

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

SCAN HEALTH PLAN,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN
SERVICES, et al.,

Defendants.

Civil Action No. 1:26-cv-02391-CRC

PLAINTIFF’S MOTION FOR EXPEDITED SUMMARY JUDGMENT

Plaintiff SCAN Health Plan (“SCAN”) respectfully moves this Court for expedited summary judgment under Federal Rule of Civil Procedure 56. SCAN is entitled to summary judgment because the Centers for Medicare and Medicaid Services (“CMS”) unlawfully determined SCAN’s 2026 “Star Ratings”—a purported measure of SCAN’s health plans’ quality and performance—in a manner that violated the Administrative Procedure Act because it is in excess of statutory authority, contrary to law, and without observance of procedure required by law.

As explained in the accompanying memorandum of law, CMS’s determination of SCAN’s 2026 Star Ratings for contract numbers H5425 and H0976—which CMS calculated as 4 stars out of a possible 5 stars—was unlawful. Under 42 U.S.C. § 1395hh(a)(2), any “rule, requirement, or other statement of policy” that “establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive benefits” must be promulgated “by regulation”—that is, published in the Code of Federal Regulations and subjected to notice-and-comment rulemaking.

Although CMS has codified nearly all aspects of the Star Ratings system in the Code of Federal Regulations, it has never codified—or subjected to notice-and-comment rulemaking—the measures or the specifications for the measures it applies, which are the most pivotal component of the Star Ratings system. Instead, CMS unilaterally publishes these specifications each year in hundreds of pages of “technical notes,” changing them annually without following required procedures under § 1395hh(a)(2).

In particular, CMS applied the following 10 unlawfully promulgated measures to SCAN in determining its 2026 Star Ratings:

Measure Identifier	Measure Description
C03	Annual Flu Vaccine
C04	Improving or Maintaining Physical Health
C05	Improving or Maintaining Mental Health
C15	Reducing the Risk of Falling
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

As the United States District Court for the Southern District of Georgia identified in a detailed and carefully reasoned 70+ page opinion, these ten measures were not promulgated “by regulation” as required by 42 U.S.C. § 1395hh(a)(2). *Clover Ins. Co. v. HHS*, 2:25-cv-142-LGW-BWC, 2026 WL 1483515, at *22-25 (S.D. Ga. May 27, 2026). Specifically, *Clover* correctly held that the 10 Star Ratings measures and their specifications qualify as “statement[s] of policy” for purposes of § 1395hh(a)(2) because they let the public know the agency’s current adjudicatory approach to critical questions involved in calculating ratings for Medicare Advantage plans

nationwide, a point that CMS did not dispute. *See id.* at *22. The court also correctly held that those measures’ specifications each provided a “substantive legal standard,” because CMS’s Star Ratings calculations based on these measures “function to define the scope of [Medicare Advantage Organizations’] legal rights to rebates” by determining their Star Ratings and resultant statutorily mandated payments, a point that CMS, again, did not contest. *Id.* at *22-23. Finally, the court found that the 10 challenged Star Ratings measures and their specifications did in fact “govern the payment for services because they serve as a ‘deciding principle’ for such payments” because “CMS is . . . obligated by statute to offer additional funding to plans with better Star Ratings” and “[t]he fact that the ratings trigger statutorily mandated funding increases is more than mere influence or an indirect effect; it is a deciding principle in the payment amount.” *Id.* at *24.

Absent CMS’s inclusion of the 10 unlawfully promulgated measures, SCAN would have received overall 2026 Star Ratings of 4.5 stars, rather than 4 stars, and would have been eligible for an approximate \$125 million in additional rebates for the 2027 plan year. Instead, CMS unlawfully determined that SCAN should receive 4-star Star Ratings, which unless remedied, will irreparably harm SCAN, causing it to lose out on \$125 million in funding, suffer reputational harm, and impair SCAN’s competitive position and market share in the health insurance marketplace.

Relief is respectfully requested from this Court before December 1, 2026: CMS will begin paying SCAN monthly payments for plan year 2027, including the applicable rebates based on SCAN’s Star Ratings, starting in January 2027. Accordingly, the parties have stipulated to a schedule for expedited summary judgment, with briefing to be completed well in advance of December 1, 2026, Dkt. 11, which the court entered on August 3, 2026.

For the reasons stated in SCAN’s accompanying memorandum of law, the Court should grant summary judgment to SCAN, setting aside CMS’s determination of SCAN’s 2026 Star

Ratings for contract numbers H5425 and H0976. The Court should further order CMS to redetermine SCAN's 2026 Star Ratings as at least 4.5 Stars, and to take the predicate operational steps necessary to afford rebate relief, including facilitating the re-submission of any bid documents CMS deems operationally necessary to do so.

Dated: August 3, 2026

Respectfully submitted,

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**MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF PLAINTIFF'S
MOTION FOR EXPEDITED SUMMARY JUDGMENT**

TABLE OF CONTENTS

INTRODUCTION	1
BACKGROUND	7
A. The Medicare Advantage Program	7
B. CMS’s History Of Plan Quality Ratings.....	8
C. Star Ratings and Quality Bonus Payments	9
D. CMS’s Annual Determination And Publication Of Star Ratings	10
E. Notice And Comment On The Star Ratings Measures	12
F. CMS’s Determination and Recalculation of SCAN’s 2024 Star Rating.....	13
G. CMS’s Determination Of SCAN’s 2026 Star Ratings And The Clover Lawsuit.....	14
H. CMS’s Recalculation of SCAN’s 2026 Star Ratings.....	16
I. SCAN Raises CMS’s Error, But CMS Denies Relief.....	17
ARGUMENT.....	18
I. CMS’S CALCULATION OF SCAN’S 2026 STAR RATINGS VIOLATED 42 U.S.C. § 1395hh(a)(2)	20
A. The Challenged Star Ratings Measures And Their Specifications Undisputedly Each Constitute A “Rule, Requirement, Or Other Statement Of Policy” That Establishes A Substantive Legal Standard	20
B. The Star Ratings Measures And Their Specifications Govern The Scope Of Benefits, The Payment For Services, And The Eligibility To Furnish Services	23
II. THE COURT SHOULD VACATE SCAN’S 2026 STAR RATINGS, ORDER THE AGENCY TO RECALCULATE THOSE RATINGS, AND REQUIRE CMS TO OPERATIONALLY FACILITATE MANDATORY REBATE RELIEF	29
CONCLUSION.....	34

TABLE OF AUTHORITIES**Page(s)****CASES**

<i>Abbott v. Biden</i> , 70 F.4th 817 (5th Cir. 2023)	24
<i>Alignment Healthcare, Inc. v. HHS</i> , 1:25-cv-74-CRC, 2025 WL 1635371 (D.D.C. June 9, 2025) (Cooper, J.)	23
<i>*Azar v. Allina Health Servs.</i> , 587 U.S. 566 (2019)	<i>passim</i>
<i>Bayer HealthCare, LLC v. U.S. Food & Drug Admin.</i> , 942 F. Supp. 2d 17 (D.D.C. 2013)	32
<i>Blue Cross & Blue Shield of Massachusetts, Inc. v. Kennedy</i> , No. 1:25-cv-693, 2025 WL 3062827 (D.D.C. Nov. 3, 2025)	30
<i>Brock v. Cathedral Bluffs Shale Oil Co.</i> , 796 F.2d 533 (D.C. Cir. 1986)	28
<i>Chippewa Dialysis Servs. v. Leavitt</i> , 511 F.3d 172 (D.C. Cir. 2007)	21
<i>Clarian Health W., LLC v. Hargan</i> , 878 F.3d 346 (D.C. Cir. 2017)	24
<i>*Clover Ins. Co. v. HHS</i> , 2:25-cv-142-LGW-BWC, 2026 WL 1483515 (S.D. Ga. May 27, 2026)	<i>passim</i>
<i>Dep't of Agric. Rural Development Rural Housing Service v. Kirtz</i> , 601 U.S. 42 (2024)	33
<i>Elevance Health, Inc. v. Becerra</i> , 736 F. Supp. 3d 1 (D.D.C. 2024) (Moss, J.)	<i>passim</i>
<i>Everglades Harvesting & Hauling, Inc. v. Scalia</i> , 427 F. Supp. 3d 101 (D.D.C. 2019)	32
<i>HMO La., Inc. v. HHS</i> , 793 F. Supp. 3d 150 (D.D.C. 2025) (Cooper, J.)	24, 27, 28
<i>Hosp. for Special Surgery v. Becerra</i> , 2023 WL 6291638 (D.D.C. May 31, 2023)	33

<i>Humana, Inc. v. U.S. Dep’t of Health & Hum. Servs.</i> , No. 4:25-cv-779, 2025 WL 2909960 (N.D. Tex. Oct. 14, 2025)	30
<i>In re Fed. Bureau of Prisons’ Execution Protocol Cases</i> , 980 F.3d 123 (D.C. Cir. 2020)	32
<i>Jimenez v. Quarterman</i> , 555 U.S. 113 (2009)	23
<i>League of Women Voters of U.S. v. Newby</i> , 838 F.3d 1 (D.C. Cir. 2016)	33
<i>Loper Bright Enters. v. Raimondo</i> , 603 U.S. 369 (2024)	18
<i>Monsanto Co. v. Geertson Seed Farms</i> , 561 U.S. 139 (2010)	32
<i>Nken v. Holder</i> , 556 U.S. 418 (2009)	32
<i>Perkins Coie LLP v. DOJ</i> , 783 F. Supp. 3d 105 (D.D.C. 2025)	32, 33
<i>S. Educ. Found. v. U.S. Dep’t of Educ.</i> , 784 F. Supp. 3d 50 (D.D.C. 2025)	32
<i>SCAN Health Plan v. HHS</i> , No. 1:23-cv-3910-CJN, 2024 WL 2815789 (D.D.C. June 3, 2024)	2, 14, 24, 27
<i>Scott & White Health Plan v. Becerra</i> , 693 F. Supp. 3d 1 (D.D.C. 2023) (Cooper, J.)	5
<i>Syncor Int’l Corp. v. Shalala</i> , 127 F.3d 90 (D.C. Cir. 1997)	21
<i>TIG Ins. Co. v. Republic of Argentina</i> , 110 F.4th 221 (D.C. Cir. 2024)	24
<i>UnitedHealthcare Benefits v. CMS</i> , No. 6:24-cv-357-JDK, 2024 WL 4870771 (E.D. Tex. Nov. 22, 2024)	23, 25
<i>Whitman-Walker Clinic, Inc. v. HHS</i> , 485 F. Supp. 3d 1 (D.D.C. 2020)	33
<i>Wilderness Soc’y v. Norton</i> , 434 F.3d 584 (D.C. Cir. 2006)	28

STATUTES

5 U.S.C.	
§ 553.....	19
§ 706.....	7, 18, 29
42 U.S.C.	
§ 1395hh.....	<i>passim</i>
§ 1395w-21	7, 8, 25
§ 1395w-22	<i>passim</i>
§ 1395w-23	<i>passim</i>
§ 1395w-24	<i>passim</i>
§ 1395w-25	8, 25, 26
§ 1395w-27	7, 26
Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327 (1997).....	7, 8
Bipartisan Budget Act of 2018, Pub. L. 115-123 § 50322, 132 Stat. 64, 201 (Feb. 9, 2018)	28
Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102(c)-(d), 124 Stat. 1029, 1043-46 (2010).....	9
Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-72 (2003).....	8

REGULATIONS

42 C.F.R.	
§ 422.....	28
§ 422.160.....	11, 27
§ 422.164.....	13
§ 422.166.....	11
§ 422.260.....	22
§ 422.502.....	10, 27
§ 422.504.....	26
§ 422.510.....	10, 27
§ 422.2420.....	26
§ 423.....	28
§ 423.182.....	11
§ 423.184.....	13
§ 423.186.....	11
63 Fed. Reg. 34, 968, 34,993 (June 26, 1998)	9
75 Fed. Reg. 71,190, 71,219 (Nov. 22, 2010).....	9

83 Fed. Reg. 16,440, 16,520, 16,537, 16,537-46 (Apr. 16, 2018).....	9, 11, 12, 28
84 Fed. Reg. 15,680, 15,761 (Apr. 16, 2019)	29
85 Fed. Reg. 33,796, 33,885-86 (June 2, 2020).....	27

OTHER AUTHORITIES

<i>Govern</i> , Webster’s III New Int’l Dictionary 982.....	5
<i>Govern</i> , Webster’s New World College Dictionary (4th ed. 1999)	24
HEDIS, CMS, https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/data-information-set (last modified Sept. 10, 2024).....	22
HOS, CMS, https://www.cms.gov/data-research/research/health-outcomes-survey (last modified Mar. 10, 2026)	22
Medicare Payment Advisory Comm’n, Medicare’s Measurement of Rural Provider Quality, Report to the Congress: Medicare and the Health Care Delivery System, Chapter 6 (June 2025), https://tinyurl.com/um2znx6u	2
Medicare Payment Advisory Comm’n, Redesigning the Medicare Advantage Quality Bonus Program, in Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8 (June 2019), https://tinyurl.com/2j2ykfy9	2
Medicare Payment Advisory Comm’n, Replacing the Medicare Advantage Quality Bonus Program, in Report to the Congress: Medicare and the Health Care Delivery System, Chapter 3 (June 2020), https://tinyurl.com/ynsmxwd2	2

INTRODUCTION

This case concerns Defendants’ unlawful actions in determining SCAN Health Plan’s (“SCAN”) 2026 Star Ratings under the Centers for Medicare & Medicaid Services’ (“CMS”) Medicare Advantage program in violation of CMS’s governing statute.

SCAN is a California nonprofit healthcare plan whose mission is to keep its over 435,000 members healthy and independent. SCAN has long enjoyed exemplary Star Ratings and is routinely recognized as a leading Medicare Advantage plan in California and nationwide.

Under the Medicare Advantage program, the government contracts with private health insurance plans like SCAN to provide benefits that meet or exceed the benefits provided by traditional, government-run Medicare. By creating a system founded on the principle of private competition—both among private plans and against government-run Medicare—Congress sought to provide Medicare beneficiaries with greater choice and higher quality healthcare.

Congress’s principal tool to promote competition among Medicare Advantage health plans is known as a “Star Rating,” which synthesizes a range of quality data about each plan into a summary rating of 1 to 5 Stars (including half-Stars in between). Those Star Ratings directly determine the payments that plans receive from the government — the seemingly small difference between a full star and a half star can mean the difference of hundreds of millions of dollars to a plan. These increased payments that are determined by the plan’s Star Ratings, in turn, flow back to Medicare beneficiaries through additional benefits such as vision and dental, lower premiums, and broader and more stable provider networks.

But CMS’s administration of the Star Ratings program went off the rails years ago, and the program now bears little resemblance to the one that Congress envisioned. The fundamental problem is that whereas Congress envisioned a stable, consistent Star Ratings program characterized by a limited number of validated “measures” of quality (*e.g.*, the percentage of plan

members receiving recommended preventive health screenings) that CMS would develop in consultation with plans and the public, CMS has instead chosen to unilaterally change the measures of quality and the contours of the Stars program each and every year. And many of these unilaterally implemented measures have little or no bearing on plan quality. Congress's own nonpartisan research arm for Medicare studies has concluded that the Star Ratings program is "overly complex," "distributes financial rewards inequitably," and "reports inaccurate information on quality."¹ That is because CMS unilaterally promulgates Star Ratings measures that are "weakly correlated with health outcomes of importance to beneficiaries and the program,"² and do "not provide a reliable basis for evaluating quality across MA [Medicare Advantage] plans."³

The system is undeniably broken, as many courts, including this Court, have recognized. Just a few years ago, *SCAN* came to this Court to correct a blatant deficiency in a new Star Ratings methodology that CMS introduced at the eleventh hour by unilateral proclamation, without observance of the required procedure, and contrary to its own binding regulations. *See SCAN Health Plan v. HHS*, No. 1:23-cv-3910-CJN, 2024 WL 2815789, at *1 (D.D.C. June 3, 2024). Two different judges of this Court held that CMS's last-minute change in its unilateral guidance was invalid and issued party-specific judgments to relieve the two plans that brought these claims of their party-specific Star Ratings, without awarding system-wide relief. *Id.* (Nichols, J.);

¹ Medicare Payment Advisory Comm'n, Replacing the Medicare Advantage Quality Bonus Program, in Report to the Congress: Medicare and the Health Care Delivery System, ch. 3 at 51 (June 2020), <https://tinyurl.com/ynsmxwd2>.

² Medicare Payment Advisory Comm'n, Redesigning the Medicare Advantage Quality Bonus Program, in Report to the Congress: Medicare and the Health Care Delivery System, ch. 8 at 248 (June 2019), <https://tinyurl.com/2j2ykfy9>.

³ Medicare Payment Advisory Comm'n, Medicare's Measurement of Rural Provider Quality, Report to the Congress: Medicare and the Health Care Delivery System, ch. 6 at 321 (June 2025), <https://tinyurl.com/um2znx6u>.

Elevance Health, Inc. v. Becerra, 736 F. Supp. 3d 1, 25 (D.D.C. 2024) (Moss, J.). CMS then implemented those judgments by recalculating the 2024 Star Ratings for *all* plans in accordance with the judgments’ reasoning, raising Star Ratings for numerous plans and resultant plan funding. See Ex. A to Decl. of Michael Plumb (“Plumb Decl.”) (attached hereto as Ex. 1), CMS, *Update to 2025 Quality Bonus Payment Determinations* (June 13, 2024).

A little over two months ago, a judge on the United States District Court for the Southern District of Georgia identified additional, fundamental flaws in the Star Ratings program in a detailed and carefully reasoned 70+ page opinion. *Clover Ins. Co. v. HHS*, 2:25-cv-142-LGW-BWC, 2026 WL 1483515, at *1 (S.D. Ga. May 27, 2026). First, the Southern District of Georgia held that 10 measures could not be validly applied to plaintiff Clover Insurance Company (“Clover”) to determine its 2026 Star Rating because they exceeded CMS’s statutory authority under 42 U.S.C. § 1395w-23(o) and § 1395w-22(e). *Id.* at *8-14. Second, that court held that another set of 10 measures could not be validly applied to Clover to determine its 2026 Star Rating because they were not promulgated “by regulation” as required by 42 U.S.C. § 1395hh(a)(2). *Id.* at *22-25.

But, rather than apply the judgment as to all plans, on June 17, 2026, CMS announced that it had only partially implemented the reasoning of the *Clover* decision in recalculating certain plans’ 2026 Star Ratings. Specifically, CMS recalculated certain plans’ Star Ratings in accordance with *only* the first holding in *Clover*, namely, with removal of the 10 measures that the Southern District of Georgia had identified as in excess of CMS’s statutory authority. Ex. B to Plumb Decl., CMS, *Update to 2027 Quality Bonus Payment Determinations* (June 17, 2026) (“Recalculation

Memo”).⁴

Critically, CMS did *not* recalculate plans’ 2026 Star Ratings in accordance with the *second* holding of the Georgia federal court, namely, with removal of the 10 measures that the court had identified as having been promulgated by CMS in its unilateral program guidance, rather than “by regulation” as required by 42 U.S.C. § 1395hh(a)(2). What SCAN seeks here is the full implementation of the Southern District of Georgia’s decision’s second holding, by removing the 10 measures that the Southern District of Georgia held CMS failed to promulgate by regulation.

The Southern District of Georgia’s second holding regarding these unlawfully promulgated measures was plainly correct. As noted, CMS determines each plan’s Star Rating by calculating a “measure score” for each plan on various “measures,” such as how often plan members obtain recommended mammograms and other cancer screenings, and how well their blood sugar and blood pressure are controlled. CMS then engages in a multi-step process to grade plans relative to other plans, akin to grading on a “curve” in a college course. While CMS has codified in the Code of Federal Regulations almost all relevant aspects of the Star Ratings system, there is a notable exception: CMS has not codified, or as a general matter subjected to notice-and-comment rulemaking, the specifications (evaluation criteria) for the *measures* CMS applies, *i.e.*, the most important aspect of the Star Rating system. Instead, CMS unilaterally promulgates its measure specifications in hundreds of pages of “technical notes” that CMS publishes each year, morphing the measures and the specifications for how they are calculated annually, generally without notice and comment, and never codifying them in the Code of Federal Regulations. *See, e.g.*, Ex. E to Plumb Decl., CMS, Medicare 2026 Part C & D Star Rating Tech. Notes (Sept. 25, 2025) (“2026

⁴ CMS also removed some measures that it apparently concluded were encompassed by the reasoning of the first *Clover* holding despite the Georgia federal court not reaching them. Ex. B to Plumb Decl., Recalculation Memo at 1.

Pt. C & D Star Ratings Tech. Notes”).

But curtailing CMS’s ability to unilaterally shift measures on plans from year to year by requiring CMS to act “by regulation” is exactly what Congress intended. *See Clover Ins. Co.*, 2026 WL 1483515, at *22-25. The Supreme Court has explained that, given the dramatic consequences for the overall healthcare system resulting from CMS’s regulation of Medicare and even small, incremental changes in that program, Congress provided expanded notice-and-comment obligations for rules, requirements, and even non-binding CMS policies impacting substantive legal standards for Medicare. *See Azar v. Allina Health Servs.*, 587 U.S. 566, 579 (2019). Specifically, Congress provided any “rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits,” must be promulgated “by regulation,” *i.e.*, published in the Code of Federal Regulations and subjected to notice-and-comment rulemaking. 42 U.S.C. § 1395hh(a)(2). Thus, as this Court has recognized, CMS must act by regulation through “the Medicare Act’s notice-and-comment process as specified in 42 U.S.C. § 1395hh(a)(2) and further detailed in *Allina I.*” *Scott & White Health Plan v. Becerra*, 693 F. Supp. 3d 1, 17 (D.D.C. 2023) (Cooper, J.).

Under these established principles, the Southern District of Georgia correctly held that, with respect to the 10 measures Clover challenged on this ground (known as C03, C04, C05, C15, C16, C22, C23, C24, C25, C27), those measure specifications constituted “substantive legal standard[s]” that did “govern the payment for services because they serve as a ‘deciding principle’ for such payments.” *Clover Ins. Co.*, 2026 WL 1483515, at *24 (quoting *Govern*, Webster’s III New Int’l Dictionary 982). The court’s reasoning was straightforward: Star Ratings measures determine hundreds of millions of dollars of statutorily-mandated payments to each plan, and thus

provide substantive legal standards governing payments for services. *See id.* That is, if measures of quality that determine hundreds of millions of dollars in payments to plans were not the type of substantive legal standards that require CMS to act “by regulation,” then what would be? Accordingly, because those 10 measures had not been promulgated “by regulation,” as the statute requires, they could not be applied to determine Clover’s 2026 Star Rating. *Id.* at *25 n.19.

CMS’s decision to determine SCAN’s 2026 Star Ratings *with inclusion* of these 10 measures (*i.e., without applying Clover’s* second holding) violates governing law and results in CMS’s unlawful determination of SCAN’s 2026 Star Ratings at 4 Stars, rather than 4.5 Stars. CMS cannot apply these 10 measures to SCAN:

Measure Identifier	Measure Description
C03	Annual Flu Vaccine
C04	Improving or Maintaining Physical Health
C05	Improving or Maintaining Mental Health
C15	Reducing the Risk of Falling
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

CMS’s unlawful determination of SCAN’s Star Ratings at 4 Stars reduces the funding that SCAN would otherwise be entitled to by \$125 million in statutorily mandated payments under a 4.5 Star Rating that SCAN can, by law, then use to increase benefits or reduce cost sharing for its members, improving the plan’s competitiveness and profitability. Because CMS’s determination of SCAN’s Star Ratings was in excess of statutory authority, contrary to law, and without observance of procedure required by law, the Administrative Procedure Act (“APA”) requires that it be set aside.

5 U.S.C. § 706(2). CMS should be ordered to recalculate SCAN’s 2026 Star Ratings without reliance on the 10 challenged measures, and to facilitate the re-submission of any relevant documents CMS deems necessary to operationally facilitate the payment of the statutorily mandated rebates.

BACKGROUND

A. The Medicare Advantage Program

The Medicare program, established by Title XVIII of the Social Security Act (the “Act”), provides government-funded health insurance to seniors and the disabled. *See* 42 U.S.C. § 1395, *et seq.* Under the Act, beneficiaries enrolled under “Original Medicare” (Medicare Parts A and B) receive benefits for covered medical services from the federal government, and the government pays providers directly. *See* 42 U.S.C. §§ 1395c to 1395i-6, 1395j to 1395w-6.

