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Trends in Medicare Advantage Quality for Nonmetropolitan Enrollees, 2019-2023

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Purpose

As Medicare Advantage (MA) program enrollment continues to grow in both metropolitan and nonmetropolitan places, it is important to assess the quality of care in the program over time. This brief analyzes star rating data (both overall ratings on a 5-point scale, and subscores on separate components) for 2019 to 2023 for all (non-special needs) MA contracts and describes patterns across geography, by region, and by plan type. High ratings (4.0 and above for established plans) generate bonus payments, within parameters of benchmarks and payment caps set by the Patient Protection and Affordable Care Act, 2010 (ACA). These findings can inform current policy discussions on measuring and paying for quality in MA.

Key Findings

- Average star ratings for MA plans selected by nonmetropolitan (i.e., both micropolitan and noncore) beneficiaries increased from about 3.90 stars in 2019 to 4.15 stars in 2023. Meanwhile, metropolitan beneficiaries' plans increased from 4.05 stars to a peak of 4.32 stars in 2022, declining to 4.15 stars in 2023.
- Star rating component scores for "staying healthy" and "managing chronic conditions" are consistently higher in metropolitan areas. Conversely, "member experience with the health plan" is reported to be lower for metropolitan beneficiaries than nonmetropolitan beneficiaries. The main source of improvement in nonmetropolitan areas is the change in the "health plan customer service" domain.
- In counties where MA plans cannot earn any quality incentives due to statutory caps in total payment, star ratings tend to be about 0.1 star lower than when quality bonus rates are not all capped based on pre-Affordable Care Act (ACA) total Medicare expenditures.

Background

In an early look at quality ratings, the RUPRI Center found that rural MA enrollees in 2012 were enrolled in plans that, on average, earned about 0.1 star less than the plans of urban MA enrollees, and that this was largely driven by differences in



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availability of plan types. Because HMOs had higher star ratings but were less likely to be available in rural counties, rural enrollment-weighted averages were lower.¹ Further analysis of quality trends from 2010 to 2016 showed that rural quality differences were associated with maturity of the MA contract and historic MA penetration rates in the county. We further showed that market dynamics, i.e., entry and exit of plans, was driving improvement in both urban and rural places, as exiting plans tended to be of lower quality while entering plans tended to be of higher quality.²

Subsequent RUPRI work on MA quality star ratings has aimed to describe the effect of several interrelated policies enacted in the ACA. One significant policy is the use of a quartile system for determining the value of the benchmark itself – the county-level dollar amount against which all MA plans must bid. Each year, all counties are ranked according to per capita spending in fee-for-service (traditional) Medicare, and benchmarks are defined as percentages of those amounts, as shown in Table 1. Another key policy establishes bonus payments for achievement of at least a 4-star (out of 5) overall rating. MA contracts earning 4 or more stars are eligible for a bonus equal to 5 percent of the standard benchmark for the county, subject to a cap. The resulting benchmark may not exceed the pre-ACA (trended) value.³ If the benchmark is capped in this manner, then the added incentive for higher performance is eliminated.

Table 1. Medicare Advantage County Benchmark Quartiles

Quartile	Percent of FFS Medicare per capita spending*
First (Lowest)	115.0%
Second	107.5%
Third	100.0%
Fourth (Highest)	95.0%

* Fee-for-Service (FFS) Medicare per capita spending are calculated by Centers for Medicare & Medicaid Services as the total spending within the traditional Medicare program in each county, divided by the total annualized enrollment.

A 2015 RUPRI analysis found that 41 percent of rural enrollees were in counties that were in the lowest quartile, for which the corresponding benchmark is 115 percent of fee-for-service spending.⁴ This finding has persisted: in 2024, 44 percent of nonmetropolitan counties in that quartile had fully capped bonuses.⁵ The lack of proportionality creates the possibility of an uneven impact of this policy on rural populations.

As the past several years have shown large increases in MA enrollment – now surpassing 50 percent Medicare enrollment overall and above 45 percent in nonmetropolitan counties⁶ – it is useful to report again on star quality, controlling for various potential explanatory factors, and provide new evidence to inform future MA policy revisions. Moreover, we explore the challenging nature of using the star rating data, which are reported at the contract level and may span many plans in many counties both urban and rural, to provide meaningful assessment of the experience of rural beneficiaries.

