Medicare 2027 Part C & D Star Ratings Technical Notes

Updated – 11/04/2026

Document Change Log

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9/30/26	Minor clarifications to Complaints about the Health/Drug Plan measure details and Attachment L	11/04/26

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
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Health Outcomes Survey (HOS)	0938-0701
Healthcare Effectiveness Data and Information Set (HEDIS)	0938-1028
Part C Reporting Requirements	0938-1054
Part D Reporting Requirements	0938-0992
Data Validation of Part C/D Reporting Requirements data	0938-1115

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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 '2027 Medicare Part C & D Star Ratings' because they are posted prior to the 2027 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 "2027" 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 ensuring the highest quality of care for all, including measures related to person-centered care, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, behavioral health, and closing gaps of care. With Meaningful Measures 2.0, CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote individual and caregiver voice. 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 2026 Star Ratings and 2027 Star Ratings

There have been several changes between the 2026 Star Ratings and the 2027 Star Ratings. This section provides a synopsis of the notable differences; the reader should examine the entire document for full details about the 2027 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 Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures increased from 1 to 3.

b. Respecified Care for Older Adults-Functional Status Assessment measure was moved into the 2027 Star Ratings as a new measure with a weight of 1.
c. Respecified Colorectal Cancer Screening measure was moved into the 2027 Star Ratings as a new measure with a weight of 1, replacing the legacy Colorectal Cancer Screening measure.
d. Concurrent Use of Opioids and Benzodiazepines (COB) measure was moved into the 2027 Star Ratings as a new measure with a weight of 1.
e. Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) measure was moved into the 2027 Star Ratings as a new measure with a weight of 1.
f. The calculation of the percentage of LIS/DE enrollees and percentage of disabled enrollees used to determine the CAI adjustment in the case of contract consolidations is based on the combined contract enrollment from all contracts in the consolidation.
g. Contracts with 30 or more enrolled members in the denominator will be included in the Star Ratings for the Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins), Statins Use in Persons with Diabetes (SUPD) COB, and Poly-ACH Part D measures.
h. Data collected through the Part C Reporting Requirements will be used to confirm the completeness of the Independent Review Entity (IRE) data used in the calculation of the Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions measures to implement scaled reductions.

- Transitioned measures (Moved to the display page on the CMS website: http://go.cms.gov/partcanddstarratings)
  a. Part D measure: MTM Program Completion Rate for CMR was transitioned to the display page for measurement years 2025 and 2026 and will return to the Star Ratings as a new measure beginning with the 2029 Star Ratings (measurement year 2027).
- Retired measures
  a. Part C measure: Care for Older Adults – Pain Assessment
  b. Part C measure: Medication Reconciliation Post-Discharge

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 2027 organization types and whether they are included in the Part C and/or Part D Star Ratings.

Table 1: Contract Year 2027 Organization Types Reported in the 2027 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)
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:

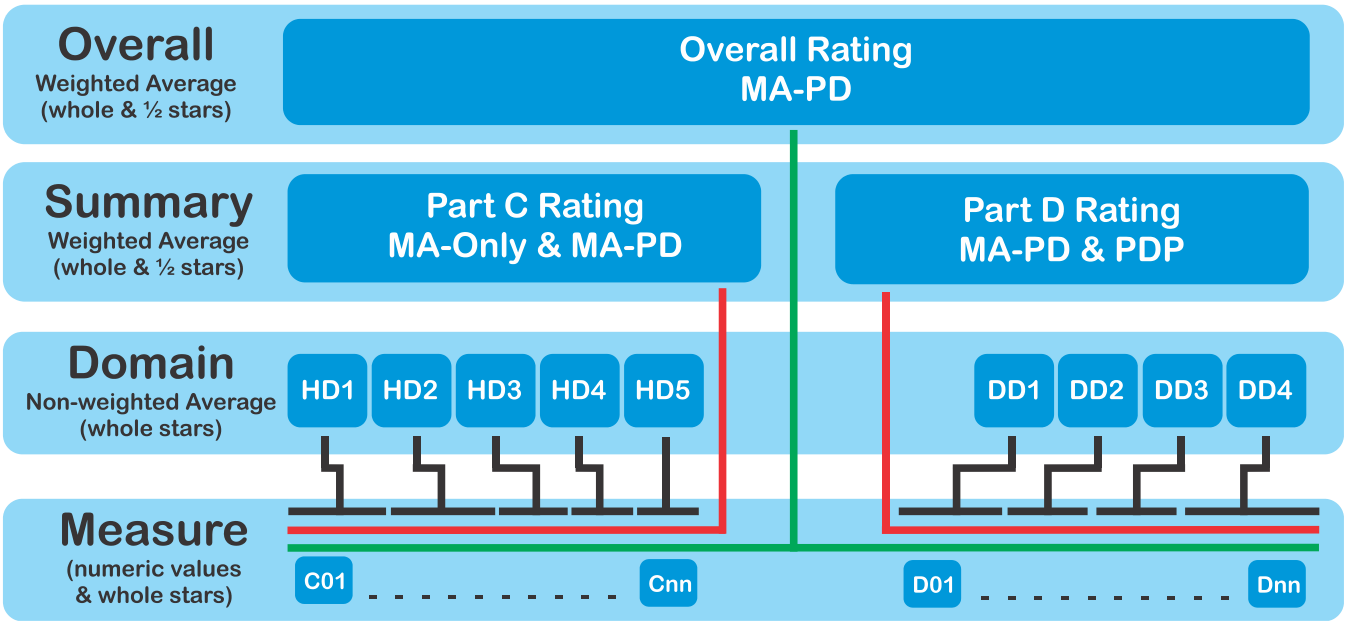
Domain: Domains group together measures of similar services. Star Ratings for domains are calculated using the non-weighted average Star Ratings of the included measures.

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 2027 Organization Types to Contract Types and Highest Rating in the 2027 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 2027 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 32 measures.
- PDPs are measured on 4 domains with a maximum of 13 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. The number of measures required may be less than the counts shown in Table 4 if any of the contract's improvement measures are removed from consideration through application of the disaster policy.

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

Part	1876 Cost	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	11 of 21	13 of 25	14 of 27	8 of 15	12 of 24	N/A	13 of 25
D	5 of 9*	5 of 10	5 of 10	4 of 8	N/A	5 of 10	5 of 10*

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

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

Contract Enrollment Data

The enrollment data used in the Part C and Part D "Complaints about the Health/Drug Plan" measures are pulled from 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 2025 through December 2025) 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. 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 2025 through December 2025), and the average enrollment in the plan across those months is used in calculating the combined rate.

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

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

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

the data submission deadline, the contract automatically receives a rating of 1 star for the CAHPS or HOS measures and the measure scores are set to "CMS identified issues with this plan's data."

Scaled Reductions for the Appeals Measures

There are two Part C Star Ratings appeals measures that rely on data submitted to the IRE: Plan Makes Timely Decisions about Appeals (C30) and Reviewing Appeals Decisions (C31). The completeness of the IRE data is critical to allow accurate measurement of each of the appeals measures. All contracts are responsible and held accountable for ensuring high quality and complete data to maintain the validity and reliability of the measures. For the 2027 Star Ratings, we will use data collected through the Part C Reporting Requirements to confirm the completeness of the IRE data used in the calculation of the Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions measures. We then use this data to implement scaled reductions if data integrity issues are identified. Data from the Part C Reporting Requirements is used to determine the total number of cases that should have been sent to the IRE over the measurement year (that is, number of partially favorable reconsiderations + number of unfavorable reconsiderations) to compare to information from the IRE about submissions received from each MA organization.

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

CMS's scaled reduction methodology is a three-stage process using the Part C Reporting Requirements data: first, whether a contract may be subject to a potential reduction for the Part C appeals measures; second, as the basis for the determination of the estimated error rate; and finally, whether the error rate value warrants scaled reductions of 1, 2, 3, or 4 stars. Details of the methodology are available in Attachment N.

Once the scaled reduction for a contract is identified using the methodology, the reduction is applied to a contract's appeals measure-level Star Ratings. Since the minimum measure-level Star Rating is one star, if the difference between the associated appeals measure-level Star Rating (before the application of the reduction) and the identified scaled reduction is less than one, the contract will receive a measure-level Star Rating of one star for the appeals measure. Contracts are subject to a possible reduction due to lack of IRE data completeness if both of the following conditions are met: (1) the calculated error rate is 20 percent or more and (2) the number of cases not forwarded to the IRE is at least 10 for the measurement year even if the contract did not submit enough cases to the IRE to calculate the appeals measures scores and stars.

Data collected as part of the Part C Reporting Requirements go through a data validation process. If a contract fails data validation of the applicable Part C Reporting Requirements sections for reconsiderations by not scoring at least 95 percent or is not compliant with data validation standards (which includes sub-standards as applicable), the two Part C appeals measure Star Ratings are reduced to 1 star since we cannot confirm the data used for the Part C appeals measures are complete.

If a scaled reduction is applied to the Part C appeals measures in either the current or the previous year, the appeals measures will not be included in the Health Plan Quality Improvement measure.

Data Handling of Measures for Contracts Affected by a Major Disaster

CMS has a policy for making adjustments in the Star Ratings to take into account major disasters. That policy was described in the 2027 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 2027 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 2026 CAHPS survey unless the contract requested and CMS approved an exemption.
    - All affected contracts with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster receive the higher of the 2026 or the 2027 Star Rating (and corresponding measure score) for each CAHPS measure (including the annual flu vaccine measure).
    - In some cases, contracts with at least 25% of enrollees residing in FEMA-designated individual Assistance areas that were affected by disasters that began in 2025 were also affected by disasters in 2024. These doubly-affected contracts receive the higher of the 2027 Star Rating or what the 2026 Star Ratings would have been in the absence of any adjustments that took into account the effects of the 2024 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 2025 Star Rating on a given measure in the 2026 Star Ratings, the 2025 Star Rating is *not* used in determining the 2027 Star Rating. Rather the 2027 Star Rating is compared to what the 2026 Star Rating would have been absent any disaster adjustments.
    - 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 again be implemented for the 2027 Star Ratings. That is, we will compare the CAHPS measure-level stars to the prior year and give these contracts impacted by the Los Angeles County wildfires the higher CAHPS measure star and associated score. The 2027 CAHPS measure-level Star Ratings would be the better of the 2027 and 2026 CAHPS measure-level Star Ratings.
- HOS adjustments:
    - The HOS data used in the 2027 Star Ratings are adjusted for 2024 disasters (see Attachment P of the 2026 Star Ratings Technical Notes for the identification of contracts affected by 2024 disasters).

- All affected contracts (i.e., contracts affected by 2024 disasters) with at least 25% of beneficiaries in Individual Assistance areas at the time of the disaster received the higher of the 2026 or the 2027 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 2024 were also affected by disasters in 2023. These doubly-affected contracts receive the higher of the 2027 Star Rating or what the 2026 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2023 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 2025 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 2026 or 2027 Star Rating (and corresponding measure scores) for each HEDIS measure.
  - n some cases, contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas affected by disasters that began in 2025 were also affected by disasters in 2024. These doubly-affected contracts receive the higher of the 2027 Star Rating or what the 2026 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2024 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 2027 Star Ratings, there are three new measures that were not in the Star Ratings last year: Care for Older Adults – Functional Status Assessment (Part C), Concurrent Use of Opioids and Benzodiazepines (COB) (Part D), and Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D).
  - 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.
- All other measures:
  - Contracts with 25% or more affected members receive the higher of the 2026 or 2027 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 2025 were also affected by disasters in 2024. These doubly-affected contracts receive the higher of the 2027 Star Rating or what the 2026 Star

Rating would have been in the absence of any adjustments that took into account the effects of the 2024 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 2026 or 2027 Star Ratings, that measure is excluded from both the count of measures (used to determine whether the contract has at least half of the measures needed to calculate the relevant improvement measure) and the improvement measures' calculation. Affected contracts do not have the option of reverting to the prior year's improvement rating.
- Affected contracts with missing data:
    - If an affected contract has missing data in either the current or previous year (e.g., because of a data integrity issue, it is too new, or it is too small), the final measure rating comes from the current year. Missing data includes data where there is a data integrity issue.

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

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

A. Clustering

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

Technically, the variance in measure scores is separated into within-cluster and between-cluster sum of squares components. The clusters reflect the groupings of numeric value scores that minimize the variance of scores within the clusters. The Star Ratings levels are assigned to the clusters that minimize the within-cluster sum of squares. The cut points for star assignments are derived from the range of measure scores per cluster, and the star levels associated with each cluster are determined by ordering the means of the clusters.

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

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

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

B. Relative Distribution and Significance Testing (CAHPS)

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

Methodology for Calculating Stars at the Domain Level

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

- If the total number of measures that comprise the domain for a contract type is odd, divide the number of measures in the domain by two and round the quotient to the next whole number.
    - Example: If the total number of measures required in a domain for a contract type is 3, the value 3 is divided by 2. The quotient, in this case 1.5, is then rounded to the next whole number. To receive a domain rating, the contract must have a Star Rating for at least 2 of the 3 required measures.
- If the total number of measures that comprise the domain for a contract type is even, divide the number of measures in the domain by two and add one to the quotient.
    - Example: If the total number of measures required in a domain for a contract type is 6, the value 6 is divided by 2. In this example, 1 is then added to the quotient of 3. To receive a domain rating, the contract must have a Star Rating for at least 4 of the 6 required measures.

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

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

Part	Domain Name (Identifier)	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
C	Staying Healthy: Screenings, Tests and Vaccines (HD1)	4 of 6	4 of 6	4 of 6	2 of 2	4 of 6	N/A	4 of 6
C	Managing Chronic (Long Term) Conditions (HD2)	5 of 8	6 of 11	8 of 14	6 of 10	6 of 11	N/A	6 of 11
C	Member Experience with Health Plan (HD3)	4 of 6	4 of 6	4 of 6	N/A	4 of 6	N/A	4 of 6
C	Member Complaints and Changes in the Health Plan's Performance (HD4)	2 of 3	2 of 3	2 of 3	2 of 3	2 of 3	N/A	2 of 3
C	Health Plan Customer Service (HD5)	2 of 2	2 of 3	2 of 3	2 of 3	2 of 2	N/A	2 of 3
D	Drug Plan Customer Service (DD1)	N/A*	1 of 1	1 of 1	1 of 1	N/A	1 of 1	1 of 1*
D	Member Complaints and Changes in the Drug Plan's Performance (DD2)	2 of 3*	2 of 3	2 of 3	2 of 3	N/A	2 of 3	2 of 3*
D	Member Experience with the Drug Plan (DD3)	2 of 2*	2 of 2	2 of 2	N/A	N/A	2 of 2	2 of 2*
D	Drug Safety and Accuracy of Drug Pricing (DD4)	4 of 7*	4 of 7	4 of 7	4 of 7	N/A	4 of 7	4 of 7*

* 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 4 out of 6 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 2027 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 / 2 = 6.5, when rounded the result is 7. The contract needs at least 7 measures with ratings out of the 13 total measures to receive a Part D summary rating.
- If the total number of measures required for the organization type is even, divide the number of measures by two.
    - Example: if there are 30 required Part C measures for the organization, 30 / 2 = 15. The contract needs at least 15 measures with ratings out of the 30 total measures to receive a Part C summary rating.

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

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

Rating	1876 Cost †	CCP w/o SNP	CCP with SNP	CCP with Only I-SNP	MSA	PDP	PFFS
Part C summary	12 of 24	14 of 28	16 of 31	9 of 17	14 of 27	N/A	14 of 28
Part D summary	6 of 11*	6 of 12	6 of 12	5 of 10	N/A	6 of 12	6 of 12*

* Note: Does not apply to MA-Only, 1876 Cost, and PFFS contracts which do not offer drug benefits.
† Note: 1876 Cost contracts which do not submit data for the MPF measure must have ratings in 5 out of 10 measures to receive a Part D rating.

Methodology for Calculating the Overall MA-PD Rating

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

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

There are a total of 45 measures (32 in Part C, 13 in Part D) in the 2027 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 2027 Star Ratings are calculated for the 2027 contract year using data primarily from measurement year 2025. If a contract offered a SNP PBP in measurement year 2025, but is no longer offering a SNP PBP for the 2027 contract year, the 2027 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 (C29) 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 (C29 & D04) for MA-PD contracts.
   a. C29 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 (C29) is used for MA-Only contracts.
2. Calculate the Part C summary rating for MA-Only contracts without including the improvement measure.
3. Calculate the Part C summary rating for MA-Only contracts with the Part C improvement measure.
4. If an MA-Only contract in step 2 has 4 or more stars, compare the two Part C summary ratings. If the rating in step 3 is less than the value in step 2, use the Part C summary rating from step 2; otherwise use the result from step 3.
5. For all other MA-Only contracts, use the Part C summary rating from step 3.

PDP Contracts

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

Applying the Reward Factor

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

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

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

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

Tables 8 and 9 show the final threshold values used in reward factor calculations for the 2027 Star Ratings.

Table 8: Performance Summary Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	65th	3.611111	3.642857	3.347826	3.545455
With	With	85th	3.914286	4.000000	3.695652	3.871795
With	Without	65th	3.600000	3.653846	3.333333	3.550000
With	Without	85th	3.885714	4.038462	3.761905	3.866667
Without	With	65th	3.632653	3.695652	3.555556	3.602941
Without	With	85th	3.938776	4.047619	3.833333	3.895522
Without	Without	65th	3.604167	3.714286	3.523810	3.600000
Without	Without	85th	3.914894	4.095238	3.904762	3.896552

Table 9: Variance Thresholds

Improvement	New Measures	Percentile	Part C Rating	Part D Rating (MA-PD)	Part D Rating (PDP)	Overall Rating
With	With	30th	1.025769	0.885960	1.134216	1.036449
With	With	70th	1.386039	1.419111	1.671918	1.378508
With	Without	30th	1.034453	0.867308	1.093491	1.033077
With	Without	70th	1.405464	1.417824	1.731771	1.385220
Without	With	30th	1.057235	0.838095	0.781250	0.999552
Without	With	70th	1.432037	1.363314	1.500000	1.385046
Without	Without	30th	1.065394	0.791131	0.730663	1.011200
Without	Without	70th	1.457601	1.358726	1.602419	1.387008

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 2026 Star Ratings. To calculate the CAI, case-mix adjustment is applied to clinical Star Rating measure scores that are not adjusted for SES (see below) 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 2026 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 2026 measures used in the 2027 CAI adjustment calculations are:

- Breast 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)
- Kidney Health Evaluation for Patients with Diabetes (Part C)
- Controlling Blood Pressure (Part C)
- Reducing the Risk of Falling (Part C)
- Improving Bladder Control (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)
- 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, MA-PD and PDP contracts, the initial groups are formed by the ten groups of LIS/DE and quintiles of disability, thus resulting in 50 initial categories. 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 the use of both 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 L3. The upper limit for each initial category is only included for the highest categories (L10 and D5), and the upper limit is equal to 100% for both of these categories.

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

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.686763
2	6.686763 to less than 10.349302
3	10.349302 to less than 15.483871
4	15.483871 to less than 20.687800
5	20.687800 to less than 29.727000
6	29.727000 to less than 41.517338
7	41.517338 to less than 58.928513
8	58.928513 to less than 89.943576
9	89.943576 to less than 100.000000
10	100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 13.857965
2	13.857965 to less than 20.256591
3	20.256591 to less than 29.063062
4	29.063062 to less than 42.883295
5	42.883295 to 100.000000

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

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

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L2	D1	-0.069659
2	L3-L4	D1	-0.036054
2	L1-L4	D2	-0.036054
3	L5-L7	D1	-0.010250
3	L5-L6	D2	-0.010250
3	L1-L5	D3	-0.010250
4	L8	D1	0.008676
4	L7-L8	D2	0.008676
4	L6-L7	D3	0.008676
5	L9-L10	D1-D2	0.042618
5	L8-L10	D3	0.042618
5	L1-L8	D4	0.042618
5	L1-L5	D5	0.042618
6	L6-L8	D5	0.075637
7	L9-L10	D4-D5	0.108248

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

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

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 6.498100
2	6.498100 to less than 10.019757
3	10.019757 to less than 15.248089
4	15.248089 to less than 20.302758
5	20.302758 to less than 28.821954
6	28.821954 to less than 41.025711
7	41.025711 to less than 58.612452
8	58.612452 to less than 89.648716
9	89.648716 to less than 100.000000
10	100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 13.624186
2	13.624186 to less than 19.983334
3	19.983334 to less than 28.599096
4	28.599096 to less than 42.694737
5	42.694737 to 100.000000

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

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

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1	D1	-0.057651
2	L2-L4	D1	-0.026685
2	L1-L4	D2	-0.026685
3	L5-L7	D1	-0.005963
3	L5-L6	D2	-0.005963
3	L1-L5	D3	-0.005963
3	L1-L2	D4	-0.005963
4	L8	D1	0.009542
4	L7-L8	D2	0.009542
4	L6-L7	D3	0.009542
4	L3-L5	D4	0.009542
4	L1-L5	D5	0.009542
5	L9-L10	D1	0.042302
5	L9	D2	0.042302
5	L8-L9	D3	0.042302
5	L6-L8	D4	0.042302
6	L6-L8	D5	0.070808
7	L10	D2-D3	0.111696
7	L9-L10	D4-D5	0.111696

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

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

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 7.018222
2	7.018222 to less than 10.907851
3	10.907851 to less than 16.438153
4	16.438153 to less than 22.528283
5	22.528283 to less than 32.518966
6	32.518966 to less than 46.524715
7	46.524715 to less than 69.440990
8	69.440990 to less than 98.437500
9	98.437500 to less than 100.000000
10	100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 14.439638
2	14.439638 to less than 21.596244
3	21.596244 to less than 30.752688
4	30.752688 to less than 44.603685
5	44.603685 to 100.000000

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

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

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L2	D1	-0.067625
1	L1	D2	-0.067625
2	L3-L9	D1	-0.023879
2	L2-L9	D2	-0.023879
3	L10	D1-D2	0.013562
3	L1-L10	D3	0.013562
4	L1-L10	D4	0.039062
4	L1-L6	D5	0.039062
5	L7-L8	D5	0.058514
6	L9-L10	D5	0.094046

Tables 19 and 20 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 PDP Part D summary.