Alternatively, beneficiaries may elect coverage under the Medicare Advantage program, Medicare Part C, which Congress created in 1997 (then known as Medicare+Choice). *Id.* § 1395w-21; Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327 (1997). CMS contracts with private plans to provide Original Medicare services and other supplemental benefits. *See* 42 U.S.C. § 1395w-27.

Medicare Advantage plans must include the same level of benefits offered by Original Medicare (Medicare Parts A and B)—although Medicare Advantage plans may also offer supplemental benefits, like vision or dental. *See generally id.* § 1395w-22. Medicare Advantage plans compete to encourage beneficiaries to select their plans (over other plans and Original Medicare) by offering high-quality care, supplemental benefits, and lower premiums. *See id.*

Medicare Advantage differs from traditional Medicare in another way: Under Medicare Advantage, *plans*, rather than the federal government, must pay for needed healthcare for the beneficiaries, *regardless* of whether the costs of that care exceed the government’s payments to

plans. 42 U.S.C. § 1395w-21(a)(2)(A)(i) (“Coordinated care plans [are those] which provide health care services”); *see also* 42 U.S.C. § 1395w-25(b) (plans must “assume full financial risk on a prospective basis for the provision of the health care services”). In this sense, the statute views *plans* as legally and financially responsible for provision of all covered services. *Id.*

Specifically, to fund Medicare Advantage benefits, the government pays plans a monthly sum for each plan enrollee, determined through a bidding system. *See id.* § 1395w-23. Each year, CMS establishes “benchmark” rates that are meant to represent what it would cost CMS to provide Medicare benefits to an average enrollee in each county. *See id.* § 1395w-23(b)(1)(B). Plans then submit bids for the estimated cost for covering Medicare-defined standard benefits to an average enrollee for the upcoming year. *See id.* § 1395w-23(a)(1)(B). If a plan bids below the benchmark, CMS returns a portion of the difference to the plan as a “rebate.” *See, e.g., id.* §§ 1395w-23(a)(1)(E), 1395w-24(a)(6)(A).

Relatedly, in 2003, Congress established Medicare Part D, effective in 2006. Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-72 (2003). Enrollees in Original Medicare or Medicare Advantage may choose to enroll in optional Part D prescription drug benefits. *See generally* 42 U.S.C. §§ 1395w-101 to 1395w-104.

B. CMS’s History Of Plan Quality Ratings

CMS has a lengthy history of shifting the goalposts for quality metrics on plans.

Under the Balanced Budget Act of 1997, each Medicare Advantage plan was required to “have arrangements . . . for an ongoing quality assurance program.” Pub. L. No. 105-33, § 4001, 111 Stat. at 291 (codified at 42 U.S.C. § 1395w-22(e)(1) (1997)). Specifically, the statute provided for collection, analysis, and reporting of data by plans to allow CMS to monitor plans and provide beneficiaries information on plan quality. *Id.* § 1395w-22(e)(2)(A)(i), (vi), (xii) (1997).

CMS has published raw data about Medicare Advantage plan quality and performance

since 1998. 83 Fed. Reg. 16,440, 16,520 (Apr. 16, 2018). Because CMS wanted “flexibility for the specific reporting and performance requirements to progress” so it could “respond rapidly to new developments,” CMS’s regulations did not “specify[] the particular measures for which reporting [would] be required.” 63 Fed. Reg. 34, 968, 34,993 (June 26, 1998). Instead, CMS committed to inform plans of its chosen measures and changes in those measures each year, “through the [annual] contracting process.” *Id.*

In 2003, Congress rejected CMS’s constantly changing approach, limiting the data that CMS could base the plan quality and performance judgments on to “the types of data that were collected by the Secretary as of November 1, 2003” and only permitting changes to those “types of data” after CMS submitted a report to Congress “prepared in consultation with MA [Medicare Advantage] organizations and private accrediting bodies.” 42 U.S.C. § 1395w-22(e)(3)(B)(i).

C. Star Ratings and Quality Bonus Payments

In 2008, CMS tried to end-run Congress’s limitations by beginning to publish annual Star Ratings, which rate Medicare Advantage plans on a scale of 1 to 5 Stars, including half-Stars, with 5 Stars being the highest, changing the measures each year at will. 83 Fed. Reg. at 16,520.

Congress had not expressly authorized Star Ratings when CMS began publishing them in 2008. Instead, they were purely a creature of sub-regulatory guidance. *See* 75 Fed. Reg. 71,190, 71,219 (Nov. 22, 2010). These Star Ratings served two purposes: (1) to provide beneficiaries information on plan performance to consider when choosing a plan; and (2) to assist CMS in identifying low performing plans for compliance actions. *Id.*

Then, in 2010, Congress codified in part, and overrode in part, CMS’s Star Ratings system. The Affordable Care Act—as amended by the Healthcare and Education Reconciliation Act—introduced the Quality Bonus Payment program, which incorporated Star Ratings into two formulas that determine certain payments to plans. *See* Pub. L. No. 111-152, § 1102(c)-(d), 124

Stat. 1029, 1043-46 (2010).

The first formula, codified at 42 U.S.C. § 1395w-23(o) and known as the quality bonus payment, rewards Medicare Advantage plans rated 4 Stars or higher with an increased 5 percent benchmark against which to bid. That effectively either increases the total amount of money the plan is eligible to receive, including in the form of a rebate (if its bid is below the benchmark), or reduces the premium the plan must charge its members (if its bid is above the benchmark). And the second formula, codified at § 1395w-24(b)(1)(C), gives higher-rated plans a larger portion of the difference between their bid and their benchmark back as a rebate.

CMS uses Star Ratings not just to determine payments to plans for their services and resultant benefits, but also to determine whether plans remain eligible to participate in the Medicare Advantage program. Specifically, CMS may terminate plans from the Medicare Advantage program if they fail to achieve a Star Rating of at least 3 Stars over 3 years, 42 C.F.R. § 422.510(a)(4)(xi), or they receive a Part C or Part D Star Rating of 2.5 or less for 2 years, *id.* § 422.502(b)(1)(i)(D). For a plan, that is the corporate death penalty. *See id.*

Critically, Congress needed to decide *which* data sources CMS could utilize for these revamped Star Ratings. Rather than deferring to CMS to select “appropriate” data as it had prior to 2003, or adopting CMS’s existing sub-regulatory Star Ratings, Congress provided that the “quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w-22(e) of this title),” *i.e.*, under their longstanding quality improvement programs. *Id.* § 1395w-23(o)(4)(A). Congress thus required CMS to focus on established data concerning clinical quality, health outcomes, and beneficiary satisfaction. *See id.*

D. CMS’s Annual Determination And Publication Of Star Ratings

CMS determines Star Ratings annually, through a four-step process that is broadly analogous to calculating a student’s overall grade in a college course.

First, CMS calculates a “measure score” on dozens of “measures.” *See* Ex. G to Plumb Decl., CMS, *2026 Star Ratings Measures and Weights* (2025) (“2026 Star Ratings Measures & Weights”). A “measure score” is the plan’s raw score on each measure, usually expressed as a percentage. 42 C.F.R. §§ 422.162(a), 422.166(a)(1), (a)(4), 423.182(a), 423.186(a)(1), (a)(4). A plan will receive over 40 of these measure scores each year. *See generally* Ex. G to Plumb Decl., *2026 Star Ratings Measures & Weights*. This is akin to a student receiving numerical scores on over 40 assignments. Each measure is derived from a specific data source, identified in CMS’s annual Technical Notes. 83 Fed. Reg. at 16,537-46.

Second, akin to grading on a “curve” in a college course, CMS uses statistical “clustering” to identify plans with similar “measure scores” and sets “cut points” for these “measure scores.” By doing so, CMS divides plans between the Star Rating levels. 42 C.F.R. §§ 422.166(a)(1), (a)(4), (a)(2), 423.186(a)(1), (a)(2), (a)(4).

Third, CMS converts the raw measure score, for each measure, into a measure-specific Star Rating between 1 and 5. *Id.* For example, 90% of beneficiaries receiving recommended cancer screenings may merit a “4 Star” Star Rating for that specific measure. This is akin to converting an 85% on a homework assignment to a “B” grade.

Fourth, CMS takes a weighted average of all the plan’s measure-specific Star Ratings. *Id.* §§ 422.166(c)(1), (d)(1), 423.186(c)(1), (d)(1). This average determines the plan’s overall Star Rating—similar to the average of all course assignments determining the final course grade.

Star Ratings are released each October, prior to the annual open enrollment period for Medicare Advantage. The year associated with Star Ratings corresponds to the year for the open enrollment period, because the Star Ratings help Medicare beneficiaries identify high performing plans to enroll in for and during the upcoming plan year. For example, the Star Ratings released

on October 9, 2025 are known as the “2026 Star Ratings” because they were published prior to the 2026 open enrollment period, which occurs in late 2025. Ex. E to Plumb Decl., 2026 Part C & D Star Ratings Tech. Notes, at 1. Meanwhile, the *data* underlying the 2026 Star Ratings were collected in 2024, and the 2026 Star Ratings impact payments to plans and resultant benefits in 2027. *See, e.g., id.* at 54 (noting the data time frame for a measure was within 2024).

CMS displays Star Ratings as part of its online “Plan Finder” tool, which beneficiaries use to research, compare, and sign up for Medicare Advantage plans. Plumb Decl. ¶ 22. Higher-rated plans are displayed above lower-rated plans, thus helping them attract a disproportionate share of enrollment. *Id.* ¶ 23. In addition, CMS publishes plans’ measures scores for each measure. *See* Ex. H to Plumb Decl., CMS, Part C & D Performance Data. For these reasons, a plan’s Star Ratings (overall and measure specific), along with the resultant quality bonus payments and rebates driven by the Star Ratings, drive plan enrollment. Plumb Decl. ¶¶ 22-25.

E. Notice And Comment On The Star Ratings Measures

Under CMS’s current methodology, Star Ratings measures change each and every year. Due to these “regular updates and revisions,” CMS does not codify its Star Ratings measures in the Code of Federal Regulations, but rather lists out its measures for a given year in its annual Technical Notes. 83 Fed. Reg. at 16,537.

The Technical Notes provide a partial, summary description of the specifications for each measure, *i.e.*, the data sources on which it is based and, generally speaking, how it is determined. *See* Ex. E to Plumb Decl., 2026 Pt. C & D Star Ratings Tech. Notes, at 29-95. To actually determine each measure, however, it is necessary to utilize the detailed specifications contained in CMS’s other sub-regulatory guidance, including specific “Technical Notes” pertaining to each measure. *See, e.g.,* Ex. F to Plumb Decl., CMS, 2022 Part C & D Call Center Monitoring Timeliness and Accuracy & Accessibility Studies Tech. Notes (Dec. 16, 2021) (partially

specifying calculation of C33 and D01 measures, among other sources of guidance). For the 2026 Star Ratings, CMS originally utilized 33 measures for Part C (“C01-C33”) and 12 measures for Part D (“D01-D12”). *See generally* Ex. G to Plumb Decl., 2026 Star Ratings Measures & Weights.

Before evaluating a plan with a given Star Ratings measure, CMS must undertake public notice-and-comment rulemaking concerning that measure. This obligation stems from two separate sources of law relevant to this case.

First, since 2018, CMS’s regulations have provided that, before adding a “new” measure, or making substantial changes to a measure’s specifications, CMS must first publicly propose the measure on its website, elicit public feedback prior to the measurement year, and then formally engage in notice-and-comment rulemaking. 42 C.F.R. § 422.164(c)(2); *see also id.* § 423.184(c)(2) (same for part D); *id.* §§ 422.164(d)(2), 423.184(d)(2) (same procedure applies for substantial changes to measure).

Second, and more importantly for present purposes, “Congress chose to write a new, Medicare-specific” “notice-and-comment regime” under § 1395hh. *Allina*, 587 U.S. at 569-70. Under that provision, CMS has a statutory obligation through the Medicare Act to promulgate Star Ratings measures “by regulation,” *i.e.*, through notice-and-comment rulemaking and promulgation in the Code of Federal Regulations. Specifically, the statute requires that CMS promulgate, “by regulation,” any “rule, requirement, or other statement of policy” that “establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter.” 42 U.S.C. § 1395hh(a)(2).

F. CMS’s Determination and Recalculation of SCAN’s 2024 Star Rating

There have been multiple Star Ratings challenges in recent years that have resulted in multiple “recalculations” of plans’ Star Ratings.

The first recalculation occurred in 2024 following a pair of decisions in this Court holding that the methodology CMS used to determine the “cut points” for a Star Rating for SCAN, as well as a second health plan, was contrary to CMS’s regulations. *SCAN*, 2024 WL 2815789, at *6 (Nichols, J.); *Elevance Health, Inc.*, 736 F. Supp. 3d at 25 (Moss, J.). Specifically, SCAN argued that CMS had erroneously determined its 2024 Star Rating at 3.5 Stars, rather than 4.0 Stars, because CMS had failed to apply the mandatory text of its regulations, instead applying CMS’s sub-regulatory guidance documents to purportedly supersede the regulatory text. *SCAN Health Plan*, 2024 WL 2815789, at *6. Elevance raised a similar challenge. 736 F. Supp. 3d at 4. This Court agreed with SCAN and Elevance that their 2024 Star Ratings had been calculated in error. *SCAN Health Plan*, 2024 WL 2815789, at *7; *Elevance Health, Inc.*, 736 F. Supp. 3d at 25.

In response to the Court’s party-specific orders, CMS did not merely implement the party-specific relief that those cases provided for SCAN’s and Elevance’s plans. Rather, CMS implemented those judgments by recalculating the 2024 Star Ratings for all plans, and allowed plans to re-submit their bids for the following plan year in accordance with their recalculated Star Ratings. Ex. A to Plumb Decl., CMS, *Update to 2025 Quality Bonus Payment Determinations* (June 13, 2024). As a result of its judgment and CMS’s recalculation, SCAN’s 2024 Star Rating increased from 3.5 Stars to 4.0 Stars, resulting in over \$250 million in quality bonus payments. Plumb Decl. ¶ 38.

G. CMS’s Determination Of SCAN’s 2026 Star Ratings And The Clover Lawsuit

On October 9, 2025, CMS issued SCAN’s 2026 Star Ratings for the plans at issue in this case (H5425 and H0976) as 4 Stars. *Id.* ¶ 39. As a direct consequence of that 4-Star rating, CMS awarded SCAN over \$200 million in quality bonus payments and rebates unavailable at a 3.5-Star rating. *Id.* ¶ 40.

Later, Clover, an unrelated Medicare Advantage plan, filed suit in the United States District

Court for the Southern District of Georgia on November 7, 2025, challenging the application of a number of measures used to calculate the 2026 Star Ratings. Compl., *Clover Ins. Co. v. HHS*, No. 2:25-cv-142-LGW-BWC (S.D. Ga. Nov. 7, 2025), ECF No. 1. Clover challenged its 2026 Star Rating, which determines payments to the plan for plan year 2027. *See id.*

The Southern District of Georgia ultimately granted in part Clover’s motion for summary judgment, based on two primary holdings. *See Clover Ins. Co.*, 2026 WL 1483515, at *1. First, the court held that 10 measures could not be validly applied to Clover to determine its 2026 Star Rating because they exceeded CMS’s statutory authority under 42 U.S.C. § 1395w-23(o) and § 1395w-22(e). *Id.* at *8-14.

Second, that court held that 10 measures that *did* conform to CMS’s statutory authority in § 1395w-22(e) nonetheless could not be validly applied to Clover to determine its 2026 Star Rating because they were not promulgated “by regulation” as required by 42 U.S.C. § 1395hh(a)(2). *Id.* at *22-25. More specifically, Congress provided a specific notice-and-comment requirement for Medicare, providing that any “rule, requirement, or other statement of policy . . . [that] establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits,” must be promulgated “by regulation,” *i.e.*, published notice in the Code of Federal Regulations and subjected to notice and comment. 42 U.S.C. § 1395hh(a)(2).

The Southern District of Georgia correctly held that the 10 Star Ratings measures and their specifications qualify as “statement[s] of policy” for purposes of § 1395hh(a)(2) because they let the public know the agency’s current adjudicatory approach to critical questions involved in calculating ratings for Medicare Advantage plans nationwide, a point that CMS did not dispute. *See Clover Ins. Co.*, 2026 WL 1483515, at *22 (citing *Allina*, 587 U.S. at 572). The court also

correctly held that, with respect to the 10 measures that Clover challenged on this ground (known as C03, C04, C05, C15, C16, C22, C23, C24, C25, C27), those measures’ specifications each provided a “substantive legal standard,” because CMS’s Star Rating calculations based on these measures “function to define the scope of [Medicare Advantage Organizations’] legal rights to rebates” by determining their Star Rating and resultant statutorily mandated payments, a point that CMS, again, did not contest. *Id.* at *22-23.

Finally, the court found that the 10 challenged Star Ratings measures and their specifications did in fact “govern the payment for services because they serve as a ‘deciding principle’ for such payments.” *Id.* at *24. Although CMS did contest this point, as the court explained, “CMS is . . . obligated by statute to offer additional funding to plans with better Star Ratings” and “[t]he fact that the ratings trigger statutorily mandated funding increases is more than mere influence or an indirect effect; it is a deciding principle in the payment amount.” *Id.*

Therefore, CMS’s decision to use the 10 disputed measures to determine Clover’s 2026 Star Rating “trigger[ed] the notice-and-comment requirements in Section 1395hh(a)(2),” and CMS’s failure to engage in notice-and-comment rulemaking with respect to those measures made the calculation of Clover’s 2026 Star Rating with these measures procedurally invalid. *Id.* at *25.

H. CMS’s Recalculation of SCAN’s 2026 Star Ratings

Given plans’ experience with the “recalculation” following the 2024 SCAN and Elevance cases, plans were closely watching *Clover* with the expectation that, if the case were resolved in Clover’s favor, CMS was likely to engage in a similar recalculation for all plans.

That expectation was not fulfilled by CMS. CMS’s second “recalculation” occurred 3 weeks after the *Clover* ruling, when CMS issued a memorandum to plans on June 17, 2026. *See* Ex. B to Plumb Decl., Recalculation Memo at 1. The memorandum announced an update to the 2026 Star Ratings calculations (which impact 2027 plan payments) in light of the *Clover* decision,

and that CMS had issued recalculated Star Ratings to certain plans. *Id.*

The memorandum explained that CMS “recalculated the 2027 [payment year] [Star] ratings for MA [Medicare Advantage] organizations only using data collected under 42 U.S.C. § 1395w-22(e) as of November 1, 2003.” *Id.* In other words, CMS would recalculate plans’ 2026 Star Ratings (which drive 2027 payments, *see supra* at 11-12) with the removal of the measures impacted by *Clover’s first* holding, namely that CMS applied those measures in violation of 42 U.S.C. § 1395w-23(o) and § 1395w-22(e) (plus certain other measures that CMS apparently deemed outside of those authorities). *Id.*

Critically, the Recalculation Memo did *not* provide for a recalculation removing the 10 measures impacted by *Clover’s second* holding—specifically the measures that *Clover* held invalid because CMS had not promulgated those measures “by regulation.” *Compare* Ex. B to Plumb Decl., Recalculation Memo, *with Clover Ins. Co.*, 2026 WL 1483515, at *22-25.

I. SCAN Raises CMS’s Error, But CMS Denies Relief

SCAN identified the preceding error through a submission to CMS on June 29, 2026, asking that its 2026 Star Ratings be recalculated in accordance with law, with the removal of the 10 measures that *Clover* held could not be validly applied, at 4.5 Stars. Ex. C to Plumb Decl., Email Correspondence Between SCAN & CMS (June 29, 2026). SCAN also noted that it was prepared to submit SCAN’s updated 4.5 Star bid, and requested CMS’s direction for how to do so at that time. *Id.*

CMS responded the same day, denying SCAN’s request:

Your request to change the terms of the hold harmless is not consistent with the HPMS memo attached and released on June 17th. In that memo, we stated “We recalculated the 2027 QBP ratings for MA [Medicare Advantage] organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data.” We held all contracts

harmless if the recalculated QBP rating resulted in a lower rating.

Id.

On July 7, 2026, SCAN filed suit against Defendants, re-raising the objections that it had previously raised to its 2026 Star Ratings. Dkt. 1. SCAN requested that the Court vacate SCAN's 2026 Star Ratings and order CMS to re-determine those Star Ratings in compliance with CMS's governing statute and regulations. *Id.* Following a conference with the Court on case scheduling issues, on July 31, 2026, SCAN filed an amended complaint, clarifying that, if necessary, SCAN also sought equitable relief requiring CMS to take any necessary operational steps to effectuate a favorable judgment resulting in mandatory statutory rebates. Dkt. 12.

ARGUMENT

A court “shall . . . hold unlawful and set aside agency action” that is “arbitrary, capricious, . . . otherwise not in accordance with law . . . in excess of statutory jurisdiction, authority, or limitations . . . [or] without observance of procedure required by law.” 5 U.S.C. § 706(2)(A), (C)-(D); *see also id.* § 702. In making such determination, the Court applies “the best reading of the statute” in its “independent judgment.” *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 394-95 (2024). CMS's determination of SCAN's 2026 Star Ratings is contrary to law, in excess of statutory authority, and without observance of required procedure. SCAN is therefore entitled to summary judgment in its favor vacating its 2026 Star Ratings and requiring CMS to redetermine that Star Rating in accordance with the law.⁵

As *Clover* correctly held, in determining the 2026 Star Ratings, CMS utilized a series of 10 measures⁶ without adopting those measures' specifications as regulations in the Code of

⁵ In accordance with the joint proposed briefing schedule, SCAN will file an updated version of this briefing including citations to the Administrative Record on October 20, 2026.

⁶ Namely, Annual Flu Vaccine (C03), Improving or Maintaining Physical Health (C04), Improving

Federal Regulations through required notice-and-comment rulemaking under 42 U.S.C. § 1395hh(a)(2). Because CMS adopted those measures without required process, those measures cannot be lawfully applied to SCAN as a part of its 2026 Star Ratings.

Under § 1395hh(a)(2) of the Medicare Act, “[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation.” 42 U.S.C. § 1395hh(a)(2). Congress so-provided because the APA’s default notice-and-comment provisions do not apply to Medicare, 5 U.S.C. § 553(a)(2), yet Medicare “touches the lives of nearly all Americans” by altering the healthcare system. *Allina*, 587 U.S. at 568. Thus, “even minor changes to the agency’s approach can impact millions of people and billions of dollars in ways that are not always easy for regulators to anticipate.” *Id.* at 582.

The Medicare Act’s rulemaking provision thus extends even further than the APA, requiring CMS to elicit notice and comment and codify “by regulation” more than just legislative rules (binding rules with force and effect of law), as is normally the rule under the APA, but also interpretative rules (non-binding rules *without* force and effect of law), including statements of agency policy, that fall within the statute’s ambit. *See id.* at 581-82.

Congress provided for codification by regulation for exactly this circumstance. Most Medicare beneficiaries elect Medicare Advantage, and as detailed below, a plan’s Star Rating is one of, if not the most important determinant of how plans are paid, what benefits they offer, and

or Maintaining Mental Health (C05), Reducing the Risk of Falling (C15), Improving Bladder Control (C16), Getting Needed Care (C22), Getting Appointments and Care Quickly (C23), Customer Service (C24), Rating of Health Care Quality (C25), and Care Coordination (C27).

whether program participation is terminated. The measures determine those outcomes, and in turn, dictate how plans must reshape American healthcare.

Here, CMS has promulgated such “rule[s], requirement[s], or other statement[s] of policy,” namely, CMS’s foregoing 10 challenged Star Rating measures and their specifications (*supra* note 6), without doing so “by regulation,” *i.e.*, without notice and comment and codification in the Code of Federal Regulations. Indeed, CMS has not historically *contested* most elements of this claim. CMS did not contest in *Clover*, and cannot contest here, that the foregoing 10 challenged Star Rating measures and their specifications amount to a “rule, requirement, or other statement of policy” and that each establishes “a substantive legal standard.” 42 U.S.C. § 1395hh(a)(2). And, as demonstrated below, those 10 challenged Star Rating measures and their specifications govern the scope of benefits, the payment for services, and the eligibility of entities and organizations to furnish Medicare services and benefits. *Id.* Accordingly, because CMS did not promulgate the 10 challenged Star Rating measures and their specifications “by regulation,” CMS cannot apply these 10 measures to SCAN in determining its 2026 Star Ratings.

I. CMS’S CALCULATION OF SCAN’S 2026 STAR RATINGS VIOLATED 42 U.S.C. § 1395hh(a)(2)

A. The Challenged Star Ratings Measures And Their Specifications Undisputedly Each Constitute A “Rule, Requirement, Or Other Statement Of Policy” That Establishes A Substantive Legal Standard

CMS has never disputed that the foregoing Star Ratings measures and CMS’s specifications for determining them, including in its annual Technical Notes, each amount to a “rule, requirement, or other statement of policy” that establishes or changes “a substantive legal standard” governing the Medicare Advantage program. 42 U.S.C. § 1395hh(a)(2).

