – 74	*0.0000*	*0.0000*
Age: 75 – 79	*0.0424*	*0.0321*
Age: 80 – 84	*0.0501*	*0.0289*
Age: 85 and older	*0.0484*	*0.0423*
Education: Less than an 8th grade education	*0.0213*	*0.0077*
Education: Some high school	*-0.0458*	*0.0090*
Education: High school graduate	*0.0000*	*0.0000*
Education: Some college	*-0.0328*	*-0.0209*
Education: College graduate	*-0.0203*	*-0.0608*
Education: More than a bachelor's degree	*-0.0578*	*-0.0799*
General health rating: excellent	*0.0769*	*0.0368*
General health rating: very good	*0.0272*	*0.0231*
General health rating: good	*0.0000*	*0.0000*
General health rating: fair	*-0.0483*	*-0.0473*
General health rating: poor	*-0.1042*	*-0.1019*
Mental health rating: excellent	*0.1265*	*0.1558*
Mental health rating: very good	*0.0775*	*0.0842*
Mental health rating: good	*0.0000*	*0.0000*
Mental health rating: fair	*-0.0258*	*-0.0275*
Mental health rating: poor	*-0.1424*	*-0.1504*
Proxy helped	*-0.0078*	*0.0023*
Proxy answered	*0.0900*	*0.0482*
Medicaid dual eligible	*0.0162*	*-0.0066*
Low-income subsidy (LIS)	*0.0187*	*-0.0575*
Asian survey language	*-0.2559*	*-0.3890*

**Coefficient value is not exactly equal to 0 but has been rounded to the same level of precision as other values in the table (4 decimal places).*

Table A-3: Coefficients of Part C Customer Service (C24) CAHPS Measure Composite Items

Predictor	Paperwork Easy	Plan Customer Service Gives Information	Plan Customer Service Courtesy and Respect
Age: 64 or under	0.0127	-0.0033	-0.0251
Age: 65 – 69	0.0095	-0.0131	-0.0003
Age: 70 – 74	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0005	0.0023	0.0038
Age: 80 – 84	-0.0187	-0.0118	-0.0052
Age: 85 and older	-0.0018	-0.0025	0.0027
Education: Less than an 8th grade education	-0.0333	-0.0104	-0.0145
Education: Some high school	-0.0091	-0.0327	-0.0255
Education: High school graduate	0.0000	0.0000	0.0000
Education: Some college	-0.0155	-0.0798	-0.0038
Education: College graduate	-0.0185	-0.1291	-0.0289
Education: More than a bachelor's degree	-0.0268	-0.1617	-0.0469
General health rating: excellent	0.0196	0.0640	-0.0201
General health rating: very good	0.0110	0.0174	-0.0230
General health rating: good	0.0000	0.0000	0.0000
General health rating: fair	-0.0309	-0.0238	0.0035
General health rating: poor	-0.0471	-0.0541	-0.0009
Mental health rating: excellent	0.0593	0.2098	0.1334
Mental health rating: very good	0.0242	0.0958	0.0626
Mental health rating: good	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0280	-0.0281	0.0025
Mental health rating: poor	-0.0702	-0.0595	-0.0394
Proxy helped	-0.0776	-0.0364	-0.0280
Proxy answered	-0.0377	-0.0034	0.0036
Medicaid dual eligible	-0.0386	0.0691	0.0196
Low-income subsidy (LIS)	0.0016	0.0682	0.0241
Asian survey language	-0.0782	-0.0731	-0.1389

Table A-4: Coefficients of Part C Stand-alone CAHPS Measures

Predictor	C25: Rating of Health Care Quality	C26: Rating of Health Plan
Age: 64 or under	-0.1032	-0.1580
Age: 65 – 69	-0.0801	-0.1132
Age: 70 – 74	0.0000	0.0000
Age: 75 – 79	0.0193	0.0587
Age: 80 – 84	-0.0412	0.0944
Age: 85 and older	-0.0859	0.0963
Education: Less than an 8th grade education	0.0757	0.1584
Education: Some high school	0.0011	0.0880
Education: High school graduate	0.0000	0.0000
Education: Some college	-0.1540	-0.2041
Education: College graduate	-0.1877	-0.3112
More than a bachelor's degree	-0.2290	-0.4332
General health rating: excellent	0.2996	0.2638
General health rating: very good	0.1828	0.1117
General health rating: good	0.0000	0.0000
General health rating: fair	-0.2072	-0.1343
General health rating: poor	-0.5387	-0.2751
Mental health rating: excellent	0.4685	0.3981
Mental health rating: very good	0.2364	0.2183
Mental health rating: good	0.0000	0.0000
Mental health rating: fair	-0.1913	-0.1087
Mental health rating: poor	-0.6445	-0.4070
Proxy helped	-0.0760	-0.0834
Proxy answered	0.0604	-0.0305
Medicaid dual eligible	0.0480	0.2888
Low-income subsidy (LIS)	0.0946	0.1077
Asian survey language	0.1792	-0.0634

Table A-5: Coefficients of Part C Care Coordination (C27) CAHPS Measure Composite Items

Predictor	MD/office Help to Manage Care	MD Informed About Specialist Care	MD Follows Up about Test Results and Gives Results as Soon as Needed	Talk with MD about Medicines	MD has Medical Records about Care
Age: 64 or under	-0.0060	-0.0006	0.0368	0.0601	-0.0206
Age: 65 – 69	0.0007	0.0097	0.0084	0.0194	-0.0063
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	-0.0147	0.0173	0.0088	-0.0347	0.0078
Age: 80 – 84	-0.0189	-0.0177	0.0007	-0.1064	-0.0086
Age: 85 and older	-0.0617	-0.0354	-0.0329	-0.1945	-0.0172
Education: Less than an 8th grade education	-0.0026	0.0565	-0.0190	0.0460	-0.0412
Education: Some high school	-0.0118	0.0426	-0.0278	-0.0096	-0.0073
Education: High school graduate	0.0000	0.0000	0.0000	0.0000	0.0000
Education: Some college	-0.0118	-0.0308	-0.0305	-0.0170	-0.0074
Education: College graduate	-0.0270	-0.1055	-0.0269	-0.0431	-0.0112
Education: More than a bachelor's degree	-0.0144	-0.1091	-0.0291	-0.0862	-0.0182
General health rating: excellent	0.0394	-0.0051	0.0835	0.0701	0.0204
General health rating: very good	0.0160	0.0050	0.0390	0.0454	0.0118
General health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0440	-0.0220	-0.0420	-0.0499	-0.0212
General health rating: poor	-0.0413	-0.0131	-0.0768	-0.0467	-0.0288
Mental health rating: excellent	0.0405	0.1835	0.1342	0.1571	0.0792
Mental health rating: very good	0.0204	0.1034	0.0655	0.0829	0.0458
Mental health rating: good	0.0000	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0628	-0.0816	-0.0576	-0.0557	-0.0340
Mental health rating: poor	-0.0819	-0.1318	-0.1352	-0.1671	-0.0694
Proxy helped	0.0150	0.0054	-0.0001	0.1036	-0.0095
Proxy answered	0.0609	0.0163	0.0515	0.1231	0.0289
Medicaid dual eligible	0.0008	0.0762	-0.0305	-0.0050	-0.0262
Low-income subsidy (LIS)	-0.0263	0.0829	-0.0098	-0.0289	-0.0059
Asian survey language	-0.0003	0.0179	0.0283	-0.1419	-0.0562

Table A-6: Coefficients of Part D CAHPS Stand-alone Measures

Predictor	*MA-PD D05: Rating of Drug Plan*	*PDP D05: Rating of Drug Plan*
Age: 64 or under	*-0.2293*	*0.1212*
Age: 65 – 69	*-0.1267*	*-0.1495*
Age: 70 – 74	*0.0000*	*0.0000*
Age: 75 – 79	*0.1239*	*0.2770*
Age: 80 – 84	*0.1774*	*0.3368*
Age: 85 and older	*0.1841*	*0.4200*
Education: Less than an 8th grade education	*0.0427*	*-0.4582*
Education: Some high school	*0.0676*	*-0.1973*
Education: High school graduate	*0.0000*	*0.0000*
Education: Some college	*-0.2061*	*-0.3762*
Education: College graduate	*-0.3163*	*-0.1688*
Education: More than a bachelor's degree	*-0.4047*	*-0.3632*
General health rating: excellent	*0.2444*	*0.2813*
General health rating: very good	*0.1309*	*0.1928*
General health rating: good	*0.0000*	*0.0000*
General health rating: fair	*-0.1548*	*-0.2680*
General health rating: poor	*-0.3410*	*-0.4054*
Mental health rating: excellent	*0.3163*	*0.0942*
Mental health rating: very good	*0.1850*	*0.0652*
Mental health rating: good	*0.0000*	*0.0000*
Mental health rating: fair	*-0.0448*	*-0.1058*
Mental health rating: poor	*-0.3079*	*-0.9739*
Proxy helped	*-0.1482*	*0.0627*
Proxy answered	*-0.0450*	*0.4117*
Medicaid dual eligible	*0.5175*	*0.6521*
Low-income subsidy (LIS)	*0.3586*	*0.4538*
Asian survey language	*-0.2289*	*0.0000*

Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items

Predictor	MA-PD: Get Needed Prescription Drugs	MA-PD: Get Prescription Drugs from Mail or Pharmacy	PDP: Get Needed Prescription Drugs	PDP: Get Prescription Drugs from Mail or Pharmacy
Age: 64 or under	-0.0756	-0.0426	0.0628	0.0323
Age: 65 – 69	-0.0275	-0.0203	0.0458	0.0029
Age: 70 – 74	0.0000	0.0000	0.0000	0.0000
Age: 75 – 79	0.0216	0.0195	0.0415	0.0175
Age: 80 – 84	0.0237	0.0081	0.0605	0.0538
Age: 85 and older	0.0157	0.0189	0.0349	-0.0014
Education: Less than an 8th grade education	-0.0536	-0.0498	-0.2152	-0.1192
Education: Some high school	-0.0095	-0.0002	-0.0627	-0.0968
Education: High school graduate	0.0000	0.0000	0.0000	0.0000
Education: Some college	-0.0458	-0.0337	-0.0803	-0.0751
Education: College graduate	-0.0405	-0.0499	-0.0902	-0.0546
Education: More than a bachelor's degree	-0.0702	-0.0836	-0.1130	-0.0956
General health rating: excellent	0.0523	0.0895	0.0971	0.0292
General health rating: very good	0.0475	0.0316	0.0819	0.0820
General health rating: good	0.0000	0.0000	0.0000	0.0000
General health rating: fair	-0.0482	-0.0471	-0.1058	-0.1382
General health rating: poor	-0.0826	-0.0775	-0.1323	-0.0798
Mental health rating: excellent	0.0967	0.1149	0.0658	0.0829
Mental health rating: very good	0.0575	0.0758	0.0933	0.0569
Mental health rating: good	0.0000	0.0000	0.0000	0.0000
Mental health rating: fair	-0.0361	-0.0300	-0.0903	-0.1071
Mental health rating: poor	-0.1208	-0.0749	-0.1247	-0.0361
Proxy helped	-0.0260	-0.0240	-0.0099	0.0566
Proxy answered	0.0198	-0.0176	0.1678	-0.0429
Medicaid dual eligible	0.0798	0.0449	0.0497	0.0344
Low-income subsidy (LIS)	0.0699	0.0351	0.1368	0.1006
Asian survey language	-0.0246	0.0243	0.0000	0.0000

HOS 2022-2024 Cohort 25 Case-Mix Adjustment

The longitudinal outcomes for the Medicare HOS 2022-2024 Cohort 25 Performance Measurement analysis are based on risk-adjusted mortality rates, changes in physical health as measured by the physical component summary (PCS) score, and changes in mental health as measured by the mental component summary (MCS) score for the participating Medicare Advantage Organizations (MAOs). For reporting purposes, death and PCS outcomes are combined into one overall measure of change in physical health. Thus, there are two primary outcomes: (1) Alive and PCS Better + Same (vs. PCS Worse or Death) and (2) MCS Better + Same (vs. MCS Worse). For the Medicare Part C Star Ratings, the primary outcomes are reported as the percentage of respondents within an MAO who are "Improving or Maintaining Physical Health" and the percentage within an MAO who are "Improving or Maintaining Mental Health" over the two-year period, after adjustment for case-mix.

The analysis of death outcomes for the HOS performance measurement includes beneficiaries who are 65 years or older at baseline, completed the HOS at baseline with a calculable PCS or MCS score, and whose MAO participated in the HOS at follow up. Beneficiaries are included in the analysis of PCS and MCS change scores if they are 65 years or older at baseline, alive at follow up, enrolled in their original MAO when the follow up sample was drawn, and completed the HOS with calculable PCS and MCS scores at baseline and follow up. HOS outcomes are analyzed by calculating the national averages, and the differences between actual and expected contract-level results for death, PCS, and MCS over two years. The expected results are adjusted for the case-mix of beneficiaries within an MAO to control for pre-existing baseline differences across MAOs with respect to covariates, such as baseline measures of sociodemographic characteristics, chronic medical conditions, and functional health status. The PCS results are combined with the percentage remaining alive in the MAO. An adjusted contract-level percentage for each of the two primary outcomes (PCS and MCS change scores) is calculated by combining the national average and the MAO difference score, using a logit transformation.

Table A-8A-8 includes one multivariate logistic regression model for each of three outcomes (i.e., death, PCS, and MCS) that are used to case-mix adjust HOS outcomes, and to calculate expected outcomes for each beneficiary. Beginning in 2022 for the 2024 Star Ratings, CMS updated the case-mix specifications for the expected outcomes of the HOS performance measures from a multi-model approach requiring non-missing values for all covariates in each model to a single model for each outcome that uses the Contract-Mean Imputation (CMI) method for covariates with missing data. Under the CMI approach, a missing case-mix adjuster (covariate) for a beneficiary is replaced with the mean value for that adjuster for other beneficiaries in the same contract who have responses contributing to the longitudinal PCS and MCS measures: Improving or Maintaining Physical Health and Improving or Maintaining Mental Health. Since the change to the case-mix specifications was substantive, the two measures remained on display through the 2025 Star Ratings and are now returning for the 2026 Star Ratings.

The coefficients in the table report the log-odds for beneficiaries with a given characteristic having the expected outcome compared to beneficiaries in the reference category for that characteristic, controlling for all other model characteristics. In Table A-8, the coefficient for "Female" in the PCS Better plus Same Model is -0.605538, indicating a lower probability of PCS Better plus Same for female compared to male respondents (the reference category), who otherwise have the same demographic and health characteristics. However, the coefficient for age and sex interaction in the PCS Better plus Same Model is 0.008386, indicating a very small positive difference in the expected outcome between females and males of the same age.

More information about the calculation of HOS outcomes at the beneficiary and MAO contract levels is available on the HOS website at www.HOSonline.org.

Table A-8: HOS Model Covariates at Baseline (Death, PCS Better + Same, and MCS Better + Same models)

Death Model Covariates	Death Model	PCS Model	MCS Model
Sociodemographic Variables			
Constant	-5.851021	2.232077	2.150314
Age (linear)	0.049369	-0.015024	-0.006411
Age 75+	0.042227	-0.027605	-0.035074
Age 85+	0.015949	0.030890	0.013175
Age and sex interaction	0.000296	0.008386	0.003247
Female	-0.539998	-0.605538	-0.275339
Hispanic only	-0.583694	0.003988	-0.235942
Asian only	-0.860608	-0.083129	-0.174167
Native Hawaiian or Pacific Islander only	-0.054307	0.115009	-0.100125
Black only	-0.323382	0.016556	-0.152964
American Indian or Alaskan Native only	-0.160022	-0.107038	-0.320198
Multiracial	-0.130566	0.020639	-0.110609
Married	-0.206517	0.013132	-0.054578
Receive Medicaid	0.126520	-0.094744	-0.329650
Eligible for SSI	0.004176	-0.143549	-0.369289
Homeowner	-0.105033	0.060250	0.181851
High school graduate or greater	-0.001094	0.122368	0.182702
Baseline Functional Status			
One-item measure of General Health compared to others	0.215457		
Physical Functioning/Activities of Daily Living Scale	-0.019277		
General Health item	0.237715		
Physical Functioning item (limitations in moderate activities)	-0.019810		
Physical Functioning item (limitations climbing several flights of stairs)	0.049275		
Role-Physical item (accomplished less than would like)	0.028639		
Role-Physical item (limited in the kind of work or other activities)	0.056056		
Role-Emotional item (accomplished less than would like)	0.037802		
Role-Emotional item (did not do work or other activities as carefully)	-0.004613		
Bodily Pain item (pain interfered with normal work)	-0.159989		
Mental Health item (felt calm and peaceful)	-0.043500		
Vitality item (had a lot of energy)	0.038276		
Mental Health item (felt downhearted and blue)	0.000888		
Social Functioning item (health interfered with social activities)	-0.068082		
Chronic Medical Conditions			
Hypertension	-0.077153		
Angina/coronary artery disease	-0.068116		
Congestive heart failure	0.466143		
Myocardial infarction	0.088617		
Other heart conditions	-0.022755		
Stroke	0.168361		
Pulmonary disease	0.199861		
Gastrointestinal disorders	-0.246909		

Death Model Covariates	Death Model	PCS Model	MCS Model
Diabetes	0.033180		
Depression	-0.146026		
Any cancer other than skin cancer	0.383996		
Colon cancer treatment	0.216094		
Breast cancer treatment	-0.077125		
Prostate cancer treatment	-0.234924		
Lung cancer treatment	0.959773		

Attachment B: Calculating Measure Data for the Surviving Contract of a Consolidation

First Year Following a Consolidation

In the first year following a consolidation, the measure values for the surviving contract of a consolidation are calculated as the enrollment-weighted mean of all contracts in the consolidation. The month(s) of enrollment used to calculate the enrollment weighted means varies by the type of measure. Table B-1 below lists the enrollment used for each type of measure and the rule followed to determine the month(s) of enrollment. Table B-2 provides an example calculation.

Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation

Type of Measure	Rule for Which Month of Enrollment is Used	Month(s) of Enrollment Used for 2026 Star Ratings
CAHPS	*Enrollment at the time survey sample is pulled*	*January 2025*
Call Center	*Average enrollment during the study period*	*Feb 2025 – May 2025*
HOS	*Enrollment at the time survey sample is pulled*	*February 2022*
HEDIS-HOS	*Enrollment at the time survey sample is pulled*	*February 2024*
HEDIS	*Enrollment in July of the measurement period*	*July 2024*
All Other Measures	*Enrollment in July of the measurement period*	*July 2024*

Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation

Contract ID	Surviving or Consumed Contract	Value for Breast Cancer Screening (BCS) Measure	July 2024 Enrollment
HAAAA	*Surviving*	*75.13*	*43,326*
HAAAB	*Consumed*	*50.91*	*20,933*

$$\text{Value for BCS for HAAAA} = \frac{75.13*43{,}326+50.91*20{,}933}{43{,}326+20{,}933} = 67.240097$$

Second Year Following a Consolidation

In the second year following a consolidation, the measure values for the surviving contract of a consolidation are as reported for CAHPS, call center, HOS, and HEDIS measures. For all other measures, with the exception of measures using Part C and D reporting requirements data, the measure values for the surviving contract of a consolidation are calculated as the enrollment weighted mean of all contracts in the consolidation. (CMS does not require consumed contracts to complete Part C and D reporting requirements and data validation, and CMS does not require data from consumed contracts.)

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of contract numeric and star values for each measure reported in the 2026 Star Ratings. The averages are calculated after the disaster adjustment has been applied.

Table C-1: National Averages for Part C Measures

Measure ID	Measure Name	Numeric Average	Star Average
C01	Breast Cancer Screening	74%	3.2
C02	Colorectal Cancer Screening	71%	3.8
C03	Annual Flu Vaccine	66%	3.2
C04	Improving or Maintaining Physical Health	71%	3.2
C05	Improving or Maintaining Mental Health	84%	3.2
C06	Monitoring Physical Activity	50%	3.1
C07	Special Needs Plan (SNP) Care Management	76%	3.5
C08	Care for Older Adults – Medication Review	94%	4.2
C09	Care for Older Adults – Pain Assessment	94%	3.9
C10	Osteoporosis Management in Women who had a Fracture	45%	2.8
C11	Diabetes Care – Eye Exam	77%	3.4
C12	Diabetes Care – Blood Sugar Controlled	84%	3.6
C13	Kidney Health Evaluation for Patients with Diabetes	61%	3.5
C14	Controlling Blood Pressure	79%	3.4
C15	Reducing the Risk of Falling	58%	2.7
C16	Improving Bladder Control	45%	2.7
C17	Medication Reconciliation Post-Discharge	77%	3.8
C18	Plan All-Cause Readmissions	10%	2.9
C19	Statin Therapy for Patients with Cardiovascular Disease	87%	3.3
C20	Transitions of Care	63%	3.1
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	61%	2.8
C22	Getting Needed Care	81	3.4
C23	Getting Appointments and Care Quickly	84	3.5
C24	Customer Service	90	3.5
C25	Rating of Health Care Quality	87	3.4
C26	Rating of Health Plan	87	3.4
C27	Care Coordination	87	3.5
C28	Complaints about the Health Plan	0.24	4.1
C29	Members Choosing to Leave the Plan	16%	3.7
C30	Health Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.5
C31	Plan Makes Timely Decisions about Appeals	98%	4.1
C32	Reviewing Appeals Decisions	97%	3.7
C33	Call Center – Foreign Language Interpreter and TTY Availability	97%	4.2

Table C-2: National Averages for Part D Measures

Measure ID	Measure Name	MA-PD Numeric Average	MA-PD Star Average	PDP Numeric Average	PDP Star Average
D01	*Call Center – Foreign Language Interpreter and TTY Availability*	*98%*	*4.4*	*98%*	*4.2*
D02	*Complaints about the Drug Plan*	*0.24*	*4.1*	*0.04*	*4.5*
D03	*Members Choosing to Leave the Plan*	*16%*	*3.7*	*7%*	*3.5*
D04	*Drug Plan Quality Improvement*	*Medicare only shows a Star Rating for this measure*	*3.4*	*Medicare only shows a Star Rating for this measure*	*3.2*
D05	*Rating of Drug Plan*	*87*	*3.3*	*85*	*3.5*
D06	*Getting Needed Prescription Drugs*	*90*	*3.5*	*90*	*3.6*
D07	*MPF Price Accuracy*	*98*	*4.6*	*98*	*4.7*
D08	*Medication Adherence for Diabetes Medications*	*87%*	*3.1*	*87%*	*2.7*
D09	*Medication Adherence for Hypertension (RAS antagonists)*	*89%*	*3.3*	*89%*	*2.6*
D10	*Medication Adherence for Cholesterol (Statins)*	*89%*	*3.2*	*88%*	*2.7*
D11	*MTM Program Completion Rate for CMR*	*91%*	*3.7*	*62%*	*3.4*
D12	*Statin Use in Persons with Diabetes (SUPD)*	*88%*	*3.3*	*84%*	*3.3*

Attachment D: Part C and D Data Time Frames

Table D-1: Part C Measure Data Time Frames

Measure ID	Measure Name	Primary Data Source	Data Time Frame
C01	Breast Cancer Screening	HEDIS	01/01/2024 – 12/31/2024
C02	Colorectal Cancer Screening	HEDIS	01/01/2024 – 12/31/2024
C03	Annual Flu Vaccine	CAHPS	03/2025 – 05/2025
C04	Improving or Maintaining Physical Health	HOS	07/19/2024 – 11/01/2024
C05	Improving or Maintaining Mental Health	HOS	07/19/2024 – 11/01/2024
C06	Monitoring Physical Activity	HEDIS-HOS	07/17/2024 – 11/01/2024
C07	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2024 – 12/31/2024
C08	Care for Older Adults – Medication Review	HEDIS	01/01/2024 – 12/31/2024
C09	Care for Older Adults – Pain Assessment	HEDIS	01/01/2024 – 12/31/2024
C10	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2024 – 12/31/2024
C11	Diabetes Care – Eye Exam	HEDIS	01/01/2024 – 12/31/2024
C12	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2024 – 12/31/2024
C13	Kidney Health Evaluation for Patients with Diabetes	HEDIS	01/01/2024 – 12/31/2024
C14	Controlling Blood Pressure	HEDIS	01/01/2024 – 12/31/2024
C15	Reducing the Risk of Falling	HEDIS-HOS	07/17/2024 – 11/01/2024
C16	Improving Bladder Control	HEDIS-HOS	07/17/2024 – 11/01/2024
C17	Medication Reconciliation Post-Discharge	HEDIS	01/01/2024 – 12/31/2024
C18	Plan All-Cause Readmission	HEDIS	01/01/2024 – 12/31/2024
C19	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2024 – 12/31/2024
C20	Transitions of Care	HEDIS	01/01/2024 – 12/31/2024
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2024 – 12/31/2024
C22	Getting Needed Care	CAHPS	03/2025 – 05/2025
C23	Getting Appointments and Care Quickly	CAHPS	03/2025 – 05/2025
C24	Customer Service	CAHPS	03/2025 – 05/2025
C25	Rating of Health Care Quality	CAHPS	03/2025 – 05/2025
C26	Rating of Health Plan	CAHPS	03/2025 – 05/2025
C27	Care Coordination	CAHPS	03/2025 – 05/2025
C28	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2024 – 12/31/2024
C29	Members Choosing to Leave the Plan	MBDSS	01/01/2024 – 12/31/2024
C30	Health Plan Quality Improvement	Star Ratings	Not Applicable
C31	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2024 – 12/31/2024
C32	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2024 – 12/31/2024
C33	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2025 – 05/2025

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*

1. Medicare Part C Reporting Requirements Measure (C07: SNP Care Management)

Step 1: Start with all contracts that offer at least one SNP plan that was active at any point during contract year 2024.