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

LIS/DE Initial Group	Percentage of Contract's Beneficiaries who are LIS/DE
1	0.000000 to less than 0.798481
2	0.798481 to less than 1.326768
3	1.326768 to less than 1.511550
4	1.511550 to less than 1.619624
5	1.619624 to less than 2.408965
6	2.408965 to less than 3.147184
7	3.147184 to less than 3.817008
8	3.817008 to less than 5.370531
9	5.370531 to less than 14.326489
10	14.326489 to 100.000000

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

Disability Quintile	Percentage of Contract's Beneficiaries who are Disabled
1	0.000000 to less than 5.632799
2	5.632799 to less than 7.412702
3	7.412702 to less than 9.940750
4	9.940750 to less than 12.215208
5	12.215208 to 100.000000

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

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

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L3	D1-D3	-0.271269
2	L4-L7	D1-D3	-0.124909
2	L1-L7	D4	-0.124909
2	L1-L6	D5	-0.124909
3	L8-L10	D1-D4	-0.106015
3	L7-L9	D5	-0.106015
4	L10	D5	0.021465

Calculation Precision

CMS and its contractors have always used software called SAS (an integrated system of software products provided by SAS Institute Inc.) to perform the calculations used in producing the Star Ratings. For all measures, except the improvement measures, the precision used in scoring the measure is indicated next to the label "Data Display" within the detailed description of each measure. The improvement measures are discussed below. The domain ratings are the unweighted average of the star measures and are rounded to the nearest integer.

The improvement measures, summary, and overall ratings are calculated with at least six digits of precision after the decimal whenever the data allow it. The HEDIS measure scores have two digits of precision after the decimal. All other measures have at least six digits of precision when used in the improvement calculation.

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

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

Rounding Rules for Measure Scores

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

Rounding Rules for Summary and Overall Ratings

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

Table 22: Rounding Rules for Summary and Overall Ratings

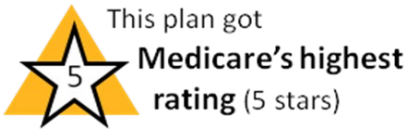
Raw Summary / Overall Score	Final Summary / Overall Rating
Greater than or equal to 0.000000 and less than 0.250000	0
Greater than or equal to 0.250000 and less than 0.750000	0.5
Greater than or equal to 0.750000 and less than 1.250000	1.0
Greater than or equal to 1.250000 and less than 1.750000	1.5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

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

Methodology for Calculating the High Performing Icon

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

Figure 3: The High Performing Icon



Methodology for Calculating the Low Performing Icon

A contract can receive a low performing icon as a result of its performance on the Part C and/or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past two years (i.e., the 2025, 2026, and 2027 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	2025 C	2026 C	2027 C	2025 D	2026 D	2027 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 2025 was at least 500 but less than 1,000 will be included in the Star Ratings in 2027 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 2027 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
- 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.

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

Part C Domain and Measure Details

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

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

Measure: C01 - Breast Cancer Screening

Title	Description
Label for Stars:	Breast Cancer Screening
Label for Data:	Breast Cancer Screening
Description:	Percent of plan members aged 50-74 who were recommended for a routine breast cancer screening and had a mammogram to screen for breast cancer.
HEDIS Label:	Breast Cancer Screening (BCS-E)
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 507
Metric:	The percentage of MA enrollees 52 to 74 years of age (denominator) as of December 31 of the measurement year who were recommended for routine breast cancer screening and who had a mammogram to screen for breast cancer in the past two years (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	• Members in hospice or using hospice services any time during the measurement period. • Members who died any time during the measurement period. • Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through December 31 of the measurement year. Any of the following meet the criteria for bilateral mastectomy: – Bilateral mastectomy. – Unilateral mastectomy with a bilateral modifier (same procedure). – Unilateral mastectomy found in clinical data with a bilateral qualifier value (same procedure). – History of bilateral mastectomy. • Any combination of the following that indicate a mastectomy on both the left and right side on the same or on different dates of service: –Unilateral mastectomy with a right-side modifier (same procedure). – Unilateral mastectomy with a left-side modifier (same procedure). –Unilateral mastectomy found in clinical data with a right-side qualifier value (same procedure). – Unilateral mastectomy found in clinical data with a left-side qualifier value procedure (same procedure). – Absence of the left breast. – Absence of the right breast. – Left unilateral mastectomy. – Right unilateral mastectomy.

Title	Description

• Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end 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 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 2025 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2025 – 12/31/2025

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Included

Case-Mix Adjusted: No

Weighting Category: Process Measure

Weighting Value: 1

Title	Description
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00093-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 63%	Greater than or equal to 63% to less than 70%	Greater than or equal to 70% to less than 77%	Greater than or equal to 77% to less than 83%	Greater than or equal to 83%

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 45-75 who had appropriate screening for colorectal cancer.
HEDIS Label:	Colorectal Cancer Screening (COL-E)
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 530
Metric:	The percentage of MA enrollees aged 45 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.

Title	Description
	• 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 2025 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 2025 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2025 – 12/31/2025
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 59%	Greater than or equal to 59% to less than 68%	Greater than or equal to 68% to less than 75%	Greater than or equal to 75% to less than 82%	Greater than or equal to 82%

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, 2025?

Data Source Category: Survey of Enrollees

Exclusions: • Scores for contracts with fewer than 11 responses are suppressed.

• Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".

General Notes: This measure is not case-mix adjusted.

CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned.

Data Time Frame: 03/2026 – 05/2026

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

Title	Description
Weighting Value:	1
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Wellness and Prevention
CMIT #:	00259-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 56%	Greater than or equal to 56% to less than 60%	Greater than or equal to 60% to less than 67%	Greater than or equal to 67% to less than 72%	Greater than or equal to 72%

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:	2023-2025 Cohort 26 Performance Measurement Results (2023 Baseline data collection, 2025 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:	07/14/2025 – 11/03/2025
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Not Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2024 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 67%	Greater than or equal to 67% to less than 71%	Greater than or equal to 71% to less than 73%	Greater than or equal to 73% 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:	2023-2025 Cohort 26 Performance Measurement Results (2023 Baseline data collection, 2025 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.

Title	Description

Data Time Frame: 07/14/2025 – 11/03/2025

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: 3

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2024 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 87%	Greater than or equal to 87%

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 2024 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).

Title	Description

Primary Data Source: HEDIS-HOS

Data Source Description: Cohort 26 Follow-up Data collection (2025) and Cohort 28 Baseline data collection (2025).

HOS Survey Question 37: 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 38: 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 37 are excluded from results calculations for Question 38. 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: 07/14/2025 – 11/03/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2024 disasters.

Meaningful Measure Area: Wellness and Prevention

CMIT #: 00450-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 46%	Greater than or equal to 46% to less than 50%	Greater than or equal to 50% to less than 55%	Greater than or equal to 55% to less than 61%	Greater than or equal to 61%

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) + Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)] / [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual reassessment HRA (Element B)]
Primary Data Source:	Part C Plan Reporting
Data Source Description:	The data for this measure were reported by contracts to CMS per the 2025 Part C Reporting Requirements (data pulled June 2026). Validation of these data was performed retrospectively during the 2026 data validation cycle (deadline June 15, 2026 and data validation results pulled July 2026).
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, 2026) 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-compliant if either it receives a "No" or a 1, 2, or 3 on the 5-point Likert scale in the specific data element's data validation. • Number of new enrollees due for an initial HRA (Element A) • Number of enrollees eligible for an annual reassessment HRA (Element B) • Number of initial HRAs performed on new enrollees (Element C)

Title	Description
	• Number of annual reassessments performed on enrollees eligible for reassessment (Element F) Contracts excluded from the SNP Care Management Assessment Rates due to data validation issues are shown as “CMS identified issues with this plan's data.” Contracts can view their data validation results in HPMS (https://hpms.cms.gov/). To access this page, from the top menu select “Monitoring,” then “Plan Reporting Data Validation.” Select the appropriate contract year. Select the PRDVM Reports. Select “Score Detail Report.” Select the applicable reporting section. If you cannot see the Plan Reporting Data Validation module, contact CMSHPMS_Access@cms.hhs.gov. Additionally, contracts must have 30 or more enrollees in the denominator [Number of new enrollees due for an Initial HRA (Element A) + Number of enrollees eligible for an annual HRA (Element B) ≥ 30] in order to have a calculated rate. Contracts with fewer than 30 eligible enrollees are listed as "No data available.”
General Notes:	More information about the data used to calculate this measure can be found in Attachment E. The Part C reporting requirement fields listed below are not used in calculating this measure: • Data Element D Number of initial HRA refusals • Data Element E Number of initial HRAs where SNP is unable to reach new enrollees • Data Element G Number of annual reassessment refusals • Data Element H Number of annual reassessments where SNP is unable to reach enrollee
Data Time Frame:	01/01/2025 – 12/31/2025
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Chronic Conditions

Title	Description

CMIT #: 00685-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 47%	Greater than or equal to 47% to less than 65%	Greater than or equal to 65% to less than 78%	Greater than or equal to 78% to less than 92%	Greater than or equal to 92%

Measure: C08 - Care for Older Adults – Medication Review

Title	Description

Label for Stars: Yearly Review of All Medications and Supplements Being Taken

Label for Data: Yearly Review of All Medications and Supplements Being Taken

Description: Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription medications, OTC medications, herbal or supplemental remedies) at least once a year.

(Medicare does not collect this information from all plans. Medicare collects it only for Special Needs Plans. These plans are a type of Medicare Advantage plan designed for certain people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

HEDIS Label: Care for Older Adults (COA) – Medication Review

Measure Reference: NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 76

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older as of December 31 of the measurement year (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: SNP benefit packages whose enrollment was less than 30 as of February 2025 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 2025 Technical Specifications Volume 2.

Title	Description

General Notes: The formula used to calculate this measure can be found in Attachment E.

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00110-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 63%	Greater than or equal to 63% to less than 90%	Greater than or equal to 90% to less than 96%	Greater than or equal to 96% to less than 99%	Greater than or equal to 99%

Measure: C09 - Care for Older Adults – Functional Status Assessment

Title	Description
Label for Stars:	Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living
Label for Data:	Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living
Description:	Percent of plan members who had at least one functional status assessment during the measurement 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 – Functional Status Assessment
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 76
Metric:	The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older as of December 31 of the measurement year (denominator) who received at least one functional status assessment during the measurement year, as documented through either administrative data or medical record review (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 2025 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 2025 Technical Specifications Volume 2.
General Notes:	The formula used to calculate this measure can be found in Attachment E.
Data Time Frame:	01/01/2025 – 12/31/2025
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No

Title	Description

Weighting Category: Process Measure

Weighting Value: 1

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 78%	Greater than or equal to 78% to less than 87%	Greater than or equal to 87% to less than 95%	Greater than or equal to 95%

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 2025 Technical Specifications Volume 2, page 175

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.

Title	Description
	• 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 on the discharge claim. • At least on acute inpatient discharge with an advanced illness diagnosis on the discharge claim. • A dispenses dementia medication. • Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the intake period through the end of the measurement year. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2025 – 12/31/2025
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure

Title	Description

Weighting Value: 1

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00484-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 29%	Greater than or equal to 29% to less than 42%	Greater than or equal to 42% to less than 52%	Greater than or equal to 52% to less than 70%	Greater than or equal to 70%

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 2025 Technical Specifications Volume 2, page 150

Metric: The percentage of MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had a retinal eye exam during the measurement year (numerator).

Primary Data Source: HEDIS

Data Source Category: Health and Drug Plans

Exclusions: (Required)

• 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 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:

Title	Description

- Advanced illness on at least two different dates of service. Do not include laboratory claims.
- Dispensed dementia medication.

• Members who had a bilateral eye enucleation any time during the member's history through December 31 of the measurement period.
–
• 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 or who had an encounter for palliative care any time during the measurement year.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 61%	Greater than or equal to 61% to less than 72%	Greater than or equal to 72% to less than 79%	Greater than or equal to 79% 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 2025 Technical Specifications Volume 2, page 134
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): o 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. o At least one acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim. o A dispensed dementia medication.

Title	Description

• (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 2025 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00204-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 59%	Greater than or equal to 59% to less than 82%	Greater than or equal to 82% to less than 89%	Greater than or equal to 89% to less than 92%	Greater than or equal to 92%

Measure: C13 - Kidney Health Evaluation for Patients with Diabetes

Title	Description
Label for Stars:	Kidney Health Evaluation for Patients with Diabetes
Label for Data:	Kidney Health Evaluation for Patients with Diabetes
Description:	Percent of plan members with diabetes who received a kidney health evaluation during the year.
HEDIS Label:	Kidney Health Evaluation for Patients with Diabetes (KED)
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 158
Metric:	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Required exclusions for members who meet any of the following criteria: • Members who did not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year. • Members with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of the measurement year. • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. • Members receiving palliative care any time during the measurement year. Exclude members who meet any of the following criteria: • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66-80 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded: – At least two indications of frailty with different dates of service during the measurement year. – Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o 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. o At least one acute inpatient encounter with an advanced illness diagnosis.

Title	Description

- At least on acute inpatient discharge with an advanced illness diagnosis on the discharge claim.
- A dispensed dementia medication.

• Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

The full set of exclusions is available in the NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00204-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 46%	Greater than or equal to 46% to less than 63%	Greater than or equal to 63% to less than 72%	Greater than or equal to 72% to less than 83%	Greater than or equal to 83%

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 2025 Technical Specifications Volume 2, page 106
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 or procedure 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.

Title	Description

- 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 2025 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00167-02-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 72%	Greater than or equal to 72% to less than 79%	Greater than or equal to 79% to less than 84%	Greater than or equal to 84% to less than 90%	Greater than or equal to 90%

Measure: C15 - Reducing the Risk of Falling

Title	Description
Label for Stars:	Reducing the Risk of Falling
Label for Data:	Reducing the Risk of Falling
Description:	Percent of plan members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.
HEDIS Label:	Fall Risk Management (FRM)
Measure Reference:	NCQA HEDIS Measurement Year 2025 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 26 Follow-up Data collection (2025) and Cohort 28 Baseline data collection (2025). HOS Survey Question 39: 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 40: Did you fall in the past 12 months? HOS Survey Question 41: In the past 12 months have you had a problem with balance or walking? HOS Survey Question 42: 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 39 or Question 42 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:	07/14/2025 – 11/03/2025
General Trend:	Higher is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2024 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 52%	Greater than or equal to 52% to less than 58%	Greater than or equal to 58% to less than 65%	Greater than or equal to 65% to less than 72%	Greater than or equal to 72%

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 2024 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 26 Follow-up Data collection (2025) and Cohort 28 Baseline data collection (2025).

Title	Description
	HOS Survey Question 33: Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? HOS Survey Question 36: 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: • Q33 = "Yes." • Q36 = "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: • Q36 = "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:	07/14/2025 – 11/03/2025
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 (2026-2027) for contracts with 25% or more enrolled affected by 2024 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00378-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 37%	Greater than or equal to 37% to less than 43%	Greater than or equal to 43% to less than 47%	Greater than or equal to 47% to less than 52%	Greater than or equal to 52%

Measure: C17 - 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 2025 Technical Specifications Volume 2, page 403
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 2025

Title	Description
	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 2025 Technical Specifications Volume 2. Contracts whose enrollment was less than 500 as of the July 2025 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:	01/01/2025 – 12/31/2025
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Admissions and Readmissions to Hospitals
CMIT #:	00561-02-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Greater than 13%	Greater than 11% to less than or equal to 13%	Greater than 10% to less than or equal to 11%	Greater than 8% to less than or equal to 10%	Less than or equal to 8%

Measure: C18 - Statin Therapy for Patients with Cardiovascular Disease

Title	Description
Label for Stars:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Heart Disease Get the Most Effective Drugs to Treat High Cholesterol
Description:	This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs. Health plans can help make sure their members are prescribed medications that are more effective for them.
HEDIS Label:	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 120
Metric:	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude members who meet any of the following criteria: • Pregnancy during the measurement year or year prior to the measurement year. • In vitro fertilization in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year. • ESRD or dialysis during the measurement year or the year prior to the measurement year. • Cirrhosis during the measurement year or the year prior to the measurement year. • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year. • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. • Members receiving palliative care any time during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Members must meet both of the following frailty and advanced illness criteria to be excluded: – At least two indications of frailty with different dates of service during the measurement year. – Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): 1. At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits, virtual check-ins, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.

Title	Description

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 2025 Technical Specifications Volume 2.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 82%	Greater than or equal to 82% to less than 86%	Greater than or equal to 86% to less than 89%	Greater than or equal to 89% to less than 93%	Greater than or equal to 93%

Measure: C19 - Transitions of Care

Title	Description
Label for Stars:	After hospital stay, members receive information and care they need
Label for Data:	After hospital stay, members receive information and care they need
Description:	This rating is based on the percent of plan members who got follow-up care after a hospital stay. Follow-up care includes: getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.
HEDIS Label:	Transitions of Care (TRC)
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 254
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 2025 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.

Title	Description

Data Time Frame: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00729-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 39%	Greater than or equal to 39% to less than 56%	Greater than or equal to 56% to less than 69%	Greater than or equal to 69% to less than 80%	Greater than or equal to 80%

Measure: C20 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Title	Description

Label for Stars: Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit

Label for Data: Members with 2 or more chronic conditions receive follow-up care within 7 days after an emergency department visit

Description: This rating is based on the percent of plan members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.

HEDIS Label: Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

Title	Description
Measure Reference:	NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2, page 264
Metric:	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Primary Data Source:	HEDIS
Data Source Category:	Health and Drug Plans
Exclusions:	Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays. 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place Required exclusions: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year. The full set of exclusions is available in the NCQA HEDIS Measurement Year 2025 Technical Specifications Volume 2. Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2025 enrollment report and having measure score reliability less than 0.7 are excluded. Contracts whose enrollment was less than 500 as of the July 2025 enrollment report are excluded from this measure.
Data Time Frame:	01/01/2025 – 12/31/2025
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure
Weighting Value:	1

Title	Description

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00263-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 55%	Greater than or equal to 55% to less than 64%	Greater than or equal to 64% to less than 72%	Greater than or equal to 72% to less than 83%	Greater than or equal to 83%

Domain: 3 - Member Experience with Health Plan

Measure: C21 - 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 based on responses to multiple survey items used to assess how easy it was for a member to get needed care and see specialists. The composite's survey items use "*Never*", "*Sometimes*", "*Usually*", and "*Always*" response options, which are scored as 1, 2, 3, and 4, respectively, on the original scale. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as 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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of "a" to a maximum value of "b". Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header "Scoring of MA & PDP CAHPS Composite Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026

Title	Description
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00293-02-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 78	Greater than or equal to 78 to less than 80	Greater than or equal to 80 to less than 83	Greater than or equal to 83 to less than 84	Greater than or equal to 84

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

Measure: C22 - 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 based on responses to multiple survey items used to assess how quickly the member was able to get appointments and care. The composite's survey items use "*Never*", "*Sometimes*", "*Usually*", and "*Always*" response options, which are scored as 1, 2, 3, and 4, respectively, on the original scale. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as the percentage of the best possible score each contract earned.