There is no real question that the foregoing 10 challenged Star Ratings measures and their specifications, including those specifications provided in CMS’s annual Technical Notes, amount

to a “rule, requirement, or other statement of policy,” because that phrase encompasses both binding legislative rules (contained in the Code of Federal Regulations), and non-binding, unilateral agency guidance like CMS’s Technical Notes. *Allina*, 587 U.S. at 572 (A “statement of policy” provides the agency’s current “adjudicatory approach.”) (quoting *Syncor Int’l Corp. v. Shalala*, 127 F.3d 90, 94 (D.C. Cir. 1997); *Chippewa Dialysis Servs. v. Leavitt*, 511 F.3d 172, 177 (D.C. Cir. 2007) (similar). CMS has clearly set forth by guidance the rules and requirements to determine plans’ Star Ratings, which provide CMS’s current adjudicatory approach, as modified by CMS unilaterally from year to year. *See Clover Ins. Co.*, 2026 WL 1483515 at *22 (finding that CMS’s Star Rating “specifications, and the agency’s annual Technical Notes announcing how these specifications are to be utilized that year,” set forth the “adjudicatory approach” to a “critical question involved in calculating” Star Ratings). As noted, CMS appropriately did not contest this first element in the *Clover* matter.

Nor did CMS contest that the foregoing Star Ratings measures and CMS’s specifications for determining them provide a “substantive legal standard.” *Allina*, 587 U.S. at 572. The Supreme Court has made clear that a “substantive legal standard” is more capacious than binding legislative rules that have the “force and effect of law,” but has not determined how much more broadly the term extends. *Id.* at 573-74. However, the term has a plain and well-worn meaning: It distinguishes between procedural legal standards, and substantive (non-procedural) legal standards. *See, e.g., id.* at 573 (contrasting “procedural” standard that defines *how* “duties, rights, and obligations should be enforced” with the “substantive” standard that “creates duties, rights and obligations”).

For example, CMS’s *procedure* for considering *post-hoc* administrative *challenges* to its determination of a given measure, like CMS’s evaluation of a specific customer service phone call

or coverage appeal, may constitute a procedural, not “substantive” legal standard. *See, e.g.*, 42 C.F.R. § 422.260. On the other hand, CMS’s actual rules for how to determine a measure score are substantive. Each Star Rating measure is accompanied by specifications, both in the annual, general Technical Notes, and within more detailed *measure-specific* Technical Notes and guidance, which specify in detail the rules that CMS shall apply to determine that measure. *See, e.g.*, Ex. E to Plumb Decl., 2026 Pt. C & D Star Ratings Tech. Notes, at 29-96. For example, the Improving Bladder Control measure specification in the Technical Notes defines *which* data CMS must analyze (HEDIS⁷ survey questions asking members about urinary incontinence), and what calculations CMS must run on those data to determine the Star Rating (*e.g.*, the percentage of members who discussed urine leakage with their doctor divided by the percentage of members who reported urine leakage). *Id.* at 50-51. As another example, the Improving or Maintaining Mental Health measure’s specification likewise defines *which* data CMS must analyze (certain HOS⁸ survey questions regarding subjective mental health responses), and what calculations CMS must run on those data to determine the Star Rating (*e.g.*, the percentage of sampled enrollees whose mental health was reported as the same or better than expected). *Id.* at 34-36; *see also id.* at 32-34, 49-50, 59-63, 64-66 (2026 Tech. Notes specifications for each of the remaining challenged measures, *see supra* note 6).

These rules not only impose duties on CMS in terms of *what* they must base a plan’s Star Rating on, but confer important rights on plans to have their Star Ratings determined based on the

⁷ The Healthcare Effectiveness Data and Information Set (“HEDIS”) contains measures for “many significant public health issues such as cancer, heart disease, behavioral health and diabetes.” HEDIS, CMS, <https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/data-information-set> (last modified Sept. 10, 2024).

⁸ The Medicare Health Outcomes Survey (HOS) collects information from people with Medicare who are enrolled in Medicare Advantage health plans. HOS, CMS, <https://www.cms.gov/data-research/research/health-outcomes-survey> (last modified Mar. 10, 2026).

measures provided in CMS’s specifications, which, in turn, directly control payments to plans. For that reason, the application of the measure specifications in the Technical Notes guidance is litigated by plans, each and every year, precisely *because* that guidance determines the payments to plans. *See, e.g., UnitedHealthcare Benefits v. CMS*, No. 6:24-cv-357-JDK, 2024 WL 4870771, at *1-2, 4-5 (E.D. Tex. Nov. 22, 2024) (vacating CMS’s determination that CMS contractor’s “test” call was “unsuccessful” because decision departed from CMS’s Star Ratings measure specifications); *Alignment Healthcare, Inc. v. HHS*, 1:25-cv-74-CRC, 2025 WL 1635371, at *3 (D.D.C. June 9, 2025) (Cooper, J.) (remanding to CMS for re-calculation because “CMS failed to adequately explain why it included adverse determinations,” and one explanation was based on incorrect reading of CMS guidance). Accordingly, *Clover* correctly concluded that these measures’ specifications constitute “substantive legal standards” because the use of measure specifications to calculate Star Ratings “define[s] the scope of [Medicare Advantage Organizations’] legal rights to rebates” by determining the *substantive* criteria used to calculate Star Ratings. *Clover Ins. Co.*, 2026 WL 1483515, at *23. CMS did not dispute that, and the same result should follow in this case.

B. The Star Ratings Measures And Their Specifications Govern The Scope Of Benefits, The Payment For Services, And The Eligibility To Furnish Services

Finally, the Star Ratings measure specifications set substantive legal standards “governing [1] the scope of benefits, [2] the payment for services, or [3] the eligibility of . . . entities, or organizations to furnish . . . services or benefits,” 42 U.S.C. § 1395hh(a)(2) (emphasis added), any one of which suffices and requires CMS to promulgate its Star Ratings measures and their specifications “by regulation.” *Clover Ins. Co.*, 2026 WL 1483515, at *23-25.

“As with any question of statutory interpretation, our analysis begins with the plain language of the statute.” *Jimenez v. Quarterman*, 555 U.S. 113, 118 (2009). “[T]he statutory text”

must be read “as a whole” and words assessed “in the context in which they are used.” *TIG Ins. Co. v. Republic of Argentina*, 110 F.4th 221, 231 (D.C. Cir. 2024). Here, “governing” clearly refers to a legal standard that “control[s] legal procedure for (an action, practice, process, etc.),” for example, in the phrase “laws that govern the sale of alcohol.” *Govern*, Webster’s Dictionary Online; *see also Govern*, Webster’s New World College Dictionary (4th ed. 1999) (“to be a rule or law for”); *id.* (“influence” or “guide”); *Abbott v. Biden*, 70 F.4th 817, 830-31 & n.9 (5th Cir. 2023) (“govern” as to “regulate,” “influence,” “manage,” “regulate by authority”); *see also Clarian Health W., LLC v. Hargan*, 878 F.3d 346, 356 (D.C. Cir. 2017) (applying this meaning, in the phrases “legal standards that govern the hospitals” and “legal standards that govern the agency”). Here, the Star Ratings measures specifications “govern” the payment for services, eligibility to furnish services and benefits, and the scope of benefits because they provide the controlling, substantive legal standards that determine payments, eligibility, and benefits for Medicare Advantage plans.

1. The Measures Govern Payment For Services

The Star Rating measure specifications “govern[] . . . the payment for services.” 42 U.S.C. § 1395hh(a)(2). As this Court has correctly identified, CMS “uses the star ratings to determine the bonuses paid to MA Plans.” *HMO La., Inc. v. HHS*, 793 F. Supp. 3d 150, 153 (D.D.C. 2025) (Cooper, J.). That is, CMS must “offer additional funding to plans with better Star Ratings.” *SCAN Health Plan*, 2024 WL 2815789, at *1. That is dispositive.

In this case, CMS has already paid SCAN over \$200 million in quality bonus payments based solely on it achieving a 4-Star rating. Plumb Decl. ¶ 39. If SCAN achieves a 4.5-Star rating, it will be entitled by law to another \$125 million in rebates. *Id.* ¶ 56; 42 U.S.C. §§ 1395w-23(a)(1)(B)(i), (E). Star Ratings are thus one of, if not the *most important factor* in determining payments to plans (especially as differentiated from *other* plans), and the measure specifications

are *the central feature* that determines those Star Ratings. *Supra* at 11-12. As noted, each year, plans file lawsuits challenging CMS’s evaluation of just a *single* encounter with a beneficiary, like a single customer service phone call or a single insurance coverage appeal, because CMS’s Star Ratings system is so sensitive to the identity of the measures and their specifications such that just a *single* encounter can and does regularly trigger over \$100 million in payments.⁹ There can be no question that the measure specifications “govern[] . . . the payment for services.” 42 U.S.C. § 1395hh(a)(2).

Notably, from the statute’s perspective, it is the Medicare Advantage plan that assumes responsibility for providing services to beneficiaries; and the Star Ratings measure specifications determine the payments from CMS to plans for these exact services. Medicare Advantage plans, including coordinated care plans like SCAN, must “provide health care services” to patients in exchange for fixed per-beneficiary payments from CMS. *Id.* § 1395w-21(a)(2)(A)(i) (“Coordinated care plans [are those] which provide health care services”); *see also id.* § 1395w-25(b) (plans must “assume full financial risk on a prospective basis for the provision of the health care services”). And “only the Medicare+Choice organization [Medicare Advantage plan] shall be entitled to receive payments from the Secretary under this subchapter [42 USCS § 1395 *et seq.*] for services furnished to the individual” electing Medicare Advantage. *Id.* § 1395w-21(i). CMS pays *only* the plan, not the provider, for provision of services. *Id.*; *id.* § 1395w-24(a)(6)(A) (plan must provide CMS monthly “bid amount for the provision of all . . . services under the plan” to determine this payment). And plans are responsible for providing

⁹ *See, e.g., UnitedHealthcare Benefits*, 2024 WL 4870771, at *1-2, 4-5 (litigating single test call under CMS’s measure specifications); Pl.’s Mem. In Support Of Its Mot. for Expedited Summ. J., *SCAN Health Plan v. HHS*, 1:23-cv-3910-CJN, at 33-43 (D.D.C. Mar. 8, 2024), ECF No. 20 (similar); *Elevance Health, Inc. v. Becerra*, 1:23-cv-03902 ¶ 93 (D.D.C. Dec. 29, 2023), ECF No. 1 (similar).

healthcare services, including paying providers. 42 U.S.C. § 1395w-25(b); 42 C.F.R. § 422.504(d) (CMS’s contract with plan shall provide for audit of plan’s “services performed under the contract”).

As explained, SCAN’s Star Ratings determine the *amount* of payments SCAN is entitled to, on a beneficiary-by-beneficiary basis, for providing services to each beneficiary. 42 U.S.C. § 1395w-23(o) (providing quality bonus payment for plans rated 4 Stars or higher); *id.* § 1395w-24(b)(1)(C)(iv) (providing that rebates increase at 3.5 and 4.5 Star Ratings). And the Star Rating measures, and their specifications, are *the* central component that determines Star Ratings because they define *both* the aspects of plan quality that are evaluated and the methodology and criteria used to evaluate them. *See generally* Ex. E to Plumb Decl., 2026 Part C & D Star Ratings Tech. Notes.

Separately, the increased funding determined by Star Ratings *also* determines enhanced payments *from plans to providers of services*. CMS requires plans to spend a fixed percentage of revenue (85%) toward patient care, known as the “medical loss ratio” (“MLR”). 42 U.S.C. § 1395w-27(e)(4); 42 C.F.R. § 422.2420(b)(2). As plan revenues increase through Star-Rating-driven payments, more funds must be spent on healthcare services to meet the MLR. *Id.*; *see also* 42 U.S.C. § 1395w-27(e)(4)(A), (C).

Thus, viewed from either perspective, *i.e.*, (i) payments from CMS to plans for providing services to members, or (ii) payments from plans to providers, the Star Rating measure specifications “govern[] . . . the payment for services.” 42 U.S.C. § 1395hh(a)(2); *see also* *Clover Ins. Co.*, 2026 WL 1483515, at *24 (rejecting CMS’s “unduly narrow interpretation” and explaining that “the Medicare Act provides for payments for services flowing between multiple parties in multiple different directions, including payments *by CMS to plans*”) (emphasis in

original).

2. The Measures Govern Eligibility To Furnish Services And Benefits

The Star Rating measure specifications also “govern[] . . . the eligibility of . . . entities, or organizations to furnish . . . services or benefits under this subchapter.” 42 U.S.C. § 1395hh(a)(2).

As this Court has correctly identified, if “a plan’s star ratings drop too low, CMS may terminate it from the MA program altogether.” *HMO La., Inc.*, 793 F. Supp. 3d at 153 (Cooper, J.) (citing 42 U.S.C. § 1395w-23(o); 42 C.F.R. §§ 422.160(b)(2), 422.510(a)(4)(xi)). CMS may terminate plans from the Medicare Advantage program if they fail to achieve an overall Star Rating of at least 3 Stars over three years, 42 C.F.R. § 422.510(a)(4)(xi), or they receive a Part C or Part D Star Rating of 2.5 or less for 2 years, *id.* § 422.502(b)(1)(i)(D). CMS has repeatedly terminated plans from Medicare Advantage on these grounds. Accordingly, the Star Ratings measures and their specifications self-evidently govern a plan’s “eligibility” to “furnish . . . services and benefits” as well. 42 U.S.C. § 1395hh(a)(2).

3. The Measures Govern The Scope Of Benefits

The Star Rating measure specifications also “govern[] the scope of benefits.” *Id.* That is because a plan’s Star Rating impacts CMS’s per-beneficiary payments to plans, which in turn determine the scope of benefits the plan may offer.

As explained, *supra* at 10, CMS is “obligated” to “offer additional funding to plans with better Star Ratings.” *SCAN Health Plan*, 2024 WL 2815789, at *1; *see also HMO La., Inc.*, 793 F. Supp. 3d at 153 (Cooper, J.) (CMS “uses the star ratings to determine the bonuses paid to MA Plans”). Plans with higher Star Ratings are able to “use those extra funds to lower costs for their beneficiaries or to provide them with additional benefits” not offered by Original Medicare, *SCAN Health Plan*, 2024 WL 2815789, at *1, such as dental and vision benefits, 85 Fed. Reg. 33,796, 33,885-86 (June 2, 2020), as well as benefits targeting a “particular health status or disease state,”

Ex. I to Plumb Decl., MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System* 57-58 (June 2025); *see also* Bipartisan Budget Act of 2018, Pub. L. 115-123 § 50322, 132 Stat. 64, 201 (Feb. 9, 2018) (expanding the scope of benefits that a plan may offer). The “majority of the supplemental benefits provided by [Medicare Advantage] plans are financed by the rebates that plans receive from Medicare,” including through annual Star Ratings. *See* Ex. I to Plumb Decl., MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System* 57-58, 64 (June 2025). Star Ratings measures thus govern SCAN’s ability to receive bonus payments and rebates, and, in turn, the “scope of benefits” that SCAN may offer. 42 U.S.C. § 1395w-23(o)(1).

* * *

For the foregoing reasons, CMS’s specification of the foregoing Star Rating measures must be promulgated “by regulation,” *i.e.*, subjected to notice and comment and codified in the Code of Federal Regulations. *See, e.g., Wilderness Soc’y v. Norton*, 434 F.3d 584, 596 (D.C. Cir. 2006); *Brock v. Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 538-39 (D.C. Cir. 1986). Unsurprisingly, CMS has chosen to codify in the Code of Federal Regulations practically every other aspect of its Star Rating system, including how CMS will translate measure scores on individual measures into an overall Star Rating, *apart from* its measures and their specifications. *See* 42 C.F.R. pt. 422; 42 C.F.R. pt. 423; *HMO La., Inc.*, 793 F. Supp. 3d at 153 (Cooper, J.) (“CMS regulations establish the methodology used to calculate annual star ratings.”); *id.* (CMS “Technical Notes” provide the “up to 40 performance measures that comprise the overall rating for each plan”). CMS chose not to codify in the Code of Federal Regulations the foregoing measures and their specifications in an effort to maintain maximum flexibility to morph its measures of quality from year to year. 83 Fed. Reg. at 16,537 (CMS chose not to codify due to measures’ “regular updates and revisions”); 84

Fed. Reg. 15,680, 15,761 (Apr. 16, 2019) (similar). Instead, CMS simply published its specifications used to calculate these Star Rating measures unilaterally in its annual Technical Notes, plus the reams of internal guidance documents and measure-specific technical notes. *See, e.g.,* Ex. E to Plumb Decl., 2026 Part C & D Star Ratings Tech. Notes; Ex. F to Plumb Decl., CMS, 2022 Part C & D Call Center Monitoring Timeliness and Accuracy & Accessibility Studies Tech. Notes (Dec. 16, 2021) (further specifying calculation of C33 and D01 measures). But that flexibility of proceeding by uncodified, unilateral guidance, rather than notice-and-comment regulation, came at a cost: CMS cannot apply these measures to determine SCAN’s 2026 Star Ratings. 42 U.S.C. § 1395hh(a)(2).

Accordingly, CMS cannot apply the 10 measures identified above to SCAN, *see supra* note 6, because they were not promulgated “by regulation” as required by 42 U.S.C. § 1395hh(a)(2).

II. THE COURT SHOULD VACATE SCAN’S 2026 STAR RATINGS, ORDER THE AGENCY TO RECALCULATE THOSE RATINGS, AND REQUIRE CMS TO OPERATIONALLY FACILITATE MANDATORY REBATE RELIEF

Because CMS calculated SCAN’s 2026 Star Ratings using ten unlawful measures, the Court should vacate SCAN’s 2026 Star Ratings and order CMS to re-calculate it in accordance with the Court’s opinion. *See* 5 U.S.C. § 706(2); *Elevance Health, Inc.*, 736 F. Supp. 3d at 26 (setting aside Star Rating and ordering recalculation); *Clover*, 2026 WL 1483515, at *25 (same).

In an ordinary case, that would be the end of the story: Once the Star Rating is recalculated, the statute mandates specific payment flows that follow inextricably from that updated Star Rating. *Supra* at 10. CMS has historically taken the position that it would take the operational steps it views as required to implement those payments, including allowing re-submission of bid-related

documents.¹⁰ And after originally expressing a preference to have Star Ratings cases decided before the June initial bid deadline due to these operational considerations,¹¹ CMS has more recently stated such urgency is unnecessary, as CMS represents it can operationalize the judgment requiring recalculation of a plan's Star Rating and make resultant payments even if a decision comes months after the June deadline.¹²

But on July 15, 2026, just days after claiming no “urgency” for a decision, CMS appears in *Elevance* (another case seeking recalculation of certain plans’ 2026 Star Ratings) to be taking a directly contrary and irreconcilable position. In response to Elevance’s motion to set a briefing schedule on its expedited motion for preliminary injunction, CMS stated that the “window of opportunity” to re-submit a bid closed the first Monday in June. Response to Mot. for Briefing Sched., *Elevance Health Inc., et al. v. HHS, et al.*, 2:26-cv-61 (July 15, 2026), ECF No. 31. Even

¹⁰ See Ex. A to Plumb Decl., CMS, *Update to 2025 Quality Bonus Payment Determinations* (June 13, 2024); Ex. B to Plumb Decl., Recalculation Memo.

¹¹ See, e.g., Joint Mot. for Briefing Schedule at 1, *SCAN Health Plan v. Dep’t of Health & Human Servs.*, No. 1:23-cv-03910-CJN (D.D.C. Feb. 23, 2024), ECF No. 19 (“The parties have developed this scheduling proposal to allow for expedited summary judgment briefing in advance of the June 3, 2024 deadline for Medicare Advantage bids. . . .”); *Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 13 (D.D.C. 2024) (Moss, J.) (“Both parties have requested expedited consideration of . . . summary judgment in light of Plaintiffs’ impending deadline to submit their bids to CMS for the upcoming contract year.”).

¹² In *Clover*, CMS explicitly took the position that it is able to award efficient and efficacious relief after the bid deadline, even many months later, and there was thus no need for an expedited resolution. See, e.g., Reply In Supp. of Mot. To Stay at 3, *Clover Ins. Co. v. HHS*, No. 2:25-cv-142-LGW-BWC, (S.D. Ga. Apr. 29, 2026), ECF No. 31. CMS argued that relief would be available many months later because “[n]umerous other district courts have decided Star Ratings cases after the end of May,” (just before the early June bidding deadline) including decisions that issued in October and November, with “no obvious ill effects attributable to the issuance of a decision at that time.” *Id.* at 3-4 (citing *Blue Cross & Blue Shield of Massachusetts, Inc. v. Kennedy*, No. 1:25-cv-693, 2025 WL 3062827 (D.D.C. Nov. 3, 2025) and *Humana, Inc. v. U.S. Dep’t of Health & Hum. Servs.*, No. 4:25-cv-779, 2025 WL 2909960 (N.D. Tex. Oct. 14, 2025)); see also Tr. of Telephonic Mediation Status Conf. at 15:8, 29:12-16, *Elevance Health Inc., et al. v. HHS, et al.*, 2:26-cv-61 (July 10, 2026) (emphasizing that there is no “urgency” for that court to rule).

more puzzlingly, CMS faulted Elevance for not seeking expedited relief on the same timeline as Clover—the very case in which CMS represented to that same court that there was no urgency to issue a decision by the initial bid deadline because it could afford relief at a later time. *See id.* At the July 29, 2026 status conference in this case to clear up CMS’s reversal, CMS continued to hedge on whether or how it would implement rebate relief, *despite having told the Clover court it could afford relief many months later*, claiming “it’s sort of difficult to say how CMS would implement any order,” and that “it seems like the remedy is something that might be subject to further litigation based on the complexity.” Tr. of July 29, 2026 Status Conf. at 3:15-17; 10:21-23.

As the Court itself suggested at the initial scheduling conference, given the doubt CMS is now sowing about its willingness to comply with the statute and operationally facilitate mandatory rebate relief, the Court should order CMS to take the operational predicate steps necessary to afford rebate relief, including facilitating the re-submission of any bid documents CMS deems operationally necessary to do so. *Id.* at 10:10-16 (the Court suggesting that “if [SCAN] prevail[s], the order would say the Star Rating was erroneously calculated because the ten measures should have gone through notice-and-comment rule-making, and as a result of that CMS is ordered to, . . . reopen the bidding process.”). Such relief is amply supported here: The statute affords CMS no discretion whether to afford rebates if a plan’s Star Rating increases to 4.5 Stars.¹³ And CMS has no discretion to use alleged operational complexities to avoid doing what the statute mandates.

To the extent required, SCAN easily satisfies each of the four prongs required to obtain

¹³ 42 U.S.C. §§ 1395w-23(a)(1)(B)(i), (a)(1)(E) (generally calculating the “monthly payment” for a plan with a “bid[] below benchmark” as the bid amount “plus the amount . . . of any rebate” “under section 1395w-24(b)(1)(C)(i)”; *id.* § 1395w-24(b)(1)(C)(v) (“[T]he final applicable rebate percentage under this clause *is* . . .”) (emphasis added).

such permanent injunctive relief: Absent permanent injunctive relief, SCAN will suffer (1) “an irreparable injury;” (2) “remedies available at law are [] inadequate to compensate for that injury;” (3) “the balance of hardships weighs in favor of an injunction;” and (4) “the public interest would not be disserved by a permanent injunction.” *In re Fed. Bureau of Prisons’ Execution Protocol Cases*, 980 F.3d 123, 137 (D.C. Cir. 2020) (quoting *Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 156-57 (2010)). The last two factors merge when the Government is a party. *Nken v. Holder*, 556 U.S. 418, 435 (2009).

