

(1) The calculated error rate is 20 percent or more.

(2) The projected number of cases not forwarded to the IRE is at least 10 in a 3-month period.

(L) A confidence interval estimate for the true error rate for the contract is calculated using a Score Interval (Wilson Score Interval) at a confidence level of 95 percent and an associated z of 1.959964 for a contract that is subject to a possible reduction.

(M) A contract's lower bound is compared to the thresholds of the scaled reductions to determine the IRE data completeness reduction.

(N) The reduction is identified by the highest threshold that a contract's lower bound exceeds.

(O) CMS reduces the measure rating to 1 star for the applicable appeals measure(s) if a contract fails to submit Timeliness Monitoring Project data for CMS's review to ensure the completeness of the contract's IRE data.

(2) CMS will reduce a measure rating to 1 star for additional concerns that data inaccuracy, incompleteness, or bias have an impact on measure scores and are not specified in paragraphs (g)(1)(i) through (iii) of this section, including a contract's failure to adhere to HEDIS, HOS, or CAHPS reporting requirements.

(h) *Review of sponsors' data.* (1) An MA organization may request that CMS or the IRE review its' contract's appeals data provided that the request is received by the annual deadline set by CMS.

(2) An MA organization may request that CMS review its' contract's Complaints Tracking Module (CTM) data provided that the request is received by the annual deadline set by CMS for the applicable Star Ratings year.

(i) *Special rule for 2021 Star Ratings only.* In the event that the threat to health and safety posed by the COVID-19 pandemic compromises the quality of the data, or ability to validate such data for all plans used to calculate a particular measure, CMS will substitute and use the 2021 Star Ratings measure score and Star Rating with

the 2020 Star Ratings measure score and Star Rating.

[83 FR 16725, Apr. 16, 2018, as amended at 84 FR 15829, Apr. 16, 2019; 85 FR 19290, Apr. 6, 2020]

§ 422.166 Calculation of Star Ratings.

(a) *Measure Star Ratings*—(1) *Cut points.* CMS will determine cut points for the assignment of a Star Rating for each numeric measure score by applying either a clustering or a relative distribution and significance testing methodology. For the Part D measures, CMS will determine MA-PD and PDP cut points separately.

(2) *Clustering algorithm for all measures except CAHPS measures.* (i) The method maximizes differences across the star categories and minimizes the differences within star categories using mean resampling with the hierarchal clustering of the current year's data. Effective for the Star Ratings issued in October 2022 and subsequent years, CMS will add a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next. Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap). New measures that have been in the Part C and D Star Rating program for 3 years or less use the hierarchal clustering methodology with mean resampling with no guardrail for the first 3 years in the program.

(ii) In cases where multiple clusters have the same measure score value range, those clusters would be combined, leading to fewer than 5 clusters.

(iii) The clustering algorithm for the improvement measure scores is done in two steps to determine the cut points for the measure-level Star Ratings. Clustering is conducted separately for improvement measure scores greater than or equal to zero and those with improvement measure scores less than zero.

(A) Improvement scores of zero or greater would be assigned at least 3 stars for the improvement Star Rating.

(B) Improvement scores less than zero would be assigned either 1 or 2 stars for the improvement Star Rating.

(3) *Relative distribution and significance testing for CAHPS measures.* The method combines evaluating the relative percentile distribution with significance testing and accounts for the reliability of scores produced from survey data; no measure Star Rating is produced if the reliability of a CAHPS measure is less than 0.60. Low reliability scores are defined as those with at least 11 respondents, reliability greater than or equal to 0.60 but less than 0.75, and also in the lowest 12 percent of contracts ordered by reliability. The following rules apply:

(i) A contract is assigned 1 star if both of the criteria in paragraphs (a)(3)(i)(A) and (B) of this section are met plus at least one of the criteria in paragraphs (a)(3)(i)(C) or (D) of this section is met:

(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 below the 15th percentile.

(ii) A contract is assigned 2 stars if it does not meet the 1-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.