Title	Description
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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of “a” to a maximum value of “b”. Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header “Scoring of MA & PDP CAHPS Composite Measures” at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026
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

Title	Description
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00292-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 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: C23 - 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 based on responses to multiple survey items used to assess how easy it was for the member to get information and help when needed. The composite's survey items use "*Never*", "*Sometimes*", "*Usually*", and "*Always*" response options, which are scored as 1, 2, 3, and 4, respectively, on the original scale. If the survey respondent answered "No" to the screener question "In the last 6 months, did your health plan give you any forms to fill out?", the response to the survey question "In the last 6 months, how often were the forms from your health plan easy to fill out?" is coded as 4 ("Always"). The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as 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?

Title	Description
Data Source Category:	Survey of Enrollees
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of “a” to a maximum value of “b”. Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header “Scoring of MA & PDP CAHPS Composite Measures” at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00181-01-C-PARTC
Data Display:	Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 88	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: C24 - 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 responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as 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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of “a” to a maximum value of “b”. Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header “Scoring of MA & PDP CAHPS Composite Measures” at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.

Title	Description

Data Time Frame: 03/2026 – 05/2026

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

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 85	Greater than or equal to 85 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: C25 - 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 responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as 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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of “a” to a maximum value of “b”. Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header “Scoring of MA & PDP CAHPS Composite Measures” at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included

Title	Description

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Person-Centered Care

CMIT #: 00643-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 83	Greater than or equal to 83 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: C26 - 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 based on responses to multiple survey items used to assess Care Coordination. Five of the six composite's survey items use "*Never*", "*Sometimes*", "*Usually*", and "*Always*" response options, which are scored as 1, 2, 3, and 4, respectively, on the original scale. The survey question "*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?*" uses "*No*", "*Yes, somewhat*", and "*Yes, definitely*" response options, which are scored as 2, 3, and 4, respectively, on the original scale. The original scale scores from the survey questions "*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?*" and "*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*

Title	Description
	them?" are averaged to generate a single score, with a minimum value of 1.2 because of the different original scales across survey items. Thus, the composite measure score is calculated as the mean of five component scores. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the responses transformed to a scale of 0 to 100. The score shown may thus be interpreted as 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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of "a" to a maximum value of "b". Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header "Scoring of MA & PDP CAHPS Composite Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026
General Trend:	Higher is better

Title	Description

Statistical Method: Relative Distribution and Significance Testing

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: Yes

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Seamless Care Coordination

CMIT #: 00106-02-C-PARTC

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
Less than 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: C27 - Complaints about the Health Plan

Title	Description
Label for Stars:	Complaints about the Health Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Health Plan (lower numbers are better because it means fewer complaints)
Description:	Rate of complaints filed with Medicare about the health plan.
Metric:	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. Therefore, all Plan Requests for 2025 complaints made by the March 31, 2026 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:	01/01/2025 – 12/31/2025
General Trend:	Lower is better

Title	Description
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 1.29	Greater than 0.66 to less than or equal to 1.29	Greater than 0.33 to less than or equal to 0.66	Greater than 0.15 to less than or equal to 0.33	Less than or equal to 0.15

Measure: C28 - 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, 2025–December 31, 2025 (numerator) divided by all members enrolled in the contract at any time during 2025 (denominator).
Primary Data Source:	MBDSS
Data Source Description:	Medicare Beneficiary Database Suite of Systems (MBDSS)
Data Source Category:	CMS Administrative Data

Title	Description
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled. • 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 1/1/2025 and 12/31/2025 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".
Data Time Frame:	01/01/2025 – 12/31/2025
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure
Weighting Value:	2

Title	Description
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Person-Centered Care
CMIT #:	00446-01-C-PARTC
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Greater than 37%	Greater than 28% to less than or equal to 37%	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: C29 - 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 2026 and 2027 Star Ratings for this contract and had no specification changes).
Primary Data Source:	Star Ratings
Data Source Description:	2026 and 2027 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.

Title	Description

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Improvement Measure

Weighting Value: 5

Major Disaster: Includes only measures which have data from both years.

Meaningful Measure Area: Person-centered Care

CMIT #: 00300-01-C-PARTC

Data Display: Not Applicable

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than -0.184029	Greater than or equal to -0.184029 to less than 0	Greater than or equal to 0 to less than 0.161052	Greater than or equal to 0.161052 to less than 0.336992	Greater than or equal to 0.336992

Measure: C30 - Plan Makes Timely Decisions about Appeals

Title	Description
Label for Stars:	Health Plan Makes Timely Decisions about Appeals
Label for Data:	Health Plan Makes Timely Decisions about Appeals
Description:	This rating shows how fast a plan sends information for an independent review.
Metric:	Percent of appeals timely processed by the plan (numerator) out of all the plan‘s appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned appeals and appeals not evaluated by the IRE because plan agreed to cover) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned] + [Appeals Not Evaluated by the IRE Because Plan Agreed to Cover])) * 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. The timeliness is based on the actual IRE received date and is compared to the date the appeal should have been received by the IRE.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the denominator is ≤ 10, the result is “Not enough data available.” Dismissed appeals (except appeals not evaluated by the IRE because plan agreed to cover) and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. The number of timely appeals can be calculated using this formula: [Number of Timely Appeals] = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) + [Appeals Not Evaluated by the IRE Because Plan Agreed to Cover]) - [Late] When reviewing IRE data from the C2C appeals website found at https://partcappeals.c2cinc.com/Search-Appeal-Status and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

Title	Description

Previous Field Name	Current Field Name
Upheld	Unfavorable
Overturn	Favorable
Partially Overturn	Partially favorable
Dismissed Because Plan Agreed to Cover	Appeals Not Evaluated by the IRE Because Plan Agreed to Cover

Data Time Frame: 01/01/2025 – 12/31/2025

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: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Affordability and Efficiency

CMIT #: 00562-01-C-PARTC

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Less than 79%	Greater than or equal to 79% to less than 95%	Greater than or equal to 95% to less than 98%	Greater than or equal to 98% to less than 100%	100%

Measure: C31 - Reviewing Appeals Decisions

Title	Description
Label for Stars:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Label for Data:	Fairness of the Health Plan's Appeal Decisions, Based on an Independent Reviewer
Description:	This rating shows how often an independent reviewer found the health plan's decision to deny coverage to be reasonable.
Metric:	Percent of appeals where a plan's decision was "upheld" by the Independent Review Entity (IRE) (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: ([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.
Primary Data Source:	Independent Review Entity (IRE)
Data Source Description:	Data were obtained from the Independent Review Entity (IRE) contracted by CMS for Part C appeals. The appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, not the date a decision was reached by the IRE. If a Reopening occurs and is decided prior to June 30, 2026, the Reopened decision is used in place of the Reconsideration decision. Reopenings decided on or after June 30, 2026 are not reflected in these data and the original decision result is used. The results of appeals that occur beyond Level 2 (i.e., Administrative Law Judge or Medicare Appeals Council appeals) are not included in the data.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	If the minimum number of appeals (upheld + overturned + partially overturned) is ≤ 10, the result is "Not enough data available." Dismissed and Withdrawn appeals are excluded from this measure.
General Notes:	This measure includes all Standard Coverage, Standard Claim, and Expedited appeals received by the IRE, regardless of the appellant. This includes appeals requested by a beneficiary, appeals requested by a party on behalf of a beneficiary, and appeals requested by non-contract providers. When reviewing IRE data from the C2C appeals website found at https://partcappeals.c2cinc.com/Search-Appeal-Status and in data files, appeal disposition codes have been updated from the prior codes. Below is a crosswalk of previous appeal disposition codes and current codes:

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

Data Time Frame:	01/01/2025 – 12/31/2025
General Trend:	Higher is better

Title	Description
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 88%	Greater than or equal to 88% to less than 96%	Greater than or equal to 96% to less than 98%	Greater than or equal to 98% to less than 100%	100%

Measure: C32 - 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.

Title	Description
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 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:	02/2026 – 05/2026
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 2024 or 2025 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 56%	Greater than or equal to 56% to less than 79%	Greater than or equal to 79% to less than 97%	Greater than or equal to 97% to less than 100%	100%

Part D Domain and Measure Details

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

Domain: 1 - Drug Plan Customer Service

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

Title	Description
Label for Stars:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Label for Data:	Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan
Description:	Percent of time that TTY services and foreign language interpretation were available when needed by people who called the drug plan's prospective enrollee customer service line.
Metric:	The calculation of this measure is the number of completed contacts with the interpreter and TTY divided by the number of attempted contacts. Completed contact with an interpreter is defined as establishing contact with an interpreter and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within eight minutes. Completed TTY contact is defined as establishing contact with and confirming that the customer service representative can answer questions about the plan's Medicare Part D benefit within seven minutes.
Primary Data Source:	Call Center
Data Source Description:	Call center monitoring data collected by CMS. The Customer Service Contact for Prospective Members phone number associated with each contract was monitored.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	Data were collected from contracts that cover U.S territories but were not collected from the following organization types: 1876 Cost, Employer/Union Only Direct Contract PDP, Employer/Union Only Direct Contract PFFS, National PACE, MSA, employer contracts, organizations that did not have a phone number accessible to survey callers, and MA-PDs and PDPs 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:	02/2026 – 05/2026
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Measures Capturing Access

Title	Description

Weighting Value: 2

Major Disaster: No adjustment for 2024 or 2025 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00096-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 50%	Greater than or equal to 50% to less than 84%	Greater than or equal to 84% to less than 97%	Greater than or equal to 97% to less than 100%	100%
PDP	Less than 80%	Greater than or equal to 80% to less than 95%	Greater than or equal to 95% to less than 98%	Greater than or equal to 98% to less than 100%	100%

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

Measure: D02 - Complaints about the Drug Plan

Title	Description
Label for Stars:	Complaints about the Drug Plan (more stars are better because it means fewer complaints)
Label for Data:	Complaints about the Drug Plan (number of complaints for every 1,000 members). (Lower numbers are better because it means fewer complaints.)
Description:	Rate of complaints filed with Medicare about the drug plan.
Metric:	Rate of complaints about the drug plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the Complaints Tracking Module (CTM)) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period). Number of Days in Period = 366 for leap years, 365 for all other years. • Complaints data are pulled after the end of the measurement timeframe to serve as a snapshot of CTM data. • Enrollment numbers used to calculate the complaint rate were based on the average enrollment for the time period measured for each contract. • A contract's failure to follow CMS's CTM Standard Operating Procedures will not result in CMS's adjustment of the data used for these measures.
Primary Data Source:	Complaints Tracking Module (CTM)
Data Source Description:	Data were obtained from the CTM in the Health Plan Management System (HPMS) based on the contract entry date (the date that complaints are assigned or re-assigned to contracts; also known as the contract assignment/reassignment date) for the reporting period specified. The status of any specific complaint at the time the data are pulled stands for use in the reports. Any changes to the complaints data subsequent to the data pull cannot be excluded retroactively. CMS allows for an approximate 6-month "wash out" period to account for any adjustments per CMS's CTM Standard Operating Procedures. All Plan Requests for 2025 complaints made by the March 31, 2026 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:	01/01/2025 – 12/31/2025
General Trend:	Lower is better

Title	Description

Statistical Method: Clustering

Improvement Measure: Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 1.29	Greater than 0.66 to less than or equal to 1.29	Greater than 0.33 to less than or equal to 0.66	Greater than 0.15 to less than or equal to 0.33	Less than or equal to 0.15
PDP	Greater than 0.31	Greater than 0.19 to less than or equal to 0.31	Greater than 0.10 to less than or equal to 0.19	Greater than 0.03 to less than or equal to 0.10	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, 2025–December 31, 2025 (numerator) divided by all members enrolled in the contract at any time during 2025 (denominator).

Primary Data Source: MBDSS

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

Title	Description
Data Source Category:	CMS Administrative Data
Exclusions:	Members who involuntarily left their contract due to circumstances beyond their control are removed from the final numerator, specifically: • Members affected by a contract service area reduction • Members affected by PBP termination • Members in PBPs that were granted special enrollment exceptions • Members affected by PBP service area reductions where there are no PBPs left within the contract that the enrollee is eligible to enroll into • Members affected by LIS reassignments • Members who are enrolled in employer group plans • Members who were passively enrolled into a Demonstration (MMP) • Contracts with less than 1,000 enrollees • 1876 Cost contract disenrollments into the transition MA contract (H contract) • Members who moved out of the service area of the contract from which they disenrolled (based on the member's address as submitted by the plan into which the member enrolled or the member's current SSA address if there is no address submitted by the plan into which the member enrolled) or where the service area of the contract they enrolled into does not intersect with the service area of the contract from which they disenrolled. • 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 1/1/2025 and 12/31/2025 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".
Data Time Frame:	01/01/2025 – 12/31/2025
General Trend:	Lower is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	No
Weighting Category:	Patients' Experience and Complaints Measure

Title	Description

Weighting Value: 2

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 37%	Greater than 28% to less than or equal to 37%	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 13%	Greater than 7% to less than or equal to 13%	Greater than 5% to less than or equal to 7%	Greater than 2% to less than or equal to 5%	Less than or equal to 2%

Measure: D04 - Drug Plan Quality Improvement

Title	Description

Label for Stars: Improvement (if any) in the Drug Plan's Performance

Label for Data: Improvement (If any) in the Drug Plan's Performance

Description: This shows how much the drug plan's performance has improved or declined from one year to the next year.
If a plan receives **1 or 2 stars**, it means, on average, the plan's scores **declined** (got worse).
If a plan receives **3 stars**, it means, on average, the plan's scores **stayed about the same**.
If a plan receives **4 or 5 stars**, it means, on average, the plan's scores **improved**.

Keep in mind that a plan that is already doing well in most areas may not show much improvement. It is also possible that a plan can start with low ratings, show a lot of improvement, and still not be performing very well.

Metric: The numerator is the net improvement, which is a weighted sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the sum of the weights associated with the measures eligible for the improvement measure (i.e., the measures that were included in the 2026 and 2027 Star Ratings for this contract and had no specification changes).

Primary Data Source: Star Ratings

Data Source Description: 2026 and 2027 Star Ratings

Data Source Category: Star Ratings

Title	Description

Exclusions: Contracts must have data in at least half of the measures used to calculate improvement to be rated in this measure.

General Notes: Attachment I contains the formulas used to calculate the improvement measure and lists indicating which measures were used.

Data Time Frame: Not Applicable

General Trend: Higher is better

Statistical Method: Clustering

Improvement Measure: Not Included

CAI Usage: Not Included

Case-Mix Adjusted: No

Weighting Category: Improvement Measure

Weighting Value: 5

Major Disaster: Includes only measures which have data from both years.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00224-01-C-PARTD

Data Display: Not Applicable

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than -0.296792	Greater than or equal to -0.296792 to less than 0	Greater than or equal to 0 to less than 0.231209	Greater than or equal to 0.231209 to less than 0.513866	Greater than or equal to 0.513866
PDP	Less than -0.142857	Greater than or equal to -0.142857 to less than 0	Greater than or equal to 0 to less than 0.245851	Greater than or equal to 0.245851 to less than 0.502381	Greater than or equal to 0.502381

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 responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as 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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
General Notes:	CAHPS Survey results were sent to each contract's Medicare Compliance Officer in August 2026. These reports provide further explanation of the CAHPS scoring methodology and provide detailed information on why a specific rating was assigned. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of "a" to a maximum value of "b". Further details, as well as examples of 0–100 scale transformations for composite measures, are provided under the section header "Scoring of MA & PDP CAHPS Composite Measures" at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing

Title	Description
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
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 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 89	Greater than or equal to 89
PDP	Less than 82	Greater than or equal to 82 to less than 83	Greater than or equal to 83 to less than 86	Greater than or equal to 86 to less than 88	Greater than or equal to 88

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

Measure: D06 - Getting Needed Prescription Drugs

Title	Description
Label for Stars:	Ease of Getting Prescriptions Filled When Using the Plan
Label for Data:	Ease of Getting Prescriptions Filled When Using the Plan (on a scale from 0 to 100)
Description:	Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.
Metric:	This case-mix adjusted measure is based on responses to multiple survey items used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The component survey items use "*Never*", "*Sometimes*", "*Usually*", and "*Always*" response options, which are scored as 1, 2, 3, and 4, respectively, on the original scale. The original scale scores from the survey questions "*In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?*" and "*In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?*" are averaged to generate a single item score.

Title	Description
	Thus, the composite measure score is based on the mean of two component scores. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the responses transformed to a scale from 0 to 100. The score shown may thus be interpreted as 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
Exclusions:	• Scores for contracts with fewer than 11 responses are suppressed. • Contract scores with very low interunit reliability (less than 0.60) are suppressed. More details on interunit reliability calculations can be found in Attachment K under the section titled "Relative Distribution and Significance Testing (CAHPS) Methodology".
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. Linear mean scoring, which takes the average of all eligible responses, is used for CAHPS measures. CAHPS measures are transformed to a 0–100 scale for public reporting using the formula Y = ((X-a)*100)/((b-a)) , where X = the CAHPS score on its original scale, ranging from a minimum value of “a” to a maximum value of “b”. Further details, as well as examples of 0–100 scale transformations for composites measures, are provided under the section header “Scoring of MA & PDP CAHPS Composite Measures” at https://www.ma-pdpcahps.org/en/scoring-and-star-ratings/.
Data Time Frame:	03/2026 – 05/2026
General Trend:	Higher is better
Statistical Method:	Relative Distribution and Significance Testing
Improvement Measure:	Included
CAI Usage:	Not Included
Case-Mix Adjusted:	Yes

Title	Description

Weighting Category: Patients' Experience and Complaints Measure

Weighting Value: 2

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Person-Centered Care

CMIT #: 00294-01-C-PARTD

Data Display: Numeric with no decimal place

Reporting Requirements:

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

Base Group Cut Points:

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

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: D07 - MPF Price Accuracy

Title	Description
Label for Stars:	Plan Provides Accurate Drug Pricing Information for This Website
Label for Data:	Plan Provides Accurate Drug Pricing Information for This Website (higher scores are better because they mean more accurate prices)
Description:	A score comparing the drug's total cost at the pharmacy to the drug prices the plan provided for the Medicare Plan Finder (MPF) website. Higher scores are better because they mean the plan provided more accurate prices.
Metric:	This measure evaluates the accuracy of drug prices posted on the MPF tool. A contract's score is based on the accuracy index, or magnitude of difference, and the claim percentage index, or frequency of difference. The accuracy index – or magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price. Therefore, prices that are overstated on MPF—that is, the reported price is higher than the actual price—will not count against a plan's score. The accuracy index is computed as: (Total amount that PDE is higher than MPF + Total PDE cost) / (Total PDE cost). The claim percentage index is computed as: (Total number of PDEs where PDE cost is higher than MPF) / (Total number of PDEs). The best possible accuracy index is 1 and claim percentage index is 0. Indexes with these values indicate that a plan did not have PDE prices greater than MPF prices. A contract's score is computed using its accuracy index and claim percentage index as: 0.5 x (100 – ((accuracy index – 1) x 100)) + 0.5 x ((1 – claim percentage index) x 100).
Primary Data Source:	PDE data, MPF Pricing Files
Data Source Description:	Data used in this measure are obtained from 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 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025-September 30, 2025. 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 2025 PDE submission deadline are used to

Title	Description
	calculate this measure. PDE adjustments made post-reconciliation were not reflected in this measure.
Data Source Category:	Data Collected by CMS Contractors
Exclusions:	A contract with less than 30 PDE claims over the measurement period will not have the measure calculated. PDEs must also meet the following criteria: • If the NPI in the Pharmacy Cost (PC) file represents a retail only pharmacy or retail and limited access drug only pharmacy, all corresponding PDEs will be eligible for the measure. However, if the NPI in the PC file represents a retail and other pharmacy type (such as Mail, Home Infusion or Long Term Care pharmacy), only the PDE where the pharmacy service type is identified as either Community/Retail or Managed Care Organization (MCO) will be eligible. • Drug must appear in formulary file and in MPF pricing file • PDE must be a 28-34, 60-62, or 90-93 day supply. If a plan's bid indicates a 1, 2, or 3 month retail days supply amount outside of the 28-34, 60-62, or 90-93 windows, then additional days supply values may be included in the accuracy measure for the plan. • Date of service must occur at a time that data are not suppressed for the plan on MPF • PDE must not be a compound claim • PDE must not be a non-covered drug • The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because MPF prices are not updated during this last quarter.
General Notes:	Please see Attachment M: Methodology for Price Accuracy Measure for more information about this measure.
Data Time Frame:	01/01/2025 – 09/30/2025
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 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 97	Greater than or equal to 97 to less than 98	Greater than or equal to 98 to less than 99	Greater than or equal to 99 to less than 100	100
PDP	Less than 87	Greater than or equal to 87 to less than 98	Greater than or equal to 98 to less than 99	Greater than or equal to 99 to less than 100	100

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 treatment 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 treatment 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 treatment period, and a treatment period that is at least 91 days during the measurement year (denominator).