First, CMS refusing to take the necessary operational steps to facilitate rebate relief will produce irreparable harm. “Where, as here, sovereign immunity limits plaintiff to seeking nonmonetary equitable relief and thus renders unrecoverable plaintiff’s monetary damages, courts have recognized these losses can . . . constitute irreparable harm.” *Perkins Coie LLP v. DOJ*, 783 F. Supp. 3d 105, 178-79 (D.D.C. 2025) (collecting cases). Here, the irrecoverable loss of \$125 million in rebate relief due to CMS refusing to operationalize a judgment triggering mandatory rebate relief not only would be self-evidently great and irreparable, it also would harm SCAN’s payments available for covered Medicare services and thus its reputation, goodwill, competitive position, and ultimately market share as against plans that receive greater rebate relief and can provide greater benefits as a result. Plumb Decl. ¶ 66 (explaining that Star Ratings and resultant payments “are the principal determinant of a plan’s success in the marketplace, competitive position, and reputation and goodwill among beneficiaries, and resultant market share”); *see also Perkins Coie LLP*, 783 F. Supp. 3d at 178-79; *Everglades Harvesting & Hauling, Inc. v. Scalia*, 427 F. Supp. 3d 101, 116 (D.D.C. 2019) (recognizing reputational harm to a business); *S. Educ. Found. v. U.S. Dep’t of Educ.*, 784 F. Supp. 3d 50, 72 (D.D.C. 2025) (similar); *Bayer HealthCare, LLC v. U.S. Food & Drug Admin.*, 942 F. Supp. 2d 17, 26 (D.D.C. 2013) (“Courts have recognized

that . . . diminished market share can constitute irreparable harm.”). These great, certain, and irrecoverable financial injuries and resultant competitive injuries constitute irreparable harm.

Second, remedies at law are inadequate to provide complete relief. *Ramirez v. ICE*, 568 F. Supp. 3d 10, 24 (D.D.C. 2021). Sovereign immunity does not allow for the recovery of damages against the federal government in this context, and so remedies at law will not provide a remedy in the nature of monetary damages if CMS refuses to operationalize the judgment as the statute requires. *See Dep’t of Agric. Rural Development Rural Housing Service v. Kirtz*, 601 U.S. 42, 48 (2024) (“[T]he United States, as sovereign, is generally immune from suits seeking money damages.”); *Perkins Coie LLP*, 783 F. Supp. 3d at 180 (“[B]ecause sovereign immunity bars recovery of money damages, [movant’s] losses could not be adequately compensated by legal remedies.”).

Third, the remaining equitable factors strongly weigh in favor of an injunction. There is a substantial public interest in funding Medicare Advantage plans in accordance with the law so that they can provide the benefits to the vulnerable senior populations they serve with the funding Congress afforded. *See Whitman-Walker Clinic, Inc. v. HHS*, 485 F. Supp. 3d 1, 60-61 (D.D.C. 2020) (recognizing public interest in access to healthcare); *Hosp. for Special Surgery v. Becerra*, 2023 WL 6291638, at *11 (D.D.C. May 31, 2023) (recognizing “robust public interest” in healthcare funding). And there is “a substantial public interest in having governmental agencies abide by the federal laws that govern their existence and operations.” *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016).

For all of these reasons, the Court should order CMS to take the predicate operational steps necessary to afford rebate relief, including facilitating the re-submission of any bid documents

CMS deems operationally necessary to do so.¹⁴

CONCLUSION

For the foregoing reasons, this Court should grant SCAN's motion for summary judgment, set aside CMS's determination of SCAN's 4-star Star Ratings, order CMS to redetermine SCAN's 2026 Star Ratings as at least 4.5 Stars, and order CMS to take the predicate operational steps necessary to afford rebate relief, including facilitating the re-submission of any bid documents CMS deems operationally necessary to do so.

¹⁴ CMS has suggested that the Court should not afford this relief because such relief should be afforded, if at all, in a future case *if* CMS flouts the statute's mandates. *See* Dkt. 10 at 7. But, as explained, CMS is bound by statute to effectuate rebate relief, so the court should reject CMS's suggestion to defer that issue in a subsequent suit, and should instead address it at this juncture.

Dated: August 3, 2026

Respectfully submitted,

/s/ Andrew D. Prins

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Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN
SERVICES, et al.,

Defendants.

Civil Action No. 26-cv-02391-CRC

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

I, Michael Plumb, declare as follows:

1. I submit this declaration in support of SCAN Health Plan's ("SCAN") Motion for Expedited Summary Judgment.

2. This Declaration is based upon my personal knowledge and review of relevant documents. I am fully familiar with the facts and circumstances set forth herein. If called as a witness, I could and would testify competently thereto.

Background

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

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

5. In my role as Chief Financial Officer of SCAN, I am responsible for all of the organization's financial operations, including financial planning and analysis, actuarial functions, and accounting.

6. I am also familiar with the Centers for Medicare & Medicaid Services (“CMS”) Medicare Part C and D programs, Medicare Advantage bidding process, CMS’s Star Ratings (including the calculation thereof), and CMS’s Quality Bonus Payment program. Additionally, I am familiar with the impact of SCAN’s Star Ratings on its business and members.

7. I hold a bachelor’s degree in economics from the University of California, San Diego and a master’s in business administration from the Haas School of Business at the University of California, Berkeley.

SCAN Health Plan

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

9. SCAN’s mission is to keep seniors healthy and independent.

10. As of 2026, SCAN ranks among the top 10 Medicare Advantage plans nationally by membership, serving more than 435,000 members.

11. SCAN operates health plans serving Medicare beneficiaries in California, Arizona, Nevada, New Mexico, Texas, and Washington.

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

13. SCAN thus derives its revenue solely from the Medicare Advantage program.

14. For SCAN to remain viable and fulfill its mission, SCAN must have beneficiaries select its Medicare Advantage plan, rather than other competing plans, by providing high-quality care, a superior member experience, and leading supplemental benefits, all while minimizing premiums and cost-sharing to members.

The Medicare Advantage Bidding System

15. Each year, CMS establishes “benchmark” rates that are meant to represent what it would cost CMS to provide Medicare benefits to an average enrollee in each county.

16. To participate in the Medicare Advantage program and determine payments to SCAN under that program, SCAN submits an annual bid to CMS that represents SCAN’s estimated cost for covering Medicare-defined standard benefits to an average enrollee for the upcoming year.

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

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

19. The initial bid submission is due in June. For Calendar Year (“CY”) 2027, SCAN’s initial submission was due by June 1, 2026. SCAN submitted its CY 2027 initial submission by the deadline.

CMS’s Star Ratings Program

20. Each year, CMS publishes its “Star Ratings,” which synthesize a range of quality data about each plan into a summary rating of 1 to 5 Stars.

21. At a high level, CMS evaluates various “measures” of plan quality, and then converts those measure data into a measure-specific Star Rating—between 1 and 5 stars—for each measure, based on the plan’s performance on that measure relative to other Medicare Advantage plans across the country.

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

23. CMS displays Star Ratings as part of its online "Plan Finder" tool, which seniors use to research, compare, and sign up for Medicare Advantage plans.

24. Higher-rated plans are displayed higher than lower-rated plans, thus helping them attract a disproportionate share of enrollment.

25. CMS also displays the measure-specific Star Ratings for each plan on its website and Plan Finder, for each of the measures that CMS evaluates.

26. In addition to impacting a plan's reputation and goodwill among beneficiaries, Star Ratings can also affect the amount of payments that a Medicare Advantage plan receives based on CMS's "Quality Bonus Payments," which are paid only to plans with a Star Rating of 4 Stars or higher, and by varying the determination of the "rebate" amount based on a Plan's Star Rating.

SCAN's Star Ratings

27. Based on its high-quality care and services, SCAN has historically received top-tier overall Star Ratings, including a Star Rating of 4.0 or higher for the last 13 consecutive years.

28. Private organizations agree with CMS: For the last several years, JD Power has ranked SCAN in the top two or three Medicare Advantage plans in California for customer satisfaction.

29. And year after year, SCAN has been named to U.S. News and World Report's list of Best Medicare Advantage plans.

30. As a result of its exemplary overall Star Ratings, SCAN has in recent years qualified for Quality Bonus Payments, which have added roughly \$200 to \$250 million per year to the CMS benchmarks.

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

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

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

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

CMS's Recalculation of SCAN's 2024 and 2026 Star Ratings

35. SCAN previously brought a challenge to CMS's Star Ratings calculation methodology to determine the "cut points" for a 3, 4, 5, etc. Star Rating, arguing that the methodology was contrary to CMS's regulations. *SCAN Health Plan v. HHS*, No. 1:23-cv-3910-CJN, 2024 WL 2815789, at *6 (D.D.C. June 3, 2024).

36. The Court agreed with SCAN that its 2024 Star Ratings had been calculated in error. *Id.*

37. In response to the Court's order, CMS recalculated the 2024 Star Ratings for all plans, and allowed plans to re-submit their bids for the following plan year in accordance with

their recalculated Star Ratings. CMS, Update to 2025 Quality Bonus Payment Determinations (June 13, 2024), attached hereto as **Exhibit A**.

38. As a result of SCAN's judgment and CMS's recalculation, SCAN's 2024 Star Rating increased from 3.5 Stars to 4.0 Stars, resulting in over \$200 million in quality bonus payments.

39. On October 9, 2025, CMS published SCAN's 2026 Star Rating as 4 Stars.

40. As a direct consequence of that 4-Star rating, CMS again awarded SCAN over \$200 million in quality bonus payments and rebates.

41. Meanwhile, another Medicare Advantage Organization, Clover Insurance Company ("Clover") filed suit in the United States District Court for the Southern District of Georgia on November 7, 2025, challenging the application of a number of measures used to calculate the 2026 Star Ratings. Complaint, *Clover Ins. Co. v. HHS*, No. 2:25-cv-142-LGW-BWC, (S.D. Ga. Nov. 7, 2025), ECF No. 1.

42. Given SCAN's experience with the 2024 "recalculation," SCAN was closely watching *Clover* with the expectation that, if that case were resolved in Clover's favor, CMS was likely to engage in a similar recalculation for all plans.

43. That expectation was not fulfilled by CMS.

44. CMS issued a memorandum on June 17, 2026, announcing an update to 2026 Star Rating calculations (which impact 2027 plan payments) in light of the decision, and that CMS had issued recalculated Star Ratings. CMS, Update to 2027 Quality Bonus Payment Determinations (June 17, 2026), attached hereto as **Exhibit B**.

45. The memorandum explained that CMS “recalculated the 2027 [Star] ratings for MA organizations using only data collected under 42 U.S.C. § 1395w-22(e) as of November 1, 2003,” in accordance with only *part* of the *Clover* court’s holding. *Id.* at 1.

46. The memorandum also invited plans whose overall Star Ratings had increased as a result of the recalculation to resubmit their bids for plan year 2027, in light of the significant revenue effects that the Star Ratings changes would have on the bids. *Id.* at 2.

47. CMS recalculated SCAN’s 2026 Star Rating, it appears, with the removal of the ten measures impacted by the Southern District of Georgia’s *first* holding, namely, that CMS applied those measures in violation of 42 U.S.C. § 1395w-23(o) and § 1395w-22(e) (plus certain other measures outside of those authorities).

48. It appears that CMS recalculated SCAN’s Star Rating pursuant to the terms of the Recalculation Memo, and determined that SCAN maintained its 4.0 Star Rating with removal of the measures identified in the memorandum. More generally, CMS applied the recalculation on a “hold harmless” basis, meaning that CMS would not implement the recalculated rating where it decreased a plan’s overall Star Rating.¹

49. However, the Recalculation Memorandum did not provide for a recalculation removing the additional ten measures impacted by the Southern District of Georgia’s decision—specifically the measures that the *Clover* court held invalid because CMS had not promulgated those measures “by regulation.” *See generally* Ex. B; *compare Clover Ins. Co.*, 2026 WL 1483515, at *22-25.

¹ A plan’s overall Star Rating is rounded to the nearest 0.5 (half-Star) amount. So, for example, a change in a plan’s overall Star Rating from 3.98 Stars to 4.21 Stars still yields the same, rounded overall Star Rating of 4.0 Stars.

50. SCAN identified the preceding error through a submission to CMS on June 29, 2026, attached hereto as **Exhibit C**, asking that its 2026 Star Rating be recalculated in accordance with the Georgia federal court's second holding, from 4.0 to 4.5 Stars.

51. Specifically, SCAN stated that "upon review, it appears that CMS did not remove all measures subject to the Clover decision, specifically, C03, C04, C05, C15, C16, C22, C23, C24, C25, and C27, from SCAN's 2026 Star Rating, which remains unchanged at 4.0 Stars. As that decision and the underlying briefing correctly explains, these measures' specifications constitute rules, requirements, or other statements of policy that establish a substantive legal standard governing the scope of benefits, the payment for services, and the eligibility of entities or organizations to furnish Medicare services or benefits under 42 U.S.C. § 1395hh(a)(2), because they determine payments to plans, the benefits they offer, and the eligibility of plans to participate in Part D. They must therefore be subjected to notice and comment rulemaking and published as regulations, which CMS indisputably has not done." *Id.*

52. SCAN therefore requested that CMS recalculate SCAN's 2026 Star Rating, as identified in HPMS under its June 17, 2026 memorandum, with the removal of these ten identified measures, which would result in SCAN's 2026 Star Rating increasing from 4 to 4.5 Stars. *Id.*

53. SCAN also noted that it was prepared to submit SCAN's updated 4.5 Star bid, and requested CMS's direction for how to do so at that time. *Id.*

54. CMS responded the same day, stating: "Your request to change the terms of the hold harmless is not consistent with the HPMS memo attached and released on June 17th. In that memo, we stated 'We recalculated the 2027 QBP ratings for MA organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of

Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data.’ We held all contracts harmless if the recalculated QBP rating resulted in a lower rating.” *Id.*

CMS’s Determination Harms SCAN

55. In addition to publishing SCAN’s 2026 4.0 Star Rating in October 2025, CMS also published on its website SCAN’s measure-specific Star Ratings associated with each Star Rating measure. As explained, SCAN’s Star Rating is an outcome-determinative measure for attracting beneficiaries and determining SCAN’s reputation and goodwill with beneficiaries.

56. Had CMS rated SCAN at 4.5 Stars, SCAN would have been entitled to a higher rebate percentage and approximately \$125 million, which would benefit SCAN and its members, including through enhanced payments to cover Medicare covered benefits.

57. As noted, CMS publishes the data underlying its Star Rating determination for each plan on its website. A true and correct copy of SCAN’s 2026 Star Rating measure scores, as excerpted from a spreadsheet published by CMS, is attached hereto as **Exhibit D**.

58. CMS also publishes regulations governing the determination of the Star Ratings, including at 42 C.F.R. § 422.162 *et seq.* and 42 C.F.R. § 423.182 *et seq.*

59. Taken together, CMS’s published data and regulations allow the public to reproduce CMS’s calculation of an individual plan’s overall Star Rating.

60. After conducting a reproduction of CMS’s calculation of SCAN’s 2026 Star Rating, SCAN, like CMS, calculated an overall Star Rating of 4.0 Stars based on CMS’s published data concerning SCAN and its regulations.

61. I am also familiar with the relief requested in this lawsuit, including an order directing CMS to recalculate SCAN’s 2026 Star Rating without inclusion of the following measures: Annual Flu Vaccine (C03), Improving or Maintaining Physical Health (C04),

Improving or Maintaining Mental Health (C05), Reducing the Risk of Falling (C15), Improving Bladder Control (C16), Getting Needed Care (C22), Getting Appointments and Care Quickly (C23), Customer Service (C24), Rating of Health Care Quality (C25), and Care Coordination (C27).

62. Using CMS's published data for SCAN, as well as its published methodology for determining a plan's Star Rating, SCAN (including individuals working under my direction) has calculated the effect on SCAN's Star Rating, if CMS were to remove the above-identified measures from the determination of SCAN's 2026 Star Rating.

63. Were CMS to remove the above-identified measures from SCAN's 2026 Star Rating and recalculate it without the inclusion of those measures, SCAN would achieve a 2026 Star Rating in excess of 4 Stars (namely, 4.5 Stars) for its plans H5425 and H0976.

64. I also understand that additional rebates to SCAN would be required under the governing statute and regulations if CMS were to re-calculate SCAN's 2026 Star Rating at 4.5.

65. My understanding is that CMS has taken the position, as an operational matter, that it would require certain information regarding SCAN's bid and benefits to pay SCAN the statutorily required rebates, including insofar as CMS has required submission of such information in connection with its prior "recalculations" of plans' Star Ratings in 2024 and 2026.

66. These increased payments via enhanced rebates at 4.5 Stars are critical, and indeed indispensable, to SCAN's ability to compete in the marketplace. A payment of \$125 million is great in the context of SCAN's overall finances and its benefits afforded to beneficiaries, and would allow SCAN to take steps such as enhancing payments for Medicare covered services, strengthening the network of providers our members have access to, providing lowered cost sharing, and providing enhancements to supplemental benefits. Even more than the critically

important published Star Rating, these financial, benefit, and network considerations are the principal determinants of a plan's success in the marketplace, competitive position, and reputation and goodwill among beneficiaries, and resultant market share. Beneficiaries choose plans based on these exact considerations; there is no logical reason for a Medicare beneficiary to choose a plan with weaker benefits and lower-compensated, thinner provider networks. SCAN competes vigorously with other plans, including plans that have obtained Star Ratings of 4.5 or 5 Stars (respectively) and SCAN's ability to attract and retain members in Plan Year 2027, commencing January 1, 2027, hinges on obtaining an improved 4.5 Star Rating *and* the resultant rebates.

Exhibits In Support of Motion for Summary Judgment

67. Attached as **Exhibit E** is a true and correct copy of CMS's Medicare 2026 Star Ratings Technical Notes, in the form published by CMS.

68. Attached as **Exhibit F** is a true and correct copy of CMS's Medicare Part C & D Call Center Monitoring Accuracy and Accessibility Study Technical Notes, dated December 16, 2021, in the form published by CMS.

69. Attached as **Exhibit G** is a true and correct copy of CMS's 2026 Star Ratings Measures and Weights, in the form published by CMS.

70. Attached as **Exhibit H** is a true and correct copy of CMS's website listing Part C and D performance data in the form published by CMS.

71. Attached as **Exhibit I** are excerpts from a true and correct copy of MedPAC's Report to the Congress: Medicare and the Health Care Delivery System, dated June 2025, in the form published by MedPAC.

72. Attached as **Exhibit J** is a true and correct copy of SCAN's 2026 Star Ratings for the plans at issue, as excerpted from a spreadsheet published by CMS.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed at Long Beach, California

A handwritten signature in black ink, appearing to read 'M. Plumb', is written over a horizontal line.

Michael Plumb

August 3, 2026

Exhibit A

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



DATE: June 13, 2024

TO: Medicare Advantage Organization Compliance Officers

FROM: Kathryn A. Coleman
Director, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare

Vanessa S. Duran
Director, Medicare Drug Benefit and C & D Data Group, Center for Medicare

Jennifer Lazio
Director, Parts C & D Actuarial Group, Office of the Actuary

SUBJECT: Update to 2025 Quality Bonus Payment Determinations

In light of recent court decisions,¹ CMS is recalculating the 2024 Star Ratings for 2025 Quality Bonus Payment (QBP) purposes to address the application of Tukey outlier deletion and guardrails as codified at 42 C.F.R. §§ 422.166(a)(2)(i) and 423.186(a)(2)(i). CMS is not announcing here any policy or position with regard to the calculation of the 2025 Star Ratings, to be issued in October 2024.

Specifically, we have recalculated the 2024 Star Ratings using the published 2023 Star Ratings cut points to determine the guardrails for the 2024 Star Ratings (i.e., Tukey outliers were not removed from the 2023 Star Ratings). We have assigned all contracts the recalculated 2024 overall and/or summary Star Ratings if those recalculated ratings result in higher QBP Ratings than what was previously assigned based on the contract's overall and/or summary 2024 Star Ratings that were released in October 2023. If this recalculation would result in a contract's QBP Rating decreasing compared to the ratings previously assigned, CMS is not implementing

¹ The decisions in *SCAN Health Plan v. Department of Health & Human Services*, Civ. A. No. 23-3910 (CJN) (D.D.C.), and *Elevance Health, Inc. v. Becerra*, Civ. A. No. 23-3902 (RDM) (D.D.C.), were issued on June 3, 2024 and June 7, 2024 respectively. A decision whether to appeal those judgments has not yet been reached. CMS's decision to recalculate 2024 Star Ratings as described herein has no bearing on CMS's potential exercise of its right to appeal those decisions.

the change for those contracts and those contracts will be held harmless in this recalculation. A contract's QBP Rating will not be decreased by CMS as a result of this recalculation.

All MA contracts can view their updated 2025 QBP Ratings and Total Beneficiary Cost (TBC) data in the Health Plan Management System (HPMS). To access the recalculated QBP Ratings data, select Quality and Performance in the navigation bar and then Performance Metrics > Reports > Costs. Select MA QBP Rating as the "Report Type." Contracts should ensure that 2025 is selected as the "Contract Year" and then click "Create Report" to view their QBP Ratings. To access the TBC data, select Quality and Performance in the navigation bar and then Performance Metrics > Reports > Costs. Select Part C Total Beneficiary Costs as the "Report Type." Contracts should select 6/11/2024 as the "Report Period" and click "Create Report."

MA contracts with increases in their QBP Ratings as described above (i.e., only contracts that have an increase in their QBP Ratings from 3 to 3.5 stars, 3.5 to 4.0 stars, or 4.0 to 4.5 stars) will have a time-limited opportunity to resubmit their Contract Year 2025 bids, including bid pricing tools (BPTs), plan benefit packages (PBPs), and formularies. In an effort to minimize disruption to the overall formulary review process, including for those MA contracts without changes to their Star Ratings, affected contracts that plan to make changes to one or more formularies associated to their contracts must contact PartDFormularies@cms.hhs.gov by June 18, 2024 to confirm next steps.

In order for CMS to effectively and efficiently complete the bid review process consistent with its statutory obligations, revised bids and any formulary changes must be submitted no later than June 28, 2024, including the updated supporting documentation. CMS will open the gates in HPMS on June 26, 2024 for affected contracts to resubmit bids to reflect the change in their QBP Rating. MA organizations, including those that are Part D sponsors, should continue to respond to staged BPT, PBP, and formulary review communications that they receive. The actuarial certification for any bid resubmissions must be completed by July 3, 2024.

Questions regarding your QBP Rating should be sent to: PartCandDStarRatings@cms.hhs.gov. Questions regarding the TBC information posted in HPMS should be sent to: actuarial-bids@cms.hhs.gov. Questions related to the TBC policy should be submitted to: <https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/>. Questions related to Part D benefits should be submitted to: PartDBenefits@cms.hhs.gov. Questions related to formularies should be sent to: PartDFormularies@cms.hhs.gov.

Additionally, we plan to update the 2024 Star Ratings information for all contracts on Medicare Plan Finder in the coming weeks.

Exhibit B

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



DATE: June 17, 2026

TO: Medicare Advantage Organizations

FROM: Gerard Mulcahy
Director, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare

Vanessa S. Duran
Director, Medicare Drug Benefit and C & D Data Group, Center for Medicare

Jennifer Lazio
Director, Parts C & D Actuarial Group, Office of the Actuary

Shruti Rajan
Acting Director, Medicare Plan Payment Group, Center for Medicare

SUBJECT: Update to 2027 Quality Bonus Payment Determinations

In light of a recent court decision,¹ CMS is voluntarily recalculating the 2027 Quality Bonus Payment (QBP) ratings for certain Medicare Advantage (MA) contracts. We assigned MA contracts the recalculated rating only if it was higher than the previously assigned QBP rating. If a contract's recalculation results in a lower rating than the previously assigned rating, CMS will not update the contract's 2027 QBP rating; it will be held harmless in this recalculation. CMS is not announcing any policy or position here regarding the calculation of the 2027 Star Ratings, which will be issued in October 2026, nor the 2028 QBP ratings.

We recalculated the 2027 QBP ratings for MA organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data. We removed all the Part D measures and the following Part C measures: Special Needs Plan Care Management, Complaints about the Health Plan, Members Choosing to Leave the Plan, Plan Makes Timely Decisions about Appeals, Reviewing Appeals Decisions, and Call Center – Foreign Language Interpreter and TTY Availability.

¹ The decision in *Clover Insurance Company v. Department of Health & Human Services*, Civ. A. No. 25-142 (S.D. Ga.) was issued on May 27, 2026. CMS's decision to recalculate 2027 Quality Bonus Payment ratings as described herein has no bearing on CMS's potential exercise of its right to appeal this decision.

MA organizations can view their recalculated 2027 QBP ratings in the Health Plan Management System (HPMS).

- To access the recalculated 2027 QBP ratings data, select Quality and Performance in the navigation bar and then Performance Metrics > Reports > Costs. Select MA QBP Rating as the “Report Type.” Contracts should ensure that 2027 is selected as the “Contract Year” and then click “Create Report” to view their QBP ratings.

Contracts will be informed when updated Total Beneficiary Cost (TBC) data are available.