Data and Methods

Data from the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Landscape Source files,⁷ which include information regarding substantially all approved contracts and plans as of October in the year prior to the offering, years 2019 through 2023 were merged with contract-plan-linked enrollment⁸ and stars/quality data⁹ in the year of offering. Enrollment data were reflective of enrollment as of July in the year of offering. Focusing on the standard plan types – Local HMOs, Local PPOs, and Regional PPOs – produced a dataset describing the 3,043 counties where MA was offered in 2023. Absent were 99 counties and county-equivalents, including 6 metropolitan and 93 non-metropolitan, without these offerings. Most were in Alaska. Additional data were merged at the county level, including geographic characteristics such as rurality, assigned based on 2013 Urban Influence Codes current as of the time of analysis,¹⁰ and Census region. UICs 1 and 2 are metropolitan; codes 3, 5, and 8 are micropolitan; and the remaining codes are rural noncore. In this brief, the word “rural” is used to encompass those living in micropolitan and noncore counties. A micropolitan county contains a small city of 10,000 to 49,999 people, whereas a noncore county contains no cities of at least 10,000.

Because values under 10 are censored (not reported) by CMS due to risk of identifying individuals, we calculated the difference between the uncensored total in the contract-plan-state-county files and the aggregate published total enrollment and prorated this enrollment across all censored cells. Enrollment was summarized at the contract/county or plan/county level, depending on the question. These enrollment data are used to calculate enrollment-weighted averages of all star rating data provided in this brief.

We approximate a measure of star ratings by rurality by assigning contract star ratings – which typically span many plans and metropolitan and non-metropolitan counties – to those plans and counties. To indirectly assess the relationship between star ratings and rurality, we also computed a measure of *contract* rurality using county-level enrollment values in affiliated plans and Urban Influence Code definitions. The “contract rural enrollment percentage” represents the proportion of total enrolled beneficiaries in each contract who live in counties classified as either micropolitan or noncore. For analytic and reporting purposes, we rounded these percentages to the nearest ten percentage points, creating reporting categories of 0 percent, 10 percent, 20 percent, etc. A contract depicted as having a rural enrollment percentage of 20 percent has total enrollment across all the counties in its service area that is 15.0 to 24.9 percent rural. This aggregation allowed us to depict enrollment differences more clearly across several categories – star rating, Census region, and plan type – while also showing variation in the contract rural enrollment percentage.

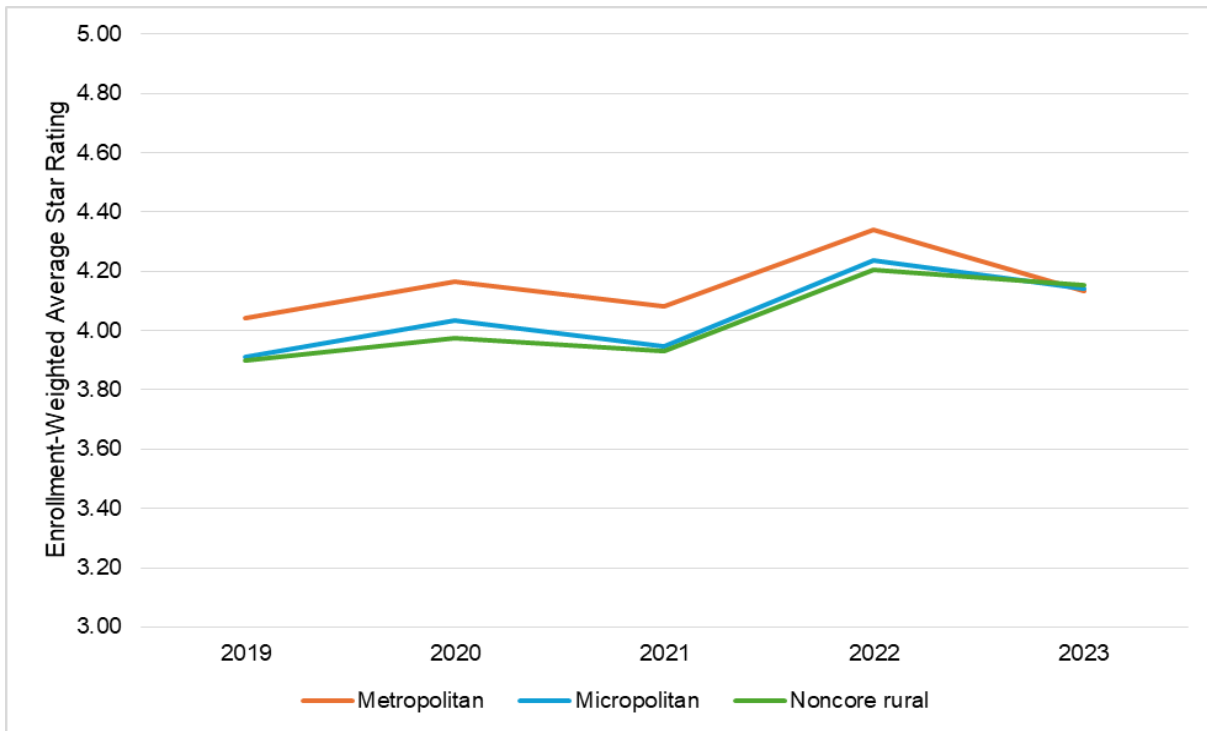
Finally, we merged CMS’s 2023 rate calculation file data¹¹ to the analytic file described above to assign counties to benchmark quartiles (see Table 1) and determine whether their quality bonus rates are capped.