Step 2: Exclude contracts that did not have 30 or more enrollees in the denominator [Number of new enrollees due for an Initial HRA (Element A) plus Number of enrollees eligible for an annual HRA (Element B) greater than or equal to 30] during contract year 2024.

Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2025), or that were not required to participate in data validation. This exclusion aligns with the statement found under subsection Exclusions from Part C Reporting of Section B. General Information of the contract year 2024 Medicare Part C Plan Reporting Requirements Technical Specifications: "**Note:** If a contract terminates before July 1 in the following year after the contract year (CY) reporting period, the contract is not required to report any data for the respective two years – the CY reporting period, and the following year… If a PBP (Plan) under a contract terminates at any time in the CY reporting period and the contract remains active through July 1 of the following year, the contract must still report data for all PBPs, including the terminated PBP."
This excludes:

- Contracts that terminate on or before 07/01/2025 according to the Contract Info extract.

Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the SNP Care Management section and contracts that scored 95% or higher on data validation for the SNP Care Management section but that were not compliant with data validation standards/sub-standards for at least one of the following SNP data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation.

- Number of new enrollees due for an initial HRA (Element A)
- Number of enrollees eligible for an annual reassessment HRA (Element B)
- Number of initial HRAs performed on new enrollees (Element C)
- Number of annual reassessments performed on enrollees eligible for reassessment (Element F)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2024 SNP Care Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2024 SNP Care Reporting Requirements data but that failed at least one of the four data elements (elements A, B, C, and F) are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have a SNP Care Assessment rate denominator [Number of New Enrollees due for an Initial HRA (Element A) plus Number of enrollees eligible for an annual reassessment HRA (Element B)] of fewer than 30 are listed as "No data available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contract using the formula:

[Number of initial HRAs performed on new enrollees (Element C)
+ Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)]
/ [Number of new enrollees due for an Initial HRA (Element A)
+ Number of enrollees eligible for an annual reassessment HRA (Element B)]

2. NCQA HEDIS Measures - (C08 – C09: Care for Older Adults)

The example NCQA measure combining methodology specifications below are written for two Plan Benefit Package (PBP) submissions, which we distinguish as 1 and 2, but the methodology easily extends to any number of submissions.

Rates are produced for any contract offering a SNP in the ratings year which provided SNP HEDIS data in the measurement year.

Definitions

Let N_1 = The Total Number of Members Eligible for the HEDIS measure in the first PBP ("fixed" and auditable)

Let N_2 = The Total Number of Members Eligible for the HEDIS measure in the second PBP ("fixed" and auditable)

Let P_1 = The estimated rate (mean) for the HEDIS measure in the first PBP (auditable)

Let P_2 = The estimated rate (mean) for the same HEDIS measure in the second PBP (auditable)

Setup Calculations

Based on the above definitions, there are two additional calculations:

Let W_1 = The weight assigned to the first PBP results (estimated, auditable). This is estimated from the formula $W_1 = N_1 / (N_1 + N_2)$

Let W_2 = The weight assigned to the second PBP results (estimated, auditable). This is estimated from the formula $W_2 = N_2 / (N_1 + N_2)$

Pooled Analysis

The pooled result from the two rates (means) is calculated as: $P_{pooled} = W_1 * P_1 + W_2 * P_2$

NOTES:
Weights are based on the eligible member population. While it may be more accurate to remove all excluded members before weighting, NCQA and CMS have chosen not to do this (to simplify the method) for two reasons: 1) the number of exclusions relative to the size of the population should be small, and 2) exclusion rates (as a percentage of the eligible population) should be similar for each PBP and negligibly affect the weights.

If one or more of the submissions has a status of NA, those submissions are dropped and not included in the weighted rate (mean) calculations. If one or more of the submissions has an audit designation of BR or NR

(which has been determined to be biased or is not reported by choice of the contract), the rate is set to zero as detailed in the section titled "Handling of Biased, Erroneous and/or Not Reportable (NR) Data" and the average enrollment for the year is used for the eligible population in the PBP. An example is shown in table E-1.

Table E-1: Example Calculation Using Effectiveness of Care Rate

Numeric Example Using an Effectiveness of Care Rate	
Number of Total Members Eligible for the HEDIS measure in PBP 1, $N_1 =$	*1500*
Number of Total Members Eligible for the HEDIS measure in PBP 2, $N_2 =$	*2500*
HEDIS Result for PBP 1, Enter as a Proportion between 0 and 1, $P_1 =$	*0.75*
HEDIS Result for PBP 2, Enter as a Proportion between 0 and 1, $P_2 =$	*0.5*
Setup Calculations Initialize Some Intermediate Results	
The weight for PBP 1 product estimated by $W_1 = N_1 / (N_1 + N_2)$	*0.375*
The weight for PBP 2 product estimated by $W_2 = N_2 / (N_1 + N_2)$	*0.625*
Pooled Results	
$P_{pooled} = W_1 * P_1 + W_2 * P_2$	*0.59375*

Attachment F: Calculating Measure C18: Plan All-Cause Readmissions

All data are available in the CMS Measurement Year 2024 HEDIS® Public Use File (PUF)[1] and can be looked up by IndicatorKey (row) and Variable name (column).

The calculations below use the Denominator, ObservedCount and ExpectedCount values from the PCR (18-64) indicator (IndicatorKey = 202025_20) and the PCR (65+) indicator (IndicatorKey = 202111_20).

For each contract, calculate the (18+) Denominator, ObservedCount, and ExpectedCount:

Denominator(18+) equals Denominator(18-64) plus Denominator(65+)
ObservedCount(18+) equals ObservedCount(18-64) plus ObservedCount(65+)
ExpectedCount(18+) equals ExpectedCount(18-64) plus ExpectedCount(65+)

Using these (18+) values, calculate the (18+) Observed-over-Expected ratio (OE):

$$OE(18+) = \left(\frac{\text{ObservedCount}(18+)}{\text{ExpectedCount}(18+)}\right)$$

And the national average of the (18+) Observed Rate:

$$\text{NatAvgObs}(18+) = \text{Average}\left(\left(\frac{\text{ObservedCount}(18+)_1}{\text{Denominator}(18+)_1}\right), \ldots, \left(\frac{\text{ObservedCount}(18+)_n}{\text{Denominator}(18+)_n}\right)\right)$$

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) OE larger than or equal to 0.2 and less than or equal to 5.0.
For each contract, calculate the Final Rate and convert to percentages:

Final Rate(18+) = OE(18+) x NatAvgObs(18+) x 100

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	Indicator Key	Denominator	Observed Count	Expected Count
Contract 1	202025_20	214	8	12
Contract 1	202111_20	4,792	641	642
Contract 2	202025_20	225	12	7
Contract 2	202111_20	4,761	688	668
Contract 3	202025_20	573	31	35
Contract 3	202111_20	8,629	1,126	1,070
Contract 4	202025_20	12	0	1
Contract 4	202111_20	533	79	73

$$\text{NatAvgObs} = \text{Average}\left(\left(\frac{8+641}{214+4{,}792}\right), \left(\frac{12+688}{225+4{,}761}\right), \left(\frac{31+1{,}126}{573+8{,}629}\right), \left(\frac{0+79}{12+533}\right)\right)$$

NatAvgObs = 0.135181

$$\text{OE Contract 1} = \left(\frac{8+641}{12+642}\right) = 0.992355$$

Final Rate Contract 1 = $0.992355 \times 0.135181 \times 100 = 13.41$

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files

Final Rate reported for Contract 1 equals 13%

The actual calculated National Observed Rate used in the 2026 Star Ratings was 0.107940666493859.

Attachment G: Weights Assigned to Individual Performance Measures

Table G-1: Part C Measure Weights

Measure ID	Measure Name	Weighting Category	Part C Summary and MA-PD Overall
C01	Breast Cancer Screening	Process Measure	1
C02	Colorectal Cancer Screening	Process Measure	1
C03	Annual Flu Vaccine	Process Measure	1
C04	Improving or Maintaining Physical Health	Intermediate Outcome Measure	1*
C05	Improving or Maintaining Mental Health	Intermediate Outcome Measure	1*
C06	Monitoring Physical Activity	Process Measure	1
C07	Special Needs Plan (SNP) Care Management	Process Measure	1
C08	Care for Older Adults – Medication Review	Process Measure	1
C09	Care for Older Adults – Pain Assessment	Process Measure	1
C10	Osteoporosis Management in Women who had a Fracture	Process Measure	1
C11	Diabetes Care – Eye Exam	Process Measure	1
C12	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C13	Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
C14	Controlling Blood Pressure	Intermediate Outcome Measure	3
C15	Reducing the Risk of Falling	Process Measure	1
C16	Improving Bladder Control	Process Measure	1
C17	Medication Reconciliation Post-Discharge	Process Measure	1
C18	Plan All-Cause Readmissions	Outcome Measure	3
C19	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C20	Transitions of Care	Process Measure	1
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
C22	Getting Needed Care	Patients' Experience and Complaints Measure	2
C23	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
C24	Customer Service	Patients' Experience and Complaints Measure	2
C25	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
C26	Rating of Health Plan	Patients' Experience and Complaints Measure	2
C27	Care Coordination	Patients' Experience and Complaints Measure	2
C28	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
C29	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
C30	Health Plan Quality Improvement	Improvement Measure	5
C31	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
C32	Reviewing Appeals Decisions	Measures Capturing Access	2
C33	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

**Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures have a weight of 1 for the 2026 Star*

Ratings because they are considered new measures. For the 2027 Star Ratings, the weight will return to 3.

Table G-2: Part D Measure Weights

Measure ID	Measure Name	Weighting Category	Part D Summary and MA-PD Overall
D01	*Call Center – Foreign Language Interpreter and TTY Availability*	*Measures Capturing Access*	*2*
D02	*Complaints about the Drug Plan*	*Patients' Experience and Complaints Measure*	*2*
D03	*Members Choosing to Leave the Plan*	*Patients' Experience and Complaints Measure*	*2*
D04	*Drug Plan Quality Improvement*	*Improvement Measure*	*5*
D05	*Rating of Drug Plan*	*Patients' Experience and Complaints Measure*	*2*
D06	*Getting Needed Prescription Drugs*	*Patients' Experience and Complaints Measure*	*2*
D07	*MPF Price Accuracy*	*Process Measure*	*1*
*D08**	*Medication Adherence for Diabetes Medications*	*Intermediate Outcome Measure*	*3*
*D09**	*Medication Adherence for Hypertension (RAS antagonists)*	*Intermediate Outcome Measure*	*3*
*D10**	*Medication Adherence for Cholesterol (Statins)*	*Intermediate Outcome Measure*	*3*
D11	*MTM Program Completion Rate for CMR*	*Process Measure*	*1*
D12	*Statin Use in Persons with Diabetes (SUPD)*	*Process Measure*	*1*

**For contracts whose service area only covers Puerto Rico, the weight for each adherence measure is set to zero (0) when calculating the summary and overall rating.*

Attachment H: Calculation of Weighted Star Rating and Variance Estimates

The weighted summary (or overall) Star Rating for contract j is estimated as:

$$\bar{x}_j = \frac{\sum_{i=1}^{n_j} w_{ij} x_{ij}}{\sum_{i=1}^{n_j} w_{ij}}$$

Where n_j is the number of performance measures for which contract j is eligible; w_{ij} is the weight assigned to performance measure i for contract j; and x_{ij} is the measure star for performance measure i for contract j. The variance of the Star Ratings for each contract j, s_j^2, must also be computed in order to estimate the reward factor (r-Factor):

$$s_j^2 = \frac{n_j}{(n_j - 1)(\sum_{i=1}^{n_j} w_{ij})} \left[\sum_{i=1}^{n_j} w_{ij} \left(x_{ij} - \bar{x}_j\right)^2\right]$$

Thus, the $\bar{x}_j$'s are the new summary (or overall) Star Ratings for the contracts. The variance estimate, s_j^2 simply replaces the non-weighted variance estimate that was previously used for the r-Factor calculation. For all contracts j, $w_{ij} = w_i$ (i.e., the performance measure weights are the same for all contracts when estimating a given Star Rating (Part C or Part D summary or MA-PD overall ratings).

Attachment I: Calculating the Improvement Measure and the Measures Used

Calculating the Improvement Measure

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

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

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

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

$$SE_y = \sqrt{\mathrm{Var}(Z_y)}$$

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

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

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

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

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

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

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

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

for y equals 2025, 2026

Star Ratings Measures Used in the Improvement Measures

Table I-1: Part C Measures Used in the Improvement Measure

Measure ID	Measure Name	Measure Usage	Correlation
C01	Breast Cancer Screening	Included	0.945918
C02	Colorectal Cancer Screening	Included	0.888326
C03	Annual Flu Vaccine	Included	0.902341
C04	Improving or Maintaining Physical Health	Not Included	-
C05	Improving or Maintaining Mental Health	Not Included	-
C06	Monitoring Physical Activity	Included	0.845725
C07	Special Needs Plan (SNP) Care Management	Included	0.868694
C08	Care for Older Adults – Medication Review	Included	0.854992
C09	Care for Older Adults – Pain Assessment	Included	0.928640
C10	Osteoporosis Management in Women who had a Fracture	Included	0.833787
C11	Diabetes Care – Eye Exam	Included	0.843728
C12	Diabetes Care – Blood Sugar Controlled	Included	0.791850
C13	Kidney Health Evaluation for Patients with Diabetes	Not Included	-
C14	Controlling Blood Pressure	Included	0.835804
C15	Reducing the Risk of Falling	Included	0.841469
C16	Improving Bladder Control	Included	0.432892
C17	Medication Reconciliation Post-Discharge	Included	0.872774
C18	Plan All-Cause Readmissions	Included	0.523042
C19	Statin Therapy for Patients with Cardiovascular Disease	Included	0.729464
C20	Transitions of Care	Included	0.887062
C21	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Included	0.463245
C22	Getting Needed Care	Included	0.787381
C23	Getting Appointments and Care Quickly	Included	0.729360
C24	Customer Service	Included	0.740178
C25	Rating of Health Care Quality	Included	0.711479
C26	Rating of Health Plan	Included	0.784188
C27	Care Coordination	Included	0.747242
C28	Complaints about the Health Plan	Included	0.713325
C29	Members Choosing to Leave the Plan	Included	0.790100
C30	Health Plan Quality Improvement	Not Included	-
C31	Plan Makes Timely Decisions about Appeals	Included	0.433903
C32	Reviewing Appeals Decisions	Included	0.490732
C33	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.453086

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*

Attachment J: Star Ratings Measure History

The tables below cross-reference the measures code in each of the yearly Star Ratings releases. Measure codes that begin with DM are display measures which are posted on CMS.gov on this page: http://go.cms.gov/partcanddstarratings.

Table J-1: Part C Measure History

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Access to Primary Care Doctor Visits	HEDIS				DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12	C11
C	Adult BMI Assessment	HEDIS						C07	C07	C07	C07	C07	C07	C08	C10	C10	C12
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06	C06
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03	DMC03
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS									DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC05
C	Asthma Medication Ratio	HEDIS									DMC18	DMC27					
C	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	C30	C28	C28	DME08	C31	C31	C32
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01	C01
C	Call Answer Timeliness	HEDIS											DMC02	DMC02	DMC02	DMC02	DMC02
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09	DMC09
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC12		DMC15	DMC15	
C	Call Center – CSR Understandability	Call Center Monitoring															
C	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	C33	C30	C30	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36	C36
C	Call Center – Information Accuracy	Call Center Monitoring													DMC10	DMC10	DMC10
C	Cardiac Rehabilitation – Achievement	HEDIS	DMC25	DMC25	DMC25	DMC29											
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC26	DMC26	DMC30											
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC27	DMC27	DMC31											
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DMC28	DMC28	DCM32											
C	Cardiovascular Care – Cholesterol Screening	HEDIS												C02	C03	C03	C03

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Care Coordination	CAHPS	C27	C24	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29	
C	Care for Older Adults – Functional Status Assessment	HEDIS	DMC21	DMC21	DMC21	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12	C14
C	Care for Older Adults – Medication Review	HEDIS	C08	C06	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11	C13
C	Care for Older Adults – Pain Assessment	HEDIS	C09	C07	C07	C07	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13	C15
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29	DMC29	DMC29												
C	Complaints about the Health Plan	CTM	C28/D02	C25/D02	C25/D02	C23/D02	C23/D02	C27/ D04	C28/ D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06
C	Computer use by provider helpful	CAHPS										DMC20	DMC21	DMC20			
C	Computer use made talking to provider easier	CAHPS										DMC21	DMC22	DMC21			
C	Computer used during office visits	CAHPS										DMC19	DMC20	DMC19			
C	Continuous Beta Blocker Treatment	HEDIS	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC03	DMC04	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C14	C11	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19	C21
C	Customer Service	CAHPS	C24	C21	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26	C28
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C12	C10	C10	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17	C19
C	Diabetes Care – Cholesterol Controlled	HEDIS												C17	C18	C18	C20
C	Diabetes Care – Cholesterol Screening	HEDIS												C03	C04	C04	C04
C	Diabetes Care – Eye Exam	HEDIS	C11	C09	C09	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15	C17
C	Diabetes Care – Kidney Disease Monitoring	HEDIS				C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16	C18
C	Doctors who Communicate Well	CAHPS	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC08
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19		
C	Enrollment Timeliness	MARx									DME01	DME01	DME01	DME01	DME01	C37 / D05	D05
C	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	C21	C18	C18	DMC15	DMC17	DMC17	DMC18								

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)	HEDIS		DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01	DMC01
C	Getting Appointments and Care Quickly	CAHPS	C23	C20	C20	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25	C27
C	Getting Needed Care	CAHPS	C22	C19	C19	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24	C26
C	Glaucoma Testing	HEDIS													C05	C05	C05
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11	
C	Health Plan Quality Improvement	Star Ratings	C30	C27	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33	
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC15	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24					
C	Improving Bladder Control	HEDIS-HOS	C16	C13	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21	C23
C	Improving or Maintaining Mental Health	HOS	C05	DMC23	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08	C09
C	Improving or Maintaining Physical Health	HOS	C04	DMC24	DMC24	DMC28	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07	C08
C	Initiation and Engagement of Substance Use Disorder (SUD) Treatment Average	HEDIS	DMC14	DMC14	DMC14												
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18		
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	C13	DMC22	DMC22	DMC26											
C	Medication Management for People With Asthma	HEDIS										DMC26					
C	Medication Reconciliation Post-Discharge	HEDIS	C17	C14	C14	C15	C15	C19	C19	C20	C20	DMC23					
C	Members Choosing to Leave the Plan	MBDSS	C29/D03	C26/D03	C26/D03	C24/D03	C24/D03	C28/ D05	C29/ D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08
C	Monitoring Physical Activity	HEDIS-HOS	C06	C04	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09	C10
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C10	C08	C08	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14	C16
C	Osteoporosis Testing	HEDIS-HOS					DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC06
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17		

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16		
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC20	DMC20	DMC24											
C	Plan All-Cause Readmissions	HEDIS	C18	C15	C15	DMC21	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23	C25
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)/Maximus	C31	C28	C28	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34	C34
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11	C07
C	Rating of Health Care Quality	CAHPS	C25	C22	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27	C29
C	Rating of Health Plan	CAHPS	C26	C23	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28	C30
C	Reducing the Risk of Falling	HEDIS-HOS	C15	C12	C12	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22	C24
C	Reminders for appointments	CAHPS										DMC16	DMC17	DMC16			
C	Reminders for immunizations	CAHPS										DMC17	DMC18	DMC17			
C	Reminders for screening tests	CAHPS										DMC18	DMC19	DMC18			
C	Reviewing Appeals Decisions	Independent Review Entity (IRE)/Maximus	C32	C29	C29	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35	C35
C	Rheumatoid Arthritis Management	HEDIS					C12	C16	C16	C17	C17	C17	C17	C19	C20	C20	C22
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C07	C05	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14	
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C19	C16	C16	C16	C16	C20	C21	C22	DMC17	DMC25					
C	Testing to Confirm Chronic Obstructive Pulmonary Disease	HEDIS		DMC04	DMC04	DMC04	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC07
C	Transitions of Care – Average	HEDIS	C20	C17	C17	DMC20	DMC22	DMC22	DMC23								
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC16	DMC16	DMC18	DMC18	DMC19								
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC17	DMC17	DMC19	DMC19	DMC20								
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC18	DMC18	DMC20	DMC20	DMC21								

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
C	*Transitions of Care – Receipt of Discharge Information*	*HEDIS*	*DMC19*	*DMC19*	*DMC19*	*DMC19*	*DMC21*	*DMC21*	*DMC22*								

Table J-2: Part D Measure History

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)															DMD03	
D	Adherence – Proportion of Days Covered	Prescription Drug Event (PDE) Data																
D	Antipsychotic Use in Persons with Dementia	Prescription Drug Event (PDE) Data	DMD08	DMD08	DMD08	DMD08	DMD08	DMD12	DMD14	DMD16	DMD18							
D	Appeals Auto–Forward	Independent Review Entity (IRE) / Maximus						D02	D02	D02	D02	D02	D02	D01	D02	D03	D03	
D	Appeals Upheld	Independent Review Entity (IRE) / Maximus						D03	D03	D03	D03	D03	D03	D02	D03	D04	D04	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	D07	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD02	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	DMD05	
D	Call Center – Calls Disconnected – Pharmacist	Call Center Monitoring																
D	Call Center – Calls Disconnected When Customer Calls Drug Plan	Call Center Monitoring	DMD01	DMD01	DMD01	DMD01	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	DMD04	
D	Call Center – CSR Understandability	Call Center Monitoring																
D	Call Center – Foreign Language Interpreter and TTY Availability	Call Center Monitoring	D01	D01	D01	D01	D01	D01	D01	D01	D01	D01	D01		D01	D02	D02	
D	Call Center – Information Accuracy	Call Center Monitoring													DMD05	DMD05	DMD06	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD04	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	D01	
D	Complaint Resolution	Complaints Tracking Module (CTM)																
D	Complaints – Enrollment	Complaints Tracking Module (CTM)																
D	Complaints – Other	Complaints Tracking Module (CTM)																