MA contracts with increases in their 2027 QBP ratings as described above (i.e., only contracts that have an increase in their QBP ratings that has an impact on their benchmark or rebate amount) will have a time-limited opportunity to resubmit their Contract Year (CY) 2027 bids, including bid pricing tools (BPTs), plan benefit packages (PBPs), and formularies. As a reminder, QBP ratings are calculated at the contract level, so all PBPs underlying a contract will be assigned the associated QBP rating.

Although bid resubmission is permitted for affected entities, it is not required. Your organization maintains the option to proceed with its original 2027 QBP rating and the corresponding final bid submitted to CMS on or before the June 1, 2026 deadline. If you opt out of the resubmission, please be advised that the original bid will be reviewed for compliance with all bid standards and requirements, and the original 2027 QBP rating will be used for payments for enrollees with functioning graft status and for Employer Group Waiver Plans (EGWP) under the contract.

CY 2027 bid submissions must match the QBP rating and associated rebate status in HPMS. For HPMS to reflect your organization’s preference for using its recalculated 2027 QBP rating (if applicable) or its original 2027 QBP rating, CMS needs notice to update HPMS accordingly for bid review and evaluation. Your organization must notify CMS of either your intention to resubmit a bid or your intention to opt out of resubmission no later than June 22, 2026, at 11:59 PM Pacific Daylight Time. Please send this information to the Part C & D Star Ratings mailbox (PartCandDStarRatings@cms.hhs.gov) using the following subject line: 2027 Bid Resubmission Decision Contract(s) HXXXX. Failure to submit your intention by COB June 22, 2026, will be treated as notice of intent to opt out of bid resubmission. After June 22, 2026, CMS will update the 2027 QBP ratings in HPMS as needed for consistency with the QBP ratings used in the final bids. For contracts that opt out of bid resubmission, their 2027 QBP rating will be updated to reflect the QBP rating used in their original bid submission.

In an effort to minimize disruption to the overall formulary review process, including for those MA contracts without changes to their 2027 QBP ratings, affected contracts that would like to make changes to one or more formularies associated with their contracts must contact PartDFormularies@cms.hhs.gov by June 22, 2026 using the following subject line: 2027 QBP Formulary Changes Request FID(s) 27XXX, to confirm next steps. For CMS to effectively and efficiently complete the bid review process consistent with its statutory obligations, CY 2027 bid resubmissions must be submitted no later than June 29, 2026, including the updated supporting documentation. CMS will open the gates in HPMS on June 25, 2026 for affected contracts to resubmit bids to reflect the change in their QBP rating. MA organizations, including Part D sponsors, should continue to respond to staged BPT, PBP, and formulary review

communications. The actuarial certification for any CY 2027 bid resubmissions must be completed by July 1, 2026.

If you intend to resubmit your bid, this is a reminder that all MA organizations are required to submit their best accurate and complete bid(s) no later than Monday, June 29, 2026, at 11:59 PM Pacific Daylight Time. For information regarding bid submission requirements and evaluation, please refer to the April 22, 2026 HPMS memorandum “Final Contract Year (CY) 2027 Standards for Part C Benefits, Bid Review and Evaluation”, as well as the February 6, 2026 HPMS memorandum “Contract Year (CY) 2027 Final Part D Bidding Instructions”.

Any organization proceeding with bid resubmission in accordance with this process is required to submit a bid that complies with issued bid guidance, including but not limited to: Part D Cost Sharing thresholds, Part C Service Category Cost Sharing, PMPM Actuarial Equivalent Cost Sharing, TBC, and/or Optional Supplemental Benefit requirements and evaluation standards.

Questions regarding your QBP rating should be sent to: PartCandDStarRatings@cms.hhs.gov. Questions regarding the TBC information that will be posted in HPMS should be sent to: actuarial-bids@cms.hhs.gov. Questions related to the TBC policy should be submitted to: <https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/>. Questions related to Part D benefits should be submitted to: PartDBenefits@cms.hhs.gov. Questions related to formularies should be sent to: PartDFormularies@cms.hhs.gov.

For impacted contracts that notify CMS of their intent to proceed with bid resubmission based on the recalculated rating, we will be updating the overall rating displayed in HPMS and Medicare Plan Finder for QBP eligibility purposes to match the recalculated 2027 QBP rating in the coming weeks.

Exhibit C

From: Sanaya Lim-Heng
Sent: Monday, June 29, 2026 11:02 AM
To: 'CMS PartC&DStarRatings' <PartCandDStarRatings@cms.hhs.gov>; Licup, Albert (CMS/OPOLE) <Albert.Licup@cms.hhs.gov>
Cc: Lyn Amor Macaraeg <l.macaraeg@scanhealthplan.com>; Tim Feher <t.feher@scanhealthplan.com>; Elizabeth Cordova <ECordova@scanhealthplan.com>
Subject: RE: Update to 2027 Quality Bonus Payment Determinations

Good morning,

We appreciate your review of our concerns and the clarification provided in your response.

Thank you,

Sanaya Lim-Heng

Director, Medicare Compliance | Compliance
s.lim-heng@scanhealthplan.com
(562) 997-3183

SCAN Health Plan

3800 Kilroy Airport Way #100
Long Beach, CA 90806



From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, June 29, 2026 10:33 AM
To: Sanaya Lim-Heng <s.lim-heng@scanhealthplan.com>; Licup, Albert (CMS/OPOLE) <Albert.Licup@cms.hhs.gov>
Cc: Lyn Amor Macaraeg <l.macaraeg@scanhealthplan.com>; Tim Feher <t.feher@scanhealthplan.com>; Elizabeth Cordova <ECordova@scanhealthplan.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Update to 2027 Quality Bonus Payment Determinations

Your request to change the terms of the hold harmless is not consistent with the HPMS memo attached and released on June 17th. In that memo, we stated “ We recalculated the 2027 QBP ratings for MA organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data.” We held all contracts harmless if the

recalculated QBP rating resulted in a lower rating.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Monday, June 29, 2026 11:40 AM
To: Sanaya Lim-Heng <s.lim-heng@scanhealthplan.com>; Licup, Albert (CMS/OPOLE) <Albert.Licup@cms.hhs.gov>
Cc: Lyn Amor Macaraeg <l.macaraeg@scanhealthplan.com>; Tim Feher <t.feher@scanhealthplan.com>; Elizabeth Cordova <ECordova@scanhealthplan.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Update to 2027 Quality Bonus Payment Determinations

Confirming receipt.

Part C & D Star Ratings Team

Medicare Drug Benefit and C&D Data Group (MDBG)

PartCandDStarRatings@cms.hhs.gov



Confidentiality and Restricted Disclosure Notice: This e-mail is intended only for the use of the named addressee(s) and may contain information that is confidential, privileged or regulated under federal and/or state law, including The Privacy Act and HIPAA. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this e-mail is strictly prohibited. If you have received this e-mail in error, please notify the sender immediately by replying to the e-mail and destroy all copies of the original message. If you are the intended recipient, you are notified that you have the obligation to ensure that any further dissemination, distribution or copying is consistent with applicable law.

From: Sanaya Lim-Heng <s.lim-heng@scanhealthplan.com>
Sent: Monday, June 29, 2026 11:35 AM
To: Licup, Albert (CMS/OPOLE) <Albert.Licup@cms.hhs.gov>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Lyn Amor Macaraeg <l.macaraeg@scanhealthplan.com>; Tim Feher <t.feher@scanhealthplan.com>; Elizabeth Cordova <ECordova@scanhealthplan.com>; Sanaya Lim-Heng <s.lim-heng@scanhealthplan.com>
Subject: Update to 2027 Quality Bonus Payment Determinations
Importance: High

Good morning Al and Part C & Star Ratings Team,

SCAN Health Plan ("SCAN") is reaching out regarding its 2027 plan year bid. SCAN appreciates CMS's June 17, 2026 "Update to 2027 Quality Bonus Payment Determinations" memorandum, which removed certain measures from SCAN's 2026 Star Rating as a consequence of the recent *Clover* decision, which held many of those measures to be beyond CMS's statutory authority. SCAN agrees with and commends

CMS for making that decision to remove these measures from its 2026 Star Rating.

However, upon review, it appears that CMS did not remove all measures subject to the *Clover* decision, specifically, C03, C04, C05, C15, C16, C22, C23, C24, C25, and C27, from SCAN's 2026 Star Rating, which remains unchanged at 4.0 Stars. As that decision and the underlying briefing correctly explains, these measures' specifications constitute rules, requirements, or other statements of policy that establish a substantive legal standard governing the scope of benefits, the payment for services, and the eligibility of entities or organizations to furnish Medicare services or benefits under 42 U.S.C. § 1395hh(a)(2), because they determine payments to plans, the benefits they offer, and the eligibility of plans to participate in Part D. They must therefore be subjected to notice and comment rulemaking and published as regulations, which CMS indisputably has not done.

SCAN respectfully requests that CMS recalculate SCAN's 2026 Star Rating, as identified in HPMS under its June 17, 2026 memorandum, with the removal of these ten additional identified measures, which would result in SCAN's 2026 Star Rating increasing from 4 to 4.5 Stars. We are also prepared to submit SCAN's updated 4.5 Star bid, and request CMS's direction for how to do so at this time.

Thank you,

Sanaya Lim-Heng

Director, Medicare Compliance | Compliance

s.lim-heng@scanhealthplan.com

(562) 997-3183

SCAN Health Plan

3800 Kilroy Airport Way #100

Long Beach, CA 90806



Exhibit D

	A	B	C	D	E	F	G	H	I
1	2026 Star View: Medicare Report Card Master Table								
2	CONTRACT_ID	Organization Type	Contract Name	Organization Marketing Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and			
3						C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine	C04: Improving or Maintaining Physical Health
4						01/01/2024 –	01/01/2024 –	03/2025 – 05/2025	07/17/2024 –
61	H0976	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	4	4	Plan too small to be	Plan too new to be
423	H5425	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	4	4	4	4

	J	K	L	M	N	O	P	Q	R
1									
2			HD2: Managing Chronic (Long Term)						
3	C05: Improving or Maintaining Mental Health	C06: Monitoring Physical Activity	C07: Special Needs Plan (SNP) Care Management	C08: Care for Older Adults – Medication Review	C09: Care for Older Adults – Pain Assessment	C10: Osteoporosis Management in Women who had a	C11: Diabetes Care – Eye Exam	C12: Diabetes Care – Blood Sugar Controlled	C13: Kidney Health Evaluation for Patients with
4	07/17/2024 –	07/17/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –
61	Plan too new to be	Plan too new to be	4	4	4	4	5	3	5
423	1	5	4	5	5	4	5	4	5

	S	T	U	V	W	X	Y	Z	AA
1									
2									HD3: Member Experience with
3	C14: Controlling High Blood Pressure	C15: Reducing the Risk of Falling	C16: Improving Bladder Control	C17: Medication Reconciliation Post-Discharge	C18: Plan All-Cause Readmissions	C19: Statin Therapy for Patients with Cardiovascular	C20: Transitions of Care	C21: Follow-up after Emergency Department Visit for	C22: Getting Needed Care
4	01/01/2024 –	07/17/2024 –	07/17/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	03/2025 – 05/2025
61	5	Plan too new to be	Plan too new to be	4	4	3	3	2	Plan too small to be
423	5	2	2	4	4	3	3	2	2

	AB	AC	AD	AE	AF	AG	AH	AI	AJ
1									
2						HD4: Member Complaints and			HD5: Health Plan Customer Service
3	C23: Getting Appointments and Care Quickly	C24: Customer Service	C25: Rating of Health Care Quality	C26: Rating of Health Plan	C27: Care Coordination	C28: Complaints about the Health Plan	C29: Members Choosing to Leave the Plan	C30: Health Plan Quality Improvement	C31: Plan Makes Timely Decisions about Appeals
4	03/2025 – 05/2025	03/2025 – 05/2025	03/2025 – 05/2025	03/2025 – 05/2025	03/2025 – 05/2025	01/01/2024 –	01/01/2024 –	Not Applicable	01/01/2024 –
61	Plan too small to be	Plan too small to be	Plan too small to be	Plan too small to be	Plan too small to be	4	4	Not enough data	5
423	2	3	3	5	2	5	5	4	5

	AK	AL	AM	AN	AO	AP	AQ	AR	AS
1									
2			DD1: Drug Plan Customer Service	DD2: Member Complaints and			DD3: Member Experience with the		DD4: Drug Safety and Accuracy of Drug
3	C32: Reviewing Appeals Decisions	C33: Call Center – Foreign Language Interpreter and TTY	D01: Call Center – Foreign Language Interpreter and TTY	D02: Complaints about the Drug Plan	D03: Members Choosing to Leave the Plan	D04: Drug Plan Quality Improvement	D05: Rating of Drug Plan	D06: Getting Needed Prescription Drugs	D07: MPF Price Accuracy
4	01/01/2024 –	02/2025 – 05/2025	02/2025 – 05/2025	01/01/2024 –	01/01/2024 –	Not Applicable	03/2025 – 05/2025	03/2025 – 05/2025	01/01/2024 –
61	5	4	5	4	4	Not enough data	Plan too small to be	Plan too small to be	5
423	4	4	5	5	5	2	5	4	5

	AT	AU	AV	AW	AX
1					
2					
3	D08: Medication Adherence for Diabetes Medications	D09: Medication Adherence for Hypertension (RAS)	D10: Medication Adherence for Cholesterol (Statins)	D11: MTM Program Completion Rate for CMR	D12: Statin Use in Persons with Diabetes (SUPD)
4	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –	01/01/2024 –
61	4	3	2	4	4
423	4	4	4	4	4

Exhibit E



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

Table of Contents

DOCUMENT CHANGE LOG.....	I
OMB APPROVED DATA SOURCES	I
INTRODUCTION	1
DIFFERENCES BETWEEN THE 2025 STAR RATINGS AND 2026 STAR RATINGS	1
HEALTH/DRUG ORGANIZATION TYPES INCLUDED IN THE STAR RATINGS.....	2
Table 1: Contract Year 2026 Organization Types Reported in the 2026 Star Ratings.....	3
THE STAR RATINGS FRAMEWORK	3
Figure 1: The Four Levels of Star Ratings.....	4
Table 2: 5-Star Scale.....	4
Table 3: Relation of 2026 Organization Types to Contract Types and Highest Rating in the 2026 Star Ratings	4
SOURCES OF THE STAR RATINGS MEASURE DATA.....	4
Figure 2: The Four Categories of Data Sources	5
IMPROVEMENT MEASURES.....	5
Table 4: Minimum Number of Measure Scores Required for an Improvement Measure Rating by Contract Type.....	6
CONTRACT ENROLLMENT DATA.....	6
HANDLING OF BIASED, ERRONEOUS, AND/OR NOT REPORTABLE (NR) DATA.....	6
DATA HANDLING OF MEASURES FOR CONTRACTS AFFECTED BY A MAJOR DISASTER	7
METHODOLOGY FOR ASSIGNING STARS TO THE PART C AND PART D MEASURES.....	9
A. Clustering	9
B. Relative Distribution and Significance Testing (CAHPS)	10
METHODOLOGY FOR CALCULATING STARS AT THE DOMAIN LEVEL	10
Table 5: Minimum Number of Rated Measures Required for a Domain Rating by Contract Type.....	11
SUMMARY AND OVERALL RATINGS: WEIGHTING OF MEASURES.....	11
METHODOLOGY FOR CALCULATING PART C AND PART D SUMMARY RATINGS	12
Table 6: Minimum Number of Rated Measures Required for Part C and Part D Ratings by Contract Type	12
METHODOLOGY FOR CALCULATING THE OVERALL MA-PD RATING.....	12
Table 7: Minimum Number of Rated Measures Required for an Overall Rating by Contract Type.....	13
COMPLETING THE SUMMARY AND OVERALL RATING CALCULATIONS.....	13
APPLYING THE IMPROVEMENT MEASURE(S).....	13
APPLYING THE REWARD FACTOR.....	14
Table 8: Performance Summary Thresholds.....	15
Table 9: Variance Thresholds	16
CATEGORICAL ADJUSTMENT INDEX (CAI)	16
Table 10: Categorization of Contract's Members into LIS/DE Initial Groups for the Overall Rating	18
Table 11: Categorization of Contract's Members into Disability Quintiles for the Overall Rating.....	18
Table 12: Final Adjustment Categories and CAI Values for the Overall Rating.....	19
Table 13: Categorization of Contract's Members into LIS/DE Initial Groups for the Part C Summary.....	19
Table 14: Categorization of Contract's Members into Disability Quintiles for the Part C Summary	20
Table 15: Final Adjustment Categories and CAI Values for the Part C Summary	20

Table 16: Categorization of Contract's Members into LIS/DE Initial Groups for the MA-PD Part D Summary	21
Table 17: Categorization of Contract's Members into Disability Quintiles for the MA-PD Part D Summary	21
Table 18: Final Adjustment Categories and CAI Values for the MA-PD Part D Summary	21
Table 19: Categorization of Contract's Members into Quartiles of LIS/DE for the PDP Part D Summary	22
Table 20: Categorization of Contract's Members into Quartiles of Disability for the PDP Part D Summary	22
Table 21: Final Adjustment Categories and CAI Values for the PDP Part D Summary	22
CALCULATION PRECISION	22
ROUNDING RULES FOR MEASURE SCORES	23
ROUNDING RULES FOR SUMMARY AND OVERALL RATINGS.....	23
Table 22: Rounding Rules for Summary and Overall Ratings.....	23
METHODOLOGY FOR CALCULATING THE HIGH PERFORMING ICON	23
Figure 3: The High Performing Icon.....	24
METHODOLOGY FOR CALCULATING THE LOW PERFORMING ICON.....	24
Figure 4: The Low Performing Icon.....	24
Table 23: Example LPI Contracts	24
MERGERS, NOVATIONS, AND CONSOLIDATIONS.....	24
RELIABILITY REQUIREMENT FOR LOW-ENROLLMENT CONTRACTS	25
SPECIAL NEEDS PLAN (SNP) DATA	25
STAR RATINGS AND MARKETING	26
CONTACT INFORMATION.....	26
FRAMEWORK AND DEFINITIONS FOR THE DOMAIN AND MEASURE DETAILS SECTION	27
PART C DOMAIN AND MEASURE DETAILS.....	29
Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines	29
Measure: C01 - Breast Cancer Screening.....	29
Measure: C02 - Colorectal Cancer Screening	30
Measure: C03 - Annual Flu Vaccine	32
Measure: C04 - Improving or Maintaining Physical Health.....	33
Measure: C05 - Improving or Maintaining Mental Health	34
Measure: C06 - Monitoring Physical Activity	34
Domain: 2 - Managing Chronic (Long Term) Conditions	37
Measure: C07 - Special Needs Plan (SNP) Care Management.....	37
Measure: C08 - Care for Older Adults – Medication Review	39
Measure: C09 - Care for Older Adults – Pain Assessment	40
Measure: C10 - Osteoporosis Management in Women who had a Fracture	41
Measure: C11 - Diabetes Care – Eye Exam	42
Measure: C12 - Diabetes Care – Blood Sugar Controlled.....	44
Measure: C13 - Kidney Health Evaluation for Patients with Diabetes	46
Measure: C14 - Controlling Blood Pressure	47
Measure: C15 - Reducing the Risk of Falling	49
Measure: C16 - Improving Bladder Control	50
Measure: C17 - Medication Reconciliation Post-Discharge	51
Measure: C18 - Plan All-Cause Readmissions	53
Measure: C19 - Statin Therapy for Patients with Cardiovascular Disease	54
Measure: C20 - Transitions of Care	56
Measure: C21 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions.....	57
Domain: 3 - Member Experience with Health Plan.....	59
Measure: C22 - Getting Needed Care.....	59
Measure: C23 - Getting Appointments and Care Quickly.....	60

Measure: C24 - Customer Service	61
Measure: C25 - Rating of Health Care Quality	62
Measure: C26 - Rating of Health Plan	63
Measure: C27 - Care Coordination	64
Domain: 4 - Member Complaints and Changes in the Health Plan's Performance	66
Measure: C28 - Complaints about the Health Plan	66
Measure: C29 - Members Choosing to Leave the Plan	67
Measure: C30 - Health Plan Quality Improvement	68
Domain: 5 - Health Plan Customer Service	70
Measure: C31 - Plan Makes Timely Decisions about Appeals	70
Measure: C32 - Reviewing Appeals Decisions	71
Measure: C33 - Call Center – Foreign Language Interpreter and TTY Availability	72
PART D DOMAIN AND MEASURE DETAILS	74
Domain: 1 - Drug Plan Customer Service	74
Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability	74
Domain: 2 - Member Complaints and Changes in the Drug Plan's Performance	76
Measure: D02 - Complaints about the Drug Plan	76
Measure: D03 - Members Choosing to Leave the Plan	77
Measure: D04 - Drug Plan Quality Improvement	79
Domain: 3 - Member Experience with the Drug Plan	81
Measure: D05 - Rating of Drug Plan	81
Measure: D06 - Getting Needed Prescription Drugs	82
Domain: 4 - Drug Safety and Accuracy of Drug Pricing	84
Measure: D07 - MPF Price Accuracy	84
Measure: D08 - Medication Adherence for Diabetes Medications	86
Measure: D09 - Medication Adherence for Hypertension (RAS antagonists)	88
Measure: D10 - Medication Adherence for Cholesterol (Statins)	90
Measure: D11 - MTM Program Completion Rate for CMR	92
Measure: D12 - Statin Use in Persons with Diabetes (SUPD)	95
ATTACHMENT A: CAHPS AND HOS CASE-MIX ADJUSTMENT	97
CAHPS Case-Mix Adjustment	97
Table A-1: Coefficients of Part C Getting Needed Care (C22) CAHPS Measure Composite Items	98
Table A-2: Coefficients of Part C Getting Appointments and Care Quickly (C23) CAHPS Measure Composite Items	99
Table A-3: Coefficients of Part C Customer Service (C24) CAHPS Measure Composite Items	100
Table A-4: Coefficients of Part C Stand-alone CAHPS Measures	101
Table A-5: Coefficients of Part C Care Coordination (C27) CAHPS Measure Composite Items	102
Table A-6: Coefficients of Part D CAHPS Stand-alone Measures	103
Table A-7: Coefficients of Part D Getting Needed Prescription Drugs (D06) CAHPS Measure Composite Items	104
HOS 2022-2024 Cohort 25 Case-Mix Adjustment	105
Table A-8: HOS Model Covariates at Baseline (Death, PCS Better + Same, and MCS Better + Same models)	106
ATTACHMENT B: CALCULATING MEASURE DATA FOR THE SURVIVING CONTRACT OF A CONSOLIDATION	108
First Year Following a Consolidation	108
Table B-1: Enrollment Month Used in Calculating Measure Scores for the Surviving Contract of a Consolidation	108
Table B-2: Example of Calculating the Measure Score for the Surviving Contract of a Consolidation	108
Second Year Following a Consolidation	108
ATTACHMENT C: NATIONAL AVERAGES FOR PART C AND D MEASURES	109
Table C-1: National Averages for Part C Measures	109
Table C-2: National Averages for Part D Measures	110
ATTACHMENT D: PART C AND D DATA TIME FRAMES	111
Table D-1: Part C Measure Data Time Frames	111
Table D-2: Part D Measure Data Time Frames	112