(iii) A contract is assigned 3 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, 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, the reliability is low, and the score is not statistically significantly higher than the national average CAHPS measure score.

(iv) A contract is assigned 4 stars if it does not meet the 5-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.

(v) A contract is assigned 5 stars if both of the following criteria in paragraphs (a)(3)(v)(A) and (B) of this section are met plus at least one of the criteria in paragraphs (a)(3)(v)(C) or (D) of this section is met:

(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 above the 80th percentile.

(4) *5-Star Scale.* Measure scores are converted to a 5-star scale ranging from 1 (worst rating) to 5 (best rating), with whole star increments for the cut points.

(b) *Domain Star Ratings.* (1)(i) CMS groups measures by domains solely for purposes of public reporting the data on Medicare Plan Finder. They are not used in the calculation of the summary or overall ratings. Domains are used to

group measures by dimensions of care that together represent a unique and important aspect of quality and performance.

(ii) The 5 domains for the MA Star Ratings are: Staying Healthy: Screenings, Tests and Vaccines; Managing Chronic (Long Term) Conditions; Member Experience with Health Plan; Member Complaints and Changes in the Health Plan's Performance; and Health Plan Customer Service. The 4 domains for the Part D Star Ratings are: Drug Plan Customer Service; Member Complaints and Changes in the Drug Plan's Performance; Member Experience with the Drug Plan; and Drug Safety and Accuracy of Drug Pricing.

(2) CMS calculates the domain ratings as the unweighted mean of the Star Ratings of the included measures.

(i) A contract must have scores for at least 50 percent of the measures required to be reported for that contract type for that domain to have a domain rating calculated.

(ii) The domain ratings are on a 1- to 5-star scale ranging from 1 (worst rating) to 5 (best rating) in whole star increments using traditional rounding rules.

(c) *Part C summary ratings.* (1) CMS will calculate the Part C summary ratings using the weighted mean of the measure-level Star Ratings for Part C, weighted in accordance with paragraph (e) of this section with an adjustment to reward consistently high performance and the application of the CAI under paragraph (f) of this section.

(2)(i) A contract must have scores for at least 50 percent of the measures required to be reported for the contract type to have the summary rating calculated.

(ii) The Part C improvement measure is not included in the count of the minimum number of rated measures.

(3) The summary ratings are on a 1- to 5-star scale ranging from 1 (worst rating) to 5 (best rating) in half-star increments using traditional rounding rules.

(d) *Overall MA-PD rating.* (1) The overall rating for a MA-PD contract will be calculated using a weighted mean of the Part C and Part D measure-level Star Ratings, weighted in accordance with paragraph (e) of this sec-

tion and with an adjustment to reward consistently high performance and the application of the CAI, under paragraph (f) of this section.

(2)(i) An MA-PD must have both Part C and Part D summary ratings and scores for at least 50 percent of the measures required to be reported for the contract type to have the overall rating calculated.

(ii) The Part C and D improvement measures are not included in the count of measures needed for the overall rating.

(iii) Any measures that share the same data and are included in both the Part C and Part D summary ratings will be included only once in the calculation for the overall rating.

(iv) The overall rating is on a 1- to 5-star scale ranging from 1 (worst rating) to 5 (best rating) in half-increments using traditional rounding rules.

(v) Low enrollment contracts (as defined in § 422.252) and new MA plans (as defined in § 422.252) do not receive an overall and/or summary rating. They are treated as qualifying plans for the purposes of QBPs as described in § 422.258(d)(7) and as announced through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act.

(e) *Measure weights—(1) General rules.* Subject to paragraphs (e)(2) and (3) of this section, CMS will assign weights to measures based on their categorization as follows.

(i) Improvement measures receive the highest weight of 5.

(ii) Outcome and Intermediate outcome measures receive a weight of 3.

(iii) Patient experience and complaint measures receive a weight of 4.

(iv) Access measures receive a weight of 4.

(v) Process measures receive a weight of 1.