Results

Figure 1 shows that, over the past five years, average star ratings for MA plans of nonmetropolitan beneficiaries have increased in both micropolitan and noncore

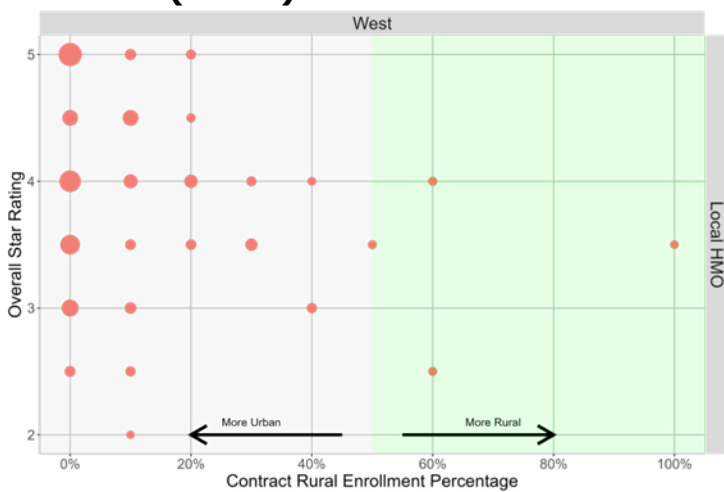
counties, from an average of about 3.90 stars in 2019 to 4.15 stars in 2023. While average star ratings have also increased slightly for metropolitan beneficiaries, the result is that the gap between average star ratings by geographic status has disappeared over time. Also, noting that 2022 star ratings were adjusted due to the public health emergency,¹² we focus on the overall upward trend between 2019 and 2023 as the key takeaway.

Figure 1. Average Quality Stars Associated with Metropolitan and Non-Metropolitan Medicare Advantage Enrollment, Based on Contract-Level Quality, 2019-23



Figures 2a and 2b below provide a scatterplot analysis that characterizes MA star ratings across multiple dimensions.

Figure 2a. MA Star Ratings and Enrollment by Rural Concentration of Contract (Inset)



First, Figure 2a displays a single region (West) and a single type of plan (Local HMOs) to demonstrate how to read Figure 2b showing all regions. The rural contract enrollment percentage (horizontal axis) is a continuous value reflecting the percentage of enrollees living in rural counties within each contract service area, from 0 percent rural to 100 percent rural, which has been grouped into deciles for easier interpretation. The

dots represent one or more contracts within a given region with the same star rating (vertical axis) and in the same rural contract enrollment decile.

The size of each circle corresponds to the proportion of MA enrollment within each region. Among Local HMOs in the West, enrollment is heavily concentrated in the most urban contracts, with many enrollees in contracts with 4, 4.5, or 5 stars. When there is enrollment in contracts that are predominantly rural (at least 50 percent, as indicated by the green region), those contracts tend to be between 3 and 4 stars.

In Figure 2b, we show for each Census region and plan type the distribution of enrollment according to star rating as well as the rural concentration of the contract, as described in the Methods section. Since star ratings are reported at the contract level, this method avoids the assumption of homogeneity across plans and counties.

Figure 2b. MA Star Ratings and Enrollment by Rural Concentration of Contract, Plan Type, and Region, 2023



Several observations can be made from displaying all MA data in this manner:

- First, Local HMOs tend to have more 4.5- and 5-star ratings, and much of the regional enrollment does gravitate toward them in contrast to Local and, in particular, Regional PPOs (i.e. the circles are larger). In almost all cases, the contracts with higher rural concentration tend to be in the 3- to 4-star range. There does not appear to be much variation in star ratings across the Midwest, Northeast, South, and West census regions within Local HMOs.