Title	Description
	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 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025-December 31, 2025. 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 2025 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 are 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 (on inpatient, outpatient, or carrier claims), 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 (on inpatient, outpatient, or carrier claims), and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 29 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,

Title	Description

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: 01/01/2025 – 12/31/2025

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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00436-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 86%	Greater than or equal to 86% to less than 89%	Greater than or equal to 89% to less than 91%	Greater than or equal to 91% to less than 93%	Greater than or equal to 93%
PDP	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% to less than 95%	Greater than or equal to 95%

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 taking their medication. The plan, the doctor, and the member can work together to do this. ("Blood pressure medication" means an *ACE (angiotensin converting enzyme) inhibitor*, an *ARB (angiotensin receptor blocker),* or a *direct renin inhibitor drug*.)
Metric:	This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: ACE inhibitor, ARB, or direct renin inhibitor medications. The proportion of days covered (PDC) is the percentage of days in the treatment 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 treatment 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 treatment 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 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025-December 31, 2025. 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

Title	Description
	single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2025 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 (on inpatient, outpatient, or carrier claims), inpatient and SNF stays for PDPs and MA-PDs (if available). • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes (on inpatient, outpatient, or carrier claims), and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 29 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:	01/01/2025 – 12/31/2025
General Trend:	Higher is better
Statistical Method:	Clustering

Title	Description
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Intermediate Outcome Measure
Weighting Value:	3
Major Disaster:	Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00437-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 84%	Greater than or equal to 84% to less than 88%	Greater than or equal to 88% to less than 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: 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 treatment 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

Title	Description
	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 treatment 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 treatment 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 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025-December 31, 2025. 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 2025 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 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 (on inpatient, outpatient, or carrier claims), IP and SNF stays for PDPs and MA-PDs (if available). • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes (on inpatient, outpatient, or carrier claims), and SNF/IP stays for MA-PD beneficiaries.
Data Source Category:	Health and Drug Plans

Title	Description
Exclusions:	Contracts with 29 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:	01/01/2025 – 12/31/2025
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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.
Meaningful Measure Area:	Chronic Conditions
CMIT #:	00435-01-C-PARTD
Data Display:	Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

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

Measure: D11 - Statin Use in Persons with Diabetes (SUPD)

Title	Description
Label for Stars:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Label for Data:	The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol
Description:	To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.
Metric:	This measure is defined as the percentage of Medicare Part D beneficiaries, 40-75 years old, who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period. The index prescription start date (IPSD) is the earliest date of service for a diabetes medication during the measurement year. Continuous enrollment (CE) is defined as being continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month. Beneficiaries are only included in the measure calculation if the IPSD occurs at least 90 days before the end of the measurement period. The percentage is calculated as the number of continuously enrolled beneficiaries, 40-75 years old, who received a statin medication fill during the measurement period (numerator) divided by the number of continuously enrolled beneficiaries, 40-75 years old, with at least two diabetes medication fills on unique dates of service during the measurement period and an IPSD that occurs at least 90 days prior to the end of the measurement period (denominator). The SUPD measure is adapted from the Statins Use in Persons with Diabetes measure that was developed and endorsed by the PQA. See the medication list for this measure. The SUPD measure is calculated using the NDC lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE) data
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS DDPS and accepted by the 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025 – December 31, 2025. 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

Title	Description
	record representing a single dispensing event. Original and adjustment final action PDEs submitted by the sponsor and accepted by DDPS prior to the 2025 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 (on inpatient, outpatient, or carrier claims). • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes (on inpatient, outpatient, or carrier claims).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 29 or fewer continuously enrolled beneficiaries (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • In hospice • 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:	01/01/2025 – 12/31/2025
General Trend:	Higher is better
Statistical Method:	Clustering
Improvement Measure:	Included
CAI Usage:	Included
Case-Mix Adjusted:	No
Weighting Category:	Process Measure

Title	Description

Weighting Value: 1

Major Disaster: Higher measure star (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Less than 83%	Greater than or equal to 83% to less than 87%	Greater than or equal to 87% to less than 90%	Greater than or equal to 90% to less than 94%	Greater than or equal to 94%
PDP	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 87%	Greater than or equal to 87%

Measure: D12 - Concurrent Use of Opioids and Benzodiazepines (COB)

Title	Description

Label for Stars: Concurrent Use of Opioids and Benzodiazepines (more stars are better meaning fewer plan members took these two drugs together, decreasing the risk of adverse events)

Label for Data: Concurrent Use of Opioids and Benzodiazepines (more stars are better meaning fewer plan members took these two drugs together, decreasing the risk of adverse events)

Description: While there may be instances where it is appropriate for concurrent use of opioids and benzodiazepines, the concurrent use of prescription opioids with benzodiazepines increases the risk of adverse events such as respiratory depression, overdose, and death.

Metric: The measure is defined as the percentage of Part D beneficiaries, 18 years or older, with concurrent use of prescription opioids and benzodiazepines during the measurement period. Concurrent use is defined as overlapping days' supply for an opioid and benzodiazepine of at least 30 cumulative days during the measurement period. Continuous enrollment (CE) is defined as continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month.

The percentage is calculated as the number of CE beneficiaries in the denominator with at least two prescription claims for any benzodiazepines with unique dates of service (DOS) and concurrent use of opioids and benzodiazepines for at least 30 cumulative days during the measurement period (numerator) divided by the number of CE beneficiaries, 18 years or older, with at least two prescription claims for opioid medications with unique DOS and at least 15 cumulative days' supply of opioids during the measurement period and an IPSD that occurs at least 30 days prior to the end of the measurement period (denominator).

Title	Description
	The COB measure is adapted from the Concurrent use of Opioids and Benzodiazepines measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). See the medication list for this measure. The COB measure is calculated using the NDC lists updated by the PQA. The complete NDC lists, including diagnosis codes, are posted along with these technical notes.
Primary Data Source:	Prescription Drug Event (PDE)
Data Source Description:	The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS DDPS and accepted by the 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025 – December 31, 2025. 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 2025 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. • CWF is used to identify exclusion diagnoses based on ICD-10-CM codes (on inpatient, outpatient, or carrier claims). • EDS is used to identify exclusion diagnoses based on ICD-10-CM codes (on inpatient, outpatient, or carrier claims).
Data Source Category:	Health and Drug Plans
Exclusions:	Contracts with 29 or fewer continuously enrolled beneficiaries (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period: • In hospice • Cancer diagnosis • Sickle cell disease diagnosis • Palliative care • Cancer-related pain treatment diagnosis
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.

Title	Description

Data Time Frame: 01/01/2025 – 12/31/2025

General Trend: Lower 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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Greater than 20%	Greater than 16% to less than or equal to 20%	Greater than 12% to less than or equal to 16%	Greater than 8% to less than or equal to 12%	Less than or equal to 8%
PDP	Greater than 18%	Greater than 14% to less than or equal to 18%	Greater than 11% to less than or equal to 14%	Greater than 6% to less than or equal to 11%	Less than or equal to 6%

Measure: D13 - Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

Title	Description

Label for Stars: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (more stars are better meaning fewer older adult plan members took two or more anticholinergic medications at the same time, decreasing the risk of cognitive decline)

Label for Data: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (more stars are better meaning fewer older adult plan members took two or more anticholinergic medications at the same time, decreasing the risk of cognitive decline)

Description: The use of multiple anticholinergics in older adults is associated with an increased risk of cognitive decline.

Title	Description

Metric: This measure is defined as the percentage of Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period. Concurrent use is defined as overlapping days' supply for at least 30 cumulative days during the measurement period. Continuous enrollment (CE) is defined as continuously enrolled in a Medicare Part D contract during the measurement period, with one allowable gap in enrollment of up to one calendar month.

The percentage is calculated as the number of CE beneficiaries in the denominator with concurrent use for at least 30 cumulative days of two or more unique ACH medications, each with at least two prescription claims with different dates of service (DOS), during the measurement period (numerator) divided by the number of CE beneficiaries, 65 years or older, with at least two prescription claims with different DOS of the same ACH medication during the measurement period (denominator). Note, the earliest DOS for any target medication with at least two prescription claims on different DOS, should be at least 30 days from the last day of the measurement period.

The Poly-ACH measure is adapted from the Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults measure developed and endorsed by the Pharmacy Quality Alliance (PQA).

See the medication list for this measure. The Poly-ACH measure is calculated using the NDC lists updated by the PQA. The complete NDC lists are posted along with these technical notes.

Primary Data Source: Prescription Drug Event (PDE)

Data Source Description: The data for this measure come from Prescription Drug Event (PDE) data submitted by drug plans to the CMS DDPS and accepted by the 2025 PDE submission deadline for annual Part D payment reconciliation with dates of service from January 1, 2025 – December 31, 2025. 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 2025 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 data cutoff date for all the additional data sources listed below such as the CME 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.

Data Source Category: Health and Drug Plans

Exclusions: Contracts with 29 or fewer continuously enrolled beneficiaries (in the denominator). The following beneficiaries are excluded from the denominator if at any time during the measurement period:

Title	Description

- In hospice

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: 01/01/2025 – 12/31/2025

General Trend: Lower 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 (2026-2027) for contracts with 25% or more enrolled affected by 2025 disasters.

Meaningful Measure Area: Chronic Conditions

CMIT #: 00702-01-C-PARTD

Data Display: Percentage with no decimal place

Reporting Requirements:

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

Cut Points:

Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MA-PD	Greater than 15%	Greater than 11% to less than or equal to 15%	Greater than 7% to less than or equal to 11%	Greater than 5% to less than or equal to 7%	Less than or equal to 5%
PDP	Greater than 7%	Greater than 6% to less than or equal to 7%	Greater than 4% to less than or equal to 6%	Greater than 1% to less than or equal to 4%	Less than or equal to 1%

Attachment A: CAHPS and HOS Case-Mix Adjustment

CAHPS Case-Mix Adjustment

Measures from the CAHPS survey, except for Annual Flu Vaccine, 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. Tables A-1 – A-7 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 0.076562, indicating that respondents in that age range tend to score their plans 0.076562 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 0.019682 points lower on this item than otherwise similar respondents without proxy help. Contracts with higher proportions of beneficiaries who are in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. Similarly, contracts with higher proportions of respondents who had proxy help will be adjusted upward on this measure to compensate for their respondents' negative response tendency. The case-mix patterns are not always consistent across measures. Missing case-mix adjustors are imputed as the contract mean.

Three components are needed to calculate the case-mix adjusted score for a measure: the weighted national mean and weighted contract mean for each case-mix variable, and the coefficients from the case-mix adjusted models. The product for each case-mix variable is calculated as follows: (contract mean – national mean) * case-mix coefficient. The net adjustment is derived by summing the products across all case-mix variables. Finally, the net adjustment is subtracted from the unadjusted score to obtain the adjusted score.
Composite scores are generally created by weighting items equally within the composite, except for the Getting Needed Prescription Drugs and Care Coordination composites. Each item in a composite is adjusted separately before combining the adjusted item scores into a composite score. Item-level coefficients are presented below separately for each composite. Case-mix adjustment is performed using the CAHPS Analysis Program as documented in the CAHPS Macro Manual. For more detailed information on the construction of weights, the application of CAHPS case-mix adjustment (including case-mix coefficients, national means, and an example worksheet) and composite scoring exceptions, please review the materials at https://www.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	0.029084	-0.020735
Age: 65 – 69	-0.021117	-0.000483
Age: 70 – 74	0.000000	0.000000
Age: 75 – 79	0.014529	0.002842
Age: 80 – 84	0.019044	0.029276
Age: 85 and older	-0.013107	0.005944
Education: Less than an 8th grade education	-0.016697	-0.046909
Education: Some high school	0.023798	0.000360
Education: High school graduate	0.000000	0.000000
Education: Some college	-0.065813	-0.056573
Education: College graduate	-0.101994	-0.072395
Education: More than a bachelor's degree	-0.162132	-0.120896
General health rating: excellent	0.105110	0.035515
General health rating: very good	0.051064	0.035826
General health rating: good	0.000000	0.000000
General health rating: fair	-0.073391	-0.058635
General health rating: poor	-0.122224	-0.133893
Mental health rating: excellent	0.182847	0.187838
Mental health rating: very good	0.078998	0.074502
Mental health rating: good	0.000000	0.000000
Mental health rating: fair	-0.063606	-0.067713
Mental health rating: poor	-0.172052	-0.218639
Proxy helped	0.009657	0.012371
Proxy answered	0.015483	0.062314
Medicaid dual eligible	0.021253	0.015444
Low-income subsidy (LIS)	0.010903	0.014967
Asian survey language	-0.086096	-0.128697

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	-0.010078	0.040715
Age: 65 – 69	-0.001450	-0.012316
Age: 70 – 74	0.000000	0.000000
Age: 75 – 79	0.028639	-0.000065
Age: 80 – 84	0.042587	0.026413
Age: 85 and older	0.074090	0.011679
Education: Less than an 8th grade education	-0.023756	-0.043122
Education: Some high school	-0.012837	-0.008964
Education: High school graduate	0.000000	0.000000
Education: Some college	-0.028825	-0.053340
Education: College graduate	-0.048582	-0.090080
Education: More than a bachelor's degree	-0.071268	-0.091633
General health rating: excellent	0.032017	0.087021
General health rating: very good	0.043781	0.032866
General health rating: good	0.000000	0.000000
General health rating: fair	-0.027644	-0.019604
General health rating: poor	-0.154949	0.007449
Mental health rating: excellent	0.143165	0.154222
Mental health rating: very good	0.081977	0.068895
Mental health rating: good	0.000000	0.000000
Mental health rating: fair	-0.069191	-0.054736
Mental health rating: poor	-0.128838	-0.187909
Proxy helped	0.033922	0.003387
Proxy answered	0.093646	0.069447
Medicaid dual eligible	0.037722	0.019418
Low-income subsidy (LIS)	0.078742	0.031567
Asian survey language	-0.383333	-0.422894

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

Predictor	Paperwork easy	Plan customer service gives information	Plan customer service courtesy and respect
Age: 64 or under	-0.003484	0.009774	-0.041427
Age: 65 – 69	-0.003549	-0.005835	-0.002224
Age: 70 – 74	0.000000	0.000000	0.000000
Age: 75 – 79	-0.021731	0.007631	-0.000144
Age: 80 – 84	-0.020270	0.025433	0.017105
Age: 85 and older	-0.017840	-0.023344	0.005283
Education: Less than an 8th grade education	-0.080136	-0.016860	-0.023542
Education: Some high school	-0.011645	0.024973	0.020202
Education: High school graduate	0.000000	0.000000	0.000000
Education: Some college	-0.011881	-0.074276	-0.017762
Education: College graduate	-0.020713	-0.101896	-0.054368
Education: More than a bachelor's degree	-0.039974	-0.169519	-0.073778
General health rating: excellent	0.032764	0.072104	-0.033929
General health rating: very good	0.022178	0.069716	0.029277
General health rating: good	0.000000	0.000000	0.000000
General health rating: fair	-0.020596	-0.034920	-0.009097
General health rating: poor	-0.105019	-0.099504	-0.020178
Mental health rating: excellent	0.069985	0.139616	0.111000
Mental health rating: very good	0.034550	0.046943	0.055096
Mental health rating: good	0.000000	0.000000	0.000000
Mental health rating: fair	-0.018423	-0.034269	-0.014837
Mental health rating: poor	-0.029126	-0.149924	-0.091256
Proxy helped	-0.045493	0.013913	-0.000903
Proxy answered	-0.026372	-0.025384	-0.034347
Medicaid dual eligible	-0.059735	0.084219	0.035616
Low-income subsidy (LIS)	-0.025749	0.064544	-0.007989
Asian survey language	-0.015081	-0.245507	-0.091548

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	-0.037102	-0.172663
Age: 65 – 69	-0.002865	-0.078246
Age: 70 – 74	0.000000	0.000000
Age: 75 – 79	0.088463	0.076562
Age: 80 – 84	0.093283	0.125615
Age: 85 and older	0.042158	0.171448
Education: Less than an 8th grade education	0.055023	0.220393
Education: Some high school	-0.025167	0.076509
Education: High school graduate	0.000000	0.000000
Education: Some college	-0.163683	-0.235401
Education: College graduate	-0.242516	-0.369497
More than a bachelor's degree	-0.295567	-0.464860
General health rating: excellent	0.311606	0.266554
General health rating: very good	0.184265	0.125586
General health rating: good	0.000000	0.000000
General health rating: fair	-0.240791	-0.146192
General health rating: poor	-0.458198	-0.372782
Mental health rating: excellent	0.477087	0.438861
Mental health rating: very good	0.228394	0.223016
Mental health rating: good	0.000000	0.000000
Mental health rating: fair	-0.241194	-0.175906
Mental health rating: poor	-0.627277	-0.607020
Proxy helped	0.010969	-0.019682
Proxy answered	0.134667	0.066776
Medicaid dual eligible	0.021595	0.278547
Low-income subsidy (LIS)	-0.022996	0.035940
Asian survey language	0.168591	-0.306840

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	-0.025928	-0.003194	0.001699	0.076094	0.010288
Age: 65 – 69	0.011759	-0.031281	-0.024558	0.040071	-0.008747
Age: 70 – 74	0.000000	0.000000	0.000000	0.000000	0.000000
Age: 75 – 79	-0.017031	-0.016674	-0.017400	-0.041125	0.006432
Age: 80 – 84	-0.022490	0.020923	-0.026942	-0.073248	-0.002659
Age: 85 and older	-0.025651	-0.064585	-0.056830	-0.162790	-0.003315
Education: Less than an 8th grade education	-0.051118	-0.012360	-0.030120	0.032627	-0.034499
Education: Some high school	-0.048451	0.024784	0.013486	0.036238	0.001513
Education: High school graduate	0.000000	0.000000	0.000000	0.000000	0.000000
Education: Some college	-0.032909	-0.045698	-0.053355	-0.012021	-0.009270
Education: College graduate	-0.079859	-0.100999	-0.080059	-0.060383	-0.033124
Education: More than a bachelor's degree	-0.043864	-0.120033	-0.070058	-0.060569	-0.019848
General health rating: excellent	0.018075	0.070647	0.076859	0.081035	0.016009
General health rating: very good	0.027091	0.009339	0.056136	0.044483	0.011547
General health rating: good	0.000000	0.000000	0.000000	0.000000	0.000000
General health rating: fair	-0.058811	-0.047908	-0.056919	-0.063466	-0.035745
General health rating: poor	-0.075104	-0.040091	-0.117186	-0.097963	-0.074102
Mental health rating: excellent	0.073689	0.180450	0.157480	0.188541	0.093975
Mental health rating: very good	0.026007	0.075821	0.065994	0.068779	0.034386
Mental health rating: good	0.000000	0.000000	0.000000	0.000000	0.000000
Mental health rating: fair	-0.052954	-0.091602	-0.070414	-0.068838	-0.041995
Mental health rating: poor	-0.064271	-0.218912	-0.130478	-0.153621	-0.098768
Proxy helped	0.016740	0.035133	0.022313	0.112729	0.000027
Proxy answered	-0.005439	-0.005475	0.046241	0.076472	-0.024451
Medicaid dual eligible	0.026292	0.046236	-0.041976	-0.002743	-0.037352
Low-income subsidy (LIS)	0.014475	0.058763	-0.032659	0.066970	0.027442
Asian survey language	-0.036987	-0.020938	0.074870	-0.171509	-0.055489

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	-0.197286	-0.131905
Age: 65 – 69	-0.136559	-0.099548
Age: 70 – 74	0.000000	0.000000
Age: 75 – 79	0.092118	0.127396
Age: 80 – 84	0.211045	0.371638
Age: 85 and older	0.282613	0.552588
Education: Less than an 8th grade education	0.078684	-0.056620
Education: Some high school	0.028741	0.044059
Education: High school graduate	0.000000	0.000000
Education: Some college	-0.191111	-0.257714
Education: College graduate	-0.303153	-0.210579
Education: More than a bachelor's degree	-0.410994	-0.316266
General health rating: excellent	0.216881	-0.115299
General health rating: very good	0.150847	0.223282
General health rating: good	0.000000	0.000000
General health rating: fair	-0.157516	-0.067550
General health rating: poor	-0.334812	-0.551237
Mental health rating: excellent	0.404949	0.341576
Mental health rating: very good	0.171423	0.149604
Mental health rating: good	0.000000	0.000000
Mental health rating: fair	-0.080561	-0.087725
Mental health rating: poor	-0.586875	-1.60543
Proxy helped	-0.086360	0.452440
Proxy answered	0.063158	0.572756
Medicaid dual eligible	0.346135	0.157732
Low-income subsidy (LIS)	0.264389	0.454858
Asian survey language	-0.022246	0.000000