(2) *Rules for new measures.* New measures to the Star Ratings program will receive a weight of 1 for their first year in the Star Ratings program. In subsequent years, the measure will be assigned the weight associated with its category.

(3) *Special rule for Puerto Rico.* Contracts that have service areas that are

wholly located in Puerto Rico will receive a weight of zero for the Part D adherence measures for the summary and overall rating calculations and will have a weight of 3 for the adherence measures for the improvement measure calculations.

(f) *Completing the Part C summary and overall rating calculations.* CMS will adjust the summary and overall rating calculations to take into account the reward factor (if applicable) and the categorical adjustment index (CAI) as provided in this paragraph (f).

(1) *Reward factor.* This rating-specific factor is added to both the summary and overall ratings of contracts that qualify for the reward factor based on both high and stable relative performance for the rating level.

(i) The contract's performance will be assessed using its weighted mean and its ranking relative to all rated contracts in the rating level (overall for MA-PDs; Part C summary for MA-PDs and MA-only; and Part D summary for MA-PDs and PDPs) for the same Star Ratings year. The contract's stability of performance will be assessed using the weighted variance and its ranking relative to all rated contracts in the rating type (overall for MA-PDs; Part C summary for MA-PDs and MA-only; and Part D summary for MA-PDs and PDPs). The weighted mean and weighted variance are compared separately for MA-PD and standalone Part D contracts (PDPs). The measure weights are specified in paragraph (e) of this section. Since highly-rated contracts may have the improvement measure(s) excluded in the determination of their final highest rating, each contract's weighted variance and weighted mean are calculated both with and without the improvement measures. For an MA-PD's Part C and D summary ratings, its ranking is relative to all other contracts' weighted variance and weighted mean for the rating type (Part C summary, Part D summary) with the improvement measure. For the 2022 Star Ratings only, since all contracts may have the improvement measure(s) excluded in the determination of their highest rating and summary rating(s), each contract's weighted variance and weighted mean

are calculated both with and without the improvement measures.

(ii) Relative performance of the weighted variance (or weighted variance ranking) will be categorized as being high (at or above 70th percentile), medium (between the 30th and 69th percentile) or low (below the 30th percentile). Relative performance of the weighted mean (or weighted mean ranking) will be categorized as being high (at or above the 85th percentile), relatively high (between the 65th and 84th percentiles), or other (below the 65th percentile).

(iii) The combination of the relative variance and relative mean is used to determine the value of the reward factor to be added to the contract's summary and overall ratings as follows:

(A) A contract with low variance and a high mean will have a reward factor equal to 0.4.

(B) A contract with medium variance and a high mean will have a reward factor equal to 0.3.

(C) A contract with low variance and a relatively high mean will have a reward factor equal to 0.2.

(D) A contract with medium variance and a relatively high mean will have a reward factor equal to 0.1.

(E) A contract with all other combinations of variance and relative mean will have a reward factor equal to 0.0.

(iv) The reward factor is determined and applied before application of the CAI adjustment under paragraph (f)(2) of this section; the reward factor is based on unadjusted scores.

(2) *Categorical Adjustment Index.* CMS applies the categorical adjustment index (CAI) as provided in this paragraph (f)(2) to adjust for the average within-contract disparity in performance associated with the percentages of beneficiaries who receive a low income subsidy or are dual eligible (LIS/DE) or have disability status. The factor is calculated as the mean difference in the adjusted and unadjusted ratings (overall, Part C, Part D for MA-PDs, Part D for PDPs) of the contracts that lie within each final adjustment category for each rating type.

(i) The CAI is added to or subtracted from the contract's overall and summary ratings and is applied after the

reward factor adjustment (if applicable).

(A) The adjustment factor is monotonic (that is, as the proportion of LIS/DE and disabled increases in a contract, the adjustment factor increases in at least one of the dimensions) and varies by a contract's categorization into a final adjustment category that is determined by a contract's proportion of LIS/DE and disabled beneficiaries.