ATTACHMENT E: SNP MEASURE SCORING METHODOLOGIES	113
1. Medicare Part C Reporting Requirements Measure (C07: SNP Care Management)	113
2. NCQA HEDIS Measures - (C08 – C09: Care for Older Adults)	114
Table E-1: Example Calculation Using Effectiveness of Care Rate	115
ATTACHMENT F: CALCULATING MEASURE C18: PLAN ALL-CAUSE READMISSIONS	116
Example: Calculating the final rate for Contract 1	116
ATTACHMENT G: WEIGHTS ASSIGNED TO INDIVIDUAL PERFORMANCE MEASURES	117
Table G-1: Part C Measure Weights	117
Table G-2: Part D Measure Weights	118
ATTACHMENT H: CALCULATION OF WEIGHTED STAR RATING AND VARIANCE ESTIMATES	119
ATTACHMENT I: CALCULATING THE IMPROVEMENT MEASURE AND THE MEASURES USED	120
Calculating the Improvement Measure	120
General Standard Error Formula	121
Improvement Change Score Standard Error Numerical Example	121
Standard Error Formulas (SEF) for Specific Measures	122
1. SEF for Measures: C01, C02, C06, C07, C10 – C12, C14 – C17, C19, C21, C29, C31 – C33, D01, D03, D08 – D12	122
2. SEF for Measures: C08, C09	122
3. SEF for Measure C18	122
4. SEF for Measure C20	123
5. SEF for Measures: C03, C22 – C27, and D05, D06	123
6. SEF for Measures: C28, D02	123
7. SEF for Measure D07	123
Star Ratings Measures Used in the Improvement Measures	125
Table I-1: Part C Measures Used in the Improvement Measure	125
ATTACHMENT J: STAR RATINGS MEASURE HISTORY	127
Table J-1: Part C Measure History	127
Table J-2: Part D Measure History	132
Table J-3: Common Part C & Part D Measure History	136
ATTACHMENT K: INDIVIDUAL MEASURE STAR ASSIGNMENT PROCESS	137
Clustering Methodology Introduction	137
Figure K-1: Diagram showing gaps in data where cut points are assigned	137
Example 1 – Clustering Methodology for a Higher is Better measure	137
Table K-1: Medication Adherence for Diabetes Medications cut points example: cut points are for illustrative purposes	138
Figure K-2: Diagram showing star assignment based cut points	138
Example 2 – Clustering Methodology for a Lower is Better measure	138
Table K-2: Members Choosing to Leave the Plan cut points example: cut points are for illustrative purposes	139
Clustering Methodology Detail	139
1. Produce the individual measure distance matrix	140
2. Create a tree of cluster assignments	140
3. Select the final set of clusters from the tree of cluster assignments	141
4. Final Thresholds	141
Determining Stars from Scores and Thresholds	141
Table K-3: 2026 Star Ratings Part C non-CAHPS Measure Mean Resampling Estimated Thresholds	142
Table K-4: 2026 Star Ratings Part D non-CAHPS Measure Mean Resampling Estimated Thresholds	144
Table K-5: 2026 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs	146
Table K-6: 2026 Star Ratings Part D non-CAHPS Measure Tukey Outlier Cutoffs	147
Relative Distribution and Significance Testing (CAHPS) Methodology	148
Table K-7: CAHPS Star Assignment Rules	149
Table K-8: CAHPS Star Assignment Alternate Representation	150
Table K-9: CAHPS Measure 12% Reliability Cutoffs	150

ATTACHMENT L: MEDICATION ADHERENCE MEASURE CALCULATIONS	151
Proportion of Days Covered Calculation.....	151
Example 1: Non-Overlapping Fills of Two Different Drugs.....	151
Table L-1: No Adjustment.....	151
Example 2: Overlapping Fills of the Same Generic Ingredient across Single and Combination Products	151
Table L-2: Before Overlap Adjustment	152
Table L-3: After Overlap Adjustment	152
Example 3: Overlapping Fills of the Same and Different Target Drugs.....	152
Table L-4: Before Overlap Adjustment	152
Table L-5: After Overlap Adjustment	153
PDC Adjustment for Inpatient, and Skilled Nursing Facility Stays Examples	153
Calculating the PDC Adjustment for IP Stays and SNF Stays.....	154
Example 1: Gap in Coverage after IP Stay.....	154
Table L-6: Before Adjustment.....	154
Table L-7: After Adjustment.....	155
Example 2: Gap in Coverage before IP Stay	155
Table L-8: Before Adjustment.....	155
Table L-9: After Adjustment.....	155
Example 3: Gap in Coverage Before and After IP Stay	155
Table L-10: Before Adjustment.....	156
Table L-11: After Adjustment.....	156
Example 4: Gap in Coverage After IP Stay and Overlap with Subsequent Fill of the Same Drug Class.....	156
Table L-12: Before Adjustment.....	156
Table L-13: After Adjustment.....	157
ATTACHMENT M: METHODOLOGY FOR MPF PRICE ACCURACY MEASURE	158
Contract Selection	158
MPF Composite Price Accuracy Score.....	158
Example of Accuracy Index Calculation.....	161
Table M-1: Example of Price Accuracy Index Calculation.....	162
ATTACHMENT N: MTM CMR COMPLETION RATE MEASURE SCORING METHODOLOGIES	163
Medicare Part D Reporting Requirements Measure (D11: MTM CMR Completion Rate Measure)	163
ATTACHMENT O: METHODOLOGY FOR THE PUERTO RICO MODEL	165
Model.....	166
Example	167
ATTACHMENT P: IDENTIFICATION OF CONTRACTS AFFECTED BY DISASTERS	168
Operational Steps to Calculating Enrollment Impacted in Affected Contracts.	168
Table P-1: Section 1135 waivers issued in relation to the FEMA major disaster declarations.....	168
Table P-2: Individual Assistance counties in FEMA Major Disaster Declared States	169
Table P-3: Organization type service areas and necessary transformations	170
Table P-4: Major Disasters with associated enrollment months.....	170
Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters.....	171
Example:	171
Table P-6: Example Contract HAAAA's Service Areas and Enrollment during Relevant Disasters.....	172
ATTACHMENT Q: MISSING DATA MESSAGES	174
Measure level messages	174
Table Q-1: Measure level missing data messages.....	174
Assignment rules for Part C measure messages	174
Assignment rules for Part D measure messages	178
Table Q-2: MTM CMR Reason(s) for Display Message conversion.....	180
Domain, Summary, and Overall level messages	180

Table Q-3: Domain, Summary, and Overall level missing data messages	180
Assignment rules for Part C & Part D domain rating level messages	180
Assignment rules for Part C & Part D summary rating level messages	180
Assignment rules for overall rating level messages	181
Disenrollment Reasons messages	181
Table Q-4: Disenrollment Reason missing data messages	181
ATTACHMENT R: GLOSSARY OF TERMS	182
ATTACHMENT S: HEALTH PLAN MANAGEMENT SYSTEM MODULE REFERENCE	186
HPMS Star Ratings Module	186
1. Measure Data page	186
Table S-1: Measure Data page sample	186
2. Measure Detail – CTM Summary page	186
Table S-2: Measure Detail – CTM Summary page fields	187
3. Measure Detail – Part C Appeals page	187
Table S-3: Measure Detail – Part C Appeals page fields	187
4. Measure Detail – SNP CM page	188
Table S-4: Measure Detail – SNP CM page fields	188
5. Measure Detail – HEDIS page	188
Table S-5: Measure Detail – HEDIS page fields	189
Table S-6: HEDIS 2024 Audit Designations and 2026 Star Ratings	189
6. Measure Detail – CTM page	189
Table S-7: Measure Detail – CTM page fields	190
7. Measure Detail – Disenrollment	190
Table S-8: Measure Detail – Disenrollment page fields	190
8. Measure Detail – DR (Disenrollment Reasons)	190
Table S-9: Measure Detail – Disenrollment Reasons page fields	191
9. Measure Detail – MTM page	191
Table S-10: Measure Detail – MTM page fields	191
10. Measure Detail – CAHPS page	192
Table S-11: Measure Detail – CAHPS page fields	192
11. Calculation Detail – MD	192
Table S-12: Calculation Detail – MD page fields	193
12. Calculation Detail – CAI	193
Table S-13: Measure Detail – CAI page fields	194
13. Measure Detail – HEDIS LE page	194
Table S-14: Measure Detail – HEDIS LE page fields	195
14. Measure Detail – C MD Results	195
Table S-15: Measure Detail – C MD Results	195
15. Measure Detail – D MD Results	195
Table S-16: Measure Detail – D MD Results	196
16. Measure Detail – C Improvement page	196
Table S-17: Part C Measure Improvement Results	196
17. Measure Detail – D Improvement page	196
Table S-18: Part D Measure Improvement Results	197
18. Measure Stars page	197
Table S-19: Measure Stars page sample	197
19. Domain Stars page	197
Table S-20: Domain Star page sample	198
20. Part C Summary Rating page	198
Table S-21: Part C Summary Rating page fields	198
21. Part D Summary Rating page	199
Table S-22: Part D Summary Rating View	199
22. Overall Rating page	199
Table S-23: Overall Rating View	200
23. Low Performing Contract List	200
Table S-24: Low Performing Contract List	201
24. High Performing Contract List	201

Table S-25: High Performing Contract List.....	201
25. Technical Notes link	201
26. Medication NDC List.....	202
27. Part C and Part D Example Measure Data.....	202

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:

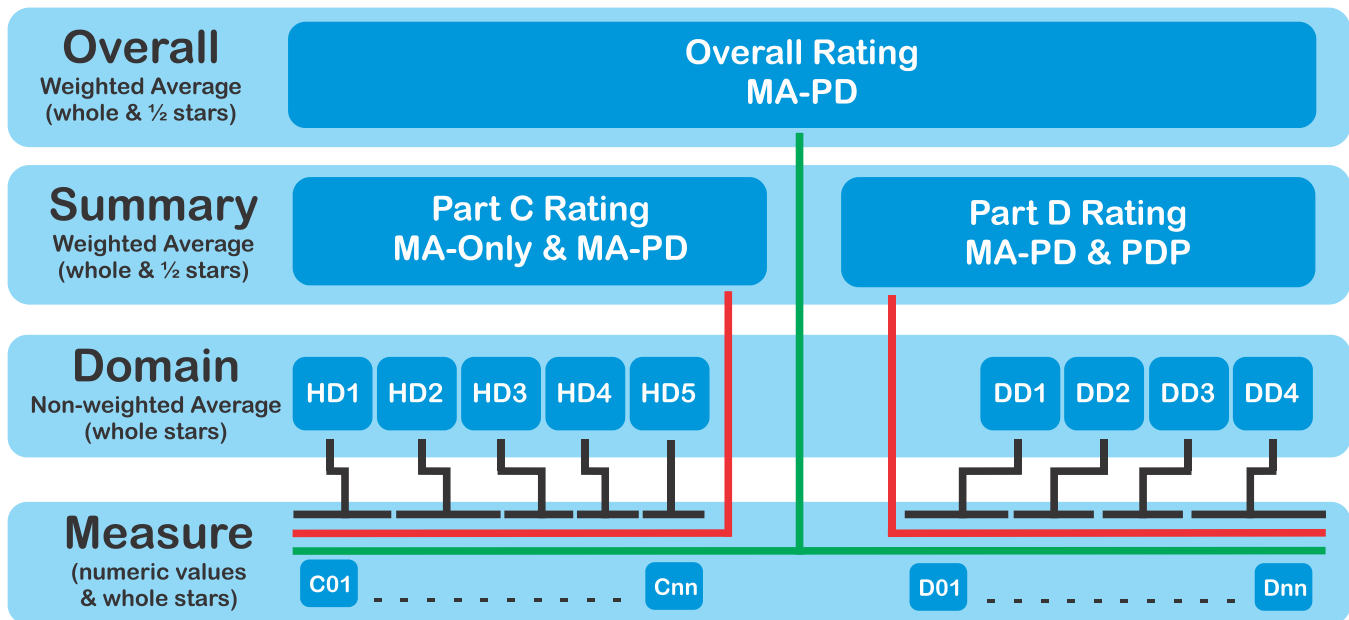
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 hierarchical 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	<i>Staying Healthy: Screenings, Tests and Vaccines (HD1)</i>	4 of 6	4 of 6	4 of 6	2 of 2	4 of 6	N/A	4 of 6
C	<i>Managing Chronic (Long Term) Conditions (HD2)</i>	5 of 9	7 of 12	8 of 15	6 of 11	7 of 12	N/A	7 of 12
C	<i>Member Experience with Health Plan (HD3)</i>	4 of 6	4 of 6	4 of 6	N/A	4 of 6	N/A	4 of 6
C	<i>Member Complaints and Changes in the Health Plan's Performance (HD4)</i>	2 of 3	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3
C	<i>Health Plan Customer Service (HD5)</i>	2 of 2	2 of 3	2 of 3	2 of 3	2 of 2	N/A	2 of 3
D	<i>Drug Plan Customer Service (DD1)</i>	N/A*	1 of 1	1 of 1	1 of 1	N/A	1 of 1	1 of 1*
D	<i>Member Complaints and Changes in the Drug Plan's Performance (DD2)</i>	2 of 3*	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3*
D	<i>Member Experience with the Drug Plan (DD3)</i>	2 of 2*	2 of 2	2 of 2	N/A	N/A	2 of 2	2 of 2*
D	<i>Drug Safety and Accuracy of Drug Pricing (DD4)</i>	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: $n * \text{SUMWX} / (W * (n-1))$. 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	65 th	3.695652	3.740741	3.385522	3.649351
With	With	85 th	4.000000	4.000000	3.913300	3.932432
With	Without	65 th	3.708333	3.740741	3.385522	3.656716
With	Without	85 th	4.019608	4.000000	3.913300	3.943662
Without	With	65 th	3.717391	3.769231	3.318182	3.686567
Without	With	85 th	4.020408	4.136364	4.117647	3.953125
Without	Without	65 th	3.736842	3.769231	3.318182	3.700000
Without	Without	85 th	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	30 th	0.918435	0.754209	0.869005	0.914850
With	With	70 th	1.285170	1.268986	1.747939	1.263462
With	Without	30 th	0.909844	0.754209	0.869005	0.905154
With	Without	70 th	1.281071	1.268986	1.747939	1.272639
Without	With	30 th	0.914326	0.736111	0.749180	0.908919
Without	With	70 th	1.328432	1.318182	1.814773	1.269610
Without	Without	30 th	0.908942	0.736111	0.749180	0.915156
Without	Without	70 th	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

<i>LIS/DE Initial Group</i>	<i>Percentage of Contract's Beneficiaries who are LIS/DE</i>
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

<i>Disability Quintile</i>	<i>Percentage of Contract's Beneficiaries who are Disabled</i>
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

<i>Final Adjustment Category</i>	<i>LIS/DE Initial Group</i>	<i>Disability Quintile</i>	<i>CAI Value</i>
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

<i>LIS/DE Initial Group</i>	<i>Percentage of Contract's Beneficiaries who are LIS/DE</i>
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

<i>Disability Quintile</i>	<i>Percentage of Contract's Beneficiaries who are Disabled</i>
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

<i>Final Adjustment Category</i>	<i>LIS/DE Initial Group</i>	<i>Disability Quintile</i>	<i>CAI Value</i>
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

<i>LIS/DE Initial Group</i>	<i>Percentage of Contract's Beneficiaries who are LIS/DE</i>
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

<i>Disability Quintile</i>	<i>Percentage of Contract's Beneficiaries who are Disabled</i>
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

<i>Final Adjustment Category</i>	<i>LIS/DE Initial Group</i>	<i>Disability Quintile</i>	<i>CAI Value</i>
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

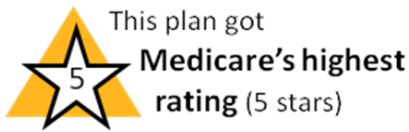
Raw Summary / Overall Score	Final Summary / Overall Rating
<i>Greater than or equal to 0.000000 and less than 0.250000</i>	<i>0</i>
<i>Greater than or equal to 0.250000 and less than 0.750000</i>	<i>0.5</i>
<i>Greater than or equal to 0.750000 and less than 1.250000</i>	<i>1.0</i>
<i>Greater than or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

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
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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 (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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes
<i>Cut Points:</i>	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
<i>Less than 41%</i>	<i>Greater than or equal to 41% to less than 47%</i>	<i>Greater than or equal to 47% to less than 53%</i>	<i>Greater than or equal to 53% to less than 59%</i>	<i>Greater than or equal to 59%</i>

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)

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.”

General Notes: More information about the data used to calculate this measure can be found in [Attachment E](#).

The Part C reporting requirement fields listed below are not used in calculating this measure:

- Data Element D Number of initial HRA refusals
- Data Element E Number of initial HRAs where SNP is unable to reach new enrollees
- Data Element G Number of annual reassessment refusals
- Data Element H Number of annual reassessments where SNP is unable to reach enrollee

Data Time Frame: 01/01/2024 – 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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	No	No	Yes	Yes	No	No	No

<i>Cut Points:</i>	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
<i>Label for Stars:</i>	Yearly Review of All Medications and Supplements Being Taken
<i>Label for Data:</i>	Yearly Review of All Medications and Supplements Being Taken
<i>Description:</i>	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.)
<i>HEDIS Label:</i>	Care for Older Adults (COA) – Medication Review
<i>Measure Reference:</i>	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 101
<i>Metric:</i>	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).
<i>Primary Data Source:</i>	HEDIS
<i>Data Source Category:</i>	Health and Drug Plans
<i>Exclusions:</i>	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.
<i>General Notes:</i>	The formula used to calculate this measure can be found in Attachment E .
<i>Data Time Frame:</i>	01/01/2024 – 12/31/2024
<i>General Trend:</i>	Higher is better
<i>Statistical Method:</i>	Clustering
<i>Improvement Measure:</i>	Included
<i>CAI Usage:</i>	Not Included
<i>Case-Mix Adjusted:</i>	No
<i>Weighting Category:</i>	Process Measure
<i>Weighting Value:</i>	1
<i>Major Disaster:</i>	Higher measure star (2025-2026) for contracts with 25% or more enrolled affected by 2024 disasters.
<i>Meaningful Measure Area:</i>	Seamless Care Coordination
<i>CMIT #:</i>	00110-01-C-PARTC
<i>Data Display:</i>	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 one 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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	No	Yes	No	Yes

<i>Cut Points:</i>	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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes
<i>Cut Points:</i>	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
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<i>Label for Stars:</i>	Kidney Health Evaluation for Patients with Diabetes
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<i>Label for Data:</i>	Kidney Health Evaluation for Patients with Diabetes
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<i>Description:</i>	Percent of plan members with diabetes who received a kidney health evaluation during the year.
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<i>HEDIS Label:</i>	Kidney Health Evaluation for Patients with Diabetes (KED)
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<i>Measure Reference:</i>	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 189
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<i>Metric:</i>	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.
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<i>Primary Data Source:</i>	HEDIS
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<i>Data Source Category:</i>	Health and Drug Plans
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- | | |
|--------------------|---|
| <i>Exclusions:</i> | <ul style="list-style-type: none"> • 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 one 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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes

<i>Cut Points:</i>	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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes

<i>Cut Points:</i>	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
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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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	No	Yes	No	Yes

<i>Cut Points:</i>	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:	<table><tr><th>1876 Cost</th><th>CCP w/o SNP</th><th>CCP with SNP</th><th>CCP with Only I-SNP</th><th>MSA</th><th>PDP</th><th>PFFS</th></tr><tr><td>No</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>No</td><td>Yes</td></tr></table>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS	No	Yes	Yes	Yes	Yes	No	Yes
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:	<table><tr><th>1 Star</th><th>2 Stars</th><th>3 Stars</th><th>4 Stars</th><th>5 Stars</th></tr><tr><td>Greater than 12%</td><td>Greater than 10% to less than or equal to 12%</td><td>Greater than 9% to less than or equal to 10%</td><td>Greater than 7% to less than or equal to 9%</td><td>Less than or equal to 7%</td></tr></table>	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%				
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
<i>Label for Stars:</i>	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
<i>Label for Data:</i>	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
<i>Description:</i>	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.
<i>HEDIS Label:</i>	Statin Therapy for Patients with Cardiovascular Disease (SPC)
<i>Measure Reference:</i>	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 148
<i>Metric:</i>	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).
<i>Primary Data Source:</i>	HEDIS
<i>Data Source Category:</i>	Health and Drug Plans
<i>Exclusions:</i>	• 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
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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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	No	Yes	Yes	Yes	Yes	No	Yes

<i>Cut Points:</i>	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
<i>Label for Stars:</i>	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
<i>Label for Data:</i>	Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit
<i>Description:</i>	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.
<i>HEDIS Label:</i>	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
<i>Measure Reference:</i>	NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2, page 304
<i>Metric:</i>	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.
<i>Primary Data Source:</i>	HEDIS
<i>Data Source Category:</i>	Health and Drug Plans
<i>Exclusions:</i>	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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes
<i>Cut Points:</i>	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
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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
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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
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Yes	Yes	Yes	No	Yes	No	Yes
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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:

$$\left[\frac{\text{(Total number of all complaints logged into the Complaints Tracking Module (CTM))}}{\text{(Average Contract enrollment)}} \right] * 1,000 * 30 / \text{(Number of Days in Period)}$$

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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes

<i>Cut Points:</i>	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
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<i>Label for Stars:</i>	Health Plan Makes Timely Decisions about Appeals
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<i>Label for Data:</i>	Health Plan Makes Timely Decisions about Appeals
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<i>Description:</i>	This rating shows how fast a plan sends information for an independent review.
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<i>Metric:</i>	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:
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$$\frac{[\text{Number of Timely Appeals}]}{([\text{Appeals Upheld}] + [\text{Appeals Overturned}] + [\text{Appeals Partially Overturned}] + [\text{Appeals Not Evaluated by the IRE Because Plan Agreed to Cover}])} * 100.$$

<i>Primary Data Source:</i>	Independent Review Entity (IRE)
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<i>Data Source Description:</i>	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.
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<i>Data Source Category:</i>	Data Collected by CMS Contractors
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<i>Exclusions:</i>	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.
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<i>General Notes:</i>	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.
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The number of timely appeals can be calculated using this formula:

$$[\text{Number of Timely Appeals}] = ([\text{Appeals Upheld}] + [\text{Appeals Overturned}] + [\text{Appeals Partially Overturned}] + [\text{Appeals Not Evaluated by the IRE Because Plan Agreed to Cover}]) - [\text{Late}]$$

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"

<i>Data Time Frame:</i>	01/01/2024 – 12/31/2024
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<i>General Trend:</i>	Higher is better
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<i>Statistical Method:</i>	Clustering
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Improvement Included*Measure:**CAI Usage:* Not Included*Case-Mix* No*Adjusted:**Weighting* Measures Capturing Access*Category:**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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	Yes	No	Yes
<i>Cut Points:</i>	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:
$$([\text{Appeals Upheld}] / ([\text{Appeals Upheld}] + [\text{Appeals Overturned}] + [\text{Appeals Partially Overturned}]) * 100.$$
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

Area:

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:

$$\left[\frac{\text{(Total number of all complaints logged into the Complaints Tracking Module (CTM))}}{\text{(Average Contract enrollment)}} \right] * 1,000 * 30 / \text{(Number of Days in Period)}$$

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
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<i>Label for Stars:</i>	Improvement (if any) in the Drug Plan's Performance
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<i>Label for Data:</i>	Improvement (If any) in the Drug Plan's Performance
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<i>Description:</i>	This shows how much the drug plan's performance has improved or declined from one year to the next year.
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	If a plan receives 1 or 2 stars , it means, on average, the plan's scores declined (got worse).
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	If a plan receives 3 stars , it means, on average, the plan's scores stayed about the same .
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	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.
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<i>Metric:</i>	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).
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<i>Primary Data Source:</i>	Star Ratings
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<i>Data Source Description:</i>	2025 and 2026 Star Ratings
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<i>Data Source Category:</i>	Star Ratings
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<i>Exclusions:</i>	Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.
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<i>General Notes:</i>	Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.
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<i>Data Time Frame:</i>	Not Applicable
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<i>General Trend:</i>	Higher is better
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<i>Statistical Method:</i>	Clustering
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<i>Improvement Measure:</i>	Not Included
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<i>CAI Usage:</i>	Not Included
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<i>Case-Mix Adjusted:</i>	No
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<i>Weighting Category:</i>	Improvement Measure
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<i>Weighting Value:</i>	5
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<i>Major Disaster:</i>	Includes only measures which have data from both years.
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<i>Meaningful Measure Area:</i>	Person-Centered Care
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<i>CMIT #:</i>	00224-01-C-PARTD
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<i>Data Display:</i>	Not Applicable
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<i>Reporting Requirements:</i>	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
<i>MA-PD</i>	<i>Less than -0.233766</i>	<i>Greater than or equal to -0.233766 to less than 0</i>	<i>Greater than or equal to 0 to less than 0.320439</i>	<i>Greater than or equal to 0.320439 to less than 0.579545</i>	<i>Greater than or equal to 0.579545</i>
<i>PDP</i>	<i>Less than -0.183824</i>	<i>Greater than or equal to -0.183824 to less than 0</i>	<i>Greater than or equal to 0 to less than 0.330927</i>	<i>Greater than or equal to 0.330927 to less than 0.672727</i>	<i>Greater than or equal to 0.672727</i>

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
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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 Person-Centered Care

Area:

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
<i>MA-PD</i>	<i>less than 87</i>	<i>Greater than or equal to 87 to less than 88</i>	<i>Greater than or equal to 88 to less than 90</i>	<i>Greater than or equal to 90 to less than 91</i>	<i>Greater than or equal to 91</i>
<i>PDP</i>	<i>less than 88</i>	<i>Greater than or equal to 88 to less than 89</i>	<i>Greater than or equal to 89 to less than 90</i>	<i>Greater than or equal to 90 to less than 91</i>	<i>Greater than or equal to 91</i>

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
<i>Label for Stars:</i>	Plan Provides Accurate Drug Pricing Information for This Website
<i>Label for Data:</i>	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
<i>Description:</i>	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.
<i>Metric:</i>	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:
	$0.5 \times (100 - ((\text{accuracy index} - 1) \times 100)) + 0.5 \times ((1 - \text{claim percentage index}) \times 100).$
<i>Primary Data Source:</i>	PDE data, MPF Pricing Files
<i>Data Source Description:</i>	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.
<i>Data Source Category:</i>	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 Chronic Conditions

Area:

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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	No	Yes	Yes

<i>Cut Points:</i>	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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	No	Yes	Yes

<i>Cut Points:</i>	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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	No	Yes	Yes
<i>Cut Points:</i>	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
<i>Label for Stars:</i>	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
<i>Label for Data:</i>	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
<i>Description:</i>	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.
<i>Metric:</i>	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.
<i>Primary Data Source:</i>	Prescription Drug Event (PDE) data
<i>Data Source Description:</i>	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

<i>Reporting Requirements:</i>	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
	Yes	Yes	Yes	Yes	No	Yes	Yes

<i>Cut Points:</i>	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 adjusters 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

<i>Predictor</i>	<i>Paperwork Easy</i>	<i>Plan Customer Service Gives Information</i>	<i>Plan Customer Service Courtesy and Respect</i>
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		

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

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

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

Attachment E: SNP Measure Scoring Methodologies**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:

$$\begin{aligned} & [\text{Number of initial HRAs performed on new enrollees (Element C)} \\ & + \text{Number of annual reassessments performed on enrollees eligible for a} \\ & \text{reassessment (Element F)}] \\ & / [\text{Number of new enrollees due for an Initial HRA (Element A)} \\ & + \text{Number of enrollees eligible for an annual reassessment HRA (Element B)}] \end{aligned}$$

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: $P_{\text{pooled}} = W_1 * P_1 + W_2 * P_2$

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	
$P_{\text{pooled}} = W_1 * P_1 + W_2 * P_2$	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):

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

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

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

Where 1 through n are all contracts with a (18+) Denominator larger than or equal to 150, and a (18+) OE larger than or equal to 0.2 and less than or equal to 5.0.