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C28/ D02	C25/ D02	C25/ D02	C23/ D02	C23/ D02	C27 / D04	C28 / D04	C29 / D04	C28 / D04	C26 / D04	C26 / D04	C29 / D03	C30 / D04	C30 / D06	C31 / D06	
D	Diabetes Medication Dosing	Prescription Drug Event (PDE) Data							DMD06	DMD06	DMD06	DMD06	DMD06	DMD04	DMD07	DMD07	DMD08	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data												D10	D12	D15	D14	
D	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website	Acumen / OIT (LIS Match Rates)						DMD06	DMD07	DMD07	DMD07	DMD07	DMD07	DMD05	DMD08	DMD08	DMD09	
D	Drug Plan Quality Improvement	Star Ratings	D04	D04	D04	D04	D04	D06	D06	D06	D07	D07	D07	D05	D07	D09		
D	Drug-Drug Interactions	Prescription Drug Event (PDE) Data						DMD05	DMD05	DMD05	DMD05	DMD05	DMD05	DMD03	DMD06	DMD06	DMD07	
D	Enrollment Timeliness	MARx									DME01	DME01	DME01	DME01	DME01	C37 / D05	D05	
D	Formulary Administration Analysis	Part D Sponsor								DMD15	DMD17							
D	Getting Information From Drug Plan	CAHPS										DMD10	DMD10	DMD09	DMD14	D10	D09	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D06	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	D11	
D	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11		
D	High Risk Medication	Prescription Drug Event (PDE) Data							DMD14	DMD14	DMD16	D11	D11	D09	D11	D14	D13	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15	DMD15	DMD15	DMD15												
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	D10	D10	D10	D10	D10	D12	D12	D12	D13	D14	D14	D13	D15	D18	D17	
D	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) Data	D08	D08	D08	D08	D08	D10	D10	D10	D11	D12	D12	D11	D13	D16	D15	
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D09	D09	D09	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	D16	
D	Members Choosing to Leave the Plan	MBDSS	C29/ D03	C26/ D03	C26/ D03	C24/ D03	C24/ D03	C28 / D05	C29 / D05	C30 / D05	C29 / D05	C27 / D05	C27 / D05	C30 / D04	C32 / D06	C32 / D08	C33 / D08	

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	MPF – Composite	PDE Data, MPF Pricing Files															D12	B
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	DMD03	DMD03	DMD03	DMD03	DMD07	DMD08	DMD08	DMD08	DMD08	DMD08	DMD06	DMD10	DMD10		A
D	MPF – Updates	PDE Data, MPF Pricing Files													DMD09	DMD09	DMD10	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	D07	D07	D07	D07	D09	D09	D09	D10	D10	D10	D08	D10	D13		A
D	MTM Program Completion Rate for CMR	Prescription Drug Event (PDE) Data	D11	D11	D11	D11	D11	D13	D13	D13	D14	D15	D15	DMD07	DMD12	DMD12		
D	Persistence to Basal Insulin (PST-INS)	Prescription Drug Event (PDE) Data	DMD16	DMD16	DMD16													
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	DMD05	DMD05	DMD05	DMD05	DMD05	DMD09	DMD10	DMD10	DMD10	DMD12	DMD12	DMD10	DMD16			
D	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Prescription Drug Event (PDE) Data	DMD13	DMD13	DMD13	DMD13	DMD13	DMD20										
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	DMD14	DMD14	DMD14	DMD14	DMD14	DMD21										
D	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes	Fu Associates										DMD09	DMD09	DMD08	DMD13	DMD13		
D	Rating of Drug Plan	CAHPS	D05	D05	D05	D05	D05	D07	D07	D07	D08	D08	D08	D06	D08	D11	D10	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13				
D	Reminders to take medications	CAHPS	DMD07	DMD07	DMD07	DMD07	DMD07	DMD11	DMD12	DMD13	DMD14	DMD16	DMD16	DMD14				
D	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Data	D12	D12	D12	D12	D12	D14	D14	D14	DMD15	DMD17						
D	Timely Effectuation of Appeals	Independent Review Entity (IRE) / Maximus						DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	
D	Timely Receipt of Case Files for Appeals	Independent Review Entity (IRE) / Maximus						DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis								DMD11								D

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	Notes
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis									DMD12	DMD14	DMD14	DMD12				C
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis									DMD11	DMD13	DMD13	DMD11				C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data						DMD15										
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data	DMD11	DMD11	DMD11	DMD11	DMD11	DMD18										
D	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Prescription Drug Event (PDE) Data	DMD12	DMD12	DMD12	DMD12	DMD12	DMD19										

Notes:

A: Part of composite measure MPF - Composite in 2011 – 2012

B: Composite measure - combined MPF - Accuracy and MPF Stability

C: Part of composite measure Transition Monitoring - Composite starting in 2019

D: Composite Measure – "Transition monitoring - failure rate for drugs within classes of clinical concern" and "Transition monitoring - failure rate for all other drugs"

Table J-3: Common Part C & Part D Measure History

Part	Measure Name	Data Source	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / D07	C32 / D07
E	Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)	Disenrollment Reasons Survey	DME04	DME04	DME04	DME04	DME04	DME04	DME04	DME04	DME05	DME05	DME05	DME05			
E	Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)	Disenrollment Reasons Survey	DME06	DME06	DME06	DME06	DME06	DME06	DME06	DME06	DME07	DME07	DME07	DME07			
E	Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)	Disenrollment Reasons Survey	DME02	DME02	DME02	DME02	DME02	DME02	DME02	DME02	DME03	DME03	DME03	DME03			
E	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)	Disenrollment Reasons Survey	DME03	DME03	DME03	DME03	DME03	DME03	DME03	DME03	DME04	DME04	DME04	DME04			
E	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)	Disenrollment Reasons Survey	DME05	DME05	DME05	DME05	DME05	DME05	DME05	DME05	DME06	DME06	DME06	DME06			
E	Enrollment Timeliness	MARx									DME01	DME01	DME01	DME01	DME01	C37 / D05	D05
E	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13/ DMD11	DMC13/ DMD11	

Attachment K: Individual Measure Star Assignment Process

This attachment provides detailed information about the clustering and the relative distribution and significance testing (CAHPS) methodologies used to assign stars to individual measures.

The analyses described in this section were run on Linux SAS/STAT v15.1 (Linux LIN 64 Red Hat Enterprise Linux release 9.6) and validated on SAS 9.4 (TS1M7) with SAS/STAT Version 15.2 installed on Version 10.0.26100 of Windows 11, 64-bit.

Clustering Methodology Introduction

To separate a distribution of scores into distinct groups or categories, a set of values must be identified to separate one group from another group. The set of values that break the distribution of the scores into non-overlapping groups is the set of cut points.

For each individual measure, CMS determines the measure cut points using the information provided from the hierarchical clustering algorithm in SAS, described in "Clustering Methodology Detail" below. Conceptually, the clustering algorithm identifies the natural gaps that exist within the distribution of the scores and creates groups (clusters) that are then used to identify the cut points that result in the creation of a pre-specified number of categories.

For Star Ratings, the algorithm is run with the goal of determining the four cut points (labeled in the Figure J-1 below as A, B, C, and D) that are used to create the five non-overlapping groups that correspond to each of the Star Ratings (labeled in the diagram below as G1, G2, G3, G4, and G5). For Part D measures, CMS determines MA-PD and PDP cut points separately. Data identified to be biased, erroneous, or excluded by disaster rules are removed from the algorithm. The scores are grouped such that scores within the same Star Rating category are as similar as possible, and scores in different categories are as different as possible.

Figure K-1: Diagram showing gaps in data where cut points are assigned.

As mentioned, the cut points are used to create five non-overlapping groups. The value of the lower bound for each group is included in the category, while the value of the upper bound is not included in the category. CMS does not require the same number of observations (contracts) within each group. The groups are identified such that within a group the measure scores must be similar to each other and between groups, the measure scores in one group are not similar to measure scores in another group. The groups are then used for the conversion of the measure scores to one of five Star Ratings categories. For most measures, a higher score is better, and thus, the group with the highest range of measure scores is converted to a rating of five stars. An example of a measure for which higher is better is *Medication Adherence for Diabetes Medications*. For some measures a lower score is better, and thus, the group with the lowest range of measure scores is converted to a rating of five stars. An example of a measure for which a lower score is better is *Members Choosing to Leave the Plan*.

Example 1 – Clustering Methodology for a Higher is Better measure

Consider the information provided for the cut points for *Medication Adherence for Diabetes Medications* in Table K-1 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately (e.g., different cut points are calculated for MA-PD and PDPs). If the MA-PD cut points identified using the clustering algorithm are 80%, 85%, 87%, and 91%; for PDPs, the cut points are 84%, 86%, 88%, and 90%. (The set of values corresponds to the cut points in figure J-2 below as A, B, C, and D and the categories

for each of the five Star Ratings are indicated above each group.) Since a measure score can only assume a value between 0% and 100% (including 0% and 100%), the one-star and five-star categories contain only a single value in the table below as the upper or lower bound.

Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	*Less than 80%*	*Greater than or equal to 80% to less than 85%*	*Greater than or equal to 85% to less than 87%*	*Greater than or equal to 87% to less than 91%*	*Greater than or equal to 91%*
PDP	*Less than 84%*	*Greater than or equal to 84% to less than 86%*	*Greater than or equal to 86% to less than 88%*	*Greater than or equal to 88% to less than 90%*	*Greater than or equal to 90%*

Figure K-2: Diagram showing star assignment based cut points.

Since higher is better for *Medication Adherence for Diabetes Medications*, a rating of one star is assigned to all MA-PD measure scores below 80% in this example. For each of the other Star Rating categories, the value of the lower bound is included in the rating category, while the upper bound value is not included. Focusing solely on the cut points for MA-PDs, a rating of two stars is assigned to each measure score that is at least 80% (the first cut point) to less than 85% (the second cut point) in this example. Since measure scores are reported as percentages with no decimal places, any measure score of 80% to 84% would be assigned two stars, while a measure score of 85% would be assigned a rating of three stars. Measure scores that are at least 85% to less than 87% would be assigned a rating of three stars. For a conversion to four stars, a measure score of at least 87% to less than 91% would be needed. A rating of five stars would be assigned to any measure score of 91% or more. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Example 2 – Clustering Methodology for a Lower is Better measure

Consider the information provided for the cut points for *Members Choosing to Leave the Plan* in Table K-2 below. As stated previously, for Part D measures CMS calculates MA-PD and PDP cut points separately. In the example, the MA-PD cut points for *Members Choosing to Leave the Plan* determined using the clustering algorithm are 44%, 29%, 16%, and 9%; for PDPs, the cut points are 20%, 13%, 19%, and 6%. (These correspond to the cut points in figure K-3 as A, B, C, and D).

Since lower is better for this measure, the five-star category will have the lowest measure score range, while the one-star category will have scores that are highest in value. For each of the other Star Rating categories, the value of the lower bound is not included in the rating category, while the upper bound value is included. (The inclusivity and exclusivity of the upper and lower bounds is opposite for a measure score where lower is better as compared to higher is better.) For MA-PDs, a rating of five stars would be assigned to measure scores of 9% or less. Measure scores that are greater than 9% up to a maximum value of 16% (including a measure score of 16%) would be assigned a rating of four stars. A rating of three stars would be assigned to measure scores greater than 16% up to a maximum value of 29%. A rating of two stars would be assigned to a measure score that is greater than 29% up to and including 44%. A rating of one star would be assigned to any measure score greater than 44%. PDPs have different cut points, but the same overall rules apply for converting the measure score to a Star Rating.

Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	*Greater than 44%*	*Greater than 29% to less than or equal to 44%*	*Greater than 16% to less than or equal to 29%*	*Greater than 9% to less than or equal to 16%*	*less than or equal to 9%*
PDP	*Greater than 20%*	*Greater than 13% to less than or equal to 20%*	*Greater than 9% to less than or equal to 13%*	*Greater than 6% to less than or equal to 9%*	*less than or equal to 6%*

Figure K-3: Diagram showing star assignment based on cut points.

Clustering Methodology Detail

This section details the steps of the clustering method performed in SAS to allow the conversion of the measure scores to measure-level stars.

Tukey outlier deletion is used to determine the cut points for all non-CAHPS measures. Tukey outlier deletion for the Part C and Part D Improvement Measures is performed separately for contracts receiving negative scores and those receiving scores of zero or higher prior to threshold estimation, consistent with how clustering is performed for these measures. Tukey outlier deletion involves removing Tukey outer fence outlier contract scores, those defined as measure-specific scores outside the bounds of 3.0 times the measure-specific interquartile range subtracted from the 1st quartile or added to the 3rd quartile. Outliers are removed prior to applying mean resampling to the hierarchical clustering algorithm. The 1st and 3rd quartiles can be obtained by using the MEANS procedure in SAS. The Tukey outer fence outlier cutoffs can then be calculated as:

- Lower outlier cutoff: first quartile – 3.0*(third quartile – first quartile)
- Upper outlier cutoff: third quartile + 3.0*(third quartile – first quartile)

Measures with data displays of percentages with no decimal places ranging from 0 to 100 will have the lower and upper outlier cutoffs capped at those values, respectively. Any other measures with range restrictions, such as have a lower bound of zero, will have the respective outlier cutoff capped at the restricted value.

Mean resampling is used to determine the cut points for all non-CAHPS measures. With mean resampling, measure-specific scores for the current year's Star Ratings are separated into 10 equal-sized groups, using a random assignment process to assign each contract's measure score to a group. The random assignment of contracts into 10 groups can be produced using the SURVEYSELECT procedure in SAS as follows:

```
proc surveyselect data=inclusterdat groups=10 seed=8675309 out=inclusterdat_random;
run;
```

In the above code, the input dataset, *inclusterdat,* is the list of contracts without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. The *group=10* option identifies that 10 random groupings of the data should be created. The *seed=8675309* option specifies the seed value that controls the starting point of the random sequence of numbers and allows for future replication of the randomization process. The output dataset, *inclusterdat_random,* is identical to the input dataset with the addition of a new column, named *groupid,* that has the group assignments (from 1 through 10) for each contract.

The hierarchal clustering algorithm (steps 1 through 4 below) is then applied 10 times, each time leaving out one of the 10 groups. For each measure and leave-one-out contract set, the clustering method does the following:

- Produces the individual measure distance matrix.
- Groups the measure scores into an initial set of clusters.
- Selects the set of clusters.

1. Produce the individual measure distance matrix.

For each pair of contracts j and k (j is greater than or equal to k) among the n contracts with measure score data, compute the Euclidian distance of their measure scores (e.g., the absolute value of the difference between the two measure scores). Enter this distance in row j and column k of a distance matrix with n rows and n columns. This matrix can be produced using the DISTANCE procedure in SAS as follows:

```
proc distance data= inclusterdat_leave1out out=distancedat method=Euclid;
        var interval(measure_score);
        id contract_id;
run;
```

In the above code, the input data set, *inclusterdat_leave1out,* is the list of contracts (excluding the group left out) without missing, flagged, excluded by disaster rules or voluntary contract scores for a particular measure. Each record has a unique contract identifier, *contract_id*. The option *method=Euclid* specifies that distances between contract measure scores should be based on Euclidean distance. The input data contain a variable called *measure_score* that is formatted to the display criteria outlined in the Technical Notes. In the *var* call, the parentheses around *measure_score* indicate that *measure_score* is considered to be an interval or numeric variable. The distances computed by this code are stored to an output data set called *distancedat.*

2. Create a tree of cluster assignments.

The distance matrix calculated in Step 1 is the input to the clustering procedure. The stored distance algorithm is implemented to compute cluster assignments. The following process is implemented by using the CLUSTER procedure in SAS:

- The input measure score distances are squared.
- The clusters are initialized by assigning each contract to its own cluster.
- In order to determine which pair of clusters to merge, Ward's minimum variance method is used to separate the variance of the measure scores into within-cluster and between-cluster sum of squares components.
- From the existing clusters, two clusters are selected for merging to minimize the within-cluster sum of squares over all possible sets of clusters that might result from a merge.
- Steps 3 and 4 are repeated to reduce the number of clusters by one until a single cluster containing all contracts results.

The result is a data set that contains a tree-like structure of cluster assignments, from which any number of clusters between 1 and the number of contract measure scores could be computed. The SAS code for implementing these steps is:

```
proc cluster data=distancedat method=ward outtree=treedat noprint;
        id contract_id;
run;
```

The *distancedat* data set containing the Euclidian distances was created in Step 1. The option *method=ward* indicates that Ward's minimum variance method should be used to group clusters. The output data set is denoted with the *outtree* option and is called *treedat*.

3. Select the final set of clusters from the tree of cluster assignments.

The process outlined in Step 2 will produce a tree of cluster assignments, from which the final number of clusters is selected using the TREE procedure in SAS as follows:

```
proc tree data=treedat ncl=NSTARS horizontal out=outclusterdat noprint;
        id contract_id;
run;
```

The input data set, treedat, is created in Step 2 above. The syntax, ncl=NSTARS, denotes the desired final number of clusters (or star levels). For most measures, NSTARS= 5. In cases where multiple clusters have the same score value range those clusters are combined, leading to fewer than 5 clusters. Since the improvement measures have a constraint that contracts with improvement scores of zero or greater are to be assigned at least 3 stars for improvement, the clustering is conducted separately for contract measure scores that are greater than or equal to zero versus those that are less than zero. Specifically, Steps 1-3 are first applied to contracts with improvement scores that are greater than or equal to zero, in which case NSTARS equals three. The resulting improvement measure stars can take on values of 3, 4, or 5. For those contracts with improvement scores less than zero, Steps 1-3 are applied with NSTARS=2 and these contracts will either receive 1 or 2 stars.

4. Final Thresholds

The cluster assignments produced by the above approach have cluster labels that are unordered. The final step after applying the above steps to all contract measure scores is to order the cluster labels so that the 5-star category reflects the cluster with the best performance and the 1-star category reflects the cluster with the worst performance. With the exception of the improvement measures which are assigned lower thresholds of zero for the 3-star category, the measure thresholds are defined by examining the range of measure scores within each of the final clusters. The lower limit of each cluster becomes the cut point for the star categories for higher is better measures.

Determining Stars from Scores and Thresholds

The mean-resampling approach results in 10 sets of measure-specific cut points, one for each of the 10 implementations of the hierarchical clustering algorithm. For higher-is-better measures, the minimum score observed in each star category defines the effective cut points for the star categories. For lower-is-better measures, the maximum score observed in each star category defines the effective cut points for the star categories. These cut points are calculated after the application of Tukey outlier deletion. The final set of estimated thresholds are then calculated as the mean cut point for each threshold per measure from the 10 different cut point values. Tables K-3 and K-4 show the mean resampling final estimated thresholds for the 2026 Star Ratings. Tables K-5 and K-6 show the upper and lower Tukey outlier cutoffs.

Table K-3: 2026 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01	Less than 63%	Greater than or equal to 63% to less than 71%	Greater than or equal to 71% to less than 76%	Greater than or equal to 76% to less than 84%	Greater than or equal to 84%
C02	Less than 41%	Greater than or equal to 41% to less than 60%	Greater than or equal to 60% to less than 70%	Greater than or equal to 70% to less than 77%	Greater than or equal to 77%
C04	Less than 66%	Greater than or equal to 66% to less than 70%	Greater than or equal to 70% to less than 72%	Greater than or equal to 72% to less than 75%	Greater than or equal to 75%
C05	Less than 81%	Greater than or equal to 81% to less than 83%	Greater than or equal to 83% to less than 85%	Greater than or equal to 85% to less than 88%	Greater than or equal to 88%
C06	Less than 41%	Greater than or equal to 41% to less than 47%	Greater than or equal to 47% to less than 53%	Greater than or equal to 53% to less than 59%	Greater than or equal to 59%
C07	Less than 42%	Greater than or equal to 42% to less than 60%	Greater than or equal to 60% to less than 73%	Greater than or equal to 73% to less than 88%	Greater than or equal to 88%
C08	Less than 81%	Greater than or equal to 81% to less than 86%	Greater than or equal to 86% to less than 93%	Greater than or equal to 93% to less than 98%	Greater than or equal to 98%
C09	Less than 83%	Greater than or equal to 83% to less than 90%	Greater than or equal to 90% to less than 95%	Greater than or equal to 95% to less than 99%	Greater than or equal to 99%
C10	Less than 32%	Greater than or equal to 32% to less than 41%	Greater than or equal to 41% to less than 53%	Greater than or equal to 53% to less than 68%	Greater than or equal to 68%
C11	Less than 60%	Greater than or equal to 60% to less than 72%	Greater than or equal to 72% to less than 80%	Greater than or equal to 80% to less than 86%	Greater than or equal to 86%
C12	Less than 74%	Greater than or equal to 74% to less than 83%	Greater than or equal to 83% to less than 87%	Greater than or equal to 87% to less than 91%	Greater than or equal to 91%
C13	Less than 34%	Greater than or equal to 34% to less than 51%	Greater than or equal to 51% to less than 62%	Greater than or equal to 62% to less than 74%	Greater than or equal to 74%
C14	Less than 67%	Greater than or equal to 67% to less than 75%	Greater than or equal to 75% to less than 80%	Greater than or equal to 80% to less than 86%	Greater than or equal to 86%
C15	Less than 51%	Greater than or equal to 51% to less than 57%	Greater than or equal to 57% to less than 62%	Greater than or equal to 62% to less than 71%	Greater than or equal to 71%
C16	Less than 41%	Greater than or equal to 41% to less than 45%	Greater than or equal to 45% to less than 49%	Greater than or equal to 49% to less than 53%	Greater than or equal to 53%
C17	Less than 40%	Greater than or equal to 40% to less than 60%	Greater than or equal to 60% to less than 74%	Greater than or equal to 74% to less than 87%	Greater than or equal to 87%
C18	Greater than 12%	Greater than 10% to less than or equal to 12%	Greater than 9% to less than or equal to 10%	Greater than 7% to less than or equal to 9%	Less than or equal to 7%
C19	Less than 81%	Greater than or equal to 81% to less than 85%	Greater than or equal to 85% to less than 88%	Greater than or equal to 88% to less than 91%	Greater than or equal to 91%
C20	Less than 44%	Greater than or equal to 44% to less than 56%	Greater than or equal to 56% to less than 69%	Greater than or equal to 69% to less than 79%	Greater than or equal to 79%
C21	Less than 50%	Greater than or equal to 50% to less than 59%	Greater than or equal to 59% to less than 67%	Greater than or equal to 67% to less than 78%	Greater than or equal to 78%
C28	Greater than 0.68	Greater than 0.46 to less than or equal to 0.68	Greater than 0.26 to less than or equal to 0.46	Greater than 0.11 to less than or equal to 0.26	Less than or equal to 0.11
C29	Greater than 39%	Greater than 28% to less than or equal to 39%	Greater than 17% to less than or equal to 28%	Greater than 8% to less than or equal to 17%	Less than or equal to 8%
C30	Less than -0.121368	Greater than or equal to -0.121368 to less than 0	Greater than or equal to 0 to less than 0.202884	Greater than or equal to 0.202884 to less than 0.391253	Greater than or equal to 0.391253

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C31	Less than 96%	Greater than or equal to 96% to less than 98%	Greater than or equal to 98% to less than 99%	Greater than or equal to 99% to less than 100%	Greater than or equal to 100%
C32	Less than 92%	Greater than or equal to 92% to less than 96%	Greater than or equal to 96% to less than 98%	Greater than or equal to 98% to less than 100%	Greater than or equal to 100%
C33	Less than 86%	Greater than or equal to 86% to less than 94%	Greater than or equal to 94% to less than 97%	Greater than or equal to 97% to less than 100%	Greater than or equal to 100%

Notes: These are not the final thresholds for the 2026 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2026 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01	MA-PD	Less than 90%	Greater than or equal to 90% to less than 94%	Greater than or equal to 94% to less than 97%	Greater than or equal to 97% to less than 100%	Greater than or equal to 100%
D01	PDP	Less than 95%	Greater than or equal to 95% to less than 97%	Greater than or equal to 97% to less than 98%	Greater than or equal to 98% to less than 100%	Greater than or equal to 100%
D02	MA-PD	Greater than 0.68	Greater than 0.46 to less than or equal to 0.68	Greater than 0.26 to less than or equal to 0.46	Greater than 0.11 to less than or equal to 0.26	Less than or equal to 0.11
D02	PDP	Greater than 0.06	Greater than 0.04 to less than or equal to 0.06	Greater than 0.02 to less than or equal to 0.04	Greater than 0.01 to less than or equal to 0.02	Less than or equal to 0.01
D03	MA-PD	Greater than 39%	Greater than 28% to less than or equal to 39%	Greater than 17% to less than or equal to 28%	Greater than 8% to less than or equal to 17%	Less than or equal to 8%
D03	PDP	Greater than 12%	Greater than 8% to less than or equal to 12%	Greater than 5% to less than or equal to 8%	Greater than 3% to less than or equal to 5%	Less than or equal to 3%
D04	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
D04	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
D07	MA-PD	Less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 99	Greater than or equal to 99
D07	PDP	Less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 0	Greater than or equal to 0 to less than 99	Greater than or equal to 99
D08	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%
D08	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%
D09	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%
D09	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%
D10	MA-PD	Less than 84%	Greater than or equal to 84% to less than 88%	Greater than or equal to 88% to less than 90%	Greater than or equal to 90% to less than 93%	Greater than or equal to 93%
D10	PDP	Less than 87%	Greater than or equal to 87% to less than 89%	Greater than or equal to 89% to less than 90%	Greater than or equal to 90% to less than 92%	Greater than or equal to 92%
D11	MA-PD	Less than 81%	Greater than or equal to 81% to less than 87%	Greater than or equal to 87% to less than 91%	Greater than or equal to 91% to less than 96%	Greater than or equal to 96%

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D11	PDP	Less than 27%	Greater than or equal to 27% to less than 51%	Greater than or equal to 51% to less than 70%	Greater than or equal to 70% to less than 83%	Greater than or equal to 83%
D12	MA-PD	Less than 81%	Greater than or equal to 81% to less than 85%	Greater than or equal to 85% to less than 89%	Greater than or equal to 89% to less than 93%	Greater than or equal to 93%
D12	PDP	Less than 82%	Greater than or equal to 82% to less than 83%	Greater than or equal to 83% to less than 84%	Greater than or equal to 84% to less than 86%	Greater than or equal to 86%

Notes: These are not the final thresholds for the 2026 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2026 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	36	100
C02	26	100
C04	57	85
C05	70	98
C06	20.5	80
C07	0	100
C08	68	100
C09	71	100
C10	0	100
C11	36	100
C12	58	100
C13	9	100
C14	51	100
C15	20.5	94
C16	24	66
C17	1	100
C18	3	17
C19	73	100
C20	0	100
C21	21	98
C28	0	1.04
C29	0	82
C30 (improve)	0	1
C30 (decline)	-0.628528	0
C31	92	100
C32	84	100
C33	80	100

Notes: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For C30 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the C30 (improved) group.