- Second, there is somewhat less enrollment in 4.5- and 5-star Local PPOs than in Local HMOs. Again, the contracts with higher rural concentration tend to have star ratings in the 3 to 4 range. Local PPOs in the South have more enrollment in the lowest star rating range of 2 to 2.5 stars than do Local PPOs in other regions.
- While there are very few Regional PPOs, and enrollment in them in each region is fairly low relative to other plan types, it is worth noting that star ratings are more uniform across the rural concentration continuum. All Regional PPO contracts are typically in the 3 to 4 range, and this appears to continue to hold true for contracts with higher rural concentration. In the West region, Regional PPOs are quite uncommon and non-existent as contracts with high rural concentration.
- Finally, it is rare to see a rural contract percentage above 50 percent, much less 80 percent or above. MA contracts are seldom comprised of a majority of rural enrollees.

While Figures 1 and 2b analyzed the “Overall Star Rating” for each contract or plan, Figure 3 reports trends in subscores from 2019 to 2023 across regions and the domains that are aggregated to produce that overall rating. See the Appendix for elements measured within each domain. While there is sometimes no meaningful difference across geographic category, it appears that metropolitan subscores for staying healthy, which includes receipt of screenings, appropriate tests, and vaccines, are consistently higher over time. The same is true for managing chronic conditions. It is important to point out that these domains are the most closely connected to healthcare outcome measures. Conversely, member experience with the health plan is reported to be lower for metropolitan beneficiaries than nonmetropolitan, both micropolitan and noncore. The main source of improvement that explains the closing of the gap shown in Figure 1 is the change in the health plan customer service domain in the last panel of Figure 3, which shows that nonmetropolitan star rating performance has caught up with metropolitan performance in that domain. Most other subscores have trended upward similarly for metropolitan, micropolitan, and noncore groups.

Figure 3. MA Star Ratings by Domain, 2023



Table 2 reports the variation in star ratings by the benchmark quartile (shown in Table 1) and whether the total payment was capped, effectively diminishing the value (capping) of any quality bonus. Together, these values affect how much payment is available relative to historic spending and how much additional payment may be available for achieving higher quality and/or additional benefits.⁵ Table 2 displays data for all 3,043 counties where MA plans were offered, and reporting is divided into two categories: counties where all bonus rates are capped, and counties where not all bonus rates are capped. The latter usually means that there is no capping, but occasionally the bonus available to new plans with limited reporting requirements is not capped while the bonus for established quality is capped. Because the benchmark quartile is an important indicator of the “room” that may exist between a plan’s costs and payments, we stratify our findings by quartile for metropolitan, micropolitan, and noncore counties.

In general, within each geographic/quartile stratum, when all quality bonus rates are capped, star ratings tend to be about 0.1 star lower on average than when not all quality bonus rates are capped – but there is variation in this finding. The

lowest quartile metropolitan counties average 0.23 stars lower, while the third quartile noncore counties average just 0.04 stars lower when the county has all bonuses capped.

Table 2. 2023 Star Ratings by Benchmark Quartile and Quality Bonus Capping, by Metropolitan Status