For each contract, calculate the Final Rate and convert to percentages:

$$Final\ Rate(18+) = OE(18+) \times NatAvgObs(18+) \times 100$$

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

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

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

$$NatAvgObs = 0.135181$$

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

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

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):

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

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:

$$\text{Improvement Change Score equals Score in 2026 minus Score in 2025}$$

For measures where a lower score is better:

$$\text{Improvement Change Score equals Score in 2025 minus Score in 2026}$$

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:

$$se(Y_{i2}) = 2.805$$

$$se(Y_{i1}) = 3.000$$

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

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**

$$SE_y = \sqrt{\frac{\text{Score}_y * (100 - \text{Score}_y)}{\text{Denominator}_y}}$$

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:

$$SE_{yj} = \sqrt{\frac{\text{Score}_{yj} * (100 - \text{Score}_{yj})}{\text{Denominator}_{yj}}}$$

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**

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

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.

$$\begin{aligned} \text{Var}(Z_y) &= \frac{1}{16} * [\text{Var}(T_{1y}) + \text{Var}(T_{2y}) + \text{Var}(T_{3y}) + \text{Var}(T_{4y}) + 2\text{Cov}(T_{1y}, T_{2y}) \\ &\quad + 2\text{Cov}(T_{1y}, T_{3y}) + 2\text{Cov}(T_{1y}, T_{4y}) + 2\text{Cov}(T_{2y}, T_{3y}) + 2\text{Cov}(T_{2y}, T_{4y}) + 2\text{Cov}(T_{3y}, T_{4y})] \\ SE_y &= \sqrt{\text{Var}(Z_y)} \end{aligned}$$

for y equals 2025 and 2026

$$\text{Var}(T_{1y}) = (100 * \frac{n_{1y}}{d_{1y}}) * \frac{(100 - (100 * \frac{n_{1y}}{d_{1y}}))}{d_{1y}}$$

In the above formula, n_{1y} is the numerator for T_{1y} and d_{1y} the denominator, and so on for each of the four component measures.

$$\text{Cov}(T_{1y}, T_{2y}) = \text{Corr}(T_{1y}, T_{2y}) * \sqrt{\text{Var}(T_{1y})} * \sqrt{\text{Var}(T_{2y})}$$

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

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

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

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

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

2025 Correlation	2026 Correlation
0.599486	0.653381

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

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

for y equals 2025, 2026

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	DMC25	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.

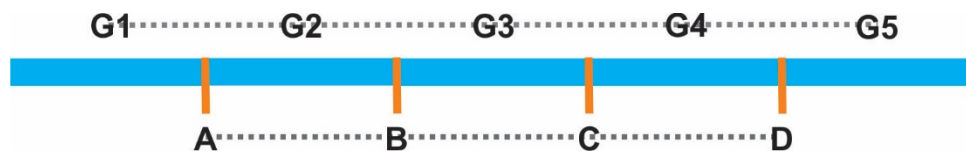
Clustering Methodology Introduction

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 hierarchical 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 hierarchical 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 15 th percentile by greater than 1 SE	1	1	1	2	2	2	2
Less than 15 th percentile by less than or equal to 1 SE	1	2	1	2	2	2	2
Greater than or equal to 15 th to less than 30 th percentile	2	2	2	3	2	3	2
Greater than or equal to 30 th to less than 60 th percentile	3	2	2	3	3	4	4
Greater than or equal to 60 th to less than 80 th percentile	4	3	4	3	4	4	4
Greater than or equal to 80 th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
Greater than or equal to 80 th 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
<i>Drug Coverage</i>	X1	+	+	+	X2	X2	X2	X2	X2			
<i>Inpatient Stay</i>												

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 price¹ 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 PDE⁵. 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:

$$\text{Price Accuracy Index} = \frac{\sum_i \max(\text{TC}_{i\text{PDE}} - \text{TC}_{i\text{MPF}}, 0) + \sum_i \text{TC}_{i\text{PDE}}}{\sum_i \text{TC}_{i\text{PDE}}}$$

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.

$$\text{Claim Percentage Index} = \frac{\sum_i \text{Claims}_{iPDE > MPF}}{\sum_i \text{Claims}_{iTotal}}$$

where

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

Claims_{iTotal} is the total number of claims

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

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{MPF Composite Price Accuracy Score} = (0.5 \times \text{Price Accuracy Score}) + (0.5 \times \text{Claim Percentage Score})$$

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

Example of Accuracy Index Calculation

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

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the MPF data that had been submitted by the contract and posted on 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
PDE = Prescription Drug Event MPF = Medicare Plan Finder											Totals	69.28		5.78
											Price Accuracy Index		1.08343	
											Claim Percentage Index		0.5	
											MPF Composite Price Accuracy Score		71	

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=A CS+1-Year+Estimates+Subject+Tables](https://data.census.gov/table/ACSST1Y2023.S0103?q=S0103&g=010XX00US$0400000&y=2023&d=A CS+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.

<i>Description</i>	<i>Value</i>
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:

$$\begin{aligned} \widehat{\text{LIS/DE}} = & (0.953992 \times \text{contract's DE percentage}) \\ & + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884) \right) \end{aligned}$$

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.

$$\begin{aligned} \widehat{\text{LIS/DE}} = & (0.953992 \times \text{contract's DE percentage}) \\ & + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884) \right) \end{aligned}$$

The hypothetical contract's DE percentage of 5.000000% is substituted into the Puerto Rico model.

$$\begin{aligned} \widehat{\text{LIS/DE}} = & (0.953992 \times 5.000000) \\ & + \left(\left(47.923411 \times \frac{58.400000}{24.328679}\right) - (0.953992 \times 28.804884) \right) \end{aligned}$$

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	$(202X_{10} + 202X_{11} + 202X_{12}) \text{ divided by } 3$
C	True	True		$(202X_{10} + 202X_{11}) \text{ divided by } 2$
F	True		True	$(202X_{10} + 202X_{12}) \text{ divided by } 2$
H	True			202X_10
J		True	True	$(202X_{11} + 202X_{12}) \text{ divided by } 2$
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
<i>Coming Soon</i>	<i>Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live</i>
<i>Medicare shows only a Star Rating for this topic</i>	<i>Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2</i>
<i>Not enough data available</i>	<i>There were data for the contract, but not enough to pass the measure exclusion rules</i>
<i>CMS identified issues with this plan's data</i>	<i>Data were materially biased, erroneous and/or not reported by a contract required to report</i>
<i>Not Applicable</i>	<i>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.</i>
<i>Benefit not offered by plan</i>	<i>The contract was required to report this HEDIS measure but doesn't offer the benefit to members</i>
<i>Plan too new to be measured</i>	<i>The contract is too new to have submitted measure data</i>
<i>No data available</i>	<i>There were no data for the contract included in the source data for the measure</i>
<i>Plan too small to be measured</i>	<i>The contract had data but did not have enough enrollment to pass the measure exclusion rules</i>
<i>Plan not required to report measure</i>	<i>The contract was not required to report the measure</i>

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

Attachment R: Glossary of Terms

AEP	The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan or re-enroll into their existing Medicare Part C or D Plan or change into another Medicare plan is known as the Annual Election Period (AEP). The chosen Medicare Part C or D plan coverage begins on January 1 st .
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						
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
				01/01/2024 - 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 PGPPNC	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 2024 disaster (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						
Contract Number	Organization Marketing Name	Contract Name	Parent Organization	HD1: Staying Healthy: Screenings, Tests and Vaccines		
				C01: Breast Cancer Screening	C02: Colorectal Cancer Screening	C03: Annual Flu Vaccine
				01/01/2024 - 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 F

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE

DATE: December 16, 2021

TO: All Medicare Advantage Organizations (MAOs), Prescription Drug Plan Sponsors and Medicare-Medicaid Plans (MMPs) (excluding PACE contracts, cost contracts, MSA contracts, and employer-only plans)

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

SUBJECT: 2022 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2022. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2022 call center information **no later than December 31, 2021**.

For 2022, CMS has contracted with Insight Policy Research, and its subcontractor IMPAQ International, to monitor the performance of plan sponsors' call centers with respect to the standards adopted to implement 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1).

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk telephone lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5percent or less. Note that thresholds are adjusted for margin of error.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the plan divided by the total number of calls made to the telephone number associated with the contract.
2. The average hold time is defined as the average time spent on hold by the caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person.

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2)

teletypewriter (TTY) functionality, and (3) the **accuracy of plan information provided by customer service representatives (CSRs)** in all languages. Languages tested in 2022 are unchanged from 2021 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2022.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via an interpreter (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures.
2. TTY functionality is defined as the ability of a caller using a TTY device to communicate with someone and receive answers to questions at the plan's call center directly or via a relay operator. A call is considered connected when the caller reaches a TTY/relay operator. The measure is considered *completed* when the caller confirms that the CSR is able to answer questions about plan benefits via the TTY/relay operator (before beginning the first of three general Medicare or plan-specific accuracy questions) within seven minutes of the TTY/relay operator reaching the plan. The percent of completed TTY calls (the number of completed TTY calls out of all TTY calls) is used for Part C and D Star Ratings measures.
3. Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.
4. Contracts or plan benefit packages (PBPs) under marketing and enrollment sanction are excluded from the study.

In the event that an organization believes that CMS may have miscalculated its call center results based on data posted in HPMS, it may bring the relevant information to CMS' attention and ask for a review of the results. Generally, CMS may revise call center results when they are shown to be based on incorrect data. CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study.

IMPORTANT ACTION: Verify 2022 Call Center Information

Compliance Officers should prepare for this monitoring effort by ensuring the accuracy of 2022 Part C and/or Part D call center telephone numbers in HPMS by **December 31, 2021**. This

includes current and prospective enrollee **toll-free** beneficiary call center telephone numbers, **toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis and updated in the monitoring contractor's automated dialing software. If any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately. 42 C.F.R. §§ 422.504(f)(2) and 423.505(f)(2)(vii). It is important that all organizations always keep these telephone numbers up-to-date in HPMS. Organizations should notify CallCenterMonitoring@cms.hhs.gov after an update is made. **If an organization achieves poor results on the measures due to calls to an inaccurate telephone numbers, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is available in HPMS prior to the launch of the studies.** Use the paths outlined below to verify and/or update the telephone numbers.

Verify your pharmacy technical help desk number, which is a contract-level contact and not a bid-level contact, using the following path: HPMS home page: > Contract Management > Basic Contract Management > [select contract number] > [enter the contract number] > Contact Data > Pharmacy Technical Help Desk Contact. There are primary and secondary contacts collected in this section. The primary contact is mandatory and the secondary contact is optional. Please note that for call center monitoring purposes, we call only the primary contact.

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: > Plan Bids > Bid Submission > CY 2022 – Manage Plans > Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

1. On the Select a Contract screen, enter a contract number into the field provided (Option 1) or select a contract number (Option 2). Click Next to advance to the Update and Save Data screen.
2. On the Update and Save Data screen, select a plan, and select a contact tab.
3. Edit the mailing address, telephone numbers, and e-mail address for applicable contracts.
4. After entering data for the first contact type, the user can complete data entry for other contact types under the same plan.

Notes:

- Our regulations at 42 C.F.R. §§ 422.111(h)(1) and 423.128(d) require the operation of a toll-free customer call center; MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.*** Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.
- **All TTY numbers must be either three numeric characters or ten numeric characters and entered into HPMS.**

Please make certain you have entered into HPMS the **TTY local telephone number** and the **TTY toll- free telephone number**. If your plan does not use a dedicated, in-house TTY device, you may enter 711 in both fields, or you may enter the toll-free ten-digit number for a specific state relay service. The toll-free TTY telephone number must be populated, as this is the telephone number we pull for the Accuracy & Accessibility Study.

This information can be found in Chapter 1 of the CY2022 Bid User Manual (*HPMS home page > Plan Bids > Bid Submission > CY2022 > View Documentation (under “Documentation” Section) > Bid Submission User manual for Contract Year 2022*).

Tips for Success/Best Practices

Based on several years of study results, CMS provides the following tips to help improve results.

General:

- Provide basic services and information to individuals with disabilities, upon request.
- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio and data CDs, and in requested alternate languages) to individuals with disabilities upon request.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot program what options they should select for each plan. We train them to listen for options such as “current members,” “pharmacy,” or an option for those “interested in learning more about enrolling” for prospective calls, for example. When you are setting up your IVR options, please keep this in mind. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. You may experience more successful call outcomes if the representative offers a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, “You need to call another number” or answering “no” to the introductory question, “Are you the right person to answer questions about....” will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make the most reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plans, or at least transfer us to the correct party who can answer those questions.

HPMS Entries:

- Current, prospective, and TTY/relay services customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or Telecommunications Relay Service (TRS) telephone numbers. CMS extracts the values found in the toll-free *and* alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. If you have

updates at any time during the year, please enter them into HPMS immediately. A delay in updating the telephone number(s) prior to the start of the study may result in unsuccessful calls attributed to your plan's performance. Calls of this nature cannot be negated.

Ability to Accept Calls:

- Callers to current enrollee and prospective enrollee customer service call centers need to be able to communicate with a live person when they call from 8:00 a.m. to 8:00 p.m. Messages that ask a caller to leave their telephone number are not appropriate and will not be counted as a successful call.
- CMS' monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Generally speaking, CMS also notes longer hold times at the beginning of a week with improvement as the week progresses. Call centers should evaluate their own needs and consider increased staffing during busier times.
- If your organization intends to implement any new technology affecting telephone systems, ensure it will not interfere with the organization's ability to accept calls, including TTY communications.
- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
 - Test every telephone number supported by the call center.
 - Pull the telephone numbers from HPMS and ensure they ring to the intended location.
 - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.
 - Test with more than one caller at the same time.
 - See TTY section below for specific TTY testing suggestions.
- CMS will occasionally solicit volunteers for abbreviated training periods prior to the beginning of an actual study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. If you are launching new technology in your call center, consider joining a pilot or interviewer training session to ensure your equipment is working as expected. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next pilot or interviewer training session.
- **Ensure that your organization does not employ IVR logic or other functions that will block calls at certain times based solely upon the area code of the caller.** CMS calls from the Columbia, Maryland, area in the Eastern time zone. We call regions from the Atlantic time zone to as far west as Guam. We will call you during the business standard hours of operation (8:00 a.m. to 8:00 p.m. in the time zone(s) the plan serves). If our caller cannot reach a live representative due to programming on your end, or we hear messages stating the office is closed during the required hours of operation, the call will

be counted as unsuccessful.

- Carefully review your service areas to ensure you are covering the call center is open and provides services at least in accordance with standard business practices. This means that the current and prospective enrollee call centers are open minimally from **8:00 a.m. to 8:00 p.m. for all of your plans' local service areas.** Check carefully to verify your coverage for any counties that are split into two time zones or to confirm observance of daylight savings time. For example, some contracts will occasionally serve counties that are split into two time zones. Also, most of Arizona is exempt from daylight savings time. However, the Navajo Nation lands, which extend to the states of Arizona, New Mexico and Utah, observe daylight savings time. Regardless of whether two time zones are served or daylight savings time is or is not observed, call centers are required to be open minimally from 8:00 a.m. to 8:00 p.m. in all local service areas for all of its current or potential enrollees.
- **Ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu. This is important for both studies.** Every year CMS encounters plans that offer limited IVR options without a clear way to select the option to speak with a current member representative or a prospective beneficiary representative, and the IVR message cycles over and over without a live representative answering the telephone. This results in unsuccessful calls due to time-outs. Test your systems. When planning the IVR choices, ask yourself, “If I am calling to get information so I can decide if I want to enroll in this plan, is there an IVR option for me on this prospective beneficiary telephone number?”
- Ensure callers with a private number are able to connect to your plan's customer service telephone numbers.
- Train CSRs to answer the introductory question asked of them (“Are you the right person to answer questions about...?”) When we call current member customer service lines, we only ask a question intended to determine if we have reached a person who has authority to answer questions about the Medicare plan we are calling. **If the CSR insists on first knowing the caller's name, date of birth, membership ID number, or Social Security Number or refuses to answer the introductory question by stating “no,” the call will be counted as an unsuccessful call unless the party transfers the call to a person who can answer “yes” in a timely manner.** Note that we only need to confirm we have reached a CSR who has authority to answer questions so we can measure the average hold time to reach a live CSR, but we do not ask any actual benefit-related questions when we call the *current member* customer service line or the pharmacy technical assistance help line.

Interpreter Availability:

- Utilize an interpretation service to identify the beneficiary's language.
- Use interpreter services personnel who are familiar with healthcare terms and Medicare

benefit concepts.

- Interpreters should:
 - Adhere to generally accepted interpreter ethics principles, including confidentiality;
 - Demonstrate proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation; and
 - Interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.
- Train CSRs to connect foreign-language callers with an interpreter.
- Ensure CSRs stay on the telephone when a foreign-language interpreter joins the call.
- In order to replicate a beneficiary's actual experience, CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the IVR system if the instruction is only in the primary language. **Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu.** If the IVR instruction is available in the language being tested, the test callers will make an appropriate IVR selection. For example, if the language being tested is French, *and instruction is available in French in the IVR* to select an option for French, the test caller will make that selection. (Please note that the primary language in Puerto Rico is Spanish and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)
- Include a note on the beneficiary's call center record that indicates his/her preferred language, if other than English, for both written and verbal communication. Record and maintain that information in a tracking system to be used in future beneficiary contacts.
- Monitor CSR calls to ensure that foreign-language calls are being handled according to the plan sponsor's policies and procedures.
- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.
- Ensure that CSRs are able to respond promptly to questions. Each accuracy question has a 7-minute timer.

TTY Functionality:

- CMS makes the following suggestions for testing in-house TTY devices:
 - Regularly test your device to ensure that it is working properly.
 - Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into your TTY system to test.)
 - Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.

- When testing, check for garbled language on both sides of the call.
 - Whenever you make a telephone system change, retest all TTY systems.
 - If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a telephone line *and* a TTY line.
 - Verify with your telecom provider that TTY calling is supported, in case there are any settings on the carrier side that need to be adjusted.
 - If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.
- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.
 - If using an in-house TTY device, ensure CSRs always use “GA” for “Go Ahead” after s/he has communicated his or her opening remark or other response via TTY device, so the other party knows it can now safely transmit its next thought. Failure to use “GA” may confuse beneficiaries who are familiar with TTY systems and could result in a plan hanging up on a TTY caller who has not responded, because the caller is waiting for the “GA” as clearance to respond.
 - Ensure that beneficiaries using relay services can reach a CSR who has been trained on how to best communicate through a relay operator.
 - Ensure that TTY services are available in languages other than English.
 - CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR.
 - Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.
 - The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan. If you use a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller’s area code. Our test calls will be placed from the Columbia, Maryland, area (443 area code). It is the plan’s responsibility to ensure that calls from this area code can be received via their relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements of 42 C.F.R. § 422.111(h)(1) and 42 C.F.R. § 423.128(d)(1). Review the 2022 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2022. Consider sharing the most recent *Medicare & You* with translator service provider.

- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.
- Because the time is limited to 7 minutes for each of the general accuracy questions, a best practice for CSRs is to speak at a high level first and offer more detail if asked.
 - When we ask our introductory question, (“Are you the right person to answer questions about...?”), it is always best for the CSR to respond “yes” or “no,” meaning yes, the CSR is the correct person to answer questions about a specific plan’s benefits, or no, the CSR is not the correct person to answer questions about the plan’s benefits. The CSR should then offer a “warm transfer” to the caller so that he or she may speak to the appropriate person. If the CSR responds at this high level first, it will save time, especially if the caller needs to be transferred to another party. If the CSR spends a great deal of time trying to get more information from the caller, the timer may expire, resulting in an unsuccessful call in the plan’s performance.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health’s (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)*. Originally published in 2000, an enhanced version of the *National CLAS Standards* was most recently updated by OMH in October 2018. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to “Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs” and serves as the overarching goal for *National CLAS Standards*’ implementation. One key area is Communication and Language Assistance, which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the *National CLAS Standards* and its guidance document, *The Blueprint*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH’s free e-learning program, [The Guide to Providing Effective Communication and Language Assistance Services](#). If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes/Frequently Asked Questions and Data Dictionaries for each study are stored in HPMS via links in the lower left corners of the Performance Metrics pages. Please refer to pages 2 and 3 above for the location of the studies' results. This same location is where you will find these reference materials.

If you have any questions about the 2022 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Please do not use secure email when communicating with this resource. CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.

Exhibit G

2026 Star Ratings Measures and Weights

There are three new measures being added beginning with the 2026 Star Ratings - Kidney Health Evaluation for Patients with Diabetes¹, Improving or Maintaining Physical Health², and Improving or Maintaining Mental Health². The Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures are returning to the Star Ratings after a substantive specification change and are treated as new measures. They will have a weight of 1 for the 2026 Star Ratings and a weight of 3 beginning with the 2027 Star Ratings.

The weight of Patients' Experience and Complaints, and Measures Capturing Access measures will decrease from 4 to 2 beginning with the 2026 Star Ratings¹.

¹ Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. <https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program>

² Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. <https://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicare-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare>

Table 1. 2026 Star Ratings Part C Measures and Measure Weights

Measure Name	Weighting Category	Part C Summary and MA-PD Overall Weight
Breast Cancer Screening	Process Measure	1
Colorectal Cancer Screening	Process Measure	1
Annual Flu Vaccine	Process Measure	1
Improving or Maintaining Physical Health	Outcome Measure	1*
Improving or Maintaining Mental Health	Outcome Measure	1*
Monitoring Physical Activity	Process Measure	1
Special Needs Plan (SNP) Care Management	Process Measure	1
Care for Older Adults – Medication Review	Process Measure	1
Care for Older Adults – Pain Assessment	Process Measure	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1
Diabetes Care – Eye Exam	Process Measure	1
Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
Controlling Blood Pressure	Intermediate Outcome Measure	3
Reducing the Risk of Falling	Process Measure	1
Improving Bladder Control	Process Measure	1
Medication Reconciliation Post-Discharge	Process Measure	1
Plan All-Cause Readmissions	Outcome Measure	3
Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
Transitions of Care	Process Measure	1
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
Getting Needed Care	Patients' Experience and Complaints Measure	2
Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
Customer Service	Patients' Experience and Complaints Measure	2
Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
Rating of Health Plan	Patients' Experience and Complaints Measure	2
Care Coordination	Patients' Experience and Complaints Measure	2
Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Health Plan Quality Improvement	Improvement Measure	5
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
Reviewing Appeals Decisions	Measures Capturing Access	2
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

*Measure has a weight of 1 for the 2026 Star Ratings because it is considered a new measure.

Table 2. 2026 Star Ratings Part D Measures and Measure Weights

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

Exhibit H



Part C and D Performance Data

This page contains performance data related to the Part C & D programs.