Table K-6: 2026 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Type	Lower Cutoff	Upper Cutoff
D01	MA-PD	88	100
D02	MA-PD	0	1.04
D03	MA-PD	0	82
D04 (improve)	MA-PD	0	1
D04 (decline)	MA-PD	-0.844155	0
D07	MA-PD	99	99
D08	MA-PD	73	100
D09	MA-PD	79	100
D10	MA-PD	75	100
D11	MA-PD	71	100
D12	MA-PD	70	100
D01	PDP	88	100
D02	PDP	0	0.19
D03	PDP	0	28
D04 (improve)	PDP	0	1
D04 (decline)	PDP	-1	0
D07	PDP	99	99
D08	PDP	76	97
D09	PDP	82	96
D10	PDP	81	95
D11	PDP	0	100
D12	PDP	80	87

Note: If the calculated lower or upper outer fence exceeds the minimum or maximum range of the measure, then the minimum or maximum measure score is shown in the table. This means that no outliers were identified at that end of the measure score range. For D04 (decline) group, the upper cut off is technically the lowest value below zero since zero is included in the D04 (improved) group.

Guardrails are then applied to all non-CAHPS measures, with a few exceptions. Guardrails are not applied to the Part C and Part D improvement measures. Additionally, guardrails are not applied to new measures that have been in the Part C and D Star Rating program for 3 years or less. Measures returning to the Star Ratings after a substantive measure specification change are treated as new measures. Cut points for these new measures and improvement measures are based on the hierarchal clustering methodology with mean resampling. When applying guardrails, the difference between the current year and prior year's cut point is calculated for each of the 1 to 5 star levels. A cap value is then calculated and compared to the observed threshold difference.

- For measures having a 0 to 100 scale, an absolute percentage cap of 5 percentage point is applied.
  - If the absolute difference between the current and prior year's cut point is less than or equal to 5 percentage points, the current year's cut point is used as the final cut point value.
  - If the absolute difference between the current and prior year's cut point is greater than 5 percentage points, a 5 percentage point cap is applied. That is, 5 percentage points are added

to or subtracted from the prior year's cut point value (depending on the direction of movement for the cut point value in the current year) to obtain the final cut point value for the current year.

- For measures not having a 0 to 100 scale, a restricted range cap of 5 percent of the prior year's score range is applied. Specifically, the restricted range cap is equal to the prior year's (maximum score value minus minimum score value excluding outer fence outliers) multiplied by 0.05.
    - If the absolute difference between the current and prior year's is less than or equal to the calculated restricted range cap value, the current year's cut point is used as the final cut point value.
    - If the absolute difference between the current and prior year's is greater than the calculated restricted range cap value, then the restricted range cap is applied. That is, the calculated restricted range cap value is added to or subtracted from the prior year's cut point value (depending on the direction of the movement of the cut point value in the current year) to obtain the final cut point value for the current year.

Relative Distribution and Significance Testing (CAHPS) Methodology

The CAHPS measures are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses. See Attachment A for the case-mix adjusters. The percentile cut points for base groups are defined by current-year distribution of case-mix adjusted contract means. Percentile cut points are rounded to the nearest integer on the 0-100 reporting scale, and each base group includes those contracts whose rounded mean score is at or above the lower limit and below the upper limit. The number of stars assigned is determined by the position of the contract mean score relative to percentile cutoffs from the distribution of contract mean scores from all contracts (which determines the base group); statistical significance of the difference of the contract mean from the national mean along with the direction of the difference; the statistical reliability of the estimate (based on the ratio of sampling variation for each contract mean to between-contract variation); and the standard error of the mean score. All statistical tests, including comparisons involving standard errors, are computed using unrounded scores. All contracts' mean scores used in star assignments are case-mix adjusted and weighted to represent eligible enrollees by Part D status.

CAHPS reliability calculation details are provided under the section header, "MA & PDP CAHPS Between-Contract Variances for Reported Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings. Tables K-7 and K-8 contain the rules applied to determine the final CAHPS measure star value.

Table K-7: CAHPS Star Assignment Rules

Star	Criteria for Assigning Star Ratings
1	*A contract is assigned one star if both criteria (a) and (b) are met plus at least one of criteria (c) and (d):* *(a) its average CAHPS measure score is lower than the 15th percentile; AND* *(b) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score;* *(c) the reliability is not low; OR* *(d) its average CAHPS measure score is more than one standard error (SE) below the 15th percentile.*
2	*A contract is assigned two stars if it does not meet the one-star criteria and meets at least one of these three criteria:* *(a) its average CAHPS measure score is lower than the 30th percentile and the measure does not have low reliability; OR* *(b) its average CAHPS measure score is lower than the 15th percentile and the measure has low reliability; OR* *(c) its average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score and below the 60th percentile.*
3	*A contract is assigned three stars if it meets at least one of these three criteria:* *(a) its average CAHPS measure score is at or above the 30th percentile and lower than the 60th percentile, AND it is not statistically significantly different from the national average CAHPS measure score; OR* *(b) its average CAHPS measure score is at or above the 15th percentile and lower than the 30th percentile, AND the reliability is low, AND the score is not statistically significantly lower than the national average CAHPS measure score; OR* *(c) its average CAHPS measure score is at or above the 60th percentile and lower than the 80th percentile, AND the reliability is low, AND the score is not statistically significantly higher than the national average CAHPS measure score.*
4	*A contract is assigned four stars if it does not meet the five-star criteria and meets at least one of these three criteria:* *(a) its average CAHPS measure score is at or above the 60th percentile and the measure does not have low reliability; OR* *(b) its average CAHPS measure score is at or above the 80th percentile and the measure has low reliability; OR* *(c) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score and above the 30th percentile.*
5	*A contract is assigned five stars if both criteria (a) and (b) are met plus at least one of criteria (c) and (d):* *(a) its average CAHPS measure score is at or above the 80th percentile; AND* *(b) its average CAHPS measure score is statistically significantly higher than the national average CAHPS measure score;* *(c) the reliability is not low; OR* *(d) its average CAHPS measure score is more than one standard error (SE) above the 80th percentile.*

Table K-8: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Significant Below Average, Low Reliability	Significant Below Average Not Low Reliability	Not Significant Different from Average, Low Reliability	Not Significant Difference from Average, not Low Reliability	Significant Above Average, Low Reliability	Significant Above Average, not Low Reliability
Less than 15th percentile by greater than 1 SE	1	1	1	2	2	2	2
Less than 15th percentile by less than or equal to 1 SE	1	2	1	2	2	2	2
Greater than or equal to 15th to less than 30th percentile	2	2	2	3	2	3	2
Greater than or equal to 30th to less than 60th percentile	3	2	2	3	3	4	4
Greater than or equal to 60th to less than 80th percentile	4	3	4	3	4	4	4
Greater than or equal to 80th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
Greater than or equal to 80th percentile by greater than 1 SE	5	4	4	4	4	5	5

Notes: If reliability is very low (less than 0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability greater than or equal to 0.60 but less than 0.75 and also in the lowest 12% of contracts ordered by reliability. The SE is considered when the measure score is below the 15th percentile (in base group 1), significantly below average, and has low reliability: in this case, 1 star is assigned if and only if the measure score is at least 1 SE below the unrounded base group 1/2 cut point. Similarly, the SE is considered when the measure score is at or above the 80th percentile (in base group 5), significantly above average, and has low reliability: in this case, 5 stars are assigned if and only if the measure score is at least 1 SE above the unrounded base group 4/5 cut point.
For example, a contract in base group 4 that was not significantly different from average and had low reliability would receive 3 final stars.

As noted above, low reliability scores for CAHPS measures are defined as those with at least 11 respondents and reliability greater than or equal to 0.60 but less than 0.75 and also in the lowest 12% of contracts ordered by reliability. Table K-9 contains the 12% reliability cutoffs.

Table K-9: CAHPS Measure 12% Reliability Cutoffs

Measure	12% Reliability Cutoff
Annual Flu Vaccine	0.845946*
Getting Needed Care	0.725813
Getting Appointments and Care Quickly	0.589771**
Customer Service	0.624092
Rating of Health Care Quality	0.666920
Rating of Health Plan	0.810887*
Care Coordination	0.582772**
Rating of Drug Plan (MA-PD)	0.719340
Getting Needed Prescription Drugs (MA-PD)	0.575119**
Rating of Drug Plan (PDP)	0.926741*
Getting Needed Prescription Drugs (PDP)	0.803801*

Note: Reliabilities must be greater than or equal to 0.60 but less than 0.75 and also in the lowest 12% of contracts ordered by reliability to be designated as low reliability.
**These cutoffs are higher than 0.75, thus these cutoffs did not affect low reliability designations.*
***These cutoffs are lower than 0.6, thus low reliability designations are not assigned for these measures.*

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.

Table L-2: Before Overlap Adjustment

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

PDC Calculation
Covered Days: 59
Measurement Period: 120
PDC: 59 out of 120 equals 49%

Table L-3: 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
Lisinopril	15	16					
Lisinopril & HCTZ			15	13	3		
Benazepril & HCTZ			15	13			

PDC Calculation
Covered Days: 62
Measurement Period: 120
PDC: 62 out of 120 equals 52%

Example 3: Overlapping Fills of the Same and Different Target Drugs
In this example, a beneficiary is refilling both lisinopril and captopril. When a single and combination product both containing lisinopril overlap, there is an adjustment to the PDC. When lisinopril overlaps with captopril, we do not make any adjustment to the days covered.

Table L-4: Before Overlap Adjustment

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

PDC Calculation
Covered Days: 92
Measurement Period: 120
PDC: 92 out of 120 equals 77%

Table L-5: After Overlap Adjustment

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

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105 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

PDC: 12 out of 15 equals 80%

With the adjustment for the IP stay, days 5 and 6 are deleted from the treatment period. Additionally, the drug coverage during the IP stay is shifted to subsequent days of no supply (in this case, days 9 and 10), based on the assumption that if a beneficiary received his/her medication through the hospital on days 5 and 6, then he/she accumulated two extra days' supply during the IP stay. The two extra days' supply is used to cover the gaps in Part D drug coverage in days 9 and 10. This is illustrated in Table L-7.

Table L-7: After Adjustment

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

PDC Calculation:
Covered Days: 12
Treatment Period: 13
PDC: 12 out of 13 equals 92%

Example 2: Gap in Coverage before 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 from days 1-7 and 12-15, and an IP stay on days 12 and 13, as illustrated in Table L-8.

Table L-8: Before Adjustment

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

PDC Calculation:
Covered Days: 11
Treatment Period: 15
PDC: 11 out of 15 equals 73%

With the adjustment for the IP stay, days 12 and 13 are deleted from the treatment period. While there are two days' supply from the IP stay on days 12 and 13, there are no days without drug coverage after the IP stay. Thus, the extra days' supply is not shifted. This is illustrated in Table L-9.

Table L-9: After Adjustment

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

PDC Calculation:
Covered Days: 9
Treatment Period: 13
PDC: 9 out of 13 equals 69%

Example 3: Gap in Coverage Before and 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 from days 1-3, 6-9, and 12-15, and an IP stay on days 6-9, as illustrated in Table L-10.

Table L-10: Before Adjustment

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			X2	X2	X2	X2			X3	X3	X3	X3
Inpatient Stay						+	+	+	+						

PDC Calculation:
Covered Days: 11
Treatment Period: 15
PDC: 11 out of 15 equals 73%

With the adjustment for the IP stay, days 6-9 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay, based on the assumption that the beneficiary received his/her medication through the hospital on days 6-9. In this case, only days 10 and 11 do not have drug coverage and are after the IP stay, so two days' supply are shifted to days 10 and 11. This is illustrated in Table L-11.

Table L-11: After Adjustment

Day	1	2	3	4	5	10	11	12	13	14	15
Drug Coverage	X1	X1	X1			+	+	X2	X2	X3	X3
Inpatient Stay											

PDC Calculation:
Covered Days: 9
Treatment Period: 11
PDC: 9 out of 11 equals 82%

Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class

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 from days 1-4, and 7-11 for the same drug class, and an IP stay on days 2-4, as illustrated in Table L-12.

Table L-12: Before Adjustment

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

PDC Calculation:
Covered Days: 9
Treatment Period: 15
PDC: 9 out of 15 equals 60%

With the adjustment for the IP stay, days 2-4 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days' supply of the subsequent fill are

shifted. In this example, the days' supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes one day supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12. This is illustrated in Table L-13.

Table L-13: After Adjustment

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

PDC Calculation:
Covered Days: 9
Treatment Period: 12
PDC: 9 out of 12 equals 75%

Attachment M: Methodology for MPF Price Accuracy Measure

CMS's drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (MPF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the MPF price to the PDE price and determining the magnitude and frequency of differences found when the PDE price exceeds the MPF price. This document summarizes the methods currently used to construct each contract's MPF Composite Price Accuracy Score.

Contract Selection

The MPF Accuracy measure relies in part on the submission of pricing data to MPF. Therefore, only contracts with at least one plan meeting all of the following criteria are included in the analysis:

Not a PACE plan
Not a demonstration plan
Not an employer plan
Part D plan
Plan not terminated during the contract year

Only contracts with at least 30 eligible claims throughout the year are included in the accuracy measure. This ensures that the sample size of PDEs is large enough to produce a reliable accuracy score.

MPF Composite Price Accuracy Score

To calculate the MPF Composite Price Accuracy Score, the point-of-sale total cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the total cost resulting from using the unit price[1] reported on Plan Finder multiplied by the quantity listed on the PDE, plus the MPF dispensing fee.

This comparison includes only PDEs for which an MPF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. NCPDP numbers are mapped to their corresponding NPI numbers.

1. The corresponding reference NDC must appear under the relevant price ID for the pharmacy in the pricing file.[2]

2. The reference NDC must be on the plan's formulary. Drugs omitted from the plan's formulary are not included in the measure calculation, regardless of whether the drug is on the excluded drug supplemental file.

3. Because the retail unit cost reported on MPF is intended to apply to a 1, 2, or 3-month supply of a drugs, only claims with a Days Supply of 28-34, 60-62, or 90-93 are included. If a plan's bid indicates a 1, 2, or

[1] MPF unit costs are reported by plan, drug, days of supply, and pharmacy. The plan, drug, days of supply and pharmacy from the PDE are used to assign the corresponding MPF unit cost posted on medicare.gov on the date of the PDE.

[2] MPF prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use Medi-Span and then First Data Bank (FDB) if Medi-Span data is unavailable to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to MPF reference NDCs.

3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. For example, a plan that submits a 3 month retail supply of 100 days in their bid will have claims with a days supply of 90-100 included in their accuracy measure calculation.

4. PDEs for dates of service during which the plan was suppressed from Plan Finder or where the relevant pharmacy or drug was not reported in Plan Finder are not included since no Plan Finder cost can be assigned.[3]
5. PDEs for compound drugs or non-covered drugs are not included.
6. The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.

The MPF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the MPF. The contract's MPF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and MPF total cost,[4] and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to MPF prices.

Once MPF unit ingredient costs are assigned, the MPF ingredient cost is calculated by multiplying the unit costs reported on MPF by the quantity listed on the PDE. The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the MPF TC is the sum of the MPF ingredient cost and the MPF dispensing fee that corresponds to the same pharmacy, plan, and days of supply as that observed in the PDE[5]. Each claim is then given a score based on the difference between the PDE TC and the MPF TC. If the PDE TC is lower than or equal to the MPF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when point of sale costs are lower than or equal to the advertised costs. However, if the PDE TC is higher than the MPF TC, then the claim receives a score equal to the difference between the PDE TC and the MPF TC.[6,7] The contract level MPF Price Accuracy Index is the sum of the claim level scores and PDE TC across all PDEs that meet the inclusion criteria, divided by the PDE TC for those same claims. The MPF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the MPF TC. Note that the best possible MPF Price Accuracy Index is 1, and the best possible MPF Claim Percentage Index is 0. This occurs when the MPF TC is never lower than the PDE TC. The formulas below illustrate the calculation of the contract level MPF Price Accuracy Index and MPF Claim Percentage Index:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(TC_{iPDE} - TC_{iMPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}$$

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.
[4] MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is $10.237, then it is rounded to $10.24. MPF unit costs are not rounded.
[5] When assigning the MPF dispensing fee, CMS identifies brand or generic status of a drug using reference data sources (FDA NSDE and RxNorm). If a drug's status is inconsistent, CMS will assign the higher of the brand or generic dispensing fee.
[6] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded MPF cost by at least two cents ($0.02) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded MPF cost is $10.23, the 2-cent difference would be counted towards plan's accuracy score. However, if the rounded MPF cost is higher than $10.23, the difference would not count towards the plan's accuracy score.
[7] The MPF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the MPF price is lower than the floor price, the PDE price is compared against the floor price.

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i, and
TC_{iMPF} is the ingredient cost plus dispensing fee calculated from MPF data, based on the PDE_i reported NDC, days of supply, and pharmacy, then rounded to the nearest cent.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{i\text{PDE}>\text{MPF}}}{\sum_i \text{Claims}_{i\text{Total}}}$$

where

$\text{Claims}_{i\text{PDE}>\text{MPF}}$ is the total number of claims where the PDE price is greater than the rounded MPF price

$\text{Claims}_{i\text{Total}}$ is the total number of claims

We use the following formulas to convert the Claim Percentage Index and Price Accuracy Index into the MPF Composite Price Accuracy score:

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$
$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$
$$\text{MPF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

The MPF Composite Price Accuracy Score is rounded to the nearest whole number.

Example of Accuracy Index Calculation

Table M-1 shows an example of the MPF Composite Price Accuracy Score calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 eligible claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the MPF data that had been submitted by the contract and posted on MPF on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength, and dosage form. Using the reference NDC, the following MPF data are obtained: brand/generic dispensing fee (from the pharmacy cost file) and unit cost (from the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The MPF cost is computed as the quantity dispensed from PDE multiplied by the MPF unit cost plus the MPF brand/generic dispensing fee (brand or generic status is assigned based on the NDC), and then rounded to the nearest cent.
The last column shows the amount by which the PDE cost is higher than the rounded MPF cost. When PDE cost is less than or equal to the rounded MPF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs all divided by the sum of PDE costs. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table M-1: Example of Price Accuracy Index Calculation

NDC	Pharmacy Number	PDE Data DOS	PDE Data Ingredient Cost	PDE Data Dispensing Fee	PDE Data Quantity Dispensed	PDE Days of Supply	MPF Data Biweekly Posting Period	MPF Data Unit Cost	MPF Data Dispensing Fee Brand	MPF Data Dispensing Fee Generic	Assigned Brand or Generic Status	Calculated Value Total Cost PDE	Calculated Value Total Cost MPF	Calculated Value Amount that PDE is higher than MPF
A	111	01/08/2024	3.82	2	60	60	01/06/24 - 01/19/24	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2024	0.98	2	30	60	01/20/24 - 02/02/24	0.83	1.75	2.5	G	2.98	27.40	0
C	333	02/11/2024	10.48	1.5	24	28	02/03/24 - 02/16/24	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2024	47	1.5	90	30	02/17/24 - 03/01/24	0.48	1.5	2.25	G	48.50	45.45	3.05
											Totals	69.28		5.78
											Price Accuracy Index			1.08343
											Claim Percentage Index			0.5
											MPF Composite Price Accuracy Score			71

PDE = Prescription Drug Event
MPF = Medicare Plan Finder

Attachment N: MTM CMR Completion Rate Measure Scoring Methodologies

Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)

Step 1: Start with all contracts that enrolled beneficiaries in MTM at any point during contract year 2024. Beneficiaries with multiple records that contain varying information for the same contract are excluded from the measure calculation for that contract.

Step 2: Exclude contracts that did not enroll 31 or more beneficiaries in their MTM program who met the measure denominator criteria during contract year 2024.

Next, exclude contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2025), or that were not required to participate in data validation.

- Contracts that terminate on or before 07/01/2025 according to the Contract Info extract.

Additionally, exclude contracts that did not score at least 95% on data validation for their plan reporting of the MTM Program section and contracts that scored 95% or higher on data validation for the MTM Program section but that were not compliant with data validation standards/sub-standards for at least one of the following MTM data elements. We define a contract as being non-complaint if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation.

- MBI Number (Element B)
- Date of MTM program enrollment (Element H)
- Met the specified targeting criteria per CMS – Part D requirements (Element I)
- Date met the specified targeting criteria per CMS – Part D requirements (Element J)
- Date of MTM program opt-out, if applicable (Element K)
- Received annual CMR with written summary in CMS standardized format (Element O)
- Date(s) of CMR(s) (Element P)

Step 3: After removing contracts' and beneficiaries' data excluded above, suppress contract rates based on the following rules:

File DV failure: Contracts that failed to submit the CY 2024 MTM Program Reporting Requirements data file or who had a missing DV score for MTM are listed as "CMS identified issues with this plan's data."

Section-level DV failure: Contracts that score less than 95% in DV for their CY 2024 MTM Program Reporting Requirements data are listed as "CMS identified issues with this plan's data."

Element-level DV failure: Contracts that score 95% or higher in DV for their CY 2024 MTM Program Reporting Requirements data but that failed at least one of the seven data elements are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have fewer than 31 beneficiaries enrolled are listed as "Not enough data available."

Organizations can view their own plan reporting data validation results in HPMS (https://hpms.cms.gov/). From the home page, select Monitoring | Plan Reporting Data Validation.

Step 4: Calculate the rate for the remaining contracts using the following formula:

Number of beneficiaries from the denominator who received a CMR at any time during their period of MTM enrollment in the reporting period divided by Number of beneficiaries who were at least 18 years or older as of the beginning of the reporting period, met the specified targeting criteria per CMS during the reporting period, weren't in hospice at any point during the reporting period, and who were enrolled in the MTM program for at least 60 days during the reporting period. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year are included in the denominator and the numerator if they received a CMR within this timeframe. Beneficiaries are excluded from the measure calculation if they were enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe.

Attachment O: Methodology for the Puerto Rico Model

Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid and a complex legal history that affects the health care system in many ways. Puerto Rican beneficiaries are not eligible for LIS. The categorization of contracts into final adjustment categories for the Categorical Adjustment Index (CAI) relies on both the use of a contract's percentages of beneficiaries with Low Income Subsidy/Dual Eligible (LIS/DE) and disabled beneficiaries. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI.