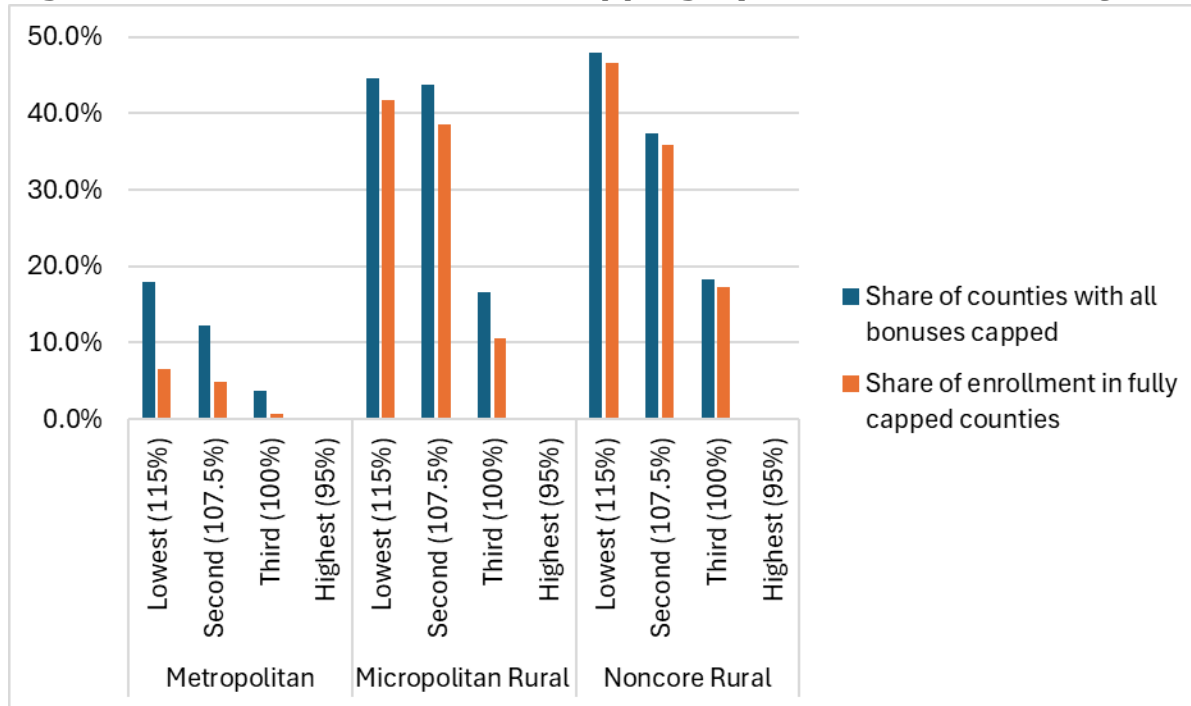
Benchmark Quartile (% of FFS Medicare)	Not All Bonus Rates Capped				All Bonus Rates Capped				Share of counties with all bonuses capped	Share of enrollment in fully capped counties
	Number of Counties	Total Enrollment	Percent Enrolled in 4+ Star Plan	Weighted Average Star Rating	Number of Counties	Total Enrollment	Percent Enrolled in a 4+ Star Plan	Weighted Average Star Rating		
Metropolitan										
Lowest (115%)	326	4,537,223	78.9%	4.25	71	313,374	70.0%	4.02	17.9%	6.5%
Second (107.5%)	306	3,919,997	71.5%	4.13	43	200,415	62.0%	3.93	12.3%	4.9%
Third (100%)	261	4,137,063	65.2%	4.05	10	29,898	83.7%	3.97	3.7%	0.7%
Highest (95%)	144	3,542,819	67.6%	4.12	0				0.0%	0.0%
Micropolitan Rural										
Lowest (115%)	123	449,091	78.9%	4.26	99	321,258	76.2%	4.16	44.6%	41.7%
Second (107.5%)	99	291,822	75.9%	4.13	77	182,334	69.2%	4.01	43.8%	38.5%
Third (100%)	126	315,665	69.8%	4.05	25	37,122	71.7%	4.04	16.6%	10.5%
Highest (95%)	80	106,414	74.0%	4.11	0				0.0%	0.0%
Noncore Rural										
Lowest (115%)	130	192,261	78.5%	4.23	120	167,541	74.0%	4.14	48.0%	46.6%
Second (107.5%)	159	215,562	73.2%	4.18	95	120,123	70.6%	4.10	37.4%	35.8%
Third (100%)	254	218,143	70.9%	4.09	57	45,240	74.1%	4.05	18.3%	17.2%
Highest (95%)	438	199,557	76.7%	4.17	0				0.0%	0.0%
Total	2,446	18,125,617	71.5%	4.14	597	1,417,305	71.2%	4.06	24.4%	7.8%

Note: The left side of the table includes 180 counties that had their 5% bonus rate for established plans capped, but not their 3.5% bonus rate for new plans. The latter rate applies to contracts that are too new to have full quality data reporting. Also, totals are smaller than the total number of U.S. counties because MA HMOs and PPOs are not offered everywhere. Weighted average star ratings are based on the star ratings of all contracts with enrollment in each county.

Also, as can be seen in the second-from-the-right column, the likelihood that all bonus rates are capped declines as the benchmark quartile goes from lowest to highest. This might be expected since there is less room between historic spending and payment, with which a plan might be able to bid under the benchmark and still leave room for a quality payment. This column shows that micropolitan and

noncore counties are more likely to have all bonus rates capped, as 44.6 percent and 48.0 percent of the counties in the lowest quartile, respectively, are capped, compared to only 17.9 percent of the metropolitan counties in that quartile. Similar comparisons may be observed for the other benchmark quartiles. These findings are highlighted in Figure 4.