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	-0.064570	-0.027970	-0.051584	-0.076166
Age: 65 – 69	-0.022198	0.005158	0.011917	0.042781
Age: 70 – 74	0.000000	0.000000	0.000000	0.000000
Age: 75 – 79	0.015933	-0.000539	0.071564	0.029733
Age: 80 – 84	0.052021	0.022705	0.065638	0.037232
Age: 85 and older	0.043762	0.012517	0.113101	0.062155
Education: Less than an 8th grade education	-0.062036	-0.065564	-0.071903	-0.014011
Education: Some high school	-0.001687	-0.006118	-0.077181	-0.108641
Education: High school graduate	0.000000	0.000000	0.000000	0.000000
Education: Some college	-0.054045	-0.028152	-0.017006	-0.058344
Education: College graduate	-0.059330	-0.044687	-0.000210	-0.046247
Education: More than a bachelor's degree	-0.100573	-0.087090	-0.089194	-0.099729
General health rating: excellent	0.045581	0.066149	0.079002	0.097763
General health rating: very good	0.039755	0.060682	0.091284	0.090898
General health rating: good	0.000000	0.000000	0.000000	0.000000
General health rating: fair	-0.043578	-0.037911	-0.045655	-0.041809
General health rating: poor	-0.119349	-0.103088	-0.098926	-0.046213
Mental health rating: excellent	0.113845	0.117369	0.061415	0.042710
Mental health rating: very good	0.054739	0.051028	0.061827	0.052630
Mental health rating: good	0.000000	0.000000	0.000000	0.000000
Mental health rating: fair	-0.044120	-0.038767	-0.066640	-0.146446
Mental health rating: poor	-0.184236	-0.097022	-0.299260	-0.385060
Proxy helped	-0.004633	0.014938	-0.009215	0.058005
Proxy answered	0.036011	0.039856	0.191698	0.105590
Medicaid dual eligible	0.043946	-0.003441	-0.009365	-0.008940
Low-income subsidy (LIS)	0.014091	0.020147	-0.029979	-0.086967
Asian survey language	-0.008867	-0.019911	0.000000	0.000000

HOS 2023-2025 Cohort 26 Case-Mix Adjustment

The longitudinal outcomes for the Medicare HOS 2023-2025 Cohort 26 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-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. The two measures returned 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 1, the coefficient for "Female" in the PCS Better + Same Model is -0.335401, indicating a lower probability of PCS Better + 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 + Same Model is 0.004937, 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	-5.636162	1.940953	2.130645
Age (linear)	0.046891	-0.011320	-0.006847
Age 75+	0.038967	-0.029537	-0.030794
Age 85+	0.025745	0.039632	0.002754
Age and sex interaction	0.000347	0.004937	0.003582
Female	-0.514870	-0.335401	-0.286672
Hispanic only	-0.525405	0.002526	-0.217379
Asian only	-0.783282	-0.110712	-0.230849
Native Hawaiian or Pacific Islander only	-0.158852	-0.217016	-0.447804
Black only	-0.264289	-0.027119	-0.114043
American Indian or Alaskan Native only	0.010226	-0.132035	-0.376856
Multiracial	-0.001474	-0.072682	-0.082357
Married	-0.165719	0.011863	-0.059388
Receive Medicaid	0.105080	-0.087473	-0.351873
Eligible for SSI	0.002736	-0.065929	-0.300149
Homeowner	-0.123879	0.074248	0.153552
High school graduate or greater	0.027307	0.106784	0.232129
Baseline Functional Status			
One-item measure of General Health compared to others	0.199866		
Physical Functioning/Activities of Daily Living Scale	-0.017586		
General Health item	0.239273		
Physical Functioning item (limitations in moderate activities)	-0.074386		
Physical Functioning item (limitations climbing several flights of stairs)	0.056819		
Role-Physical item (accomplished less than would like)	0.046489		
Role-Physical item (limited in the kind of work or other activities)	0.032726		
Role-Emotional item (accomplished less than would like)	0.019256		
Role-Emotional item (did not do work or other activities as carefully)	-0.005279		
Bodily Pain item (pain interfered with normal work)	-0.164190		
Mental Health item (felt calm and peaceful)	-0.022876		
Vitality item (had a lot of energy)	0.038386		
Mental Health item (felt downhearted and blue)	-0.002049		
Social Functioning item (health interfered with social activities)	-0.074677		
Chronic Medical Conditions			
Hypertension	-0.124406		
Angina/coronary artery disease	-0.063387		
Congestive heart failure	0.483466		
Myocardial infarction	0.091716		
Other heart conditions	0.022273		
Stroke	0.120256		
Pulmonary disease	0.228172		
Gastrointestinal disorders	-0.274969		
Diabetes	0.020440		
Depression	-0.135984		

Death Model Covariates	Death Model	PCS Model	MCS Model
Any cancer other than skin cancer	0.388450		
Colon cancer treatment	0.246232		
Breast cancer treatment	-0.102887		
Prostate cancer treatment	-0.280317		
Lung cancer treatment	1.001638		

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 2027 Star Ratings
CAHPS	Enrollment at the time survey sample is pulled	January 2026
Call Center	Average enrollment during the study period	Feb 2026 – May 2026
HOS	Enrollment at the time survey sample is pulled	February 2023
HEDIS-HOS	Enrollment at the time survey sample is pulled	February 2025
HEDIS	Enrollment in July of the measurement period	July 2025
All Other Measures	Enrollment in July of the measurement period	July 2025

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 2025 Enrollment
HAAAA	Surviving	75.13	43,326
HAAAB	Consumed	50.91	20,933

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

Second Year Following a Consolidation

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

Attachment C: National Averages for Part C and D Measures

The tables below contain the average of contract numeric and star values for each measure reported in the 2027 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%	3.3
C02	Colorectal Cancer Screening	73%	3.4
C03	Annual Flu Vaccine	64%	3.1
C04	Improving or Maintaining Physical Health	71%	3.0
C05	Improving or Maintaining Mental Health	84%	3.2
C06	Monitoring Physical Activity	51%	2.8
C07	Special Needs Plan (SNP) Care Management	77%	3.4
C08	Care for Older Adults – Medication Review	96%	4.2
C09	Care for Older Adults – Functional Status Assessment	90%	4.0
C10	Osteoporosis Management in Women who had a Fracture	45%	2.8
C11	Diabetes Care – Eye Exam	75%	3.2
C12	Diabetes Care – Blood Sugar Controlled	88%	3.7
C13	Kidney Health Evaluation for Patients with Diabetes	68%	3.2
C14	Controlling Blood Pressure	81%	3.0
C15	Reducing the Risk of Falling	60%	2.7
C16	Improving Bladder Control	45%	3.1
C17	Plan All-Cause Readmissions	10%	3.4
C18	Statin Therapy for Patients with Cardiovascular Disease	88%	3.3
C19	Transitions of Care	66%	3.4
C20	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	64%	2.5
C21	Getting Needed Care	82	3.3
C22	Getting Appointments and Care Quickly	84	3.7
C23	Customer Service	90	3.4
C24	Rating of Health Care Quality	87	3.4
C25	Rating of Health Plan	86	3.4
C26	Care Coordination	87	3.5
C27	Complaints about the Health Plan	0.30	4.0
C28	Members Choosing to Leave the Plan	16%	3.7
C29	Health Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.3
C30	Plan Makes Timely Decisions about Appeals	98%	3.9
C31	Reviewing Appeals Decisions	98%	3.9
C32	Call Center – Foreign Language Interpreter and TTY Availability	97%	4.4

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	97%	4.4	99%	4.5
D02	Complaints about the Drug Plan	0.31	4.0	0.06	4.2
D03	Members Choosing to Leave the Plan	16%	3.7	9%	3.0
D04	Drug Plan Quality Improvement	Medicare only shows a Star Rating for this measure	3.1	Medicare only shows a Star Rating for this measure	2.8
D05	Rating of Drug Plan	87	3.5	85	3.5
D06	Getting Needed Prescription Drugs	90	3.6	89	3.4
D07	MPF Price Accuracy	99	4.2	99	4.4
D08	Medication Adherence for Diabetes Medications	89%	2.7	88%	2.9
D09	Medication Adherence for Hypertension (RAS antagonists)	89%	3.4	89%	3.1
D10	Medication Adherence for Cholesterol (Statins)	89%	3.3	88%	2.9
D11	Statin Use in Persons with Diabetes (SUPD)	88%	3.1	84%	3.5
D12	Concurrent Use of Opioids and Benzodiazepines (COB)	13%	3.5	12%	3.3
D13	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	9%	3.3	6%	2.7

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	01/01/2025 – 12/31/2025
C02	Colorectal Cancer Screening	HEDIS	01/01/2025 – 12/31/2025
C03	Annual Flu Vaccine	CAHPS	03/2026 – 05/2026
C04	Improving or Maintaining Physical Health	HOS	07/14/2025 – 11/03/2025
C05	Improving or Maintaining Mental Health	HOS	07/14/2025 – 11/03/2025
C06	Monitoring Physical Activity	HEDIS-HOS	07/14/2025 – 11/03/2025
C07	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	01/01/2025 – 12/31/2025
C08	Care for Older Adults – Medication Review	HEDIS	01/01/2025 – 12/31/2025
C09	Care for Older Adults – Functional Status Assessment	HEDIS	01/01/2025 – 12/31/2025
C10	Osteoporosis Management in Women who had a Fracture	HEDIS	01/01/2025 – 12/31/2025
C11	Diabetes Care – Eye Exam	HEDIS	01/01/2025 – 12/31/2025
C12	Diabetes Care – Blood Sugar Controlled	HEDIS	01/01/2025 – 12/31/2025
C13	Kidney Health Evaluation for Patients with Diabetes	HEDIS	01/01/2025 – 12/31/2025
C14	Controlling Blood Pressure	HEDIS	01/01/2025 – 12/31/2025
C15	Reducing the Risk of Falling	HEDIS-HOS	07/14/2025 – 11/03/2025
C16	Improving Bladder Control	HEDIS-HOS	07/14/2025 – 11/03/2025
C17	Plan All-Cause Readmission	HEDIS	01/01/2025 – 12/31/2025
C18	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	01/01/2025 – 12/31/2025
C19	Transitions of Care	HEDIS	01/01/2025 – 12/31/2025
C20	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	01/01/2025 – 12/31/2025
C21	Getting Needed Care	CAHPS	03/2026 – 05/2026
C22	Getting Appointments and Care Quickly	CAHPS	03/2026 – 05/2026
C23	Customer Service	CAHPS	03/2026 – 05/2026
C24	Rating of Health Care Quality	CAHPS	03/2026 – 05/2026
C25	Rating of Health Plan	CAHPS	03/2026 – 05/2026
C26	Care Coordination	CAHPS	03/2026 – 05/2026
C27	Complaints about the Health Plan	Complaints Tracking Module (CTM)	01/01/2025 – 12/31/2025
C28	Members Choosing to Leave the Plan	MBDSS	01/01/2025 – 12/31/2025
C29	Health Plan Quality Improvement	Star Ratings	Not Applicable
C30	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	01/01/2025 – 12/31/2025
C31	Reviewing Appeals Decisions	Independent Review Entity (IRE)	01/01/2025 – 12/31/2025
C32	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	02/2026 – 05/2026

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	02/2026– 05/2026
D02	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	01/01/2025 – 12/31/2025
D03	Members Choosing to Leave the Plan	MBDSS	01/01/2025 – 12/31/2025
D04	Drug Plan Quality Improvement	Star Ratings	Not Applicable
D05	Rating of Drug Plan	CAHPS	03/2026 – 05/2026
D06	Getting Needed Prescription Drugs	CAHPS	03/2026 – 05/2026
D07	MPF Price Accuracy	PDE data, MPF Pricing Files	01/01/2025 – 09/30/2025
D08	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	01/01/2025 – 12/31/2025
D09	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	01/01/2025 – 12/31/2025
D10	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	01/01/2025 – 12/31/2025
D11	Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) data	01/01/2025 – 12/31/2025
D12	Concurrent Use of Opioids and Benzodiazepines (COB)	Prescription Drug Event (PDE) data	01/01/2025 – 12/31/2025
D13	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Prescription Drug Event (PDE) data	01/01/2025 – 12/31/2025

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 2025.

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) + Number of enrollees eligible for an annual HRA (Element B) greater than or equal to 30] during contract year 2025.

Exclude any contracts with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2026), 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 2025 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 07/01/2026 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- compliant 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 2025 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 2025 SNP Care Reporting Requirements data but that failed at least one of the four data elements (elements A, B, C, and F) are listed as "CMS identified issues with this plan's data."

Small size: Contracts that have not yet been suppressed and have a SNP Care Assessment rate denominator [Number of New Enrollees due for an Initial HRA (Element A) + Number of enrollees

eligible for an annual reassessment HRA (Element B)] of fewer than 30 are listed as "No data available."

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

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

[Number of initial HRAs performed on new enrollees (Element C)

+ Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)]

/ [Number of new enrollees due for an Initial HRA (Element A)

+ Number of enrollees eligible for an annual reassessment HRA (Element B)]

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

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

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

Definitions

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

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

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

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

Setup Calculations

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

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

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

Pooled Analysis

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

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

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

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

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

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

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

All data are available in the CMS Measurement Year 2025 HEDIS® Public Use File (PUF) and can be looked up by IndicatorKey (row) and Variable name (column).

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

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

Denominator(18+) = Denominator(18-64) + Denominator(65+)
ObservedCount(18+) = ObservedCount(18-64) + ObservedCount(65+)
ExpectedCount(18+) = ExpectedCount(18-64) + ExpectedCount(65+)

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

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

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

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

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

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

And round to the nearest integer.

Example: Calculating the final rate for Contract 1

Contract	IndicatorKey	Denominator	ObservedCount	ExpectedCount
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 × 0.135181 x 100 = 13.41
Final Rate reported for Contract 1 = 13%

The actual calculated National Observed Rate used in the 2027 Star Ratings was 0.108967772822345.

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	Outcome Measure	3
C05	Improving or Maintaining Mental Health	Outcome Measure	3
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 – Functional Status 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	Plan All-Cause Readmissions	Outcome Measure	3
C18	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
C19	Transitions of Care	Process Measure	1
C20	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
C21	Getting Needed Care	Patients' Experience and Complaints Measure	2
C22	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
C23	Customer Service	Patients' Experience and Complaints Measure	2
C24	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
C25	Rating of Health Plan	Patients' Experience and Complaints Measure	2
C26	Care Coordination	Patients' Experience and Complaints Measure	2
C27	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
C28	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
C29	Health Plan Quality Improvement	Improvement Measure	5
C30	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
C31	Reviewing Appeals Decisions	Measures Capturing Access	2
C32	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

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	Statin Use in Persons with Diabetes (SUPD)	Process Measure	1
D12	Concurrent Use of Opioids and Benzodiazepines (COB)	Process Measure	1
D13	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	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):

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

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

Attachment 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 2026 and 2027.

For measures where a higher score is better:

$$\text{Improvement Change Score} = \text{Score in 2027} - \text{Score in 2026}$$

For measures where a lower score is better:

$$\text{Improvement Change Score} = \text{Score in 2026} - \text{Score in 2027}$$

An eligible measure was defined as a measure for which a contract was scored in both the 2026 and 2027 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 2026 and 2027 was determined by a two-sided t-test at the 0.05 significance level:

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

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

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

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

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

Measures are generally weighted as follows:

Outcome or intermediate outcome measure: Weight of 3

Access or patient experience/complaints measure: Weight of 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 = Net improvement for process measures
Net_Imp_Outcome = Net improvement for outcome and intermediate outcome measures
Net_Imp_PtExp = Net improvement for patient experience/complaints and access measures
Elig_Process = Number of eligible process measures
Elig_Outcome = Number of eligible outcome and intermediate outcome measures
Elig_PtExp = Number of eligible patient experience/complaints and access measures

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

General Standard Error Formula

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

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

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

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

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

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

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

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

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

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

Improvement Change Score Standard Error Numerical Example

For measure C03, contract A:

$se(Y_{i2})$ = 2.805

$se(Y_{i1})$ = 3.000

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

Improvement change score standard error for measure C03 for contract A = sqrt ($2.805^2 + 3.000^2 – 2 * 0.901 * 2.805 * 3.000$) = 1.305

Standard Error Formulas (SEF) for Specific Measures

The following formulas are used for calculating the contract-specific standard errors for specific measures in the 2027 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 – C16, C18, C20, C28, C30 – C32, D01, D03, D08 – D11**

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

for y = 2026, 2027

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

2. **SEF for Measure: C08**

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

The plan level standard error is calculated as:

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

for y = 2026, 2027 and j = Plan 1, Plan 2

The contract level standard error is then calculated as:

Let W_{y1} = The weight assigned to the first PBP results (estimated, auditable) for year y, where y = 2026, 2027. 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 = 2026, 2027. This result is estimated by the formula

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

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

for y = Contract Year 2026, Contract Year 2027 and i = Contract i

3. **SEF for Measure C17**

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

for y = 2026, 2027

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

4. SEF for Measure C19

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

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

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

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

for y = 2025, 2026

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

$Cov(T_{1y}, T_{2y}) = Corr(T_{1y}, T_{2y}) * \sqrt{Var(T_{1y})} * \sqrt{Var(T_{2y})}$ and so on for each pair of component measures. We estimate the correlations between pairs of component measures by calculating the sample correlation across all contract scores. These correlations are shown in the table below.

Measures		2026 Correlation	2027 Correlation
Patient Engagement After Inpatient Discharge	Receipt of Discharge Information	0.533101802	0.458990958
Patient Engagement After Inpatient Discharge	Notification of Inpatient Admission	0.474357902	0.322276254
Patient Engagement After Inpatient Discharge	Medication Reconciliation Post-Discharge	0.471027895	0.4452248
Receipt of Discharge Information	Notification of Inpatient Admission	0.770939278	0.76019171
Receipt of Discharge Information	Medication Reconciliation Post-Discharge	0.450202368	0.498416754
Notification of Inpatient Admission	Medication Reconciliation Post-Discharge	0.580296699	0.733056533

5. SEF for Measures: C03, C21 – C26, and D05, D06

The CAHPS measure standard errors for 2026 and 2027 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: C27, D02

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

NumDays: 2026 = 366, 2027 = 365

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 x Price Accuracy Score) + (0.5 x Claim Percentage Score), the composite measure's variance (and standard error) is a

function of the variance of the Price Accuracy Score, the variance of the Claim Percentage Score, and the covariance between them. We assume that the product of the total PDE cost and the Price Accuracy Score (on a 0-1 scale) follows a binomial distribution, and likewise that the product of the number of PDE claims and the 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 = 2026, 2027.