The contract-level modified LIS/DE percentages for Puerto Rico contracts for the 2026 Star Ratings are developed using the following sources of information:

- The 2023 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2023 ACS 5-year estimates for the percentage of people living below 150% of the FPL; for Puerto Rico and for the 10 poorest US states (which may include the District of Columbia).
- The Medicare enrollment data file for those enrolled during 2024 provided for beneficiaries who were alive at least through December 2024, the percentage of each contract's beneficiaries who were DE, and for non-Puerto Rico contracts, the percentage who were LIS/DE. Beneficiary DE status was determined using the monthly beneficiary dual status codes. For non-Puerto Rico contracts, beneficiaries who were LIS were determined using the monthly beneficiary LIS status codes, and beneficiaries were classified LIS/DE by combining the beneficiaries identified as DE and beneficiaries identified as LIS.

The following steps are employed to determine the modified percentages of LIS/DE for MA contracts solely serving the population of beneficiaries in Puerto Rico. All references to contracts in Puerto Rico are limited to the contracts solely serving the population of beneficiaries in Puerto Rico.

- The 10 states with the highest proportion of people living below the FPL are identified, based on 2023 1-year data from ACS (U.S. Census Bureau, U.S. Department of Commerce. "Population 65 Years and Over in the United States." *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S0103*, https://data.census.gov/table/ACSST1Y2023.S0103?q=S0103&g=010XX00US$0400000&y=2023&d=ACS+1-Year+Estimates+Subject+Tables. Accessed on 6 Jun 2025.) The states identified are *Alabama, Arkansas, District of Columbia, Kentucky, Louisiana, Mississippi, New Mexico, New York, Oklahoma, and West Virginia.*
- Data are aggregated from Medicare Advantage contracts that had at least 90% of their beneficiaries enrolled with mailing addresses within the 10 highest poverty states identified in step (1).
  For the 2026 Star Ratings adjustment, the data used for the model development included a total of 134 Medicare Advantage contracts with at least 90% of their beneficiaries with mailing addresses in one of the ten poorest states listed above.
- A linear regression model is developed using the known LIS/DE percentage and the corresponding DE percentage from the MA contracts in the 10 highest poverty states with at least 90% of their beneficiaries with mailing addresses in one of the ten states.
- The model for Puerto Rico is developed using the model in step (3) as its base.

  The estimated slope from the linear fit in the previous step (3) is retained to approximate the expected

relationship between the hypothetical percentage of beneficiaries with LIS/DE status for each contract in Puerto Rico and its DE percentage. Note that the percentage of Puerto Rican beneficiaries eligible for LIS is hypothetical, since LIS status is not available to beneficiaries in Puerto Rico. However, as Puerto Rico contracts are expected to have a larger percentage of low-income beneficiaries, the intercept term is adjusted to be more suitable for use with Puerto Rico contracts as follows:

The intercept term for the Puerto Rico model is estimated by assuming that the Puerto Rico model will pass through the point (x, y) where x is the observed average DE percentage in the Puerto Rico contracts, and y is the expected hypothetical average percentage of LIS/DE in Puerto Rico. The expected hypothetical average percentage of LIS/DE in Puerto Rico (the y value) is not observable but is estimated by multiplying the observed average percentage of LIS/DE in the 10 highest poverty states identified in step (1) by the ratio based on the 2023 5-year ACS estimates of the percentage living below 150% of the FPL in Puerto Rico compared to the corresponding percentage in the 10 poorest US states.

- To obtain each Puerto Rico contract's modified LIS/DE percentage, a contract's observed DE percentage is used in the Puerto Rico model developed in the previous step (4).

  A contract's observed DE percentage is multiplied by the slope estimate, and then, the newly derived intercept term is added to the product. The estimated modified LIS/DE percentage is capped at 100%. Any estimated LIS/DE percentage that exceeds 100% is categorized in the final adjustment category for LIS/DE with an upper bound of 100%.

  Note that the District of Columbia is included with the 50 US states when determining the 10 poorest in 2023. All estimated modified LIS/DE values for Puerto Rico are rounded to six decimal places when expressed as a percentage. (This rounding rule aligns with the limits for the adjustment categories for LIS/DE for the CAI.)

Model

The generic model developed to estimate a contract's LIS/DE percentage using its DE percentage is as follows:

$$\widehat{\text{LIS/DE}} = (\text{ Slope} \times \text{contract's DE percentage }) + (\text{ intercept })$$

Using the data from the 10 highest poverty states, the estimated slope was calculated to be 0.953992.

$$\widehat{\text{LIS/DE}} = (0.953992 \times \text{contract's DE percentage }) + (\text{ intercept })$$

Next, the intercept for the Puerto Rico model was determined using the point (x, y) where x is the observed average DE percentage in Puerto Rico contracts (28.804884%) and y is an estimated expected average hypothetical percentage of LIS/DE in Puerto Rico.

To calculate the estimated expected average percentage of LIS/DE in Puerto Rico, the observed average percentage of LIS/DE in the 10 poorest US states identified in step (1) is multiplied by the ratio of the percentage of Puerto Rico residents living below 150% of the FPL to the analogous percentage in the 10 poorest US states.

Description	Value
Percent of PR residents below 150% of FPL	*58.400000%*
Percent of residents in the 10 poorest US states below 150% of FPL	*24.328679%*
Observed average LIS/DE percentage in the 10 poorest US states	*47.923411%*
Observed average DE percentage in Puerto Rico contracts	*28.804884%*

The product thus becomes $\left(47.923411 \times \frac{58.400000}{24.328679}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.953992 \times \text{contract's DE percentage}) + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)\right)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 5%, the value of 5.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.953992 \times \text{contract's DE percentage}) + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)\right)$$

The hypothetical contract's DE percentage of 5.000000% is substituted into the Puerto Rico model.

$$\widehat{\text{LIS/DE}} = (0.953992 \times 5.000000) + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884)\right)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 5.000000% is 92.328521%.

The final adjustment category for the CAI adjustment is identified using the LIS/DE percentage 92.328521%.

Attachment P: Identification of Contracts Affected by Disasters

Natural disasters such as hurricanes and wildfires can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide them with important medical care and prescription drug coverage. These disasters may negatively affect the underlying operational and clinical systems that CMS relies on for accurate performance measurement in the Star Ratings program.

The 2026 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html) describes CMS's policy for making adjustments in the Star Ratings to take into account the effects of extreme and uncontrollable circumstances which occurred during the performance period. This is also codified in regulation at §422.166(i) and §423.186(i).

Operational Steps to Calculating Enrollment Impacted in Affected Contracts.

- Identify the areas which experienced both extreme and uncontrollable circumstances as defined in Section 1135 (g) of the Act and also are within a county or statistically equivalent entity, U.S. territory or tribal government designated in a major disaster declaration under the Stafford Act.
  - Areas where the Health and Human Services (HHS) Secretary exercised their authority under Section 1135 of the Act can be found at the Public Health Emergency website at https://www.phe.gov/emergency/news/healthactions/section1135/Pages/default.aspx
  - Major disaster areas are identified by the Federal Emergency Management Agency (FEMA) website at: https://www.fema.gov/disasters.

  Table P-1 lists the Section 1135 waivers issued by the HHS Secretary along with associated FEMA major disaster information that falls within the performance period for the 2026 Star Ratings.

Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations

Section 1135 Waiver Date Issued	*Waiver or Modification of Requirements Under Section 1135 of the Social Security Act*	*FEMA Incident Type*	*Affected State*	*Incident Start Date*
7/12/2024	*Hurricane Beryl*	*Hurricane*	*Texas*	***7/5/2024***
8/6/2024	*Hurricane Debby*	*Hurricane*	*Florida*	***8/1/2024***
8/7/2024	*Hurricane Debby*	*Hurricane*	*Georgia*	***8/4/2024***
9/12/2024	*Hurricane Francine*	*Hurricane*	*Louisiana*	*9/9/2024*
9/26/2024	*Hurricane Helene*	*Hurricane*	*Florida*	*9/23/2024*
9/27/2024	*Hurricane Helene*	*Hurricane*	*Georgia*	*9/24/2024*
9/28/2024	*Hurricane Helene*	*Hurricane*	*North Carolina*	*9/25/2024*
9/30/2024	*Hurricane Helene*	*Hurricane*	*Tennessee*	*9/26/2024*
9/30/2024	*Hurricane Helene*	*Hurricane*	*South Carolina*	*9/25/2024*
10/8/2024	*Hurricane Milton*	*Hurricane*	*Florida*	*10/5/2024*
*1/10/2025**	*Wildfires*	*Wildfires and Straight-line Winds*	*California*	*1/7/2025*

*Applies to CAHPS measures only. For all contracts affected by the 2025 Los Angeles County wildfires (i.e., at least 25 percent of their enrollees resided in Los Angeles County at the time of the disaster), the CAHPS

measure-level better-of policy codified at §§ 422.166(i)(2)(iv) and 423.186(i)(2)(iv) will be implemented for the 2026 and 2027 Star Ratings.

- Identify the counties or statistically equivalent entities which were declared as Individual Assistance areas by each of the FEMA major disaster declarations that meet the criteria set out in Step 1 below.

  Table P-2 lists all of the relevant FEMA major disaster declarations along with the state and associated Individual Assistance counties.

Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4798-TX	Texas	Austin, Bowie, Brazoria, Chambers, Fort Bend, Galveston, Harris, Jackson, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Nacogdoches, Orange, Polk, San Jacinto, Shelby, Trinity, Walker, Waller, Wharton
DR-4806-FL	Florida	Alachua, Baker, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hillsborough, Jefferson, Lafayette, Levy, Madison, Manatee, Pinellas, Sarasota, Suwannee, Taylor
DR-4821-GA	Georgia	Bryan, Bulloch, Chatham, Effingham, Evans, Liberty, Long, Screven
DR-4817-LA	Louisiana	Ascension, Assumption, Jefferson, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne
DR-4828-FL	Florida	Alachua, Baker, Bradford, Charlotte, Citrus, Collier, Columbia, DeSoto, Dixie, Duval, Franklin, Gilchrist, Gulf, Hamilton, Hernando, Hillsborough, Jefferson, Lafayette, Lee, Leon, Levy, Madison, Manatee, Pasco, Pinellas, Putnam, Sarasota, Suwannee, Taylor, Union, Wakulla
DR-4830-GA	Georgia	Appling, Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Bryan, Bulloch, Burke, Butts, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Colquitt, Columbia, Cook, Dodge, Echols, Effingham, Elbert, Emanuel, Evans, Fulton, Glascock, Glynn, Hancock, Irwin, Jeff Davis, Jefferson, Jenkins, Johnson, Lanier, Laurens, Liberty, Lincoln, Long, Lowndes, McDuffie, McIntosh, Montgomery, Newton, Pierce, Rabun, Richmond, Screven, Stephens, Taliaferro, Tattnall, Telfair, Thomas, Tift, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler, Wilkes
DR-4827-NC	North Carolina	Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Eastern Band of Cherokee Indians of North Carolina, Forsyth, Gaston, Graham, Haywood, Henderson, Iredell, Jackson, Lee, Lincoln, Macon, Madison, McDowell, Mecklenburg, Mitchell, Nash, Polk, Rowan, Rutherford, Stanly, Surry, Swain, Transylvania, Union, Watauga, Wilkes, Yadkin, Yancey
DR-4832-TN	Tennessee	Carter, Cocke, Greene, Hamblen, Hawkins, Johnson, Unicoi, Washington
DR-4829-SC	South Carolina	Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Catawba Indian Reservation, Cherokee, Chester, Edgefield, Fairfield, Greenville, Greenwood, Hampton, Jasper, Kershaw, Laurens, Lexington, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union, York
DR-4834-FL	Florida	Brevard, Charlotte, Citrus, Clay, Collier, DeSoto, Duval, Flagler, Glades, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miccosukee Indian Reservation, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia
DR-4856-CA*	California	Los Angeles

*Applies to CAHPS measures only. For all contracts affected by the 2025 Los Angeles County wildfires (i.e., at least 25 percent of their enrollees resided in Los Angeles County at the time of the disaster), the CAHPS measure-level better-of policy codified at §§ 422.166(i)(2)(iv) and 423.186(i)(2)(iv) will be implemented for the 2026 and 2027 Star Ratings.

- Identify the service area at the state/county level for each contract in operation during the performance period. The service area of some organization types rated in the Star Ratings are not defined at the state/county level, so their service area must be transformed to include all states and counties covered by their service area.

  Table P-3 lists how the service area for each organization type rated in the Star Ratings is defined and what transformation, if any, is needed to create a common state/county level file for all contracts.

Table P-3: Organization type service areas and necessary transformations

Star Rating Organization Types	How Service Area is defined	How Service Area is transformed
1876 Cost, E-CCP, E-PDP, E-PFFS, Local CCP, MSA, PFFS, R-PFFS & R-CCP	*State/County*	*Not necessary, service area is defined at the state/county level*
Regional CCP	*MA Region*	*A record is created for each state/county within the MA region*
PDP	*PDP Region*	*A record is created for each state/county within the PDP region*

- Compare the Individual Assistance states and counties from Step 2 below to the service area from all contracts created in Step 3 below with the state and counties. Create a list of all contracts which have any county that matches in both lists.
- Create a second list of all contracts that do not share any service area with the Individual Assistance counties, so that information on the status of all contracts is accounted for during the performance period.
- Identify the timeframe for each disaster and the associated enrollment files. Each of the disasters occurred during a specific period of time. Since the enrollment in a contract is constantly changing, CMS used the enrollment the contract was paid for in a month that as closely matched the disaster period in the specific state/county as possible for all further processing, following the months in the table below.

  Table P-4 shows each of the disasters where relief was granted along with the disaster start date, and the enrollment file month that was used for that specific disaster. The enrollment file choice was based on the enrollment file cut-off date the file was created.

Table P-4: Major Disasters with associated enrollment months

FEMA Declaration	State	Start Date	Enroll File	Enroll Cut Off
DR-4798-TX	*Texas*	*7/5/2024*	*August 2024*	*July 5, 2024*
DR-4806-FL	*Florida*	*8/1/2024*	*September 2024*	*August 9, 2024*
DR-4821-GA	*Georgia*	*8/4/2024*	*September 2024*	*August 9, 2024*
DR-4817-LA	*Louisiana*	*9/9/2024*	*October 2024*	*September 6, 2024*
DR-4828-FL	*Florida*	*9/23/2024*	*November 2024*	*October 4, 2024*
DR-4830-GA	*Georgia*	*9/24/2024*	*November 2024*	*October 4, 2024*
DR-4827-NC	*North Carolina*	*9/25/2024*	*November 2024*	*October 4, 2024*
DR-4832-TN	*Tennessee*	*9/26/2024*	*November 2024*	*October 4, 2024*
DR-4829-SC	*South Carolina*	*9/25/2024*	*November 2024*	*October 4, 2024*
DR-4834-FL	*Florida*	*10/5/2024*	*November 2024*	*October 4, 2024*
DR-4856-CA	*California*	*1/7/2025*	*February 2025*	*January 3, 2024*

- Calculate disaster impacted enrollment for contracts experiencing multiple disasters. Because the contracts serve areas of different sizes and can sometimes serve large, diverse areas, it is common for a contract to be affected by more than one of the disasters. To account for this, CMS averaged the county/state level enrollments from each of corresponding enrollment periods in which the contract was affected.

  Table P-5 shows an example where all possible enrollment periods are accounted for and how the enrollment for a contract in a state/county which matched the contract's service area state/county was calculated. Enrollment in out of service area state/counties was not included.

Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters

Formula ID	Enrolled 202X_10	Enrolled 202X_11	Enrolled 202X_12	Enrollment Used
B	*True*	*True*	*True*	*(202X_10 + 202X_11 + 202X_12) divided by 3*
C	*True*	*True*		*(202X_10 + 202X_11) divided by 2*
F	*True*		*True*	*(202X_10 + 202X_12) divided by 2*
H	*True*			*202X_10*
J		*True*	*True*	*(202X_11 + 202X_12) divided by 2*
L		*True*		*202X_11*
N			*True*	*202X_12*
P				*0 (zero)*

- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in the entire service area for the contract to be used in further processing.
- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in all of the Individual Assistance counties that correspond to the contract service area.
- Using the final list of affected contracts from Step 4 below, calculate the percentage of the contract's total service area enrollment that was affected by the Individual Assistance area enrollment. Create flags for the greater than or equal to 25% threshold for processing of the ratings data for those contracts.

Example:

Steps 1 and 2 use the disasters and counties that have already been defined in Tables P-1 & P-2. For Steps 3 through 10, we use an example contract, HAAAA, which offers services to some counties from both California and Texas.

Step 3, Table P-6 below contains the full list of counties that make up the service area for contract HAAAA.

Step 4, the Individual Assistance County column is included in Table P-6. Rows marked TRUE are matches from Individual Assistance counties in the disasters for year 202X and the service areas of HAAAA. The rows marked FALSE were not Individual Assistance counties for any of the disasters in HAAAA.

Step 5, since the example contract HAAAA has service areas that coincide with disaster counties, it is not included in the list of contracts not affected.

Step 6, there are two separate enrollment periods associated with the disasters that match example contract HAAAA's service area. Those enrollment periods are 202X/09 & 202X/11. Columns for all enrollment periods are included in Table P-6, but only the valid enrollment periods contain the necessary data.

Step 7, the average enrollment is calculated for the included enrollment periods. The result of each average enrollment calculation for each county in the example contract's service area is shown in the final column of Table P-6.

Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
06003	Alpine	CA	No	FALSE	8	-	8	8
06009	Calaveras	CA	No	FALSE	849	-	850	850
06011	Colusa	CA	No	FALSE	168	-	166	167
06015	Del Norte	CA	No	FALSE	369	-	360	364
06023	Humboldt	CA	No	FALSE	702	-	710	706
06045	Mendocino	CA	No	TRUE	428	-	429	428
06049	Modoc	CA	No	FALSE	157	-	158	158
06063	Plumas	CA	No	FALSE	182	-	181	182
06093	Siskiyou	CA	No	FALSE	798	-	800	799
06105	Trinity	CA	No	FALSE	150	-	150	150
48043	Brewster	TX	Yes	FALSE	16	-	15	16
48047	Brooks	TX	Yes	FALSE	28	-	27	28
48049	Brown	TX	Yes	FALSE	64	-	65	64
48057	Calhoun	TX	Yes	TRUE	28	-	28	28
48093	Comanche	TX	Yes	FALSE	33	-	32	32
48103	Crane	TX	Yes	FALSE	8	-	8	8
48109	Culberson	TX	Yes	FALSE	3	-	3	3
48123	DeWitt	TX	Yes	TRUE	26	-	26	26
48131	Duval	TX	Yes	FALSE	30	-	28	29
48133	Eastland	TX	Yes	FALSE	64	-	62	63
48143	Erath	TX	Yes	FALSE	61	-	59	60
48163	Frio	TX	Yes	FALSE	43	-	42	42
48171	Gillespie	TX	Yes	FALSE	17	-	17	17
48175	Goliad	TX	Yes	TRUE	18	-	18	18
48177	Gonzales	TX	Yes	TRUE	41	-	41	41
48237	Jack	TX	Yes	FALSE	35	-	34	34
48239	Jackson	TX	Yes	TRUE	30	-	30	30
48255	Karnes	TX	Yes	TRUE	19	-	19	19
48265	Kerr	TX	Yes	FALSE	85	-	86	86
48283	La Salle	TX	Yes	FALSE	25	-	25	25
48297	Live Oak	TX	Yes	FALSE	24	-	24	24
48301	Loving	TX	Yes	FALSE	0	-	0	0
48311	McMullen	TX	Yes	FALSE	4	-	4	4
48321	Matagorda	TX	Yes	TRUE	144	-	140	142
48323	Maverick	TX	Yes	FALSE	160	-	156	158
48371	Pecos	TX	Yes	FALSE	20	-	21	20
48377	Presidio	TX	Yes	FALSE	50	-	49	50

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48389	Reeves	TX	Yes	FALSE	8	-	8	8
48391	Refugio	TX	Yes	TRUE	21	-	21	21
48443	Terrell	TX	Yes	FALSE	9	-	9	9
48463	Uvalde	TX	Yes	FALSE	13	-	10	12
48469	Victoria	TX	Yes	TRUE	158	-	154	156
48475	Ward	TX	Yes	FALSE	15	-	15	15
48495	Winkler	TX	Yes	FALSE	20	-	20	20

Step 8, sum the average enrollment from all rows from Table P-6. The total comes out to 5,120 for contract HAAAA.

Step 9, sum the average enrollment from all the rows from Table P-6 where the Individual Assistance counties is TRUE for contract HAAAA. The Individual Assistance total comes out to 909.

Step 10, calculate the final percentage for contract HAAAA. (909 / 5,120) * 100 = 17.753906 = 18%. The flag for greater than or equal to 25% is set to false since the example contract did not meet those thresholds.

Attachment Q: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages in each level of the Star Ratings.

Measure level messages

Table Q-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table Q-1: Measure level missing data messages

Message	Measure Level
Coming Soon	*Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live*
Medicare shows only a Star Rating for this topic	*Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2*
Not enough data available	*There were data for the contract, but not enough to pass the measure exclusion rules*
CMS identified issues with this plan's data	*Data were materially biased, erroneous and/or not reported by a contract required to report*
Not Applicable	*Used in the numeric data for the improvement measures in Plan Preview 1. In the HPMS Measure Star Page when a measure does not apply for a contract. When a Disenrollment Reasons Survey measure does not apply to the contract type.*
Benefit not offered by plan	*The contract was required to report this HEDIS measure but doesn't offer the benefit to members*
Plan too new to be measured	*The contract is too new to have submitted measure data*
No data available	*There were no data for the contract included in the source data for the measure*
Plan too small to be measured	*The contract had data but did not have enough enrollment to pass the measure exclusion rules*
Plan not required to report measure	*The contract was not required to report the measure*

Assignment rules for Part C measure messages

Part C uses a set of rules for assigning the missing data message that varies by the data source. The rules for each data source are defined below.

Appeals (IRE) measures (C31 & C32):

Has CMS identified issues with the contract's data?
- Yes: Display message: CMS identified issues with this plan's data
- No: Is there a valid numeric measure rate?
  - Yes: Display the numeric measure rate
  - No: Is the contract effective date greater than 01/01/2024?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

CAHPS measures (C03, C22, C23, C24, C25, C26, & C27):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date greater than 07/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (C33):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost, MSA, or Employer/Union Only Direct Contract PDP?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date greater than 01/01/2025?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C28):

Is the contract effective date greater than 01/01/2024?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment less than 800 in 2024?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

HEDIS measures except PCR and TRC (C01, C02, C10 – C14, C17, C19, C21):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment less than 500 in July 2024?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR 18 and older (C18)

Was the contract required to report HEDIS?

- Yes: Was the contract enrollment less than 500 in July 2024?
  - Yes: Display message: Plan too small to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the combined denominator for the 18-64 and 65+ measures less than 150?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS TRC average (C20):

Was the contract required to report HEDIS?