(B) To determine a contract's final adjustment category, contract enrollment is determined using enrollment data for the month of December for the measurement period of the Star Ratings year. The count of beneficiaries for a contract is restricted to beneficiaries that are alive for part or all of the month of December of the applicable measurement year. A beneficiary is categorized as LIS/DE if the beneficiary was designated as full or partially dually eligible or receiving a LIS at any time during the applicable measurement period. Disability status is determined using the variable original reason for entitlement (OREC) for Medicare using the information from the Social Security Administration and Railroad Retirement Board record systems.

(C) MA-PD contracts may be adjusted up to three times with the CAI; one for the overall Star Rating and one for each of the summary ratings (Part C and Part D).

(D) An MA-only contract may be adjusted only once for the CAI for the Part C summary rating.

(E) The CAI values are rounded and displayed with 6 decimal places.

(ii) In determining the CAI values, a measure will be excluded from adjustment if the measure meets any of the following:

(A) The measure is already case-mix adjusted for socioeconomic status.

(B) The focus of the measurement is not a beneficiary-level issue but rather a plan or provider-level issue.

(C) The measure is scheduled to be retired or revised.

(D) The measure is applicable only to SNPs.

(iii) The Star Ratings measures that remain after the exclusion criteria, paragraph (f)(2)(ii) of this section, have

been applied will be adjusted for the determination of the CAI. CMS will announce the measures identified for adjustment in the calculations of the CAI under this paragraph (f)(2) through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act.

(iv) The adjusted measure scores for the selected measures are determined using the results from regression models of beneficiary-level measure scores that adjust for the average within-contract difference in measure scores for MA or PDP contracts.

(A) A logistic regression model with contract fixed effects and beneficiary level indicators of LIS/DE and disability status is used for the adjustment.

(B) The adjusted measure scores are converted to a measure-level Star Rating using the measure thresholds for the Star Ratings year that corresponds to the measurement period of the data employed for the CAI determination.

(v) The rating-specific CAI values will be determined using the mean differences between the adjusted and unadjusted Star Ratings (overall, Part C summary, Part D summary for MA-PDs and Part D summary for PDPs) in each final adjustment category.

(A) For the annual development of the CAI, the distribution of the percentages for LIS/DE and disabled using the enrollment data that parallels the previous Star Ratings year's data would be examined to determine the number of equal-sized initial groups for each attribute (LIS/DE and disabled).

(B) The initial categories are created using all groups formed by the initial LIS/DE and disabled groups.

(C) The mean difference between the adjusted and unadjusted summary or overall ratings per initial category would be calculated and examined. The initial categories would then be collapsed to form the final adjustment categories. The collapsing of the initial categories to form the final adjustment categories would be done to enforce monotonicity in at least one dimension (LIS/DE or disabled).

(D) The mean difference within each final adjustment category by rating-type (overall, Part C, Part D for MA-

PD, and Part D for PDPs) would be the CAI values for the next Star Ratings year.

(vi) CMS develops the model for the modified contract-level LIS/DE percentage for Puerto Rico using the following sources of information:

(A) The most recent data available at the time of the development of the model of both 1-year American Community Survey (ACS) estimates for the percentage of people living below the Federal Poverty Level (FPL) and the ACS 5-year estimates for the percentage of people living below 150 percent of the FPL. The data to develop the model will be limited to the 10 states, drawn from the 50 states plus the District of Columbia with the highest proportion of people living below the FPL, as identified by the 1-year ACS estimates.

(B) The Medicare enrollment data from the same measurement period as the Star Ratings' year. The Medicare enrollment data would be aggregated from MA contracts that had at least 90 percent of their enrolled beneficiaries with mailing addresses in the 10 highest poverty states.

(vii) A linear regression model is developed to estimate the percentage of LIS/DE for a contracts that solely serve the population of beneficiaries in Puerto Rico.

(A) The maximum value for the modified LIS/DE indicator value per contract would be capped at 100 percent.

(B) All estimated modified LIS/DE values for Puerto Rico would be rounded to 6 decimal places when expressed as a percentage.

(C) The model's coefficient and intercept are updated annually and published in the Technical Notes.