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

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

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

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

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

2026 Correlation	2027 Correlation
0.63789335	0.49636438

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

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

for y = 2026, 2027

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	0.946640
C02	Colorectal Cancer Screening	Not Included	NA
C03	Annual Flu Vaccine	Included	0.883388
C04	Improving or Maintaining Physical Health	Not Included	NA
C05	Improving or Maintaining Mental Health	Not Included	NA
C06	Monitoring Physical Activity	Included	0.830088
C07	Special Needs Plan (SNP) Care Management	Included	0.915660
C08	Care for Older Adults – Medication Review	Included	0.499951
C09	Care for Older Adults – Functional Status Assessment	Not Included	NA
C10	Osteoporosis Management in Women who had a Fracture	Included	0.855347
C11	Diabetes Care – Eye Exam	Included	0.839139
C12	Diabetes Care – Blood Sugar Controlled	Included	0.668262
C13	Kidney Health Evaluation for Patients with Diabetes	Included	0.839842
C14	Controlling Blood Pressure	Included	0.717890
C15	Reducing the Risk of Falling	Included	0.845097
C16	Improving Bladder Control	Included	0.339250
C17	Plan All-Cause Readmissions	Included	0.638581
C18	Statin Therapy for Patients with Cardiovascular Disease	Included	0.648948
C19	Transitions of Care	Included	0.819116
C20	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Included	0.887587
C21	Getting Needed Care	Included	0.824778
C22	Getting Appointments and Care Quickly	Included	0.715054
C23	Customer Service	Included	0.702474
C24	Rating of Health Care Quality	Included	0.755624
C25	Rating of Health Plan	Included	0.808933
C26	Care Coordination	Included	0.712722
C27	Complaints about the Health Plan	Included	0.736583
C28	Members Choosing to Leave the Plan	Included	0.805028
C29	Health Plan Quality Improvement	Not Included	NA

Measure ID	Measure Name	Measure Usage	Correlation
C30	Plan Makes Timely Decisions about Appeals	Included	0.365400
C31	Reviewing Appeals Decisions	Included	0.569935
C32	Call Center – Foreign Language Interpreter and TTY Availability	Included	0.476294

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	0.571922
D02	Complaints about the Drug Plan	Included	0.744838
D03	Members Choosing to Leave the Plan	Included	0.802758
D04	Drug Plan Quality Improvement	Not Included	NA
D05	Rating of Drug Plan	Included	0.726078
D06	Getting Needed Prescription Drugs	Included	0.652781
D07	MPF Price Accuracy	Included	0.812236
D08	Medication Adherence for Diabetes Medications	Included	0.520668
D09	Medication Adherence for Hypertension (RAS antagonists)	Included	0.708107
D10	Medication Adherence for Cholesterol (Statins)	Included	0.677332
D11	Statin Use in Persons with Diabetes (SUPD)	Included	0.848424
D12	Concurrent Use of Opioids and Benzodiazepines (COB)	Not Included	NA
D13	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Not Included	NA

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	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
C	Access to Primary Care Doctor Visits	HEDIS					DMC08	DMC09	DMC09	DMC09	DMC09	DMC10	DMC10	DMC11	DMC10	DMC12	DMC12
C	Adult BMI Assessment	HEDIS							C07	C07	C07	C07	C07	C07	C08	C10	C10
C	Annual Flu Vaccine	CAHPS	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C03	C04	C06	C06
C	Antidepressant Medication Management (6 months)	HEDIS	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC02	DMC03	DMC03	DMC03	DMC03
C	Appropriate Monitoring of Patients Taking Long-term Medications	HEDIS										DMC04	DMC04	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	DME07	C30	C28	C28	DME08	C31	C31
C	Breast Cancer Screening	HEDIS	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	C01	DMC22	C01	C01
C	Call Answer Timeliness	HEDIS												DMC02	DMC02	DMC02	DMC02
C	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMC06	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC09		DMC09	DMC09
C	Call Center - Calls Disconnected When Customer Calls Health Plan	Call Center Monitoring	DMC09	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	C32	C33	C30	C30	C28	C28	C32	C33	C34	C34	C32	C32		C36	C36
C	Call Center – Information Accuracy	Call Center Monitoring														DMC10	DMC10
C	Cardiac Rehabilitation – Achievement	HEDIS	DMC25	DMC25	DMC25	DMC25	DMC29										
C	Cardiac Rehabilitation – Engagement 1	HEDIS	DMC26	DMC26	DMC26	DMC26	DMC30										
C	Cardiac Rehabilitation – Engagement 2	HEDIS	DMC27	DMC27	DMC27	DMC27	DMC31										
C	Cardiac Rehabilitation – Initiation	HEDIS	DMC28	DMC28	DMC28	DMC28	DCM32										
C	Cardiovascular Care – Cholesterol Screening	HEDIS													C02	C03	C03
C	Care Coordination	CAHPS	C26	C27	C24	C24	C22	C22	C26	C27	C28	C27	C25	C25	C28	C29	C29

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
C	Care for Older Adults – Functional Status Assessment	HEDIS	C09	DMC21	DMC21	DMC21	DMC25	DCM25	C10	C10	C10	C10	C10	C10	C11	C12	C12
C	Care for Older Adults – Medication Review	HEDIS	C08	C08	C06	C06	C06	C06	C09	C09	C09	C09	C09	C09	C10	C11	C11
C	Care for Older Adults – Pain Assessment	HEDIS		C09	C07	C07	C07	C07	C11	C11	C11	C11	C11	C11	C12	C13	C13
C	Colorectal Cancer Screening	HEDIS	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C02	C01	C02	C02
C	Colorectal Cancer Screening – Age 45-75	HEDIS	DMC29	DMC29	DMC29	DMC29											
C	Complaints about the Health Plan	CTM	C27/D02	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
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	DMC03	DMC04	DMC04	DMC04	DMC04
C	Controlling Blood Pressure	HEDIS	C14	C14	C11	C11	C12	DMC16	DMC16	DMC17	C16	C16	C16	C16	C18	C19	C19
C	Customer Service	CAHPS	C23	C24	C21	C21	C19	C19	C23	C24	C25	C24	C22	C22	C25	C26	C26
C	Diabetes Care – Blood Sugar Controlled	HEDIS	C12	C12	C10	C10	C11	C11	C15	C15	C15	C15	C15	C15	C16	C17	C17
C	Diabetes Care – Cholesterol Controlled	HEDIS													C17	C18	C18
C	Diabetes Care – Cholesterol Screening	HEDIS													C03	C04	C04
C	Diabetes Care – Eye Exam	HEDIS	C11	C11	C09	C09	C09	C09	C13	C13	C13	C13	C13	C13	C14	C15	C15
C	Diabetes Care – Kidney Disease Monitoring	HEDIS					C10	C10	C14	C14	C14	C14	C14	C14	C15	C16	C16
C	Doctors who Communicate Well	CAHPS	DMC05	DMC05	DMC05	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08
C	Engagement of Substance Use Disorder (SUD) Treatment	HEDIS	DMC13	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC14	DMC14	DMC15	DMC15	DMC16	DMC15	DMC19	
C	Enrollment Timeliness	MARx										DME01	DME01	DME01	DME01	DME01	C37 / D05
C	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	C20	C21	C18	C18	DMC15	DMC17	DMC17	DMC18							

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
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
C	Getting Appointments and Care Quickly	CAHPS	C22	C23	C20	C20	C18	C18	C22	C23	C24	C23	C21	C21	C24	C25	C25
C	Getting Needed Care	CAHPS	C21	C22	C19	C19	C17	C17	C21	C22	C23	C22	C20	C20	C23	C24	C24
C	Glaucoma Testing	HEDIS														C05	C05
C	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11
C	Health Plan Quality Improvement	Star Ratings	C29	C30	C27	C27	C25	C25	C29	C30	C31	C31	C29	C29	C31	C33	C33
C	Hospitalizations for Potentially Preventable Complications	HEDIS	DMC15	DMC15	DMC15	DMC15	DMC14	DMC15	DMC15	DMC15	DMC15	DMC16	DMC24				
C	Improving Bladder Control	HEDIS-HOS	C16	C16	C13	C13	C14	C14	C18	C18	C19	C19	DMC22	DMC23	C20	C21	C21
C	Improving or Maintaining Mental Health	HOS	C05	C05	DMC23	DMC23	DMC27	DMC27	C05	C05	C05	C05	C05	C05	C06	C08	C08
C	Improving or Maintaining Physical Health	HOS	C04	C04	DMC24	DMC24	DMC28	DMC28	C04	C04	C04	C04	C04	C04	C05	C07	C07
C	Initiation and Engagement of Substance Use Disorder (SUD) Treatment Average	HEDIS	DMC14	DMC14	DMC14	DMC14											
C	Initiation of Substance Use Disorder (SUD) Treatment	HEDIS	DMC12	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC13	DMC13	DMC14	DMC14	DMC15	DMC14	DMC18	
C	Kidney Health Evaluation for Patients with Diabetes	HEDIS	C13	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	C28/D03	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
C	Monitoring Physical Activity	HEDIS-HOS	C06	C06	C04	C04	C04	C04	C06	C06	C06	C06	C06	C06	C07	C09	C09
C	Osteoporosis Management in Women who had a Fracture	HEDIS	C10	C10	C08	C08	C08	C08	C12	C12	C12	C12	C12	C12	C13	C14	C14
C	Osteoporosis Testing	HEDIS-HOS						DMC04	DMC04	DMC04	DMC04	DMC05	DMC05	DMC06	DMC06	DMC06	DMC06
C	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	HEDIS	DMC11	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC12	DMC12	DMC13	DMC13	DMC14	DMC13	DMC17	

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
C	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	HEDIS	DMC10	DMC10	DMC10	DMC10	DMC10	DMC11	DMC11	DMC11	DMC11	DMC12	DMC12	DMC13	DMC12	DMC16	
C	Physical Functioning Activities of Daily Living	HOS	DMC20	DMC20	DMC20	DMC20	DMC24										
C	Plan All-Cause Readmissions	HEDIS	C17	C18	C15	C15	DMC21	DMC23	DMC23	C20	C21	C21	C19	C19	C22	C23	C23
C	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE) / C2C	C30	C31	C28	C28	C26	C26	C30	C31	C32	C32	C30	C30	C32	C34	C34
C	Pneumonia Vaccine	CAHPS	DMC07	DMC07	DMC07	DMC07	DMC07	DMC08	DMC08	DMC08	DMC08	DMC09	DMC09	DMC10	DMC09	DMC11	DMC11
C	Rating of Health Care Quality	CAHPS	C24	C25	C22	C22	C20	C20	C24	C25	C26	C25	C23	C23	C26	C27	C27
C	Rating of Health Plan	CAHPS	C25	C26	C23	C23	C21	C21	C25	C26	C27	C26	C24	C24	C27	C28	C28
C	Reducing the Risk of Falling	HEDIS-HOS	C15	C15	C12	C12	C13	C13	C17	C17	C18	C18	C18	C18	C21	C22	C22
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) / C2C	C31	C32	C29	C29	C27	C27	C31	C32	C33	C33	C31	C31	C33	C35	C35
C	Rheumatoid Arthritis Management	HEDIS						C12	C16	C16	C17	C17	C17	C17	C19	C20	C20
C	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	C07	C07	C05	C05	C05	C05	C08	C08	C08	C08	C08	C08	C09	DMC14	DMC14
C	Statin Therapy for Patients with Cardiovascular Disease	HEDIS	C18	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
C	Transitions of Care – Average	HEDIS	C19	C20	C17	C17	DMC20	DMC22	DMC22	DMC23							
C	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS	DMC16	DMC16	DMC16	DMC16	DMC16	DMC18	DMC18	DMC19							
C	Transitions of Care – Notification of Inpatient Admission	HEDIS	DMC17	DMC17	DMC17	DMC17	DMC17	DMC19	DMC19	DMC20							
C	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	DMC18	DMC18	DMC18	DMC18	DMC18	DMC20	DMC20	DMC21							

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
C	Transitions of Care – Receipt of Discharge Information	HEDIS	DMC19	DMC19	DMC19	DMC19	DMC19	DMC21	DMC21	DMC22							

Table J-2: Part D Measure History

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	Notes
D	4Rx Timeliness	Acumen / OIS (4Rx)																
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	DMD08	DMD12	DMD14	DMD16	DMD18						
D	Antipsychotic Use in Persons with Dementia – for Community-Only Residents (APD-COMM)	Prescription Drug Event (PDE) Data							DMD13	DMD15	DMD17							
D	Antipsychotic Use in Persons with Dementia – For Long-Term Nursing Home Residents (APD-LTNH)	Prescription Drug Event (PDE) Data	DMD09	DMD09	DMD09	DMD09	DMD09	DMD09	DMD14	DMD16	DMD18							
D	Appeals Auto–Forward	Independent Review Entity (IRE) / C2C							D02	D02	D02	D02	D02	D02	D01	D02	D03	
D	Appeals Upheld	Independent Review Entity (IRE) / C2C							D03	D03	D03	D03	D03	D03	D02	D03	D04	
D	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	D06	D06	D06	DME08	D05	D07	
D	Call Center – Beneficiary Hold Time	Call Center Monitoring	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04		DMD04	DMD04	
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	DMD01	DMD03	DMD03	DMD03	DMD03	DMD03	DMD03		DMD03	DMD03	
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		D01	D02	
D	Call Center – Information Accuracy	Call Center Monitoring														DMD05	DMD05	
D	Call Center – Pharmacy Hold Time	Call Center Monitoring	DMD04	DMD04	DMD04	DMD04	DMD04	DMD04	DMD08	DMD09	DMD09	DMD09	DMD11	DMD11		DMD15	D01	

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	Notes
D	Complaint Resolution	Complaints Tracking Module (CTM)																
D	Complaints – Enrollment	Complaints Tracking Module (CTM)																
D	Complaints – Other	Complaints Tracking Module (CTM)																
D	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	C27/ D02	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	
D	Concurrent Use of Opioids and Benzodiazepines	Prescription Drug Event (PDE) Data	D12	DMD10	DMD10	DMD10	DMD10	DMD10	DMD17									
D	Diabetes Medication Dosing	Prescription Drug Event (PDE) Data								DMD06	DMD06	DMD06	DMD06	DMD06	DMD04	DMD07	DMD07	
D	Diabetes Treatment	Prescription Drug Event (PDE) Data													D10	D12	D15	
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	
D	Drug Plan Quality Improvement	Star Ratings	D04	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	
D	Enrollment Timeliness	MARx										DME01	DME01	DME01	DME01	DME01	C37 / D05	
D	Formulary Administration Analysis	Part D Sponsor									DMD15	DMD17						
D	Getting Information From Drug Plan	CAHPS											DMD10	DMD10	DMD09	DMD14	D10	
D	Getting Needed Prescription Drugs	CAHPS	D06	D06	D06	D06	D06	D06	D08	D08	D08	D09	D09	D09	D07	D09	D12	
D	Grievance Rate	Part C & D Plan Reporting	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME01	DME02	DME02	DME02	DME02	DMC13 / DMD11	DMC13 / DMD11	

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	Notes
D	High Risk Medication	Prescription Drug Event (PDE) Data								DMD14	DMD14	DMD16	D11	D11	D09	D11	D14	
D	Initial Opioid Prescribing	Prescription Drug Event (PDE) Data	DMD15	DMD15	DMD15	DMD15	DMD15											
D	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Data	D10	D10	D10	D10	D10	D10	D12	D12	D12	D13	D14	D14	D13	D15	D18	
D	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) Data	D08	D08	D08	D08	D08	D08	D10	D10	D10	D11	D12	D12	D11	D13	D16	
D	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) Data	D09	D09	D09	D09	D09	D09	D11	D11	D11	D12	D13	D13	D12	D14	D17	
D	Medication Adherence for Cholesterol (Statins) with Risk Adjustment (RA)	Prescription Drug Event (PDE) Data	DMD19	DMD19														
D	Medication Adherence for Diabetes Medications with Risk Adjustment	Prescription Drug Event (PDE) Data	DMD17	DMD17														
D	Medication Adherence for Hypertension (RAS antagonists) with Risk Adjustment (ADH-RAS)	Prescription Drug Event (PDE) Data	DMD18	DMD18														
D	Members Choosing to Leave the Plan	MBDSS	C28/ D03	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	
D	MPF – Composite	PDE Data, MPF Pricing Files															D12	B
D	MPF – Stability	PDE Data, MPF Pricing Files	DMD03	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	
D	MPF Price Accuracy	PDE Data, MPF Pricing Files	D07	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	DMD16												
D	Plan Submitted Higher Prices for Display on MPF	PDE Data, MPF Pricing Files	DMD05	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	D13	DMD13	DMD13	DMD13	DMD13	DMD13	DMD20									

Part	Measure Name	Data Source	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	Notes
D	Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)	Prescription Drug Event (PDE) Data	DMD14	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	D05	D07	D07	D07	D08	D08	D08	D06	D08	D11	
D	Reminders to fill prescriptions	CAHPS	DMD06	DMD06	DMD06	DMD06	DMD06	DMD06	DMD10	DMD11	DMD12	DMD13	DMD15	DMD15	DMD13			
D	Reminders to take medications	CAHPS	DMD07	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	D11	D12	D12	D12	D12	D12	D14	D14	D14	DMD15	DMD17					
D	Timely Effectuation of Appeals	Independent Review Entity (IRE) / C2C							DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	DMD02	
D	Timely Receipt of Case Files for Appeals	Independent Review Entity (IRE) / C2C							DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	DMD01	
D	Transition monitoring	Transition Monitoring Program Analysis									DMD11							D
D	Transition monitoring – failure rate for all other drugs	Transition Monitoring Program Analysis									DMD12	DMD14	DMD14	DMD12				C
D	Transition monitoring – failure rate for drugs within classes of clinical concern	Transition Monitoring Program Analysis									DMD11	DMD13	DMD13	DMD11				C
D	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Prescription Drug Event (PDE) Data							DMD15									
D	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Prescription Drug Event (PDE) Data	DMD11	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	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	2027	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
E	Beneficiary Access and Performance Problems	Administrative Data	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	DME07	C30 / D06	C28 / D06	C28 / D06	DME08	C31 / D05	C31 / 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
E	Grievance Rate	Part C & D Plan Reporting	DME01	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).

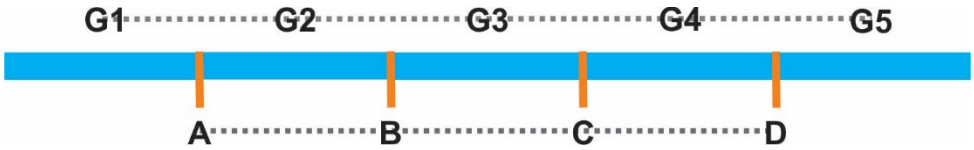
Clustering Methodology Introduction

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

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

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

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



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

Example 1 – Clustering Methodology for a Higher is Better measure

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

value between 0% and 100% (including 0% and 100%), the one-star and five-star categories contain only a single value in the table below as the upper or lower bound.

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

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

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

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

Example 2 – Clustering Methodology for a Lower is Better measure

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

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

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

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

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

Clustering Methodology Detail

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

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

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

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

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

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

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

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

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

1. Produce the individual measure distance matrix.

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

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

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

2. Create a tree of cluster assignments.

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

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

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

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

```
        id contract_id;
run;
```

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

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

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

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

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

4. Final Thresholds

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

Determining Stars from Scores and Thresholds

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

Table K-3: 2027 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 70%	Greater than or equal to 70% to less than 77%	Greater than or equal to 77% to less than 83%	Greater than or equal to 83%

Measure ID	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C02	Less than 59%	Greater than or equal to 59% to less than 68%	Greater than or equal to 68% to less than 75%	Greater than or equal to 75% to less than 82%	Greater than or equal to 82%
C04	Less than 67%	Greater than or equal to 67% to less than 71%	Greater than or equal to 71% to less than 73%	Greater than or equal to 73% 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 87%	Greater than or equal to 87%
C06	Less than 46%	Greater than or equal to 46% to less than 50%	Greater than or equal to 50% to less than 55%	Greater than or equal to 55% to less than 61%	Greater than or equal to 61%
C07	Less than 50%	Greater than or equal to 50% to less than 69%	Greater than or equal to 69% to less than 80%	Greater than or equal to 80% to less than 92%	Greater than or equal to 92%
C08	Less than 88%	Greater than or equal to 88% to less than 92%	Greater than or equal to 92% to less than 96%	Greater than or equal to 96% to less than 99%	Greater than or equal to 99%
C09	Less than 65%	Greater than or equal to 65% to less than 78%	Greater than or equal to 78% to less than 87%	Greater than or equal to 87% to less than 95%	Greater than or equal to 95%
C10	Less than 29%	Greater than or equal to 29% to less than 42%	Greater than or equal to 42% to less than 52%	Greater than or equal to 52% to less than 70%	Greater than or equal to 70%
C11	Less than 61%	Greater than or equal to 61% to less than 72%	Greater than or equal to 72% to less than 79%	Greater than or equal to 79% to less than 86%	Greater than or equal to 86%
C12	Less than 81%	Greater than or equal to 81% 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%
C13	Less than 46%	Greater than or equal to 46% to less than 63%	Greater than or equal to 63% to less than 72%	Greater than or equal to 72% to less than 83%	Greater than or equal to 83%
C14	Less than 75%	Greater than or equal to 75% to less than 79%	Greater than or equal to 79% to less than 84%	Greater than or equal to 84% to less than 90%	Greater than or equal to 90%
C15	Less than 52%	Greater than or equal to 52% to less than 58%	Greater than or equal to 58% to less than 65%	Greater than or equal to 65% to less than 72%	Greater than or equal to 72%
C16	Less than 37%	Greater than or equal to 37% to less than 43%	Greater than or equal to 43% to less than 47%	Greater than or equal to 47% to less than 52%	Greater than or equal to 52%
C17	Greater than 13%	Greater than 11% to less than or equal to 13%	Greater than 10% to less than or equal to 11%	Greater than 8% to less than or equal to 10%	Less than or equal to 8%
C18	Less than 82%	Greater than or equal to 82% to less than 86%	Greater than or equal to 86% to less than 89%	Greater than or equal to 89% to less than 93%	Greater than or equal to 93%
C19	Less than 38%	Greater than or equal to 38% to less than 56%	Greater than or equal to 56% to less than 69%	Greater than or equal to 69% to less than 80%	Greater than or equal to 80%
C20	Less than 55%	Greater than or equal to 55% to less than 65%	Greater than or equal to 65% to less than 74%	Greater than or equal to 74% to less than 90%	Greater than or equal to 90%
C27	Greater than 0.84	Greater than 0.56 to less than or equal to 0.84	Greater than 0.33 to less than or equal to 0.56	Greater than 0.15 to less than or equal to 0.33	Less than or equal to 0.15
C28	Greater than 37%	Greater than 28% to less than or equal to 37%	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%
C29	Less than -0.184029	Greater than or equal to -0.184029 to less than 0	Greater than or equal to 0 to less than 0.161052	Greater than or equal to 0.161052 to less than 0.336992	Greater than or equal to 0.336992
C30	Less than 94%	Greater than or equal to 94% 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%
C31	Less than 94%	Greater than or equal to 94% 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%
C32	Less than 92%	Greater than or equal to 92% to less than 95%	Greater than or equal to 95% to less than 97%	Greater than or equal to 97% to less than 100%	100%