- Yes: Was the contract enrollment less than 500 in July 2024?
  - Yes: Display message: Plan too small to be measured
  - No: Is the audit designation for all four TRC measures R?
    - No: Is the audit designation for any of the four TRC measures BD, BR, or NR?
      - Yes: Display message: CMS identified issues with this plan's data
      - No: Is the audit designation for any of the four TRC measures NB?
        - Yes: Display message: Benefit not offered by plan
        - No: The audit designation for one of the four TRC measures is NQ.
          Display message: Plan not required to report measure
    - Yes: Was a valid patient level detail file 1 submitted and the measure data usable?
      - Yes: Is the status for any component of the TRC average measure NA?
        - Yes: Display message: Not enough data available
        - No: Was contract enrollment at least 500 but less than 1,000?
          - Yes: Is the measure reliability at least 0.7?
            - Yes: Display the HEDIS measure numeric rate
            - No: Display message: No data available
          - No: Display the HEDIS measure numeric rate
      - No: Display message: CMS identified issues with this plan's data
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS SNP measures (C08 & C09):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2026?
- Yes: Display message: Plan not required to report measure
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: What is the HEDIS measure audit designation?
    - BD: Display message: CMS identified issues with this plan's data
    - BR: Display message: CMS identified issues with this plan's data
    - NB: Display message: Benefit not offered by plan
    - NR: Display message: CMS identified issues with this plan's data
    - NQ: Display message: Plan not required to report measure
    - R: Is there a valid HEDIS measure numeric rate?
      - Yes: What is the status?
        - NA: Display message: Not enough data available
        - R: Display the HEDIS measure numeric rate
      - No: Display message: No data available

HEDIS-HOS measures (C06, C15, & C16):

Is there a valid HEDIS-HOS numeric rate?
- Yes: Display the HEDIS-HOS numeric rate
- No: Is the contract effective date greater than 01/01/2023?
  - Yes: Display message: Plan too new to be measured
  - No: Is the February 2024 contract enrollment less than 500?
    - Yes: Display message: Plan too small to be measured
    - No: Is there a HEDIS-HOS rate code?
      - Yes: Assign message according to value below:
        - NA: Display message: Not enough data available
        - NB: Display message: Benefit not offered by plan
      - No: Display message: No data available

HOS measures (C04 & C05):

Is there a valid numeric HOS measure rate?
- Yes: Display the numeric HOS rate
- No: Did the contract include only I-SNPs in 2022 or have fewer than 500 non-I-SNP enrollees in February 2022?
  - Yes: Display message: Plan not required to report measure
  - No: Was the HOS measure rate NA or is the denominator less than 100?
    - Yes: Display message: Not enough data available
    - No: Is the contract effective date greater than 01/01/2021?
      - Yes: Display message: Plan too new to be measured
      - No: Is the February 2022 contract enrollment less than 500?
        - Yes: Display message: Plan too small to be measured
        - No: Display message: No data available

Members Choosing to Leave the Plan (C29):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Plan Reporting SNP measure (C07):

Is the organization type (1876 Cost, PFFS, MSA) or is SNP not offered in 2026?
- Yes: Display message: Plan not required to report measure
- No: Is there a valid Plan Reporting numeric rate?
  - Yes: Display the Plan Reporting numeric rate
  - No: Were there Data Issues Found?
    - Yes: Display message: CMS identified issues with this plan's data
    - No: Is the contract effective date greater than 01/01/2024?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C30):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part D measure messages

CAHPS measures (D05, D06):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date greater than 07/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Is the CAHPS measure rate NR?
    - Yes: Display message: Not enough data available
    - No: Is the CAHPS measure rate NA?
      - Yes: Display message: No data available
      - No: Display message: Plan too small to be measured

Call Center – Foreign Language Interpreter and TTY Availability measure (D01):

Is there a valid call center numeric rate?
- Yes: Display the call center numeric rate
- No: Is the organization type 1876 Cost?
  - Yes: Display message: Plan not required to report measure
  - No: Is the contract effective date greater than 01/01/2025?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (D02):

Is the contract effective date greater than 01/01/2024?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment less than 800 in 2024?
  - Yes: Display message: Not enough data available
  - No: Is there a valid numeric CTM rate?
    - Yes: Display the numeric CTM rate
    - No: Display message: No data available

Improvement (Star Ratings) measure (D04):

Is there a valid improvement measure rate?
- Yes: Display message: Medicare shows only a Star Rating for this topic
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Members Choosing to Leave the Plan (D03):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

MPF Price Accuracy measure (D07):

Is the contract effective date greater than 9/30/2024?
- Yes: Display message: Plan too new to be measured
- No: Does contract have at least 30 claims over the measurement period for the price accuracy index?
  - Yes: Display the numeric price accuracy rate
  - No: Is the organization type 1876 Cost or Employer plan and does not offer Drugs?
    - Yes: Display message: Plan not required to report measure
    - No: Display message: Not enough data available

Patient Safety measures – Adherence (D08 - D10) & SUPD (D12):

Does the contract offer Part D?

Yes: Is the contract effective date greater than 12/31/2024?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 30 or fewer enrolled beneficiaries continuously enrolled (measure denominator)?
  - Yes: Display message: Not enough data available
  - No: Display numeric measure percentage

No: Plan not required to report measure

Patient Safety measure – MTM CMR (D11)

Is the contract effective date greater than 12/31/2024?
- Yes: Display message: Plan too new to be measured
- No: Is Part D offered?
  - Yes: Is there a numeric rate?
    - Yes: Display numeric measure percentage
    - No: Is there a Reason(s) for Display Message?
      - Yes: Display appropriate message per Table Q-2
  - No: Display message: Plan not required to report measure

Table Q-2: MTM CMR Reason(s) for Display Message conversion

Reason(s) for Display Message	Star Ratings Message
Contract failed to submit file and pass system validation by the reporting deadline	*CMS identified issues with this plan's data*
Contract did not pass element-level DV for at least one element	*CMS identified issues with this plan's data*
Contract had missing score on MTM section DV	*CMS identified issues with this plan's data*
Contract scored less than 95% on MTM section DV	*CMS identified issues with this plan's data*
Contract had 30 or fewer beneficiaries meeting denominator criteria	*Not enough data available*
Contract had all plans terminate by validation deadline	*Not required to report*
Contract had no MTM enrollees to report	*Not required to report*
Contract has 0 Part D enrollees	*Not required to report*
Contract not required to submit MTM program	*Not required to report*

Domain, Summary, and Overall level messages

Table Q-3 contains all of the possible messages that could be assigned to missing data at the domain, summary, and overall levels.

Table Q-3: Domain, Summary, and Overall level missing data messages

Message	Domain Level	Summary & Overall Level
Coming Soon	*Used for all domain ratings in MPF between Oct 1 and when the actual Star Rating data go live*	*Used for all summary and overall ratings in MPF between Oct 1 and when the actual Star Rating data go live*
Not enough data available	*The contract did not have enough rated measures to calculate the domain rating*	*The contract did not have enough rated measures to calculate the summary or overall rating*
Plan too new to be measured	*The contract is too new to have submitted measure data for a domain rating to be calculated*	*The contract is too new to have submitted data to be rated in the summary or overall levels*

Assignment rules for Part C & Part D domain rating level messages

Part C & D domain message assignment rules:

Is there a numeric domain star?
- Yes: Display the numeric domain star
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for Part C & Part D summary rating level messages

Part C & D summary rating message assignment rules:

Is there a numeric summary rating star?
- Yes: Display the numeric summary rating star
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Assignment rules for overall rating level messages

Overall rating message assignment rules:

Is there a numeric overall rating star?
- Yes: Display the numeric overall rating star
- No: Is the contract effective date greater than 01/01/2024?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

Disenrollment Reasons messages

The 2026 Star Ratings posted to the CMS downloadable Master Table and HPMS includes data collected from the Disenrollment Reasons Survey (DRS). The DRS data was not used at any point in the calculation of the Star Ratings. The data are provided for information only at this time and are shown in HPMS with the Star Ratings data and on the display page at http://go.cms.gov/partcanddstarratings.

Because there are instances where a contract does not have data to display, a set of rules was developed to assign messages where data was missing so the data area would not be left blank.
Table Q-4 contains all of the possible messages that could be assigned to missing data in the disenrollment reason data displayed in HPMS.

Table Q-4: Disenrollment Reason missing data messages

Message	Meaning
Not Applicable	*Used when the DRS measure does not apply to the contract type*
Not Available	*Used when there is no numeric data available or data reliability indicated the value should be suppressed*
Plan too new to be measured	*The contract is too new for data to be collected for the measure*

Disenrollment Reasons message assignment rules:

Is the contract effective date greater than 1/1/2024?
- Yes: Display message: Plan too new to be measured
- No: Is there numeric data for the contract in this DRS measure?
  - Yes: Did the data reliability check indicate the data should be suppressed?
    - Yes: Display message: Not Available
    - No: Display the numeric DRS rate
  - No: Does the DRS measure apply to the organization type
    - Yes: Display message: Not Available
    - No: Display message: Not Applicable

AEP	The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan or re-enroll into their existing Medicare Part C or D Plan or change into another Medicare plan is known as the Annual Election Period (AEP). The chosen Medicare Part C or D plan coverage begins on January 1st.
C-SNP	Chronic Condition Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2.
CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
CCP	A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS's requirements.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Cost Plan	A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan in accordance with a cost reimbursement contract under §1876(h) of the Act. In the Star Ratings, CMS classifies a Cost Plan not offering Part D as MA-Only and a Cost Plan offering Part D as MA-PD.
D-SNP	Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Disability Status	Based on the original reason for entitlement for Medicare (Disability insurance benefits or both Disability insurance benefits and End-Stage Renal Disease).
Dual eligibles	Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
Euclidean distance	The absolute value of the difference between two points, x-y.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
I-SNP	Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to institutionalized special needs individuals defined in 42 CFR 422.2.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-Only	An MA organization that does not offer Medicare prescription drug coverage.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
MSA	Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder).
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.

Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
PFFS	Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers who are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality (“signal”) rather than random variation (“noise”). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
SNP	A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP).
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how likely differences observed are due to chance when plans are actually the same. CMS uses statistical tests (e.g., t-test) to determine if a contract’s measure value is statistically significantly greater or less than the national average for that measure, or whether conversely the observed differences from the national average could have arisen by chance.
Sum of Squares	Method used to measure variation or deviation from the mean.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.

Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

Attachment S: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS (https://hpms.cms.gov) to understand the various pages and fields shown in the HPMS Star Ratings module. This module employs standard HPMS user access rights so that users can only see contracts associated with their user id.

HPMS Star Ratings Module

The HPMS Star Ratings module contains the Part C & Part D data and stars for all contracts that were rated in the ratings year along with much of the detailed data that went into the various calculations. To access the Star Ratings module you must be logged into HPMS. If you do not have access to HPMS, information on how to obtain access can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Overview.html

Once you are logged into HPMS, from the home page, select *Performance Metrics* from the *Quality and Performance* menu; the Performance Metrics page will be displayed. If you do not see *Performance Metrics*, your user id does not have the correct access permissions; please contact CMSHPMS_Access@cms.hhs.gov From the Performance Metrics page, select *Reports* and then *Star Ratings and Display Measures* from the left side menu. The *Star Ratings and Display Measures* home page will be displayed.

On the *Star Ratings and Display Measures* home page, select *Star Ratings* as the Report Type and select a reporting period. The remainder of this attachment describes the HPMS pages available for the 2026 Star Ratings.

1. Measure Data page

The Measure Data page displays the numeric data for all Part C and Part D measures. This page is available during the first plan preview.

The first four columns contain contract identifying information. The remaining columns contain the measures which will display in MPF. There is one column for each of the Part C and Part D measures. The measure columns are identified by measure id and measure name. The row immediately above this measure information contains the domain name. The row immediately below the measure information contains the data time frame of the measure. All subsequent rows contain the data for all individual contracts associated with the user's login id. Table S-1 below shows a sample of the left hand most columns shown in HPMS.

Table S-1: Measure Data page sample

Medicare Star Ratings Report Card Master Table						
				HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	*C02: Colorectal Cancer Screening*	*C03: Annual Flu Vaccine*
Contract Number	*Organization Marketing Name*	*Contract Name*	*Parent Organization*	*01/01/2024 - 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*	*73%*	*81%*
HCCCC	*Market C*	*Contract C*	*PO C*	*63%*	*71%*	*80%*

2. Measure Detail – CTM Summary page

The Measure Detail – CTM Summary page contains the underlying data used for the Part C and Part D Complaints (C28/D02) measures. This page is available during the first plan preview. Table S-2 below explains each of the columns displayed on this page.

Table S-2: Measure Detail – CTM Summary page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Total Number of Complaints	*Number of non-excluded complaints for the contract*
Complaint Average Enrollment	*The average enrollment used in the final calculation*
Complaints Less Than 800 Enrolled	*Yes / No, Yes equals average enrollment less than 800, No equals average enrollment greater than or equal to 800*

3. Measure Detail – Part C Appeals page

The Measure Detail – Part C Appeals page contains the case-level data of the non-excluded cases used in producing the Part C Appeals measures Plan Makes Timely Decisions about Appeals (C31) and Reviewing Appeals Decisions (C32). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2026 Star Ratings. This page is available during the first plan preview. Table S-3 below explains each of the columns displayed on this page.

Table S-3: Measure Detail – Part C Appeals page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The parent organization of the contract*
Appeal Number	*The case ID assigned to the appeal request*
Appeal Priority	*The priority of the appeal (Std Pre-Service, Exp Pre-Service, Pre-Service B Drug, or Retro)*
Status	*The status of the appeal (Closed, Decided, Pending, Promoted, Remanded, Reopened, Requested)*
Date Appeal Filed	*The Date the Plan Reconsideration was requested, as reported by the Part C Plan*
Corrected Appeal Date	*The Date Appeal Filed, as determined by the IRE/QIC*
Date File Received (QIC)	*The Date the IRE/QIC received the Appeal from the Part C Plan*
Level 1 Extension	*Indicates if the contract took an extension during their processing of the reconsideration, as reported by the contract*
Adjusted Plan Interval	*The number of days between the Date Appeal Filed (or Corrected Appeal Date, if applicable) and the Date File Received (QIC) adjusted based on the Appeal Priority (Std Pre-Service, Exp Pre-Service, or Retro) and adjusted to account for 5 mailing days*
Appeal Decision	*Decision associated with the appeal: Dismiss Appeal, Dismissed – Plan Approved Coverage, Favorable (Overturn MCO Denial), Partially Favorable (Partly Overturn MCO Denial), Unfavorable (Uphold MCO Denial), Withdraw Appeal, Remand to Plan.*
Late Indicator	*Indicates if the appeal case was considered late or not (0=Not Late, 1=Late)*

4. Measure Detail – SNP CM page

The Measure Detail – SNP CM page contains the underlying data used in calculating the Part C SNP Care Management measure (C07). The formulas used to calculate the SNP CM measure are detailed in Attachment E. This page is available during the first plan preview. Table S-4 below explains each of the columns displayed on this page.

Table S-4: Measure Detail – SNP CM page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Number of new enrollees	*Number of new SNP enrollees eligible for an initial assessment (Data Element A)*
Number of enrollees eligible for an annual HRA	*Number of SNP enrollees eligible for an annual reassessment (Data Element B)*
Number of initial HRAs performed on new enrollees	*Number of initial assessments performed on new SNP enrollees (Data Element C)*
Number of annual reassessments performed	*Number of annual reassessments performed on eligible SNP enrollees (Data Element F)*
Total Number of SNP Enrollees Eligible	*Final measure numerator (Data Elements A + B)*
Total Number of Assessments Performed	*Final measure denominator (Data Elements C + F)*
Percent of Eligible SNP Enrollees Receiving an Assessment	*Final measure score*
Data Validation Score	*The data validation score for the contract*
Reason for Exclusion	*Reason (if any) contract submitted data was not used to generate a score*

5. Measure Detail – HEDIS page

The Measure Detail – HEDIS page contains the underlying data used in calculating the Part C HEDIS SNP Care for Older Adults measures, the Transitions of Care measure and the Plan All-Cause readmissions measure. The formulas used to calculate the SNP measures are detailed in Attachment E. The formula used to calculate the PCR measure is detailed in Attachment F. This page is available during the first plan preview. Table S-5 below explains each of the columns displayed on this page and Table S-6 explains the HEDIS audit designations.

Table S-5: Measure Detail – HEDIS page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
PBP ID	*The Plan Benefit Package number associated with the data*
Measure ID	*The Star Ratings measure ID that corresponds to the data in the given row*
Measure Name	*The measure name that corresponds to the data in the given row*
Rate	*The measure rate*
Eligible Population	*The measure eligible population*
Observed Count	*The measure observed count (only applicable for PCR)*
Expected Count	*The expected count (only applicable for PCR)*
Denominator	*The measure denominator*
Audit Designation	*The audit designation (the audit codes are defined in the next table)*
Status	*The status (the status codes are defined in the next table)*
Average Plan Enrollment	*The average enrollment in the PBP during 2024 (see section Contract Enrollment Data)*

Table S-6: HEDIS 2024 Audit Designations and 2026 Star Ratings

Audit Designation	Status	NCQA Description	Resultant Star Rating
R	*R*	*Reportable*	*Assigned 1 to 5 stars depending on reported value*
BR	*R or NA*	*Biased Rate*	*1 star, numeric data set to "CMS identified issues with this plan's data"*
R	*NA*	*Small Denominator*	*"Not enough data available"*
NB	*R or NA*	*No Benefit*	*"Benefit not offered by plan"*
NR	*R or NA*	*Not Reported*	*1 star, numeric data set to "CMS identified issues with this plan's data"*
NQ	*R or NA*	*Not Required*	*"Plan not required to report measure" (applies only to 1876 Cost in the PCRb measure)*
UN		*Un-Audited*	*Not possible in Star Ratings measures which only use audited data*

6. Measure Detail – CTM page

The Measure Detail – CTM page contains the case level data of the non-excluded cases used in producing the Part C & Part D Complaints measure (C28/D02). This page is available during the first plan preview. Table S-7 below explains each of the columns displayed on this page.

Table S-7: Measure Detail – CTM page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Complaint ID	*The case number associated with the complaint in the HPMS CTM module*
Complaint Category	*The complaint category code*
Category	*The complaint category description of CMS or plan lead*
Subcategory	*The complaint subcategory description associated with this case*
Subcategory — Other	*The complaint additional subcategory description associated with this case*
Contract Assignment / Reassignment Date	*The date that complaints are assigned or re-assigned to contracts*

7. Measure Detail – Disenrollment

The Measure Detail – Disenrollment page contains data that are used in calculating the Part C & Part D disenrollment measure (C29/D03). The page shows the denominator, unadjusted numerator and original rate received from the MBDSS annual report. It also contains the adjusted numerator and final rate after all members meeting the measure exclusion criteria described in the measure description have been removed. This page is available during the first plan preview. Table S-8 below explains each of the columns displayed on this page.

Table S-8: Measure Detail – Disenrollment page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The parent organization of the contract*
Number Enrolled	*The number of all members in the contract from MBDSS annual report*
Number Disenrolled	*The number disenrolled with a disenrollment reason code of 11, 13, 14 or 99, from the MBDSS annual report*
Original Rate	*The disenrollment rate as calculated by the annual MBDSS report*
Adjusted Disenrolled	*The adjusted numerator when all members who meet the measure exclusion criteria are removed*
Adjusted Rate	*The final adjusted disenrollment rate used in the Star Ratings*
Greater than 1000 Enrolled	*Flag indicates contract non-employer group enrollment greater than 1,000 members during the year or contracts that did not have any disenrollments meeting the inclusion criteria (True equals Yes, False equals No)*

8. Measure Detail – DR (Disenrollment Reasons)

The Measure Detail – Disenrollment Reasons page contains the data from the Disenrollment Reasons Survey (DRS). The Disenrollment Reasons data are not used at any point in the calculations of the Star Ratings but are provided in HPMS for information only at this time. The data come from surveys sent to enrollees who disenrolled between 1/1/2024 and 12/31/2024. Scores are suppressed if they are measured with very low reliability (less than 0.60) and not statistically different from the national mean. This page is available during the first plan preview. Table S-9 below explains each of the columns displayed on this page.

Table S-9: Measure Detail – Disenrollment Reasons page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The parent organization of the contract*
DR PGPPPNC	*Disenrollment Reasons - Problems Getting the Plan to Provide and Pay for Needed Care (MA-PD, MA-Only)*
DR PCDH	*Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals (MA-PD, MA-Only)*
DR FRD	*Disenrollment Reasons - Financial Reasons for Disenrollment (MA-PD, MA-Only, PDP)*
DR PPDBC	*Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage (MA-PD, PDP)*
DR PGIHP	*Disenrollment Reasons - Problems Getting Information and Help from the Plan (MA-PD, PDP)*

9. Measure Detail – MTM page

The Measure Detail – MTM page contains each contract's underlying denominator and numerator after measure specifications have been applied to the plan-reported validated data to calculate the Part D MTM Program Completion Rate for CMR (D11). The formulas used to calculate the MTM measure are detailed in Attachment N. This page is available during the first plan preview. Table S-10 below explains each of the columns displayed on this page.

Table S-10: Measure Detail – MTM page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Total Part D Enrollees	*The number of Part D enrollees in the contract (average monthly HPMS enrollment)*
Total MTM Enrollees, All	*The number of Part D enrollees enrolled in the contract's MTM program (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.*
Total MTM Enrollees, Targeted	*The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D MTM plan-reported data). Includes beneficiaries that had an enrollment start date anytime in the measurement period, regardless of age, hospice status, or duration of MTM enrollment. Excludes records where the MBI could not be mapped to a valid beneficiary or where the beneficiary was reported with multiple, conflicting records in the same contract's data.*
Total MTM Enrollees, Targeted, Adjusted	*The number of Part D enrollees enrolled in the contract's MTM program that met the specified targeting criteria per CMS-Part D requirements pursuant to §423.153(d) of the regulations (as reported in the Part D plan-reported data) after measure specifications applied as detailed in Attachment N. (Measure Denominator)*
Total MTM Enrollees, Targeted, Adjusted, Who Received a CMR	*The number of beneficiaries from the denominator who received a CMR. (Measure Numerator)*
MTM Program Completion Rate for CMR	*The percent of MTM program enrollees who received a CMR. (Measure Numerator) divided by (Measure Denominator)*
MTM Section Data Validation Score	*Contract's score in data validation (DV) for their MTM Program Reporting Requirements data*
Reason(s) for Display Message	*Reason(s) for display message assignment (if applicable)*

10. Measure Detail – CAHPS page

The Measure Detail – CAHPS page contains the underlying data used in calculating the Part C & D CAHPS measures: Annual Flu Vaccine (C03), Getting Needed Care (C22), Getting Appointments and Care Quickly (C23), Customer Service (C24), Rating of Health Care Quality (C25), Rating of Health Plan (C26), Care Coordination (C27), Rating of Drug Plan (D05), and Getting Needed Prescription Drugs (D06). This page is available during the first plan preview. Table S-11 below explains each of the columns displayed on this page.

Table S-11: Measure Detail – CAHPS page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The parent organization of the contract*
CAHPS Measure	*The CAHPS measure identifier followed by the Star Ratings measure id in parenthesis*
Reliability	*The contract-level reliability of the measure data*
Statistical Significance	*The statistical significance of the measure data (Below Average, No Difference, Above Average)*
Use N	*The number of usable surveys with responses to the item, or at least one item of a composite*
Mean Score on Original Scale	*The mean score on the original survey response scale*
Variance of Mean on Original Scale	*The sampling variance of contract mean ("Mean score") on the original scale*
Standard Error on Original Scale	*The standard error of the contract mean ("Mean score") on the original scale; square root of "variance"*
Scaled Mean	*The contract mean score rescaled to a 0-100 scale*
Scaled SE	*The standard error of the 0-100 scaled mean*
Base Group	*Categories determined by the percentile cutoffs from the distribution of mean scores*
Star Rating	*Determined by the percentile cutoffs, statistical significance of the difference of the contract mean from the overall mean, the statistical reliability of the estimate, and standard error of the mean score*

11. Calculation Detail – MD

The Calculation Detail – MD page contains the summary of service area and enrollment data used to calculate the percentages for use in the Major Disaster rules for the individual measures. This page is available during the first plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Calculation Detail – MD page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The parent organization of the contract*
Disaster Flag 2024	*Indicates if the contract was affected by a 2024 disaster or not (valid values "Affected", "Not Affected" or "Too New")*
Total Cnty in SA 2024	*The total number of counties in the contract's 2024 service area (SA)*
Num Cnty IA 2024	*The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2024 disaster*
IA Enrolled 2024	*The number of members residing in the contract SA designated FEMA IA counties in a 2024 disaster*
Total Enrolled 2024	*The total number of members residing in the contract's 2024 SA*
IA% 2024	*The percent of members living in IA areas in a 2024disaster (IA Enrolled) divided by (Total Enrolled)*
IA% Rounded 2024	*The percent of members living in IA areas in a 2024 disaster rounded to an integer*
Greater than or equal to 25% 2024	*Flag that indicates if the contract has met the 25% threshold for 2024 disasters (Yes: greater than or equal to 25%, No: less than 25%)*
IA% 2025 LA Wildfires	*The percent of members living in IA areas for the 2025 Los Angeles County wildfires.*
IA% Rounded 2025 LA Wildfires	*The percent of members living in IA areas for the 2025 Los Angeles County wildfires rounded to an integer.*
Greater than or equal to 25% LA Wildfires	*Flag that indicates if the contract has met the 25% threshold for 2025 Los Angeles County wildfires (Yes: greater than or equal to 25%, No: less than 25%)*
CAHPS Exemption for 2025 LA Wildfires	*Flag that indicates if the contract met the 25% threshold for the 2025 Los Angeles County wildfires, and requested and received an exemption for the CAHPS survey (Yes: received an exemption, No: did not qualify for an exemption)*
Disaster Flag 2023	*Indicates if the contract was affected by a 2023 disaster or not (valid values "Affected", "Not Affected" or "Too New")*
Total Cnty in SA 2023	*The total number of counties in the contract's 2023 service area (SA)*
Num Cnty IA 2023	*The number of counties from the contract's total SA designated as FEMA Individual Assistance (IA) counties in a 2023 disaster*
IA Enrolled 2023	*The number of members residing in the contract SA designated FEMA IA counties in a 2023 disaster*
Total Enrolled 2023	*The total number of members residing in the contract's 2023 SA*
IA% 2022	*The percent of members living in IA areas in a 2023 disaster (IA Enrolled)/(Total Enrolled)*
IA% Rounded 2023	*The percent of members living in IA areas in a 2023 disaster rounded to an integer*
Greater than or equal to 25% 2023	*Flag that indicates if the contract has met the 25% threshold for 2022 disasters (Yes: greater than or equal to 25%, No: less than 25%)*

12. Calculation Detail – CAI

The Calculation Detail – CAI page contains the enrollment data used to calculate the percentages for use in the Categorical Adjustment Index (CAI) to determine the Final Adjustment Categories for each of the summary and overall rating calculations. This page is available during the first plan preview. Table S-13 below explains the columns displayed on this page.