(g) *Applying the improvement measure scores.* (1) CMS runs the calculations twice for the highest level rating for each contract-type (overall rating for MA-PD contracts and Part C summary rating for MA-only contracts), with all applicable adjustments (CAI and the reward factor), once including the improvement measure(s) and once without including the improvement measure(s). In deciding whether to include the improvement measures in a con-

tract's final highest rating, CMS applies the following rules:

(i) If the highest rating for each contract-type is 4 stars or more without the use of the improvement measure(s) and with all applicable adjustments (CAI and the reward factor), a comparison of the highest rating with and without the improvement measure(s) is done. The higher rating is used for the rating.

(ii) If the highest rating is less than 4 stars without the use of the improvement measure(s) and with all applicable adjustments (CAI and the reward factor), the rating will be calculated with the improvement measure(s).

(2) The Part C summary rating for MA-PDs will include the Part C improvement measure and the Part D summary rating for MA-PDs will include the Part D improvement measure.

(3) For 2022 Star Ratings only, CMS runs the calculations twice for the highest rating for each contract-type (overall rating for MA-PD contracts and Part C summary rating for MA-only contracts) and Part C summary rating for MA-PDs with all applicable adjustments (CAI and the reward factor), once including the improvement measure(s) and once without including the improvement measure(s). In deciding whether to include the improvement measures in a contract's highest and summary rating(s), CMS applies the following rules:

(i) For MA-PDs and MA-only contracts, a comparison of the highest rating with and without the improvement measure is done. The higher rating is used for the highest rating.

(ii) For MA-PDs, a comparison of the Part C summary rating with and without the improvement measure is done. The higher rating is used for the summary rating.

(h) *Posting and display of ratings.* For all ratings at the measure, domain, summary and overall level, posting and display of the ratings is based on there being sufficient data to calculate and assign ratings. If a contract does not have sufficient data to calculate a rating, the posting and display would be the flag "Not enough data available." If the measurement period is prior to one year past the contract's effective

date, the posting and display would be the flag “Plan too new to be measured”.

(1) *Medicare Plan Finder Performance icons.* Icons are displayed on Medicare Plan Finder to note performance as provided in this paragraph (h)(1):

(i) *High-performing icon.* The high performing icon is assigned to an MA-only contract for achieving a 5-star Part C summary rating and an MA-PD contract for a 5-star overall rating.

(ii) *Low-performing icon.* (A) A contract receives a low performing icon as a result of its performance on the Part C 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 2 years. If the contract had any combination of Part C or Part D summary ratings of 2.5 or lower in all 3 years of data, it is marked with a low performing icon. A contract must have a rating in either Part C or Part D for all 3 years to be considered for this icon.

(B) CMS may disable the Medicare Plan Finder online enrollment function (in Medicare Plan Finder) for Medicare health and prescription drug plans with the low performing icon; beneficiaries will be directed to contact the plan directly to enroll in the low-performing plan.

(2) *Plan preview of the Star Ratings.* CMS will have plan preview periods before each Star Ratings release during which MA organizations can preview their Star Ratings data in HPMS prior to display on the Medicare Plan Finder.

(i) *Extreme and uncontrollable circumstances.* In the event of extreme and uncontrollable circumstances that may negatively impact operational and clinical systems and contracts’ abilities to conduct surveys needed for accurate performance measurement, CMS calculates the Star Ratings as specified in paragraphs (i)(2) through (10) of this section for each contract that is an affected contract during the performance period for the applicable measures. We use the start date of the incident period to determine which year of Star Ratings could be affected, regardless of whether the incident period lasts until another calendar year.

(1) *Identification of affected contracts.* A contract that meets all of the following criteria is an affected contract:

(i) The contract’s service area is within an “emergency area” during an “emergency period” as defined in section 1135(g) of the Act.

(ii) The contract’s service area is within a county, parish, U.S. territory or tribal area designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s).

(iii) As specified in paragraphs (i)(2) through (10) of this section, a certain minimum percentage (25 percent or 60 percent) of the enrollees under the contract must reside in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance.