Notes: These are not the final thresholds for the 2027 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-4: 2027 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 91%	Greater than or equal to 91% to less than 94%	Greater than or equal to 94% to less than 97%	Greater than or equal to 97% to less than 100%	100%
D01	PDP	Less than 94%	Greater than or equal to 94% to less than 97%	Greater than or equal to 97% to less than 98%	Greater than or equal to 98% to less than 100%	100%
D02	MA-PD	Greater than 0.84	Greater than 0.56 to less than or equal to 0.84	Greater than 0.33 to less than or equal to 0.56	Greater than 0.15 to less than or equal to 0.33	Less than or equal to 0.15
D02	PDP	Greater than 0.13	Greater than 0.08 to less than or equal to 0.13	Greater than 0.04 to less than or equal to 0.08	Greater than 0.01 to less than or equal to 0.04	Less than or equal to 0.01
D03	MA-PD	Greater than 37%	Greater than 28% to less than or equal to 37%	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 13%	Greater than 7% to less than or equal to 13%	Greater than 5% to less than or equal to 7%	Greater than 2% to less than or equal to 5%	Less than or equal to 2%
D04	MA-PD	Less than -0.296792	Greater than or equal to -0.296792 to less than 0	Greater than or equal to 0 to less than 0.231209	Greater than or equal to 0.231209 to less than 0.513866	Greater than or equal to 0.513866
D04	PDP	Less than -0.142857	Greater than or equal to -0.142857 to less than 0	Greater than or equal to 0 to less than 0.245851	Greater than or equal to 0.245851 to less than 0.502381	Greater than or equal to 0.502381
D07	MA-PD	Less than 97	Greater than or equal to 97 to less than 98	Greater than or equal to 98 to less than 99	Greater than or equal to 99 to less than 100	100
D07	PDP	0	Greater than or equal to 0 to less than 98	Greater than or equal to 98 to less than 99	Greater than or equal to 99 to less than 100	100
D08	MA-PD	Less than 86%	Greater than or equal to 86% to less than 89%	Greater than or equal to 89% to less than 91%	Greater than or equal to 91% to less than 93%	Greater than or equal to 93%
D08	PDP	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% to less than 95%	Greater than or equal to 95%
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 90%	Greater than or equal to 90% to less than 93%	Greater than or equal to 93%
D09	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%
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 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% to less than 93%	Greater than or equal to 93%
D11	MA-PD	Less than 83%	Greater than or equal to 83% to less than 87%	Greater than or equal to 87% to less than 90%	Greater than or equal to 90% to less than 94%	Greater than or equal to 94%

Measure ID	Type	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D11	PDP	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 87%	Greater than or equal to 87%
D12	MA-PD	Greater than 20%	Greater than 16% to less than or equal to 20%	Greater than 12% to less than or equal to 16%	Greater than 8% to less than or equal to 12%	Less than or equal to 8%
D12	PDP	Greater than 18%	Greater than 14% to less than or equal to 18%	Greater than 11% to less than or equal to 14%	Greater than 6% to less than or equal to 11%	Less than or equal to 6%
D13	MA-PD	Greater than 15%	Greater than 11% to less than or equal to 15%	Greater than 7% to less than or equal to 11%	Greater than 5% to less than or equal to 7%	Less than or equal to 5%
D13	PDP	Greater than 7%	Greater than 6% to less than or equal to 7%	Greater than 4% to less than or equal to 6%	Greater than 1% to less than or equal to 4%	Less than or equal to 1%

Notes: These are not the final thresholds for the 2027 Star Ratings. See the Measure Details section for final thresholds after guardrails have been applied.

Table K-5: 2027 Star Ratings Part C non-CAHPS Measure Tukey Outlier Cutoffs

Measure ID	Lower Cutoff	Upper Cutoff
C01	33	100
C02	36	100
C04	57	85
C05	70	98
C06	23	79
C07	0	100
C08	80	100
C09	42	100
C10	0	100
C11	37	100
C12	67	100
C13	23	100
C14	56	100
C15	20	97
C16	20	69
C17	3	17
C18	74	100
C19	0	100
C20	24	100
C27	0	1.30
C28	0	81
C29 (improve)	0	0.805194
C29 (decline)	-0.606756	0
C30	92	100
C31	92	100
C32	88	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: 2027 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	1.30
D03	MA-PD	0	81
D04 (improve)	MA-PD	0	1
D04 (decline)	MA-PD	-1	0
D07	MA-PD	96	100
D08	MA-PD	78	99
D09	MA-PD	79	100
D10	MA-PD	75	100
D11	MA-PD	67	100
D12	MA-PD	0	33
D13	MA-PD	0	22
D01	PDP	92	100
D02	PDP	0	0.26
D03	PDP	0	36
D04 (improve)	PDP	0	1
D04 (decline)	PDP	-1	0
D07	PDP	96	100
D08	PDP	78	99
D09	PDP	82	96
D10	PDP	79.5	97
D11	PDP	74	95
D12	PDP	0	26
D13	PDP	0	13

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

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

- For measures having a 0 to 100 scale, an absolute percentage cap of 5 percentage point is applied.

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

Measures from the CAHPS survey, except for Annual Flu Vaccine, 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 and CAHPS-specific information about composite scoring.

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.

Two-tailed t-tests are used to compare the case-mix adjusted mean for each contract to the overall mean for all other contracts in the nation as described in the CAHPS Macro Manual. A contract's mean score is considered to be statistically significantly different from the national mean if the t-test p-value is below the 0.05 threshold. Calculation of the t-statistic requires case-mix adjusted means and sampling variances for all contracts. National means are provided at https://www.ma-pdpcahps.org/en/comparative-data.

Interunit reliability is calculated for each contract's score for each measure. This continuous measure, taking values between 0 and 1, indicates how well the case-mix adjusted mean score for a single contract is measured and how well it distinguishes its performance from that of other contracts. Interunit reliability is calculated using the following formula: $R = 1-V/(V+t^2)$, where t^2 is the between-contract variance of the mean for that measure and V is the sampling variance of the contract's mean score. An Expectation-Maximization (EM) algorithm is employed to estimate between-contract variance, which requires case-mix adjusted means and sampling variances for all contracts. Further details, as well as between-contract variance values (t^2) for each

measure, 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. Very low reliability (less than 0.60) scores do not receive a Star Rating. 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-7 contains the 12% reliability cutoffs.

Table K-7: CAHPS Measure 12% Reliability Cutoffs

Measure	12% reliability cutoff
Annual Flu Vaccine	0.843883*
Getting Needed Care	0.710035
Getting Appointments and Care Quickly	0.535129**
Customer Service	0.622428
Rating of Health Care Quality	0.623005
Rating of Health Plan	0.810061*
Care Coordination	0.543141**
Rating of Drug Plan (MA-PD)	0.724583
Getting Needed Prescription Drugs (MA-PD)	0.527908**
Rating of Drug Plan (PDP)	0.916082*
Getting Needed Prescription Drugs (PDP)	0.802110*

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.

Tables K-8 and K-9 contain the rules applied to determine the final CAHPS measure star value.

Table K-8: 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-9: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
Less than 15th percentile by greater than 1 SE	1	1	1	2	2	2	2
Less than 15th percentile by less than or equal to 1 SE		2	1	2	2	2	2
Greater than or equal to 15th to less than 30th percentile	2	2	2	3	2	3	2
Greater than or equal to 30th to less than 60th percentile	3	2	2	3	3	4	4
Greater than or equal to 60th to less than 80th percentile	4	3	4	3	4	4	4
Greater than or equal to 80th percentile by less than or equal to 1 SE	5	4	4	4	4	4	5
Greater than or equal to 80th percentile by greater than 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (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.

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

Covered Days Start Date	1/1/20XX	1/16/20XX	2/1/20XX	2/16/20XX	3/1/20XX	3/16/20XX	4/1/20XX	4/16/20XX
Benazepril	15	16	15	13				
Captopril					15	16	30	

Covered days indicated by color: yellow = benazepril; blue = captopril

PDC Calculation
Covered Days: 120
Treatment Period: 120
PDC: 120/120 = 100.00%

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

Covered Days Start Date	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					
Benazepril & HCTZ			15	13				

Covered days indicated by color: pink = lisinopril; dark pink = lisinopril & HCTZ; dark yellow = benazepril & HCTZ

PDC Calculation
Covered Days: 59
Measurement Period: 120
PDC: 59/120 = 49.17%

Table L-3: After Overlap Adjustment

Covered Days Start Date	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			
Benazepril & HCTZ			15	13				

Covered days indicated by color: pink = lisinopril; dark pink = lisinopril & HCTZ; dark yellow = benazepril & HCTZ

PDC Calculation
Covered Days: 62
Measurement Period: 120
PDC: 62/120 = 51.67%

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

Covered Days Start Date	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	

Covered days indicated by color: pink = lisinopril; dark pink = lisinopril & HCTZ; blue = captopril

PDC Calculation
Covered Days: 92
Measurement Period: 120
PDC: 92/120: 76.67%

Table L-5: After Overlap Adjustment

Covered Days Start Date	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	

Covered days indicated by color: pink = lisinopril; dark pink = lisinopril & HCTZ; blue = captopril

PDC Calculation
Covered Days: 105
Measurement Period: 120
PDC: 105/120: 87.50%

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 treatment 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: 12/15 = 80.00%

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: 12/13 = 92.31%

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: 11/15 = 73.33%

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: 9/13 = 69.23%

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: 11/15 = 73.33%

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: 9/11 = 81.82%

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: 9/15 = 60.00%

With the adjustment for the IP stay, days 2-4 are deleted from the treatment period. Additionally, the drug coverage during the IP stay can be applied to any days without drug coverage after the IP stay. In the case of overlapping days with a subsequent fill of the same drug class, the days' supply of the subsequent fill are shifted. In this example, the days' supply of 2 to 4 during the IP stay are shifted to days 5 to 7 after the IP stay. Because day 7 includes one day supply of a subsequent fill (X2) of the same drug class, days 7 to 11 that corresponds to the subsequent fill are shifted to days 8 to 12. This is illustrated in Table L-13.

Table L-13: After Adjustment

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

PDC Calculation:
Covered Days: 9
Treatment Period: 12
PDC: 9/12 = 75.00%

Attachment M: Methodology for MPF Price Accuracy Measure

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

Contract Selection

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

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

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

MPF Composite Price Accuracy Score

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

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

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

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

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

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

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

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

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

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

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

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

where

[3] Because CMS continues to display pharmacy and drug pricing data for sanctioned plans on MPF to their current enrollees, sanctioned plans are not excluded from this measure. If, however, CMS completely suppresses a sanctioned contract's data from MPF display, then they would be excluded from the measure.

[4] MPF total costs are rounded to the nearest cent. For example, if the MPF total cost is $10.237, then it is rounded to $10.24. MPF unit costs are not rounded.

[5] When assigning the MPF dispensing fee, CMS identifies brand or generic status of a drug using reference data sources (FDA NSDE and RxNorm). If a drug's status is inconsistent, CMS will assign the higher of the brand or generic dispensing fee.

[6] To account for potential rounding errors, this analysis requires that the PDE cost exceed the rounded MPF cost by at least two cents ($0.02) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the rounded MPF cost is $10.23, the 2-cent difference would be counted towards plan's accuracy score. However, if the rounded MPF cost is higher than $10.23, the difference would not count towards the plan's accuracy score.

[7] The MPF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the MPF price is lower than the floor price, the PDE price is compared against the floor price.

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

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

where

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

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

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

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

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

Example of Accuracy Index Calculation

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

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

Table M-1: Example of Price Accuracy Index Calculation

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

PDE = Prescription Drug Event
MPF = Medicare Plan Finder

Part C Scaled Reduction Methodology

CMS's scaled reduction methodology is a three-stage process that uses the Part C Reporting Requirements data as the means to determine: first, whether a contract may be subject to a potential reduction for the Part C appeals measures due to an IRE data completeness issue; second, as the basis to determine the estimated error rate; and finally, to see whether the estimated error rate is statistically significantly greater than established thresholds for a scaled reduction.

Stage 1: Determine Whether the Contract is Subject to a Potential Reduction for the Part C Appeals Measures Due to an IRE Data Completeness Issue

Step 1A: Data Source and Data Values

The scaled reduction methodology uses the data submitted for the Part C Reporting Requirements for the measurement year that is associated with the Star Ratings' year. For example, the 2027 Star Ratings scaled reductions are based on the 2025 Part C Reporting Requirements data.

The following information is needed to begin the steps to determine whether a contract will be subject to a possible scaled reduction for their Part C appeals measures because of data integrity issues. The information is available in HPMS as part of the Plan Preview. The field name in HPMS is provided within parentheses after the description in the bulleted list below.

- Failed Validation in the Part C Reporting Requirements (Failed Data Validation)
  - Failed Data Validation- Yes/No
- Appeals Measure Related Standards Flag (Failed Appeals Measure Related)
  - Failed Appeals Measure-related Standards in the Part C Reporting Requirements-Yes/No
- Number of Cases Forwarded to IRE (Cases Forwarded to IRE)
  - The number of level 1 appeals where the plan made an unfavorable (adverse) or partially favorable (partially adverse) decision that was received by the IRE regardless of the disposition the IRE subsequently gave the case
- Number of Cases that Should Have Been Forwarded to the IRE (Cases Should Have Forward IRE)
- Part C Calculated Error Rate (Calculated Error Rate)

The Total Number of Cases that Should Have Been Forwarded to the IRE is calculated by adding Total of the Number of Partially Favorable (partially adverse) reconsiderations and the Total Number of Unfavorable (adverse) reconsiderations from the Part C Reporting Requirements during the measurement year (January 1st to December 31st)) [8] (Equation A).

Equation (A)

Total Number of Cases that Should Have Been Forwarded to IRE = Total Number of Partially Favorable Claims, Service Requests by Enrollees/Representatives and Non-Contract Providers + Total Number of Unfavorable Claims, Service Requests by Enrollees/Representatives and Non-Contract Providers

[8] These types of appeals can be found in the Medicare Part C Technical Specifications Document Contract Year 2025 under Section II: Organization Determinations & Reconsiderations in Subsection #4. Data Elements E through L.

Step 1B: Calculate Error Rate

Using the value in Step 1A, determine the Calculated Error Rate.

The Calculated Error Rate is calculated by taking 1 minus the quotient of the Number of Cases Received by IRE during measurement period and the Total Number of Cases that Should Have Been Forwarded to the IRE in the same period (Equation B).

Equation (B)

$$\text{Part C Calculated Error Rate} = 1 - \frac{\text{Total Number of Cases Received by the IRE}}{\text{Total Number of Cases that Should Have Been Forwarded to the IRE}}$$

Step 1C: Subject to Reduction

Criteria were developed to determine if a contract's Part C appeals measures may be subject to a possible IRE data completeness reduction.

A contract is subject to a possible reduction due to lack of IRE data completeness if both conditions are met:

- The Calculated Error Rate is 20% or more.
- The Number of Cases Not Forwarded to the IRE is at least 10.

Using the Part C Calculated Error Rate and the Number of Cases Not Forwarded to the IRE, check the criteria to determine if the contract is subject to a possible reduction. Table N-1 below is provided to determine if a contract is subject to a possible reduction.

Table N-1: Identification of a Contract that is Subject to a Possible Scaled Reduction

Calculated Error Rate	Number of Cases Not Forwarded to IRE	Contract Subject to a Possible Reduction
Less than 20%	Less than 10 cases	No
Less than 20%	10 cases or more	No
At Least 20%	Less than 10 cases	No
At Least 20%	10 cases or more	Yes

Stage 2: Estimated Error Rate

Step 2A: Lower Bound of the Score Interval

Using the Part C Calculated Error Rate in Step 1C, the lower bound of the confidence interval (Wilson Score Interval) is determined and used to statistically test the value against a set of thresholds to identify the scaled reduction for a contract's Part C appeals measures.

To determine the lower bound, first, the midpoint of the interval must be calculated. There are two values needed to calculate the midpoint of the interval for a contract – the Part C Calculated Error Rate and the Total Number of Cases that Should Have Been Forwarded to the IRE in the measurement period.

Substitute the Calculated Error Rate and the Total Number of Cases that Should Have Been Forwarded to the IRE for the Total Number of Cases in Equation (C). The z value used for the calculation of the interval is 1.959964. [9]

Equation (C)

$$\text{Midpoint} = \text{Calculated Error Rate} * \left(\frac{\text{Total Number of Cases}}{\text{Total Number of Cases } Z^2}\right) + \frac{1}{2}\left(\frac{Z^2}{\text{Total Number of Cases} + Z^2}\right)$$

Once the midpoint is calculated, determine the value of the lower bound of the interval.

The lower bound of the interval is found by substituting the value determined for the midpoint, the Calculated Error Rate, the value of 1.959964 for z, and the Total Number of Cases that Should Have Been Forwarded to the IRE for the value for n in Equation (D).

Equation (D)

$$\text{Lower Bound} = \text{Midpoint} - z\times\sqrt{\frac{1}{n+z^2}\left[(\text{Calculated Error Rate})\,(1-\text{Calculated Error Rate})\left(\frac{n}{n+z^2}\right) + \frac{1}{4}\left(\frac{z^2}{n+z^2}\right)\right]}$$

Convert the lower bound to a percent by multiplying by 100.

Stage 3: Scaled Reduction

Step 3A: Statistical Testing

Once the value of the lower bound is determined (Stage 2), the value is compared to the thresholds in Table N-2 to determine if a contract's estimated value is significantly greater than the thresholds.

Using the calculated value for the lower bound in Step 2A, identify the value(s) in the table for which the calculated lower bound exceeds the threshold in the row. Next, identify the highest threshold that the lower bound exceeds.

Note: A contract's lower bound can be statistically significantly higher for more than one threshold. The scaled reduction will be determined by the highest associated scaled reduction.

Table N-2: Thresholds and Associated Reductions

Threshold	Reduction for Incomplete IRE Data (Stars)
20%	1
40%	2
60%	3
80%	4

Using the highest threshold in Table N-2 that the contract's lower bound exceeds, identify the associated reduction for incomplete IRE data.

[9] The z used for the calculation of the interval corresponds to a level of statistical significance of 0.05.

Step 3B: Application of the Scaled Reduction

The identified scaled reduction in Table N-2 is subtracted from the measure-level Star Rating for both Part C appeals measure-level Star Ratings. If the resulting measure-level Star Rating is less than one-star, the measure is assigned one star.

Note: If the Part C appeals measures receive a scaled reduction in either measurement year included in the Part C improvement measure, the Part C appeals measures would not be eligible for inclusion in the Part C improvement measure.

Attachment 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 2027 Star Ratings are developed using the following sources of information:

- The 2024 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL).
- The 2024 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 2025 provided for beneficiaries who were alive at least through December 2025, 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 2024 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?q=S0103:+Population+65+Years+and+Over+in+the+United+States&g=010XX00US$0400000&y=2024 Accessed on 22 Jun 2026.) 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 2027 Star Ratings adjustment, the data used for the model development included a total of 129 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 2024 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 2024. 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 0.963228.

$$\widehat{\text{LIS/DE}} = (0.963228 \times \text{contract's DE percentage }) + (\text{ intercept })$$

Next, the intercept for the Puerto Rico model was determined using the point (x, y) where x is the observed average DE percentage in Puerto Rico contracts (29.990262%) and y is an estimated expected average hypothetical percentage of LIS/DE in Puerto Rico.

To calculate the estimated expected average percentage of LIS/DE in Puerto Rico, the observed average percentage of LIS/DE in the 10 poorest US states identified in step (1) is multiplied by the ratio of the percentage of Puerto Rico residents living below 150% of the FPL to the analogous percentage in the 10 poorest US states.