Table S-13: Measure Detail – CAI page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Puerto Rico Only	*Does the contract's non-employer service area only cover Puerto Rico? Yes or No*
Contract Type	*The contract plan type used to compute the ratings*
Part D Offered	*Is Part D offered by the contract? Yes or No*
Enrolled	*The total number enrolled in the contract used to determine the % LIS/DE and % Disabled*
Num LIS/DE	*The number of LIS/DE enrolled in the contract*
Num Disabled	*The number of Disabled enrolled in the contract*
% LIS/DE	*The percent of LIS/DE in the contract*
% Disabled	*The percent Disabled in the contract*
Part C LIS/DE Initial Group	*The Part C LIS/DE initial group this contract is in*
Part C Disabled Quintile	*The Part C Disabled Quintile group this contract is in*
Part C FAC	*The Part C Final adjustment category this contract is in*
Part C CAI Value	*The CAI value that will be combined with the final Part C summary score prior to rounding to half stars*
Part D MA-PD LIS/DE Initial Group	*The Part D MA-PD LIS/DE initial group this contract is in*
Part D MA-PD Disabled Quintile	*The Part D MA-PD Disabled Quintile group this contract is in*
Part D MA-PD FAC	*The Part D MA-PD Final adjustment category this contract is in*
Part D MA-PD CAI Value	*The CAI value that will be combined with the final Part D MA-PD summary score prior to rounding to half stars*
Part D PDP LIS/DE Quartile	*The Part D PDP LIS/DE Quartile group this contract is in*
Part D PDP Disabled Quartile	*The Part D PDP Disabled Quartile group this contract is in*
Part D PDP FAC	*The Part D PDP Final adjustment category this contract is in*
Part D PDP CAI Value	*The CAI value that will be combined with the final Part D PDP summary score prior to rounding to half stars*
Overall LIS/DE Initial Group	*The overall LIS/DE initial group this contract is in*
Overall Disabled Quintile	*The overall disabled Quintile group this contract is in*
Overall FAC	*The overall final adjustment category this contract is in*
Overall CAI Value	*The CAI value that will be combined with the final overall score prior to rounding to half stars*

13. Measure Detail – HEDIS LE page

The Measure Detail – HEDIS LE page contains the data used to calculate the reliability of the HEDIS measures (C01, C02, C10 – C14, C17 – C21) data for contracts with greater than or equal to 500 and less than 1,000 members enrolled in July of the measurement year (July 01, 2024). This page is available during the second plan preview. Table S-14 below explains each of the columns displayed on this page.

Table S-14: Measure Detail – HEDIS LE page fields

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The parent organization of the contract*
Measure ID	*The Star Ratings measure that the other data on this row is associated with*
Rate	*The submitted HEDIS rate*
Score	*The rounded value used for the measure in the Star Ratings*
Enrollment	*The contract enrollment for July 2024*
Reliability	*The computed reliability for the contract measure*
Usable	*The computed reliability greater than or equal to 0.7 and rate is used equals True, reliability less than 0.7 and rate was not used equals False*

14. Measure Detail – C MD Results

The Part C Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-15 below explains the columns displayed on this page.

Table S-15: Measure Detail – C MD Results

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Measure ID	*The 2026 Star Ratings Part C 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*

15. Measure Detail – D MD Results

The Part D Disaster Results page displays the measure level data handling results for contracts which had greater than or equal to 25% of their enrollment living in areas affected by major disasters during the measurement period. Only the measures where the disaster policy required a comparison between two ratings years are displayed in the data. This page is available during the second plan preview. Table S-16 below explains the columns displayed on this page.

Table S-16: Measure Detail – D MD Results

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Measure ID	*The 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.

The first four columns contain contract identifying information. The remaining columns contain the domain stars which will display in MPF. There is one column for each of the Part C and Part D domains. The domain columns are identified by the domain id and domain name. All subsequent rows contain the stars associated with an individual contract. Table S-20 below shows a sample of the left hand most columns shown in HPMS.

Table S-20: Domain Star page sample

Medicare Star Ratings Report Card Master Table						
Contract Number	*Organization Marketing Name*	*Contract Name*	*Parent Organization*	*HD1: Staying Healthy: Screenings, Tests and Vaccines*	*HD2: Managing Chronic (Long Term) Conditions*	*HD3: Member Experience with Health Plan*
HAAAA	*Market A*	*Contract A*	*PO A*	*4*	*3*	*4*
HBBBB	*Market B*	*Contract B*	*PO B*	*3*	*3*	*3*
HCCCC	*Market C*	*Contract C*	*PO C*	*3*	*3*	*4*

20. Part C Summary Rating page

The Part C Summary Rating page displays the Part C rating and data associated with calculating the final Part C summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-21 below explains each of the columns contained on this page.

Table S-21: Part C Summary Rating page fields

HPMS Field Label	***Field Description***
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Contract Type	*The contract plan type used to compute the ratings*
SNP Plans	*Does the contract offer a SNP? (Yes/No)*
Major Disaster Percentage 2023	*The percentage of members living in an Individual Assistance area in 2023 rounded to an integer*
Major Disaster Percentage 2024	*The percentage of members living in an Individual Assistance area in 2024 rounded to an integer*
Number Measures Required	*The minimum number of measures required to calculate a rating out all required for the contract type.*
Number Missing Measures	*The number of measures that were missing stars*
Number Rated Measures	*The number of measures that were assigned stars*
Calculated Summary Mean	*Contains the mean of the stars for rated measures*
Calculated Variance	*The variance of the calculated summary mean*
Calculated Score Percentile Rank	*Percentile ranking of Calculated Summary Mean*
Variance Percentile Rank	*Percentile ranking of Calculated Variance*
Variance Category	*The reward factor variance category for the contract (low, medium, or high)*
Reward Factor	*The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)*
Interim Summary	*The sum of the Calculated Summary Mean and the Reward Factor*
Part C Summary FAC	*Part C summary final adjustment category for the contract*
CAI Value	*The Part C summary CAI value for the contract*
Final Summary	*The sum of the Interim Summary and the CAI Value*
Improvement Measure Usage	*Did the final Part C summary rating come from the calculation using the improvement measure? (Yes/No)*
New Measure Usage	*Did the final Part C summary rating come from the calculation using the new measures? (Yes/No)*

HPMS Field Label	Field Description
2026 Part C Summary Rating	The final rounded 2026 Part C Summary Rating

21. Part D Summary Rating page

The Part D Summary Rating page displays the Part D rating and data associated with calculating the final Part D summary rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-22 below explains each of the columns contained on this page.

Table S-22: Part D Summary Rating View

HPMS Field Label	Field Description
Contract Number	The contract number associated with the data
Organization Marketing Name	The name the contract markets to members
Contract Name	The name the contract is known by in HPMS
Parent Organization	The name of the parent organization for the contract
Contract Type	The contract plan type used to compute the ratings
Major Disaster Percentage 2023	The percentage of members living in an Individual Assistance area in 2023 rounded to an integer
Major Disaster Percentage 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Number Measures Required	The minimum number of measures required to calculate a rating out all required for the contract type
Number Missing Measures	The number of measures that were missing stars
Number Rated Measures	The number of measures that were assigned stars
Calculated Summary Mean	Contains the mean of the stars for rated measures
Calculated Variance	The variance of the calculated summary mean
Calculated Score Percentile Rank	Percentile ranking of Calculated Summary Mean
Variance Percentile Rank	Percentile ranking of Calculated Variance
Variance Category	The reward factor variance category for the contract (low, medium, or high)
Reward Factor	The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)
Interim Summary	The sum of the Calculated Summary Mean and the Reward Factor
Part D Summary FAC	Part D summary final adjustment category for the contract
CAI Value	The Part D summary CAI value for the contract
Final Summary	The sum of the Interim Summary and the CAI Value
Improvement Measure Usage	Did the final Part D summary rating come from the calculation using the improvement measure? (Yes/No)
2026 Part D Summary Rating	The final rounded 2026 Part D Summary Rating

22. Overall Rating page

The Overall Rating page displays the overall rating for MA-PD contracts and data associated with calculating the final overall rating. This page is available during the second plan preview. There are flags to indicate if the final rating came from the without improvement measures calculation. Table S-23 below explains each of the columns contained on this page.

Table S-23: Overall Rating View

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Contract Type	*The contract plan type used to compute the ratings*
SNP Plans	*Does the contract offer a SNP? (Yes/No)*
Major Disaster Percentage 2023	*The percentage of members living in an Individual Assistance area in 2023 rounded to an integer*
Major Disaster Percentage 2024	*The percentage of members living in an Individual Assistance area in 2024 rounded to an integer*
Number Measures Required	*The minimum number of measures required to calculate a rating out all required for the contract type*
Number Missing Measures	*The number of measures that were missing stars*
Number Rated Measures	*The number of measures that were assigned stars*
2026 Part C Summary Rating	*The 2026 Part C Summary Rating*
2026 Part D Summary Rating	*The 2026 Part D Summary Rating*
Calculated Summary Mean	*Contains the weighted mean of the stars for rated measures*
Calculated Variance	*The variance of the calculated summary mean*
Calculated Score Percentile Rank	*Percentile ranking of Calculated Summary Mean*
Variance Percentile Rank	*Percentile ranking of Calculated Variance*
Variance Category	*The reward factor variance category for the contract (low, medium, or high)*
Reward Factor	*The calculated reward factor for the contract (0, 0.1, 0.2, 0.3, or 0.4)*
Interim Summary	*The sum of the Calculated Summary Mean and the Reward Factor*
Overall FAC	*Overall final adjustment category for the contract*
CAI Value	*The Overall CAI value for the contract*
Final Summary	*The sum of the Interim Summary and the CAI Value*
Improvement Measure Usage	*Did the final overall rating come from the calculation using the improvement measures? (Yes/No)*
New Measure Usage	*Did the final overall rating come from the calculation using the new measures? (Yes/No)*
2026 Overall Rating	*The final 2026 Overall Rating*

23. Low Performing Contract List

The Low Performing Contract List page displays the contracts that received a Low Performing Icon and the data used to calculate the assignment. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a Low Performing Icon. Table S-24 below explains each of the columns contained on this page.

Table S-24: Low Performing Contract List

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Rated As	*The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"*
2024 C Summary	*The 2024 Part C Summary Rating earned by the contract*
2024 D Summary	*The 2024 Part D Summary Rating earned by the contract*
2025 C Summary	*The 2025 Part C Summary Rating earned by the contract*
2025 D Summary	*The 2025 Part D Summary Rating earned by the contract*
2026 C Summary	*The 2026 Part C Summary Rating earned by the contract*
2026 D Summary	*The 2026 Part D Summary Rating earned by the contract*
Reason for LPI	*The combination of ratings that met the Low Performing Icon rules. Valid values are "Part C," "Part D," "Part C and D," & "Part C or D." See the section titled "Methodology for Calculating the Low Performing Icon" for details.*

24. High Performing Contract List

The High Performing Contract List page displays the contracts that received a High Performing Icon. This page is available during the second plan preview. HPMS users in contracting organizations will see only their own contracts in this list. None will be displayed if no contract in the organization was assigned a High Performing Icon. Table S-25 below explains each of the columns contained on this page.

Table S-25: High Performing Contract List

HPMS Field Label	Field Description
Contract Number	*The contract number associated with the data*
Organization Marketing Name	*The name the contract markets to members*
Contract Name	*The name the contract is known by in HPMS*
Parent Organization	*The name of the parent organization for the contract*
Rated As	*The type of rating for this contract, valid values are "MA-Only," "MA-PD," and "PDP"*
Highest Rating	*The highest level of rating that can be achieved for this organization, valid values are "Part C Summary," "Part D Summary," "Overall Rating"*
Rating	*The star value attained in the highest rating for the organization type*

25. Technical Notes link

The Technical Notes link provides the user with a copy of the 2026 Star Ratings Technical Notes. A draft version of these technical notes is available during the first plan preview. The draft is then updated for the second plan preview, and then finalized when the ratings data have been posted to MPF. Other updates may occur to the technical notes if errors are identified outside of the plan preview periods and after MPF data release.

Left clicking on the Technical Notes link will open a new browser window which will display a PDF (portable document format) copy of the 2026 Star Ratings Technical Notes. Right clicking on the Technical Notes link will pop up a context menu which contains Save Target As…; clicking on this will allow the user to download and save a copy of the PDF document.

26. Medication NDC List

The Medication NDC List link provides the user a means to download a copy of the medication lists used for the Medication Adherence measures (D08 – D10) & SUPD (D12). This downloadable file is in Zip format and contains two Excel files.

27. Part C and Part D Example Measure Data

The Part C and Part D Example Measure Data link provides the user with a means to download a copy of the data for sample measures for the full set of contracts used to calculate the cut points. The data are de-identified such that individual contract's data cannot be determined. The data include the measure value, a flag for contracts that had data issues where applicable, a flag for HEDIS low enrollment contracts where applicable, and a flag identifying MAPD or PDP contracts where applicable. The cut points were calculated using Linux SAS/STAT v15.1 (Linux LIN 64 Red Hat Enterprise Linux release 9.6) and validated on SAS 9.4 (TS1M7) with SAS/STAT Version 15.2 installed on Version 10.0.26100 of Windows 11, 64-bit.

Exhibit 4

to Declaration of James Haskins

Placeholder for native file entitled Haskins Declaration - Exhibit 4 (ElevanceH4036_2026_SR_Calculations_2025_09_10), which was e-mailed to the Court and to opposing counsel at the time of filing on 08/04/2026.

Exhibit 5

to Declaration of James Haskins

Placeholder for native file entitled Haskins Declaration - Exhibit 5 (Recal H4036_2026_IM_Calcs_2025_09_10), which was e-mailed to the Court and to opposing counsel at the time of filing on 08/04/2026.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

SUPPLEMENTAL DECLARATION OF TYLER O. MARSHALL

I, Tyler O. Marshall, declare the following to be true and correct:

1. I am over twenty-one years of age, of sound mind, and fully competent to make this declaration.

2. I am a Director at Berkeley Research Group ("BRG"). Counsel, Crowell & Moring LLP, retained BRG on behalf of Elevance Health, Inc. and its affiliated entities ("Elevance"). I have been asked to provide my opinions on how the Centers for Medicare and Medicaid Services ("CMS") calculated the 2026 Medicare Advantage Stars Ratings ("Star Ratings").

3. BRG is a global consulting firm that helps organizations with disputes and investigations, corporate finance, and performance improvement. For more than a decade, BRG has advised clients on operations, compliance, and strategy in the Medicare Advantage ("MA") arena.

4. I am a leading expert in managed care, especially Medicare Advantage. My work includes compliance consulting to Medicare Advantage Organizations ("MAOs"), as well as forensic and analytics support in internal investigations, government investigations, and litigation and arbitration matters. I have provided expert guidance to multiple MAOs and their counsel on legal and strategic matters related to CMS's annual Star Ratings program.

5. Counsel has asked me to explain and opine on the differences between two recalculations of the 2026 Overall Star Rating for Elevance's H4036 contract: (1) CMS's recalculation, described in the Declaration of Elizabeth Goldstein ("Goldstein Declaration")[1] filed with Defendants' Motion to Dismiss, and (2) Elevance's own recalculation.

Medicare Star Ratings

6. The Medicare Advantage Star Ratings program measures the quality of health and prescription drug services for people enrolled in MA and Part D plans. It gives Medicare beneficiaries and their caregivers useful information to compare plans and choose the best coverage for their needs.[2] CMS calculates an annual Star Rating for each MAO contract using a weighted average of that contract's ratings across several quality and performance measures (up to 43 for MA-PD plans, up to 33 for Part C only plans, and up to 12 for Part D only plans).[3]

7. Each Star measure is based on data that CMS identifies for that measure. Contracts receive a numerical score for each applicable measure, and that score translates into a Star Rating from 1 (worst) to 5 (best).[4] CMS uses "cut points" to convert scores into ratings. For most

[1] See Goldstein Declaration, submitted on August 1, 2026.
[2] CMS, "2026 Medicare Advantage and Part D Star Ratings,"November 18, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-fact-sheet.pdf accessed July 3, 2026.
[3] A maximum of 33 Part C measures are grouped to calculate a Part C Rating and a maximum of 12 Part D measures are grouped to calculatea Part D Rating. Summary ratings are calculated from the weighted average StarRatings of the included measures. (CMS, "Medicare Part C & D Star Ratings Technical Notes,"Updated September25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.).
[4] CMS, "Medicare Part C & D Star Ratings Technical Notes,"Updated September25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.

measures, CMS sets cut points using a clustering algorithm that finds natural gaps in the distribution of scores across all Medicare contracts. For CAHPS survey measures, CMS uses a relative distribution method with additional significance testing. These methods create four cut points, producing five rating levels. The individual measure Star Ratings are then combined into Part C and Part D summary ratings, and an Overall Star Rating for each contract.

2026 Star Ratings Recalculation for H4036

8. Each year, CMS provides MAOs with two Excel workbooks for each contract that receives a Star Rating—a Quality Improvement Measure calculation workbook and a Star Ratings calculation workbook. For 2026, CMS released these on September 10, 2025 (e.g., "H4036_2026_IM_Calcs_2025_09_10" and "H4036_2026_SR_Calculations_2025_09_10"). These workbooks show how CMS calculated each contract's Quality Improvement Measures (C30 and/or D04 for 2026) and its Overall Star Rating.

9. Through Attachment 1 to the Goldstein Declaration, CMS submitted a revised Star Ratings calculation workbook for one Plaintiff contract (H4036), purporting to show a recalculation of this contract's Star Rating in a hypothetical setting.[5] CMS provided only this revised Star Ratings workbook and did not include the Quality Improvement Measure calculation workbook. This revised workbook shows CMS's proposed recalculation of H4036's Overall Star Rating after removing the twenty measures found unlawful in the Clover lawsuit ("Clover Decision")[6]:

Clover Decision Measures

C03: Annual Flu Vaccine
C04: Improving or Maintaining Physical Health
C05: Improving or Maintaining Mental Health
C15: Reducing the Risk of Falling

[5] See Goldstein Attachment 1, submitted on August 1, 2026.
[6] *Clover Insurance Company v. U.S. Department of Health and Human Services*, No. 2:25-cv-00142 (S.D. Ga. May 27, 2026), Order.

Clover Decision Measures

C16: Improving Bladder Control
C22: Getting Needed Care
C23: Getting Appointments and Care Quickly
C24: Customer Service
C25: Rating of Health Care Quality
C27: Care Coordination
C32: Reviewing Appeals Decisions
C33: Call Center – Foreign Language Interpreter and TTY Availability
D01: Call Center – Foreign Language Interpreter and TTY Availability
D05: Rating of Drug Plan
D06: Getting Needed Prescription Drugs
D08: Medication Adherence for Diabetes Medications
D09: Medication Adherence for Hypertension (RAS antagonists)
D10: Medication Adherence for Cholesterol (Statins)
D11: MTM Program Completion Rate for CMR
D12: Statin Use in Persons with Diabetes (SUPD)

10. CMS's proposed recalculation not only removes the above measures from H4036's Star Ratings calculation, but also introduces a hypothetical scenario whereby it uses a different, theoretical version of industrywide metrics that are key to the Overall Star Ratings calculation. These metrics further adjust each contract's Star Ratings by comparing its performance to other contracts in the Stars Program. CMS's recalculation uses theoretical versions of these metrics to support its "hypothetical scenario."[7] The theoretical version used by CMS for this litigation was not used by CMS in calculating the 2026 Star Rating for H4036, was not used by CMS for any other contract, and is not used in any publicly acknowledged real-world application. Normally, CMS calculates these industrywide metrics before releasing each contract's Star Ratings and then sends them to MAOs through the Quality Improvement Measure and Star Ratings calculation workbooks, as well as the Star Ratings Technical Notes.

[7] See Goldstein Declaration, submitted on August 1, 2026.

11. Elevance also submitted its own recalculation for H4036.[8] In Elevance's approach, the original Quality Improvement Measure and Star Ratings calculation workbooks ("H4036_2026_IM_Calcs_2025_09_10" and "H4036_2026_SR_Calculations_2025_09_10") are kept as received from CMS in September. The only change Elevance makes is to remove the twenty Clover Decision measures from both the Quality Improvement Measure calculation (for C30 and D04) and the Overall Star Ratings calculation. Elevance's recalculation uses the same industrywide metrics that CMS published and reported to all MAOs and that remain published by CMS to-date.[9]

12. Both CMS's and Elevance's recalculations produce a final summary Star Rating that translates into the Overall Star Rating for the contract. Importantly, CMS's recalculation yields an Overall Star Rating of 4, while Elevance's recalculation yields a 4.5.

Industrywide Metrics Used in Star Ratings Calculation

13. The industrywide metrics that differ between CMS's and Elevance's recalculations relate to three key parts of the Star Ratings calculation. These are: 1) the Part C and Part D Quality Improvement Measure cut points used to determine Quality Improvement Measure Star Ratings; 2) the Variance Thresholds and Performance Summary Thresholds used to calculate the Reward Factor; and 3) the Categorical Adjustment Index ("CAI") factor value. I discuss each component and how it factors into the Overall Star Ratings calculation below.

14. The first industrywide metric is the set of Part C and Part D Quality Improvement Measure cut points. CMS uses these cut points to translate each contract's Quality Improvement Measure score into a rating from 1 to 5. CMS creates these cut points using a clustering method

[8] See Supplemental Declaration of James Haskins, submitted on August 4, 2026.
[9] CMS, 2026 Star Ratings Data Tables, available at: https://www.cms.gov/files/zip/2026-star-ratings-data-tables.zip, accessed July 30, 2026.

designed to find natural gaps in the distribution of all contract scores. Because the cut points depend on which contract scores are included, changing the set of included scores will change the cut points. Quality Improvement Measures score a contract on how well it has improved its measure ratings from the prior year.

15. In its recalculation, CMS does not explicitly show how it arrived at its revised Star Ratings for the two Quality Improvement Measures, C30 and D04, though the Goldstein Declaration alludes to a theoretical set of Quality Improvement Measure cut points. CMS presents revised measure Star Ratings of 5 for C30 and 4 for D04 in its proposed Star Rating workbook. By contrast, Elevance recalculates a 5 for both measures, as shown in its revised Quality Improvement Measure workbook. Elevance's workbook removes the applicable Clover Decision measures and compares the revised scores to the cut points published in the 2026 Star Rating Technical Notes and most recently in an updated Master Table on July 22, 2026[10].

16. The second industrywide metric relates to the Reward Factor. The Variance Thresholds and Performance Summary Thresholds are industrywide benchmarks used to compare a contract's weighted average Star Rating and variance to determine its Reward Factor. Contracts with a weighted average above the 65th percentile and low variability below the 70th percentile can earn a Reward Factor between 0.1 and 0.4, which boosts the contract's Star Rating.