Figure 4. Prevalence of Bonus Capping by Metro Status and Quartile



Moreover, returning to Table 2, it is interesting to note in the rightmost column that enrollment is skewed away from the fully capped counties in metropolitan areas; only 6.5 percent of metropolitan enrollment is in the lowest quartile, even though 17.9 percent of the counties are fully capped. This is likely because some metropolitan counties without capped bonus rates have extremely high MA enrollment. In contrast, in micropolitan and noncore counties, the shares of enrollment at each benchmark quartile level are very similar to the shares of capped counties, indicating that more individuals are potentially affected in some way by the capping.

Discussion

This brief has shown that, at a high level, nonmetropolitan (rural) star ratings have become almost identical to star ratings for metropolitan MA beneficiaries over the past five years. However, differences do still exist, both in terms of domain subscores and across other dimensions. Improvement in the “health plan customer service” subscore contributed to improvement in the overall ratings for plans serving rural beneficiaries. Differences by plan type continue to exist, with Local HMOs and Local PPOs continuing to outperform Regional PPOs. There is some regional variation, particularly in the South as compared to the other Census regions. But the overall trend is that plans belonging to contracts with higher star ratings are available and being selected by many nonmetropolitan people.

A significant limitation of this analysis is the fact that all star rating data are reported at the contract level. Our effort to solve for this by creating a measure for the “rural concentration of the contract” did show some suggestive evidence that contracts with higher rural concentration may be less likely to have the highest star values, indicating that there would be value in establishing some rural-specific reporting. For example, issuers could be asked to report data to support a “rural-only” subscore across all the rural counties/enrollees within each contract.

This brief illustrates the concern that the benchmark quartile system and the quality bonus program may be somewhat at cross-purposes. While the benchmark quartile system seeks to create similar incentives to enroll beneficiaries by creating relatively higher benchmarks in counties with historically low spending and relatively lower benchmarks in counties with historically high spending,¹³ it is less clear what it means to anchor spending on fee-for-service Medicare when it represents only about half of the total enrollment: MA beneficiaries in a lower-quartile rural county may or may not require less spending on the part of the MA plan. This issue, coupled with the bonus-rate capping policy, may be creating unintended consequences that may disproportionately affect rural beneficiaries. This is because, as Table 2 indicates, star ratings in capped counties are lower, and capped counties are more likely to be rural because they are more likely to be in the lower two quartiles of FFS spending. This dampens the incentive to improve quality. An improved policy design might rely more on bidding among the private plans to establish the benchmark (similar to the Health Insurance Marketplaces) and could also discontinue the reference to pre-ACA benchmarks for capping purposes. While it was beyond the scope of this brief to analyze those values in detail, we note that they were determined through a complex formula that included urban and rural floors and minimum increases, resulting in non-uniform relationships of benchmarks with the actual costs in the county,¹⁴ so even with trending, they do not have intrinsic meaning. If caps are viewed as a necessary aspect of the policy, they could be defined as internal elements to a coherent new approach (e.g., a cap of two standard deviations above the mean bid in a county or state) rather than being defined with reference to a prior policy that was otherwise intended to be replaced. If budget neutrality is a policy goal, an adjustment factor could be applied across the program.

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Appendix. Elements Measured in Star Domains, 2023

Domain	Measure Name (weights)
Staying healthy: screenings, tests, and vaccines	Breast cancer screening (1) Colorectal cancer screening (1) Annual flu vaccine (1) Monitoring physical activity (1)
Managing chronic (long term) conditions	Special Needs Plan (SNP) care management (1) Medication review (1) Pain assessment (1) Osteoporosis management in women who had a fracture (1) Diabetes care – eye exam (1) Diabetes care – kidney disease monitoring (1) Diabetes care – blood sugar controlled (3) Controlling blood pressure (1*) Reducing risk of falling (1) Improving bladder control (1) Medication reconciliation post-discharge (1)

	Statin therapy for patients with cardiovascular disease (1)
Member experience with health plan	Getting needed care (4) Getting appointments and care quickly (4) Customer service (4) Rating of health care quality (4) Rating of health plan (4) Care coordination (4)
Member complaints and changes in performance	Complaints about the health plan (4) Members choosing to leave the health plan (4) Health plan quality improvement (5)
Health plan customer service	Plan makes timely decisions about appeals (4) Reviewing appeals decisions (4) Call center – foreign language interpreter and TTY availability (4)

* Controlling blood pressure has a weight of 1 because it is a new measure for 2023.
Source: CMS Medicare 2023 Part C&D Star Ratings Technical Notes, Attachment F.8