Please check back again as this page is updated on a regular basis.



Downloads

[2027 Categorical Adjustment Index Measure Supplement \(PDF\)](#)

[2027 Star Ratings Measures \(PDF\)](#)

[2026 Display Measures \(ZIP\)](#)

[2026 Star Ratings Fact Sheet \(PDF\)](#)

[2026 Star Ratings Data Tables \(ZIP\)](#)

[2026 Star Ratings Technical Notes \(PDF\)](#)

[2026 Categorical Adjustment Index Measure Supplement \(PDF\)](#)

[2025 Display Measures \(ZIP\)](#)

[HEI Webinar November 2024 \(PPTX\)](#)

[2025 Star Ratings Data Tables \(ZIP\)](#)

[2025 Star Ratings Technical Notes \(PDF\)](#)

[2025 Categorical Adjustment Index Measure Supplement \(PDF\)](#)

[2024 Star Ratings Data Tables \(Jul 2 2024\) \(ZIP\)](#)

[Updated 2024 Star Ratings Cutpoints and Star Averages \(XLSX\)](#)

[Cut Point Trends \(ZIP\)](#)

[2024 Display Measures \(ZIP\)](#)

[2024 Star Ratings Technical Notes \(PDF\)](#)

[Stratified reporting documentation - 2022-2023 Star Ratings \(PDF\)](#)

[2024 Categorical Adjustment Index Measure Supplement \(PDF\)](#)

[Tukey Outlier Deletion Simulations \(ZIP\)](#)

[2023 Star Ratings and Display Measures \(ZIP\)](#)

[2022 Star Ratings and Display Measures \(ZIP\)](#)

[2021 Star Ratings and Display Measures \(ZIP\)](#)

[2020 Star Ratings and Display Measures \(ZIP\)](#)

[2019 Star Ratings and Display Measures \(ZIP\)](#)

[Industry-wide Appeals Timeliness Monitoring Memo \(November 28, 2016\) \(PDF\)](#)

[Industry-wide Timeliness Monitoring \(PDF\)](#)

[2018 Star Ratings and Display Measures \(ZIP\)](#)

[2017_Star_Ratings_and_Display_Measures \(ZIP\)](#)

[2016_Star_Ratings_and_Display_Measures \(ZIP\)](#)

[2015_Star_Ratings_and_Display_Measures \(ZIP\)](#)

[2014_Star_Ratings_and_Display_Measures \(ZIP\)](#)

[2013_Plan_Ratings_and_Display_Measures \(ZIP\)](#)

[2012_Plan_Ratings_and_Display_Measures \(ZIP\)](#)

[2011_Plan_Ratings_and_Display_Measures \(ZIP\)](#)

[2010_Plan_Ratings_and_Display_Measures \(ZIP\)](#)

[2009_Plan_Ratings \(ZIP\)](#)

[2008_Plan_Ratings \(ZIP\)](#)

[2007_Plan_Ratings \(ZIP\)](#)

[2014 RFI Submissions \(02252015\) v2a \(ZIP\)](#)

[Historical Categorical Adjustment Index Documents \(ZIP\)](#)

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[Help with File Formats and Plug-Ins](#)



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7500 Security Boulevard, Baltimore, MD 21244

Exhibit I

J U N E 2 0 2 5

Report to the Congress

Medicare and the Health Care Delivery System



The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

C H A P T E R

2

Supplemental benefits in Medicare Advantage

Chapter summary

In addition to covering basic Part A and Part B services, Medicare Advantage (MA) plans may provide “supplemental” benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under fee-for-service (FFS) Medicare such as dental, vision, or hearing services (non-Medicare services). These supplemental benefits, which are intended to provide more generous coverage and better financial protection for MA enrollees, are a defining feature of MA, but relatively little is known about the use of the benefits and the costs associated with them.

The majority of the supplemental benefits provided by MA plans are financed by the rebates that plans receive from Medicare. Medicare spending on plan rebates has increased sharply in recent years. Our analysis shows that, in 2025, Medicare will pay MA plans approximately \$86 billion in rebates—or about \$2,530 per enrollee (roughly 17 percent of Medicare’s payments to MA plans)—to provide supplemental benefits, up from \$21 billion (or about \$1,160 per enrollee) in 2018.

According to their 2025 bid projections, plans expect to use about \$39 billion (of the total \$86 billion, equivalent to about \$100 per member per month (PMPM)) to provide non-Medicare services to their enrollees and

In this chapter

- Background
- Marked growth since 2018 in the rebates that finance MA supplemental benefits
- Conventional MA plans and SNPs report using rebates very differently
- Little is known about use of supplemental benefits
- Supplemental benefits: Cost-sharing and premium reductions
- Supplemental benefits: Non-Medicare services
- The role of vendors, community-based organizations, and vertically integrated entities
- Appendix: Additional information about supplemental benefits

about \$27 billion (\$64 PMPM) to reduce enrollees' cost sharing for Medicare-covered services (such as doctors' visits). Though plans' bids indicate how they intend to use rebate dollars, projections may vary from actual experience, and little is known about how MA rebate dollars are actually spent. Because Part D benefit enhancements and Part D and Part B premium reductions are adjudicated directly between CMS and MA plans, there is less uncertainty about plans' spending for these supplemental benefits. For 2025, we estimate that MA plans will use about \$15 billion of the rebates they receive from Medicare to enhance Part D benefits and reduce Part D premiums (equivalent to about \$37 PMPM), and they will use about \$5 billion (\$10 PMPM) to reduce their enrollees' Part B premiums.

Different types of MA plans tend to offer different types of supplemental benefits. Conventional MA plans (i.e., nonemployer, non-special-needs plans) typically allocate the largest share of their rebate dollars to reducing enrollee cost sharing for Part A and B services. In contrast, special-needs plans (SNPs) report allocating a small share of their rebates to reducing cost sharing because most of their enrollees are dually eligible for Medicare and Medicaid and so will have their out-of-pocket (OOP) costs covered by Medicaid and other programs. Instead, SNPs allocate most of their rebate dollars to the provision of non-Medicare services.

In recent years, CMS and the Congress have gradually increased plans' flexibility in the types of supplemental benefits that can be offered, and plans can now target supplemental benefits to enrollees with a particular health status or disease state. Plans also can provide supplemental benefits that are not primarily health related to chronically ill enrollees; these benefits—which include services like meals, nonmedical transportation, and pest-control services—are known as special supplemental benefits for the chronically ill (SSBCI).

These new flexibilities, combined with the growth in rebate dollars, have allowed MA plans to significantly expand the number of supplemental benefits they offer. Across almost every type of supplemental benefit, our analysis of benefits offered by plans finds that the share of MA enrollees in plans offering these benefits has increased since 2018. Many plans offer supplemental benefits as “combination benefits,” in which enrollees are provided with a “flex card” that can be used to pay for a number of different services. Growth in the share of SNP enrollees in plans offering the newer forms of benefits has been particularly dramatic. According to plans' bid data, SNPs now intend to devote

more rebate dollars to other non-Medicare services than to dental, vision, hearing, and transportation benefits combined.

As Medicare spending for MA supplemental benefits grows, it becomes increasingly valuable for policymakers to fully understand their use. CMS requires MA organizations to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient, home health, and skilled nursing facility services) are incomplete. And to the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of supplemental benefits—likely because the reliability of the data has been unclear.

Indeed, until 2024, the system that CMS used to collect encounter records was not configured to accept records for dental services. For this report, we used data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. We found that between 2017 and 2022, just over half of non-dually eligible MA enrollees who had dental coverage through their MA plan visited the dentist during the year. These enrollees paid for a considerable portion of their dental expenses OOP, but the percentage decreased over time, falling from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share of non-dually eligible MA enrollees reported difficulty accessing dental care due to cost. For most of the outcomes we assessed, trends for FFS beneficiaries without a form of dental coverage followed a directional trend similar to that of MA enrollees with dental coverage. However, FFS beneficiaries without a form of dental coverage paid for a significantly larger share of their dental care OOP. The similar trends in dental utilization for MA and FFS beneficiaries suggest that the recent decline in OOP costs for non-dually eligible MA enrollees cannot be attributed entirely to growth in MA supplemental benefits. Other underlying factors may also have played a role. Without further analysis, it is difficult to assess the extent to which the changes observed for MA enrollees are due to changes in MA supplemental benefits, to broader changes affecting the Medicare population as a whole, or to other changes such as the composition of the MA population. Survey data, however, offer limited insight into how MA enrollees use and pay for dental care, underscoring the need for better encounter data pertaining to the services.

We analyzed encounter data for 2021 to assess whether plans are submitting records for other supplemental benefits and whether the submission rates are suggestive of problems with the reliability of the data. Our analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, we focused on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

We identified significant limitations to using the encounter data to assess supplemental benefits. First, as noted above, few encounter records have been collected for dental services, which is one of the largest categories of supplemental benefits. Second, MA plans have reported that the supplemental-benefit encounter records that they do submit are incomplete because of confusion about reporting requirements and how to populate the records for services that do not have well-established procedure codes. Third, the encounter data system does not contain a way to distinguish which records are for basic or supplemental services or for optional or mandatory supplemental benefits.

Nevertheless, for some services—particularly vision and hearing services—plans experience fewer technical limitations to submitting the data. We found that for these services, MA plans are submitting records and that the submission rates follow patterns in line with what can reasonably be expected based on survey data about MA enrollees' use of vision and hearing services. This is an encouraging sign that indicates that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits. For other types of supplemental benefits, however, we found few encounter records, and the submission rates were well below the utilization rates suggested by survey data. Considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing services—the encounter data are insufficient for characterizing enrollees' use of the benefits.

In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding utilization of and spending for supplemental benefits. The new data-reporting requirements will address some, but not all, of the data limitations that hinder our ability to assess how MA enrollees use supplemental benefits and how much plans spend on the

benefits, and it will be several more years before the full range of data are available for analysis.

In addition to assessing the data pertaining to MA enrollees' use of supplemental benefits, we provide information about how MA plans administer supplemental benefits. Because many supplemental benefits are nonmedical, MA organizations (MAOs) often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. Medicare does not collect information about the entities with which MAOs contract. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits. Several themes emerged from our review. First, we found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, although some insurers manage the benefits themselves or have acquired organizations that manage the benefits on their behalf. Second, we found that MAOs often contract with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. Third, we found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated and that several of the large MAOs have acquired or developed subsidiary businesses that specialize in providing services that can be offered as supplemental benefits. We also found several instances in which MAOs structure their supplemental benefits to be provided exclusively by providers owned by the plan's parent organization.

Altogether, our review of numerous data sources pertaining to MA supplemental benefits reveals a fundamental lack of transparency about how often enrollees use the benefits and plans' spending for the benefits. The data that Medicare collects are currently insufficient for examining the use of most of these benefits. The lack of reliable data makes it difficult to answer many important questions about how the rebates Medicare pays to MA plans are used. For example, we do not know how much plans spend on each type of benefit, which enrollees use each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use. But, because of different challenges in the program, including the complexity of the choice environment and the absence of reliable data,

it is unclear to what extent supplemental benefits address enrollees' needs or affect outcomes. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently. ■

The Medicare Advantage (MA) program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional fee-for-service (FFS) Medicare program. MA plans are required, with few exceptions, to cover all Part A and Part B services to which Medicare beneficiaries are entitled.¹ MA plans may also provide their enrollees with “supplemental” benefits such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). For beneficiaries, a primary trade-off in choosing between MA and FFS is access to the supplemental benefits that plans provide versus a broader choice of providers and minimal utilization management in FFS.

The Commission has noted that supplemental benefits are intended to provide more generous coverage and better financial protection for MA enrollees. Supplemental benefits may provide MA enrollees with access to important services not covered by Medicare or address health-related challenges beneficiaries face, but little is known about enrollees’ use of the benefits. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use, but evidence regarding the extent to which supplemental benefits address enrollees’ needs or affect outcomes is lacking and the reliability of the data Medicare collects about the benefits has not been well explored. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently.

CMS requires MA organizations (MAOs) to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees’ use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient,

home health, and skilled nursing facility services) are incomplete. The Commission has not previously assessed encounter data for MA supplemental benefits.

In this chapter, we explore trends in the rebates paid to MA plans to finance the provision of supplemental benefits, measure the premium and cost-sharing reductions provided as supplemental benefits, chart changes in the types of benefits plans offer enrollees, and analyze MA encounter data to better understand the data and their potential utility for measuring enrollees’ use of supplemental benefits. Because encounter data for dental services are unavailable, we also use data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. For assessing vision and hearing benefits, we use encounter data because there are well-defined procedure codes that should make it possible for plans to submit encounter records related to the services. For other non-Medicare services that are commonly offered as supplemental benefits, we analyze the encounter data and outline the data limitations that hinder our ability to reliably assess enrollees’ use of the services. Last, we provide information about how MA plans are administering supplemental benefits and the entities with which plans are partnering to provide the services.

Background

MA supplemental benefits can be organized into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including reduced Part D premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). Plans have flexibility regarding which supplemental benefits they offer and the generosity of the coverage. The Congress and CMS have gradually expanded the types of supplemental benefits that MA plans can offer and how the benefits can be offered.

Supplemental benefits in MA are financed primarily by rebates

MA plans primarily finance the provision of supplemental benefits using “rebates” that are added to the capitated payments they receive to cover basic

Medicare benefits. The rebate amount a plan receives is determined by Medicare's payment formula for MA plans and depends on how the plan's bid compares with a county-specific payment benchmark, as well as on a plan's star rating.

Organizations seeking to offer MA plans submit bids representing the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average spending risk.² Plans' bids are compared with a benchmark amount that is based on the projected costs of providing Part A and Part B services to FFS beneficiaries in the county; the benchmark is the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits.³ If a plan's bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings). The added payment to the plan, based on the difference between the bid and the benchmark, is referred to as the "rebate." Plans are required to use the rebate to provide supplemental benefits. For 2025, almost 100 percent of plans bid below their benchmarks and received rebates to offer supplemental benefits.⁴

Plans have the option of offering more supplemental benefits than what can be covered by the rebate they receive from Medicare. In such cases, plans typically charge enrollees additional premiums to cover the costs of providing the benefits. This arrangement rarely takes place: In an analysis of plans' bid data for 2022, the Government Accountability Office (GAO) found that 83 percent of MA plans, enrolling 86 percent of MA enrollees, expected to finance supplemental benefits solely with rebates; for special-needs plans (SNPs), the share was even higher, at 96 percent (Government Accountability Office 2023).⁵ In other words, the supplemental benefits offered by MA plans are primarily financed by the rebates the plans receive from Medicare.

Medicare has gradually expanded the types of supplemental benefits that MA plans can offer

MA plans' supplemental benefits are intended to provide more generous coverage and better financial protection for MA enrollees (Medicare Payment Advisory Commission 2024b). The supplemental

benefits that MA plans may offer fall into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including lower premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). Plans have flexibility regarding which supplemental benefits they offer and the generosity of the additional coverage. Each category is subject to some limitations, but—over time—CMS and the Congress have gradually increased plan flexibility and expanded the types of supplemental benefits that MA plans can offer and how the benefits can be offered.

Cost-sharing reductions

MA plans have the flexibility to develop their own cost-sharing rules instead of using those applied under FFS Medicare. However, plans are subject to limitations intended to guard against the use of benefit designs that might discriminate against beneficiaries who are sicker by charging high cost sharing for the services those enrollees are likely to use. Plans must abide by these rules but may charge cost sharing below the minimum required levels. Some of the limitations apply to overall cost sharing, while others apply to cost sharing for particular services.⁶

The level of overall cost sharing that plans can impose is constrained in two ways. First, plans must ensure that their cost sharing for all Part A and Part B services is, in aggregate, at least actuarially equivalent to FFS cost sharing. To maintain actuarial equivalence, any increase in cost sharing for some services must be offset by lower cost sharing for other services. Second, MA plans must provide an annual cap on enrollees' out-of-pocket (OOP) spending for in-network services, known as a maximum out-of-pocket (MOOP) limit.⁷

In addition to the limits on aggregate cost sharing, plans must also comply with a complex set of limits on the cost sharing they can charge for certain service categories (Medicare Payment Advisory Commission 2023). Conceptually, there are three major types of service-specific limits:

- Services for which plans cannot charge more in cost sharing than FFS Medicare does. This limit applies to such major categories as inpatient care, skilled nursing facility (SNF) care, dialysis, and Part B drugs.

- Services for which plans can charge more than FFS does but are subject to some specified limit. This limit applies to categories such as physician services.
- Services for which plans cannot charge more than 50 percent in coinsurance or an actuarially equivalent copayment. This general limit applies to any categories, such as outpatient hospital services, for which CMS does not have any specific limits on cost sharing.

Some of these limits—such as the prohibition on charging higher cost sharing than FFS for dialysis, SNF care, or Part B drugs—are specified in law. CMS also has the authority to put cost-sharing limits on other services to prevent plans from using benefit designs that the agency considers discriminatory. For example, CMS added cost-sharing limits for rehabilitation services, starting with the 2020 plan year, and has indicated that it may add a limit for ambulance services in the future (Centers for Medicare & Medicaid Services 2022b). MA enrollees may also pay cost sharing for non-Medicare services that their plan offers as supplemental benefits; CMS does not set limits on the cost sharing that can be charged for these services, and the cost sharing enrollees pay for them does not count toward the MOOP limit.⁸

Altogether, plans can charge less in overall cost sharing than would be charged under FFS as long as their benefit design complies with the limitations described above. For plans providing more generous coverage than would be provided under FFS, the difference between the two amounts is treated as a supplemental benefit.

Enhanced Part D benefits and Part B premium reductions

All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS Medicare or MA, are required to pay the Medicare Part B premium.⁹ However, MA plans may pay a portion of their members' Part B premium as a supplemental MA benefit. Beneficiaries may face an additional premium to enroll in Part D; MA prescription drug plans (MA-PDs), which provide integrated Part C and Part D coverage under the same plan, can also reduce or eliminate the Part D premium as a supplemental MA benefit. Further, MA-PDs may provide additional Part D benefit

enhancements as a supplemental benefit, such as reduced cost sharing or coverage of additional drugs.

For plans reducing their enrollees' Part B premium, CMS limits the amount by which the premium can be reduced; the maximum reduction is generally equal to the Part B premium for the year preceding the contract year (although this rule is typically not binding since very few plans offer full Part B–premium reductions).¹⁰ For plans reducing or eliminating the Part D premium for their enrollees, the maximum reduction is based on the Part D premium for that plan, and the plan cannot reduce the total Part D premium below zero.

Coverage of non-Medicare services

MA plans may offer coverage of non-Medicare services (those not covered under FFS Medicare) as a supplemental benefit. Plans' ability to offer these benefits has always been subject to limitations that specify the types of benefits that can be offered and the types of enrollees who can receive them. For many years, two key requirements were that the benefits had to be (1) "primarily health related," meaning that their main purpose was "to prevent, cure, or diminish an illness or injury," and (2) "offered uniformly to all enrollees" (Centers for Medicare & Medicaid Services 2016). These requirements had prevented plans from providing benefits that were not directly health related but that could address other enrollee needs (such as in-home supports for people with functional limitations) and from targeting benefits to specific types of enrollees (such as those with a particular health condition).

Policymakers have taken several steps in recent years to loosen those requirements:

- In 2018, CMS broadened its definition of "primarily health related" to include services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Under this new definition, plans can provide services such as in-home support services and home modifications. This change took effect in 2019.
- At the same time, CMS modified the uniformity requirement to let plans target supplemental benefits to enrollees with a particular "health

not capture quality results for beneficiaries residing in rural areas who are assigned to ACOs because of the sampling approach to measurement.

Medicare's quality measurement for Medicare Advantage and Part D plans

As of 2024, more than half of eligible Medicare beneficiaries nationwide were enrolled in MA plans (Medicare Payment Advisory Commission 2025). MA enrollment patterns differ in urban and rural areas. In 2024, the majority (56 percent) of eligible urban beneficiaries were enrolled in MA compared with 47 percent of eligible beneficiaries residing in rural counties.¹⁶ However, the growth of MA enrollment in rural areas has been faster in recent years. In 2024, MA enrollment in rural areas grew by 8 percent, compared with 6 percent growth in urban areas. The predominant plan type often differs between urban and rural areas as well. In 2024, 39 percent of rural MA enrollees were in HMO plans compared with about 59 percent of urban enrollees. By contrast, 58 percent of rural enrollees were in local preferred provider organizations compared with 40 percent of urban enrollees.

In 2006, CMS introduced the MA star-rating system to give beneficiaries information about the clinical quality, administrative capability, and patient experience that an enrollee can expect from a given MA plan. Medicare currently collects over 100 MA quality measures, 42 of which are used to determine a star rating from 1 to 5 for each MA contract (Centers for Medicare & Medicaid Services 2023c). These ratings are available on the medicare.gov Plan Finder website so that beneficiaries can compare plans. Twelve of these 42 measures are also used to calculate Part D star ratings that are displayed on the Plan Finder website for each Part D organization.

However, the Commission has determined that the current system for MA quality measurement and reporting is flawed and does not provide a reliable basis for evaluating quality across MA plans (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019). Nonetheless, these measures are the basis for the MA quality-bonus program, which increases MA payments (and program spending) by about \$15 billion annually.

A primary flaw of current MA quality reporting is that quality results for MA are reported on a contract-wide

basis, and those results are used to determine the star ratings for all plans offered under the contract.¹⁷ MA contracts often cover wide geographic areas that include multiple diverse health care markets. In January 2024, over half of MA enrollees were in contracts that spanned two or more states. A third of MA enrollees were in multistate MA contracts that spanned noncontiguous states. The largest MA contract, with 2.6 million enrollees, had over 1,000 MA enrollees in each of 46 states and over 20,000 enrollees in each of 30 states. Another multistate contract had about 200,000 enrollees in Florida; 100,000 enrollees in Indiana; 70,000 enrollees in Arizona; and 40,000 enrollees in Oregon. The star ratings for such contracts reflect performance averaged across different service areas and thus are unlikely to accurately reflect plan quality in any one of those areas.

Plan sponsors rely exclusively on administrative data (such as encounter data) as the source for many measures, but there are some “hybrid” measures for which MA organizations can or must use both administrative data and data collected from a sample of enrollee medical records (e.g., data on breast cancer screening or diabetic A1c control). To report data for hybrid measures, MA organizations collect data for a random sample of 411 enrollees, chosen at the contract level.¹⁸ Like many of the ACO measures previously described, MA plans work with providers (including those that furnish care in rural areas) to gather the information on this sample of enrollees to report the measure. However, because of the sampling approach at the contract level, MA quality measures may or may not capture quality results for beneficiaries residing in rural areas who are enrolled in MA plans.

Initiatives to improve measurement of rural providers' quality of care

While acknowledging the limitations in measuring quality of care for many small providers, including those in rural areas, we have identified several federal and multistakeholder initiatives to improve quality measurement, including identifying and developing metrics most relevant for rural providers and furnishing technical assistance to rural providers. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Exhibit J

2026 Summary Star View: Medicare Report Card Master Table

Contract Number	Organization Type	Contract Name	Organization Marketing Name	Parent Organization	2026 Overall
H0976	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	4
H5425	Local CCP	SCAN HEALTH PLAN	SCAN Health Plan	SCAN Group	4

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SCAN HEALTH PLAN,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN
SERVICES, et al.,

Defendants.

Civil Action No. 1:26-cv-02391-CRC

[PROPOSED] ORDER

UPON CONSIDERATION of Plaintiff's Motion for Expedited Summary Judgment, Defendants' Cross-Motion for Expedited Summary Judgment, and the parties' submissions on these motions, it is **HEREBY ORDERED** that:

1. Plaintiff's Motion for Expedited Summary Judgment is **GRANTED**;
2. Defendants' Cross-Motion For Expedited Summary Judgment is **DENIED**;
3. CMS's calculation of SCAN Health Plan's 4-star 2026 Star Ratings for contract numbers H5425 and H0976 is **SET ASIDE** and **VACTED**;
4. Defendants are **ORDERED** to recalculate SCAN Health Plan's 2026 Star Ratings for contract numbers H5425 and H0976 as at least 4.5 stars consistent with the Court's Memorandum Opinion On Plaintiff's Motion For Expedited Summary Judgment; and
5. Defendants are **ORDERED** to take the predicate operational steps necessary to afford rebate relief, including facilitating the re-submission of any bid documents CMS deems operationally necessary to do so.

This matter is **REMANDED** to CMS for further proceedings consistent with the Court's opinion.

IT IS SO ORDERED.

SO ORDERED this ____ day of _____, 2026.

HONORABLE CHRISTOPHER R. COOPER
United States District Judge