17. In CMS's recalculation, different values are used for these benchmark thresholds compared to those published in the Technical Notes and provided to MAOs in September 2025. This difference arises because CMS removed the Clover Decision measures from all contracts' weighted average Star Ratings and variances in its theoretical scenario, producing a different set of averages and variances. As a result, CMS's theoretical thresholds differ from the original

[10] CMS, 2026 Star Ratings Data Tables, available at: https://www.cms.gov/files/zip/2026-star-ratings-data-tables.zip, accessed July 30, 2026.

published thresholds that Elevance uses and that CMS used when calculating Elevance's 2026 Star Rating for H4036 when published in the Fall of 2025. The table below shows the different sets of thresholds:

With Improvement		
Variance Thresholds		
Percentile	**Published**	**CMS's Theoretical**
30th	0.914850	0.854524
70th	1.263462	1.303631
Performance Summary Thresholds		
Percentile	**Published**	**CMS's Theoretical**
65th	3.649351	3.658537
85th	3.932432	4.000000

18. The final industrywide metric that differs relates to the CAI factor value. The CAI is an adjustment factor added to or subtracted from a contract's Overall or Summary Star Rating. It accounts for average within-contract differences in performance for Low Income Subsidy/Dual Eligible (LIS/DE) beneficiaries and disabled beneficiaries.[11] CMS's recalculation uses a different CAI value than the one published in the Technical Notes and provided to MAOs in September 2025. Elevance's recalculation uses the original published value. The table below shows the different CAI values for H4036:

Categorical Adjustment Index (CAI)

Contract	**Published**	**CMS's Theoretical**
H4036	-0.063262	-0.101580

[11] CMS, "Medicare Part C & D Star Ratings Technical Notes,"Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.

To carry out its Star Ratings recalculation, CMS created theoretical industrywide metrics from hypothetical datasets. CMS then used those metrics—instead of the actual published metrics—to recalculate Star Ratings solely for H4036.

19. To recalculate contract H4036's Overall Star Rating, CMS created hypothetical industrywide recalculations of the necessary underlying data across all contracts. From this, CMS developed theoretical industrywide metrics for use in its recalculation. These recreated theoretical metrics—based on hypothetical datasets—are what cause the difference between CMS's recalculated Overall Star Rating of 4 and Elevance's recalculation of 4.5, which relies on the real-world published industrywide metrics.

20. In the Goldstein Declaration, CMS justifies these theoretical metrics by stating that "it is not possible to calculate improvement measure stars (and, in particular, to calculate improvement measure cut points) without using data from all contracts" and that "[t]here are two further adjustments to a contract's weighted summary mean [the Reward Factor and the CAI] that are calculated with and without the improvement measures, both of which require a comparison of all contracts' data to calculate accurately." Regarding the Reward Factor, Goldstein states that per 42 C.F.R. § 422.166(f)(1)(i), "[i]t is impossible to perform the necessary calculations unless all contracts in the calculation have identical measures." Elevance's recalculation shows that this data already exists and was published by CMS in September and/or October 2025. The regulation at 42 C.F.R. § 422.166(f)(1)(i) refers only to a contract's relative assessment compared to "all rated contracts in the rating level" "for the same Star Ratings year." It does not require identical measures, especially in a year like 2026 where Star Ratings have been calculated using multiple distinct methodologies. Moreover, each year many contracts factored into these industrywide metrics are not scored on every available measure due to a lack of data.

21. Under CMS's recalculation, CMS assumes that every applicable contract's Part C and Part D Quality Improvement Measure, Overall Star Rating, Variance, and CAI value

contribution would be recalculated after removing the Clover Decision measures. The hypothetical nature of this approach is underscored by the Goldstein Declaration, which acknowledges that the Clover contract, H5141, was itself recalculated to a 4.5—but not under this or any theoretical set of industrywide metrics.

22. Despite removing the same set of measures, CMS's recalculation arrives at a different Overall Star Rating than Elevance's (4 vs. 4.5). This is because CMS applies different theoretical metrics in its comparisons and adjustments—a treatment that CMS has not acknowledged applying to any contract outside of H4036. The differences are: 1) comparing the contract's Quality Improvement Measure scores to recreated theoretical cut points instead of the published cut points; 2) comparing the contract's weighted average Summary Rating and Variance to recreated theoretical thresholds instead of the published thresholds; and 3) applying a theoretical CAI value instead of the published CAI value. Tables 1 through 3 below show the results of both CMS's and Elevance's recalculation of the Overall Star Rating for H4036.

23. Table 1 shows that CMS's theoretical recalculation gives D04 a Star Rating of 4 instead of the 5 that Elevance calculates. Elevance's calculation uses the actual published cut points applied to the rest of the industry for this measure.

Table 1: Quality Improvement Measure

Recalculation Methodology	Measure	Recalculated Measure Score	Cut Point Threshold: 2 Star	Cut Point Threshold: 3 Star	Cut Point Threshold: 4 Star	Cut Point Threshold: 5 Star	Revised Measure Star Rating
CMS	C30	Not Produced					**5**
CMS	D04	Not Produced					**4**
Elevance	C30	**0.461538**	-0.121368	0.000000	0.202884	0.391253	**5**
Elevance	D04	**0.600000**	-0.233766	0.000000	0.320439	0.579545	**5**

24. Table 2 shows that the combination of a lower D04 Star Rating (and thus a lower weighted average summary rating) and CMS's more demanding theoretical percentile thresholds results in a Reward Factor of 0.1 instead of 0.3.

Table 2: Reward Factor

Recalculation Methodology	Weighted Average Metric	Recalculated Weighted Average Metric	Percentile (65th Summary / 30th Variance)	Percentile (85th Summary / 70th Variance)	Revised Reward Factor Category	Revised Reward Factor
CMS	Summary	**3.947368**	3.658537	4.000000	**Relatively High**	**0.1**
CMS	Variance	**0.883511**	0.854524	1.303631	**Medium**	**0.1**
Elevance	Summary	**4.078947**	3.649351	3.932432	**High**	**0.3**
Elevance	Variance	**1.018370**	0.914850	1.263462	**Medium**	**0.3**

Per the 2026 Technical Notes, the reward factor formula is as follows as it relates to comparing the 'weighted average summary (or mean) as well as the variance to calculated thresholds:

- 0.4 = low variance & high mean (mean greater than or equal to 85th percentile))
- 0.3 = medium variance & high mean (mean greater than or equal to 85th percentile))
- 0.2 = low variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
- 0.1 = medium variance & relatively high mean (mean greater than or equal to 65th & less than 85th percentile))
- 0.0 = all other contracts

25. Finally, Table 3 shows that when these first two factors use theoretical metrics instead of published metrics, and a different theoretical CAI value is applied, H4036's revised final summary rating translates to an Overall Star Rating of 4 instead of 4.5.

Table 3: Overall Star Rating

Recalculation Methodology	Recalculated Weighted Average Summary	Reward Factor	CAI	Revised Final Summary	Overall Star Rating
CMS	3.947368	0.1	-0.101580	**3.945788**	**4**
Elevance	4.078947	0.3	-0.063262	**4.315685**	**4.5**

26. In summary, Elevance's recalculation shows that H4036 has a revised Overall Star Rating of 4.5 when the Clover Decision measures are removed and the revised datapoints are compared against the actual published industrywide metrics originally used for all contracts. These metrics include the cut points for the Part C and Part D Quality Improvement Measures, the Variance Thresholds and Performance Summary Thresholds used to calculate the Reward Factor,

and the CAI value. CMS's alternative recalculation produces an Overall Star Rating of 4, but only by using hypothetical, theoretical, non-published industrywide metrics that CMS has not disclosed applying to any other contract to date.

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

Executed on August 4, 2026, in Washington, DC.

By: /s/ Tyler O. Marshall
Tyler O. Marshall
Director
Berkeley Research Group

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

DECLARATION OF NEIL STEFFENS

I, Neil Steffens, declare as follows:

1. I am the President, Group Retiree Solutions for Elevance Health, Inc. ("Elevance"). I submit this declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case. I am making these statements based on my personal knowledge and professional experience and judgment.

2. As President, Group Retiree Solutions, my role is to manage our overall book of business for Group Medicare Advantage, nationally. Group Medicare Advantage includes Medicare Advantage plans that Elevance offers to employers or other groups like unions. My responsibilities include leading teams that sell our Medicare Advantage plans to new employer groups, stand up and implement new employer group accounts, and service existing employer group accounts, among other functions. I also support the overall performance of this business,

including financial performance, Stars/quality performance, and overall enrollee and employer group experience.

3. In connection with its Contract H4036, Elevance has a substantial presence in the Southern District of Georgia (the "District"), where Elevance filed this lawsuit. H4036 is also one of Elevance's largest contracts, with approximately 365,000 enrollees nationally, approximately 81,000 enrollees in the State of Georgia, and with 12,509 current enrollees residing in the District. These enrollees depend on Elevance's Contract H4036 for their Medicare coverage, access to strong provider networks, to receive home delivery of necessary prescriptions, and to receive outreach to ensure they are accessing preventative screenings and services.

4. This significant presence in the District allows Elevance to support entities that contract with Elevance to offer Group Medicare Advantage plans. Elevance maintains strong relationships with its employer partners in the District and endeavors to provide excellent care and customer service to these employer partners.

5. Elevance currently supports 56 employer group customers with members in the District. Attached hereto as Exhibit 1 is a letter from one of our employer partners attesting to the strength of Elevance's partnership with them and the importance of Elevance to their retirees and the dependents of their retirees. *See* Letter from Liberty County Board of Commissioners to Peter Cassidy, Elevance (Aug. 3, 2026).

6. Liberty County is a county located in the District. Since 2017, the Liberty County Board of Commissioners has contracted with Elevance Health for its Group Medicare Advantage coverage, including on Contract H4036 since 2020. Approximately 71 Liberty County retirees and eligible dependents are currently enrolled in the Anthem Medicare Advantage Prescription Drug PPO plan, with 67 residing within the District.

7. Star Ratings are an important part of selling our Group Medicare Advantage coverage as retirees often view Star Ratings as an indication of a plan's quality, reliability, and ability to deliver effective care. A lower rating may create meaningful uncertainty among members, even when their personal experiences with their physicians, medications, and health plan services have been positive. It may also affect the resources available to maintain or enhance benefits, care-management programs, member support, and other services that are important to this population. In addition, groups that purchase Group Medicare Advantage coverage focus on Star Ratings as they are indicative of a plan's quality and drive revenue to the plan, which in turn creates more benefits that can be provided to group members. Thus, lower Star ratings make plans less competitive in the market for selling Group Medicare Advantage products. For instance, a 4 Star plan is less competitive than a 4.5 Star plan because of the lower Star rating.

8. To determine Elevance's Star Rating for H4036, CMS has collected and analyzed data concerning Elevance's members on Contract H4036, including thousands of members within this District. This includes data concerning Elevance's members' drug prescribing histories and their adherence to their medications. Indeed, Elevance has made significant investments of millions of dollars to improve medication adherence metrics for its members, including those in the District, and those metrics were critical data inputs for Star ratings measures that were stricken by the Clover court (e.g., D08, D09, D10, D11, and D12). Elevance also collected extensive clinical information from providers and ancillary service providers on its members to ensure their data was appropriately included or excluded from these Star rating measures. Given that thousands of Elevance's members are located within this District, the foregoing data collected and utilized to determine Elevance's Star Rating includes data that originated in this District.

9. Elevance performs activities focused on supporting members in accessing care, namely preventative services. We have developed our HomeWell program that focuses on key preventative services, such as Colorectal Cancer Screening, Breast Cancer Screening, Diabetes Testing and Blood Sugar Control, and Kidney Health activities. In 2025, these programs reached over 20,000 Elevance members in GA and over 3,100 members in the District alone.

10. In addition to these home-based services, Elevance engages members with home lab kits that enable ease of access for critical preventative screenings and tests. In GA, 8,449 members received these kits, of which approximately 1,300 reside in the District. Further, Elevance supports the prescription pharmacy needs of close to 15,000 members with a variety of services focused on medication adherence, improving access through at home delivery, and ensuring safe prescribing.

11. In order to serve its enrollees in the District, Elevance maintains a significant "on-the-ground" presence and network of employees to support the aforementioned contracts. The work performed by Elevance in the District includes clinical support for enrollees, provider relations, network development, and care coordination, in addition to other activities. In addition, significant amounts of data have been collected from Elevance enrollees on Contract H4036 who reside in the District.

12. There are approximately 78 Elevance associates assigned to offices in the District, who reside at addresses in the District, or have roles whereby they may support Elevance's Medicare Advantage contracts and Elevance's Medicare Advantage enrollees in the District. Eight of those 78 Elevance associates are directly assigned to a Medicare Advantage cost center and work exclusively in support of Elevance's Medicare Advantage products and Medicare Advantage enrollees, while others may support other products in addition to Medicare Advantage. Elevance

maintains an office location within the District at 6001 Chatham Center Drive, Suite 360, Savannah, Georgia, 31405 for the purpose of providing regular office and meeting space for associates across a number of Government Business departments.

13. Elevance also maintains a strong network of providers in the District. Our provider network for the District has a presence in the 43 counties that comprise the District to serve the enrollees of Contract H4036.

a. **Augusta, Georgia:** 410 primary care physicians ("PCPs"), 966 specialists, and 5 hospitals. Key health systems include Piedmont Healthcare, Augusta University Health, and HCA Healthcare.

b. **Savannah:** 405 PCPs, 785 specialists, and 4 hospitals. Key health systems include Saint Joseph's/Candler and HCA Healthcare's Memorial Health.

c. **Brunswick/Coastal:** 117 PCPs, 195 specialists.

d. **Statesboro:** 80 PCPs, 138 specialists, and 2 hospitals. Key health systems include Community Health Systems' (CHS) East Georgia Regional Medical Center, along with Evans Memorial Hospital (all PAR).

14. Further, Elevance has a partial ownership interest in the Millennium Physician Group, a physician group that is vertically-integrated with Elevance and has four clinics in Georgia, with one located in the District, at 2382 3rd Street, Folkston, Georgia. As part of ongoing efforts to engage members and ensure quality outcomes, Millennium Physician Group clinicians work with members to, among other things, engage in care coordination and data collection for things such as medication adherence.

15. Elevance has a significant financial stake in the outcome of this litigation, connected to the District, and its enrollees in the District would face serious consequences if the

Court does not grant the requested relief. Our Star Rating performance in these markets, and the Quality Bonus Payments ("QBP") associated with those ratings, is directly linked to our ability to support members in maintaining their health, accessing services in a timely manner, ensuring consistent pharmacy delivery, and engaging with key preventative services.

16. In 2024, as well as in more recent years, Elevance also collected extensive information from providers on its members to ensure their data was appropriately included or excluded from Star rating measures.

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

Executed this 4th day of August, 2026.

/s/ Neil Steffens
Neil Steffens

Exhibit 1

to Declaration of Neil Steffens

BOARD OF COMMISSIONERS
LIBERTY COUNTY

100 Main Street, Suite 1320
HINESVILLE, GEORGIA 31313
(912) 876-2164
www.libertycountyga.gov

August 3, 2026

Dear Mr. Peter Cassidy:

At your request, I am writing this letter of recommendation on behalf of the Liberty County Board of Commissioners in support of the Anthem Group Medicare Advantage program, offered by Elevance Health. I understand from what you've told me that Elevance is pursuing a lawsuit in federal district court in the Southern District of Georgia against the Centers for Medicare and Medicaid Services related to its Star Rating, and a question has been raised about the Anthem plan's impact in the community encompassed by that district.

Since 2017, The Liberty County Board of Commissioners has contracted with Elevance Health for its Group Medicare Advantage coverage. Approximately 71 Liberty County retirees and eligible dependents are currently enrolled in the Anthem Medicare Advantage Prescription Drug PPO plan, with 67 residing within what I understand to be the geographic boundary of the Southern District.

We have a significant and valued relationship with Elevance Health and the coverage Anthem provides to our retirees. We selected Elevance Health for its experience serving Medicare-eligible retirees, its established provider relationships, and its ability to offer integrated medical and prescription drug coverage through a PPO plan. This structure provides our retirees with the flexibility to obtain care from a broad range of providers – a feature that is particularly important for older adults who may receive services from multiple physicians or specialists.

Liberty County is deeply rooted in Georgia. The County was established in 1777 and has served residents of coastal Georgia for nearly 250 years. Our county seat, Hinesville, is home to a diverse community that includes public-sector employees, retirees, military families, and longtime Georgia residents. Supporting the health and well-being of our retirees is an important responsibility, and access to dependable, high-quality healthcare coverage is central to that commitment.

In Liberty County, the Medicare Advantage population includes individuals managing diabetes, cardiovascular disease, respiratory conditions, and other chronic health needs. For these members, continuity of care, access to medications, preventive services, care coordination, and timely follow-up

are especially important. Anthem's program is designed to support these needs and to help retirees navigate a healthcare system that can be complex and difficult to manage independently, which is why our relationship with Elevance Health is so meaningful. I hope you find this letter of support helpful to your cause.

Sincerely,

Laura Woodworth

Laura Woodworth, PHR
HR Manager
Liberty County Board of Commissioners
Hinesville, Georgia

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

SUPPLEMENTAL DECLARATION OF VERONIKA CHERVENSKA

I, Veronika Chervenska, declare as follows:

1. I am the Medicare Chief Pricing Actuary for Elevance Health, Inc. ("Elevance"). I previously submitted a declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case. I have been asked to submit this supplemental declaration to address an issue raised in the government's response brief.

2. My role and responsibilities at Elevance are the same as described in paragraph 2 of my earlier declaration. I am making these statements based on my personal knowledge and professional experience and judgment.

3. On July 28, 2026, CMS released the Part D national average monthly bid amount ("NAMBA"). CMS calculates NAMBA under section 1860D-13(a)(4) of the Social Security Act

and 42 C.F.R. § 423.279. NAMBA is an enrollment-weighted average of the applicable standardized bid amounts for stand-alone prescription drug plans ("PDPs") and applicable Medicare Advantage plans offering Part D coverage ("MA-PD plans"). NAMBA is an input to CMS's calculation of the Part D base beneficiary premium under 42 C.F.R. § 423.286(c). NAMBA publication is a scheduled step in CMS's annual bid process.

4. It is my understanding that in responding to Elevance's motion for a preliminary injunction, CMS takes the position that revising and resubmitting a bid after the publication of the NAMBA would give an MA-PD plan a competitive advantage in structuring its bid. However, in reviewing Ms. Lazio's declaration, she does not explain how submitting a bid after the release of NAMBA would give a plan a competitive advantage. Indeed, to my knowledge, the very purpose of rebate reallocation is to revise bids based upon NAMBA when needed. And it is certainly not true that Elevance would knowingly or intentionally gain a competitive advantage by revising and resubmitted its impacted bids with respect to any Elevance MA-PD plan with a contract at issue in this lawsuit.

5. NAMBA publication is part of the ordinary CMS bid calendar and occurs at approximately the same date each year. Initial MA-PD bids are submitted by the first Monday of June of each year, as provided by 42 C.F.R. § 423.265(b)(1). Those initial bids necessarily use estimated NAMBA, base beneficiary premium, and other applicable published values because CMS cannot calculate the final values until after bids have been submitted and reviewed.

6. After CMS publishes the final NAMBA and Base Beneficiary Premium values, MA organizations offering MA-PD plans update their Part D Bid Pricing Tool ("BPT") to reflect those published values. Depending on the circumstances of a particular bid, CMS may require or permit adjustments to the allocation of Part C rebate dollars in the MA BPT. CMS generally does

not permit changes to the Part D BPT other than the required updates for published NAMBA and Base Beneficiary Premium amounts, subject to a narrow exception for certain negative-premium situations. In addition, 42 C.F.R. § 422.256(c) provides that the rebate reallocation process may include resubmission of information to allow MA organizations to modify their initial submissions to account for CMS's calculation of NAMBA.

7. On July 28, 2026, CMS published the NAMBA, Base Beneficiary Premium and other applicable values for CY 2027. As a result of that publication, the rebate-reallocation and resubmission period is currently underway and plans are in the process of revising their bids.

8. NAMBA publication on July 28th, therefore, initiated a planned phase of bid processing pursuant to which plans adjust their bids as needed to account for, among other things, rebate reallocation. The NAMBA release did not terminate CMS's bid review process. Each year, CMS publicly schedules the release in advance, and, depending on the circumstances of a particular BPT, an MA-PD may be required, permitted, or not permitted to make specified updates. CMS reviews those updates in its controlled HPMS environment, applies technical and actuarial tests, requests explanations or supporting documentation when necessary and requires final actuarial certification.

9. During this rebate reallocation period and bid processing period, MA-PDs may have an opportunity to adjust premiums, Medicare Part B rebate buy-down, MA supplemental benefits and MA cost-sharing. These changes occur routinely after NAMBA publication each year.

10. On July 30, 2026, CMS published an HPMS memo stating that the final actuarial certification deadline for CY 2027 is not until August 12, 2026, with recertifications required for any resubmissions that occurred during the bid review process. As a result, bids are not finalized under the normal process until at least August 12th of this year.

11. Moreover, CMS allows Plan Benefit Package corrections even after the final actuarial certification deadline. Specifically, after the release of NAMBA and after the submission of the actuarial certification, CMS allows plans to identify bid errors and potentially correct them—this is called the "Plan Correction Module". For instance, on August 29, 2025 for plan year 2026, CMS released a memorandum through HPMS advising plans that they can use that module to submit plan correction requests to CMS through the month of September 2025 (for plan year 2026). This is part of the normal bid process and, therefore, will likely occur in late August 2026. This further demonstrates that CMS allows plans to make corrections to their bids after the release of NAMBA.

12. Contrary to CMS's assertions on this topic, the release of NAMBA does not reveal competitively actionable information. NAMBA is an enrollment-weighted national average of applicable standardized Part D bids. It is one aggregate number generated from many underlying plan bids. It does not disclose the underlying bids themselves, does not disclose any information about the plan that submitted the bid, or the bids specific to geographic markets such as in Georgia. Knowing the result of that calculation does not identify its individual components. Many different combinations of plan bids can produce the same weighted average. Even if a sponsor could estimate some enrollment weights, one aggregate equation cannot be solved backward into the many plan-specific bids.

13. NAMBA does not disclose Part C competitive strategy regarding a competitor's plan or service area, including:

- the Part C basic bid or the spread between that bid and the applicable local benchmark;
- the competitor's Star Rating-related rebate amount or allocation;
- premiums or Part A/B cost-sharing by plan;

- dental, vision, hearing, transportation, food, allowance, or other supplemental-benefit designs;
- the actuarial value or cost of any individual benefit;
- utilization, trend, provider reimbursement, risk-adjustment, administrative-expense, or margin assumptions;
- network strategy, target membership, or county-level positioning.

14. NAMBA also does not disclose Part D benefit design. It does not identify a particular sponsor's standardized bid, formulary, tier structure, cost sharing, supplemental coverage, assumptions, margin, or final premium. A plan-specific Part D premium is produced from several components, including the Base Beneficiary Premium, the difference between the plan's standardized bid and NAMBA, the supplemental premium, for an MA-PD plan, any applicable Part C rebate buy-down, and other applicable adjustments. NAMBA alone therefore does not reveal a competitor's premium or benefit package.

15. Moreover, Elevance Health develops its Part D strategy through Part D national guiding principles established through a centralized enterprise governance process and would not make selective Part D changes to just a subset of the contracts. Those principles are applied across Elevance's similarly situated MA-PD contracts and are not reopened on an ad hoc, contract-by-contract basis merely because a subset of contracts experiences a change in Part C revenue. A corrected Star Rating would not cause Elevance to reconsider or selectively depart from its nationally established Part D strategy for only the contracts affected by the litigation. It would change only those Part C rebate-funded benefits necessary to reflect the corrected QBP and rebate amount.

16. Given the above, in my professional judgment, CMS's release of the NAMBA on July 28 does not provide Elevance with any competitively actionable advantage from which

Elevance would or could benefit for purposes of submitting a revised bid should this Court grant Elevance's requested relief.

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

Executed this 4th day of August, 2026.

/s/Veronika Chervenska

Veronika Chervenska