Description	Value
Percent of PR residents below 150% of FPL	57.300000%
Percent of residents in the 10 poorest US states below 150% of FPL	24.392539%
Observed average LIS/DE percentage in the 10 poorest US states	47.377845%
Observed average DE percentage in Puerto Rico contracts	29.990262%

The product thus becomes $\left(47.377845 \times \frac{57.300000}{24.392539}\right)$.

The new intercept for the Puerto Rico model is as follows:

$$\text{new intercept} = \left(47.377845 \times \frac{57.300000}{24.392539}\right) - (0.963228 \times 29.990262)$$

The final model to estimate the percentage of LIS/DE in Puerto Rico model is as follows:

$$\widehat{\text{LIS/DE}} = (0.963228 \times \text{contract's DE percentage}) + \left(\left(47.377845 \times \frac{57.300000}{24.392539}\right) - (0.963228 \times 29.990262)\right)$$

Example

To calculate the contract-level modified LIS/DE percentage for a hypothetical contract from Puerto Rico with an observed DE percentage of 5%, the value of 5.000000% is used in the model developed.

$$\widehat{\text{LIS/DE}} = (0.963228 \times \text{contract's DE percentage}) + \left(\left(47.377845 \times \frac{57.300000}{24.392539}\right) - (0.963228 \times 29.990262)\right)$$

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

$$\widehat{\text{LIS/DE}} = (0.963228 \times 5.000000) + \left(\left(47.377845 \times \frac{57.300000}{24.392539}\right) - (0.963228 \times 29.990262)\right)$$

The contract-level modified LIS/DE percentage for a hypothetical Puerto Rico contract that has an observed DE percentage of 5.000000% is 87.222978%.

The final adjustment category for the CAI adjustment is identified using the LIS/DE percentage 87.222978%.

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 2027 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 https://aspr.hhs.gov/legal/1135-Waivers/pages/1135-waivers.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 2027 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
1/10/2025	Wildfires	Wildfires and Straight-line Winds	California	1/7/2025
7/8/2025	Severe Storms, Straight-line Winds, and Flooding	Severe Storms, Straight-line Winds, and Flooding	Texas	7/2/2025
12/23/2025	Severe Storms, Straight-line Winds, and Flooding	Washington Severe Storms, Straight-line Winds, Flooding, Landslides, and Mudslides	Washington	12/5/2025

- 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-4856-CA	California	Los Angeles
DR-4879-TX	Texas	Burnet, Guadalupe, Kerr, Kimble, McCulloch, Menard, San Saba, Tom Green, Travis, Williamson
DR-4906-WA	Washington	Chehalis Indian Reservation, Chelan, Grays Harbor, King, Lewis, Lummi Indian Reservation, Muckleshoot Indian Reservation, Nisqually Indian Reservation, Nooksack Indian Reservation,

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
		Pacific, Pierce, Puyallup Indian Reservation, Quinault Indian Reservation, Samish (TDSA), Sauk-Suiattle Indian Reservation, Shoalwater Bay Reservation, Skagit, Snohomish, Squaxin Island Indian Reservation, Stillaguamish Indian Reservation, Swinomish Indian Reservation, Thurston, Tulalip Indian Reservation, Upper Skagit Indian Reservation, Whatcom

- 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-4856-CA	California	1/7/2025	February 2025	January 3, 2025
DR-4879-TX	Texas	7/2/2025	August 2025	July 4, 2025
DR-4906-WA	Washington	12/5/2025	January 2026	December 5, 2025

- Calculate disaster impacted enrollment for contracts experiencing multiple disasters. Because the contracts serve areas of different sizes and can sometimes serve large, diverse areas, it is common for a

contract to be affected by more than one of the disasters. To account for this, CMS averaged the county/state level enrollments from each of corresponding enrollment periods in which the contract was affected.

Table P-5 shows an example where all possible enrollment periods are accounted for and how the enrollment for a contract in a state/county which matched the contract's service area state/county was calculated. Enrollment in out of service area state/counties was not included.

Table P-5: How enrollment periods were combined for contracts experiencing multiple disasters

Formula ID	Enrolled 202X_10	Enrolled 202X_11	Enrolled 202X_12	Enrollment Used
B	True	True	True	(202X_10 + 202X_11 + 202X_12) / 3
C	True	True		(202X_10 + 202X_11) / 2
F	True		True	(202X_10 + 202X_12) / 2
H	True			202X_10
J		True	True	(202X_11 + 202X_12) / 2
L		True		202X_11
N			True	202X_12
P				0 (zero)

- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in the entire service area for the contract to be used in further processing.
- Using the enrollment for the contract developed in Step 7 below, take the sum of the enrollment in all of the Individual Assistance counties that correspond to the contract service area.
- Using the final list of affected contracts from Step 4 below, calculate the percentage of the contract's total service area enrollment that was affected by the Individual Assistance area enrollment. Create flags for the 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
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

FIPS Code	County Name	ST CD	EGHP County	Individual Assistance County	Enrolled 202X/09	Enrolled 202X/10	Enrolled 202X/11	Average Enrollment
48469	Victoria	TX	Yes	TRUE	158	-	154	156
48475	Ward	TX	Yes	FALSE	15	-	15	15
48495	Winkler	TX	Yes	FALSE	20	-	20	20

Step 8, sum the average enrollment from all rows from Table P-6. The total comes out to 5,120 for contract HAAAA.

Step 9, sum the average enrollment from all the rows from Table P-6 where the Individual Assistance counties is TRUE for contract HAAAA. The Individual Assistance total comes out to 909.

Step 10, calculate the final percentage for contract HAAAA. (909 / 5,120) * 100 = 17.753906 = 18%. The flag for greater than or equal to 25% is set to false since the example contract did not meet those thresholds.

Attachment Q: Missing Data Messages

CMS uses a standard set of messages in the Star Ratings when there are no numeric data available for a contract. This attachment provides the rules for assignment of those messages in each level of the Star Ratings.

Measure level messages

Table Q-1 contains all of the possible messages that could be assigned to missing data at the measure level.

Table Q-1: Measure level missing data messages

Message	Measure Level
Coming Soon	Used for all measures in MPF between Oct 1 and when the actual Star Rating data go live
Medicare shows only a Star Rating for this topic	Used in the numeric data for the Part C & D improvement measures in MPF and Plan Preview 2
Not enough data available	There were data for the contract, but not enough to pass the measure exclusion rules
CMS identified issues with this plan's data	Data were materially biased, erroneous and/or not reported by a contract required to report
Not Applicable	Used in the numeric data for the improvement measures in Plan Preview 1. In the HPMS Measure Star Page when a measure does not apply for a contract.
Benefit not offered by plan	The contract was required to report this HEDIS measure but doesn't offer the benefit to members
Plan too new to be measured	The contract is too new to have submitted measure data
No data available	There were no data for the contract included in the source data for the measure
Plan too small to be measured	The contract had data but did not have enough enrollment to pass the measure exclusion rules
Plan not required to report measure	The contract was not required to report the measure

Assignment rules for Part C measure messages

Part C uses a set of rules for assigning the missing data message that varies by the data source. The rules for each data source are defined below.

Appeals (IRE) measures (C30 & C31):

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 01/01/2025?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Table Q-2: Part C Appeals 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 scored less than 95% on relevant data elements section DV	CMS identified issues with this plan's data
Contract had fewer than 10 cases meeting denominator criteria	Not enough data available

CAHPS measures (C03, C21, C22, C23, C24, C25, & C26):

Is there a valid numeric CAHPS measure rate?
- Yes: Display the numeric CAHPS measure rate
- No: Is the contract effective date greater than 07/01/2025?
  - 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 (C32):

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 01/01/2026?
    - Yes: Display message: Plan too new to be measured
    - No: Display message: Not enough data available

Complaints (CTM) measure (C27):

Is the contract effective date greater than 01/01/2025?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment less than 800 in 2025?
  - 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, C18, C20):

Was the contract required to report HEDIS?
- Yes: Was the contract enrollment less than 500 in July 2025?
  - 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 01/01/2025?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS PCR 18 and older (C17):

Was the contract required to report HEDIS?

- Yes: Was the contract enrollment less than 500 in July 2025?
  - 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 01/01/2025?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Plan not required to report measure

HEDIS TRC average (C19):

Was the contract required to report HEDIS?

- Yes: Was the contract enrollment less than 500 in July 2025?
  - 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 01/01/2025?
  - 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 2027?

- 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: 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: Did the contract include only I-SNPs or have fewer than 500 non-I-SNP enrollees in February 2025?
  - 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: Is the February 2025 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 2023 or have fewer than 500 non-I-SNP enrollees in February 2023?
  - 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 01/01/2022?
      - Yes: Display message: Plan too new to be measured
      - No: Is the February 2023 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 (C28):

Is there a valid numeric voluntary disenrollment rate?
- Yes: Display the numeric voluntary disenrollment rate
- No: Is the contract effective date greater than 01/01/2025?
  - 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 2027?
- 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 01/01/2025?
      - Yes: Display message: Plan too new to be measured
      - No: Display message: No data available

Improvement (Star Ratings) measure (C29):

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 01/01/2025?
  - 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 07/01/2025?
  - 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 01/01/2026?
    - 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 01/01/2025?
- Yes: Display message: Plan too new to be measured
- No: Was the average contract enrollment less than 800 in 2025?
  - 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 01/01/2025?
  - 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 01/01/2025?
  - 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 9/30/2025?
- 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 (D11) & COB (D12) & Poly-ACH (D13):

Does the contract offer Part D?

Yes: Is the contract effective date greater than 12/31/2025?
- Yes: Display message: Plan too new to be measured
- No: Does contract have 29 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

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 01/01/2025?
  - 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 01/01/2025?
  - 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 01/01/2025?
  - Yes: Display message: Plan too new to be measured
  - No: Display message: Not enough data available

AEP	The annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan or re-enroll into their existing Medicare Part C or D Plan or change into another Medicare plan is known as the Annual Election Period (AEP). The chosen Medicare Part C or D plan coverage begins on January 1st.
C-SNP	Chronic Condition Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2.
CAHPS	The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. CAHPS initially stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the acronym now stands for Consumer Assessment of Healthcare Providers and Systems.
CCP	A Coordinated Care Plan (CCP) is a health plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of CCP that meets CMS's requirements.
Cohort	A cohort is a group of people who share a common designation, experience, or condition (e.g., Medicare beneficiaries). For the HOS, a cohort refers to a random sample of Medicare beneficiaries that is drawn from each Medicare Advantage Organization (MAO) with a minimum of 500 enrollees and surveyed every spring (i.e., a baseline survey is administered to a new cohort each year). Two years later, the baseline respondents are surveyed again (i.e., follow up measurement). For data collection years 1998-2006, the MAO sample size was 1,000. Effective 2007, the MAO sample size was increased to 1,200.
Cost Plan	A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan in accordance with a cost reimbursement contract under §1876(h) of the Act. In the Star Ratings, CMS classifies a Cost Plan not offering Part D as MA-Only and a Cost Plan offering Part D as MA-PD.
D-SNP	Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Disability Status	Based on the original reason for entitlement for Medicare (Disability insurance benefits or both Disability insurance benefits and End-Stage Renal Disease).
Dual eligibles	Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
Euclidean distance	The absolute value of the difference between two points, x-y.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HOS	The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.
I-SNP	Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to institutionalized special needs individuals defined in 42 CFR 422.2.
IRE	The Independent Review Entity (IRE) is an independent entity contracted by CMS to review Medicare health and drug plans' adverse reconsiderations of organization determinations.
LIS	The Low Income Subsidy (LIS) from Medicare provides financial assistance for beneficiaries who have limited income and resources. Those who receive the LIS get help paying for their monthly premium, yearly deductible, prescription coinsurance, and copayments and they will have no gap in coverage.
LIS/DE	Beneficiaries who qualify at any point in the year for a low income subsidy through the application process and/or who are full or partial Dual (Medicare and Medicaid) beneficiaries.
MA	A Medicare Advantage (MA) organization is a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
MA-Only	An MA organization that does not offer Medicare prescription drug coverage.
MA-PD	An MA organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.
MSA	Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established for the purpose of paying the qualified medical expenses of the account holder).
Percentage	A part of a whole expressed in hundredths. For example, a score of 45 out of 100 possible points is the same as 45%.

Percentile	The value below which a certain percent of observations fall. For example, a score equal to or greater than 97 percent of other scores attained on the same measure is said to be in the 97th percentile.
PDP	A Prescription Drug Plan (PDP) is a stand-alone drug plan, offered by insurers and other private companies to beneficiaries who receive their Medicare Part A and/or B benefits either through the Original Medicare Plan, Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage, or Medicare Cost Plans that do not offer Medicare prescription drug coverage.
PFFS	Private Fee-for-Service (PFFS) is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers who are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. The Medicare Improvements for Patients and Providers Act (MIPPA) added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider based on increased utilization of specified preventive or screening services. See section 30.4 of the Medicare Managed Care Manual Chapter 1 for further details on PFFS plans.
Reliability	A measure of the fraction of the variation among the observed measure values that is due to real differences in quality (“signal”) rather than random variation (“noise”). On a scale from 0 (all differences among plans are due to randomness of sampling) to 1 (every plan's quality is measured with perfect accuracy).
SNP	A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limits enrollment to special needs individuals. A special needs individual could be any one of the following: 1) an institutionalized individual, 2) a dual eligible beneficiary, or 3) an individual with a severe or disabling chronic condition, as specified by CMS. A SNP may be any type of MA CCP. There are three major types of SNPs: 1) Chronic Condition SNP (C-SNP), 2) Dual Eligible SNP (D-SNP), and 3) Institutional SNP (I-SNP).
Sponsor	An entity that sponsors a health or drug plan.
Statistical Significance	Statistical significance assesses how likely differences observed are due to chance when plans are actually the same. CMS uses statistical tests (e.g., t-test) to determine if a contract’s measure value is statistically significantly greater or less than the national average for that measure, or whether conversely the observed differences from the national average could have arisen by chance.
Sum of Squares	Method used to measure variation or deviation from the mean.
TTY	A teletypewriter (TTY) is an electronic device for text communication via a telephone line, used when one or more of the parties has hearing or speech difficulties.

Very Low Reliability	For CAHPS, an indication that reliability is less than 0.6, indicating that 40% or more of observed variation is due to random noise.

Attachment S: Health Plan Management System Module Reference

This attachment is designed to assist reviewers of the data displayed in HPMS (https://hpms.cms.gov) to understand the various pages and fields shown in the HPMS Star Ratings module. This module employs standard HPMS user access rights so that users can only see contracts associated with their user id.

HPMS Star Ratings Module

The HPMS Star Ratings module contains the Part C & Part D data and stars for all contracts that were rated in the ratings year along with much of the detailed data that went into the various calculations. To access the Star Ratings module you must be logged into HPMS. If you do not have access to HPMS, information on how to obtain access can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Overview.html

Once you are logged into HPMS, from the home page, select *Performance Metrics* from the *Quality and Performance* menu; the Performance Metrics page will be displayed. If you do not see *Performance Metrics*, your user id does not have the correct access permissions; please contact CMSHPMS_Access@cms.hhs.gov From the Performance Metrics page, select *Reports* and then *Star Ratings and Display Measures* from the left side menu. The *Star Ratings and Display Measures* home page will be displayed.

On the *Star Ratings and Display Measures* home page, select *Star Ratings* as the Report Type and select a reporting period. The remainder of this attachment describes the HPMS pages available for the 2027 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
				01/01/2025 - 12/31/2025	01/01/2025 - 12/31/2025	03/2026 - 06/2026
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 (C27/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 (C30) and Reviewing Appeals Decisions (C31). The data displayed on this page reflect the state of the appeals case at the time the data were pulled for use in the 2027 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 and adjusted to account for 5 mailing days for standard appeals
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)
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 2025 Audit Designations and 2027 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 (C27/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 (C28/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 – 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 (C21), Getting Appointments and Care Quickly (C22), Customer Service (C23), Rating of Health Care Quality (C24), Rating of Health Plan (C25), Care Coordination (C26), Rating of Drug Plan (D05), and Getting Needed Prescription Drugs (D06). 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 – 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

9. 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-10 below explains the columns displayed on this page.

Table S-10: 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 2025	Indicates if the contract was affected by a 2025 disaster or not (valid values “Affected”, “Not Affected” or “Too New“)
Total Cnty in SA 2025	The total number of counties in the contract’s 2025 service area (SA)
Num Cnty IA 2025	The number of counties from the contract’s total SA designated as FEMA Individual Assistance (IA) counties in a 2025 disaster
IA Enrolled 2025	The number of members residing in the contract SA designated FEMA IA counties in a 2025 disaster
Total Enrolled 2025	The total number of members residing in the contract’s 2025 SA
IA % 2025	The percent of members living in IA areas in a 2025 disaster (IA Enrolled) divided by (Total Enrolled)
IA % Rounded 2025	The percent of members living in IA areas in a 2025 disaster rounded to an integer
Greater than or equal to 25% 2025	Flag that indicates if the contract has met the 25% threshold for 2025 disasters (Yes: greater than or equal to 25 %, No: less than 25%)
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)/(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)

10. 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-11 below explains the columns displayed on this page.

Table S-11: 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

11. Calculation Detail – CSR

The Calculation Detail – CSR (Part C Scaled Reduction) page contains the underlying data used in calculating the reduction applied to the two Part C appeals measures. This page is available during the second plan preview. Table S-12 below explains the columns displayed on this page.

Table S-12: Measure Detail – Part C Scaled Reduction 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
Data Validation Score	Data validation score
Cases Should Have Forwarded to IRE	Number of eligible cases that should have been sent to IRE for the measurement year as determined in the data validation of Part C Reporting Requirements
Cases Forwarded to IRE	The number of cases forwarded to the IRE in the measurement year
Failed Appeals Measure Related	A flag that indicates whether the contract failed one or both data standards related to the appeals measures (Failed None, Failed One or Both)
Failed Data Validation	Failed data validation flag indicating a score of less than 95% (Yes/No)
Calculated Error Rate	The calculated error rate
Part C Star Reduction Amount	Part C Star Rating star reduction amount

12. 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 – C20) 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, 2025). This page is available during the second plan preview. Table S-13 below explains each of the columns displayed on this page.

Table S-13: 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 2025
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

13. 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-14 below explains the columns displayed on this page.

Table S-14: 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 2027 Star Ratings Part C measure ID
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
2027 Value	The numeric measure value for the contract from the 2027 Star Ratings
2027 Star	The measure star for the contract from the 2027 Star Ratings
Final Value	The measure value to be used in the 2027 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2027 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

14. 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-15 below explains the columns displayed on this page.

Table S-15: 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 2027 Star Ratings Part D measure ID
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
2027 Value	The numeric measure value for the contract from the 2027 Star Ratings
2027 Star	The measure star for the contract from the 2027 Star Ratings
Final Value	The measure value to be used in the 2027 Star Ratings after the data handling policy for disasters was applied
Final Star	The measure star to be used in the 2027 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 – 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-16 below.

Table S-16: 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

16. 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-17 below.

Table S-17: 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

17. 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-18 below shows a sample of the left hand most columns shown in HPMS.

Table S-18: 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
				01/01/2025 - 12/31/2025	01/01/2025 - 12/31/2025	03/2026 - 06/2026
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

18. 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-19 below shows a sample of the left hand most columns shown in HPMS.

Table S-19: 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

19. 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-20 below explains each of the columns contained on this page.

Table S-20: 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 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Major Disaster Percentage 2025	The percentage of members living in an Individual Assistance area in 2025 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)
2027 Part C Summary Rating	The final rounded 2027 Part C Summary Rating

20. 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-21 below explains each of the columns contained on this page.

Table S-21: 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 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Major Disaster Percentage 2025	The percentage of members living in an Individual Assistance area in 2025 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)
2027 Part D Summary Rating	The final rounded 2027 Part D Summary Rating

21. 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-22 below explains each of the columns contained on this page.

Table S-22: 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 2024	The percentage of members living in an Individual Assistance area in 2024 rounded to an integer
Major Disaster Percentage 2025	The percentage of members living in an Individual Assistance area in 2025 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
2027 Part C Summary Rating	The 2027 Part C Summary Rating
2027 Part D Summary Rating	The 2027 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)
2027 Overall Rating	The final 2027 Overall Rating

22. 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-23 below explains each of the columns contained on this page.

Table S-23: 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”
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
2027 C Summary	The 2027 Part C Summary Rating earned by the contract
2027 D Summary	The 2027 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.

23. 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-24 below explains each of the columns contained on this page.

Table S-24: 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

24. Technical Notes link

The Technical Notes link provides the user with a copy of the 2027 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 2027 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.

25. 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 (D11), COB (D12) and Poly-ACH (D13). This downloadable file is in Zip format and contains multiple Excel files.

26. 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 very low reliability 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).