(2) *CAHPS adjustments.* (i) A contract, even if an affected contract, must administer the CAHPS survey unless exempt under paragraph (i)(2)(ii) of this section.

(ii) An affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance is exempt from administering the CAHPS survey if the contract completes both of the following:

(A) Demonstrates to CMS that the required sample for the survey cannot be contacted because a substantial number of the contract’s enrollees are displaced due to the FEMA-designated disaster identified in paragraph (i)(1)(iii) of this section in the prior calendar year.

(B) Requests and receives a CMS approved exemption.

(iii) An affected contract with an exemption described in paragraph (i)(2)(ii) of this section receives the contract’s CAHPS measure stars and corresponding measure scores from the prior year.

(iv) For an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance, the contract receives the higher of the previous year’s Star Rating or the current

year's Star Rating (and corresponding measure score) for each CAHPS measure.

(v) When a contract is an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance with regard to separate extreme and uncontrollable circumstances that begin in successive years, it is a multiple year-affected contract. A multiple year-affected contract receives the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure (using the corresponding measure score for the Star Ratings year selected).

(3) *HOS adjustments.* (i) An affected contract must administer the HOS survey unless exempt under paragraph (i)(3)(ii) of this section.

(ii) An affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance is exempt from administering the HOS survey if the contract completes the following:

(A) Demonstrates to CMS that the required sample for the survey cannot be contacted because a substantial number of the contract's enrollees are displaced due to the FEMA-designated disaster identified in paragraph (i)(1)(iii) of this section during the measurement period.

(B) Requests and receives a CMS approved exemption.

(iii) Affected contracts with an exemption described in paragraph (i)(3)(ii) of this section receive the prior year's HOS and Healthcare Effectiveness Data and Information Set (HEDIS)-HOS measure stars and corresponding measure scores.

(iv) For an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance, the affected contract receives the higher of the previous year's Star Rating or the current year's Star Rating (and corresponding measure score) for each HOS and HEDIS-HOS measure.

(v) When a contract is an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance with regard to separate extreme and uncontrollable circumstances that begin in successive years, it is a multiple year-affected contract. A multiple year-affected contract receives the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure (using the corresponding measure score for the Star Ratings year selected).

(4) *HEDIS adjustments.* (i) An affected contract must report HEDIS data unless exempted under paragraph (i)(4)(ii) of this section.

(ii) An affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance is exempt from reporting HEDIS data if the contract completes the following:

(A) Demonstrates an inability to obtain both administrative and medical record data that are required for reporting HEDIS measures due to a FEMA-designated disaster in the prior calendar year.

(B) Requests and receives a CMS approved exemption.

(iii) Affected contracts with an exemption described in paragraph (i)(4)(ii) of this section receive the prior year's HEDIS measure stars and corresponding measure scores.

(iv) Contracts that do not have an exemption defined in paragraph (i)(4)(ii) of this section may contact National Committee for Quality Assurance (NCQA) to request modifications to the samples for measures that require medical record review.

(v) For an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance, the affected contract receives the higher of the previous year's Star Rating or the current year's Star Rating (and corresponding measure score) for each HEDIS measure.

(vi) When a contract is an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance with regard to separate extreme and uncontrollable circumstances that begin in successive years, it is a multiple year-affected contract. A multiple year-affected contract receives the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure (using the corresponding measure score for the Star Ratings year selected).

(5) *New measure adjustments.* For affected contracts with at least 25 percent of enrollees in a FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance, CMS holds the affected contract harmless by using the higher of the contract's summary or overall rating or both with and without including all of the applicable new measures.

(6) *Other Star Ratings measure adjustments.* (i) For all other measures except those measures identified in this paragraph (i)(6)(ii) of this section, affected contracts with at least 25 percent of enrollees in a FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance receive the higher of the previous or current year's measure Star Rating (and corresponding measure score).

(ii) CMS does not adjust the scores or Star Ratings for the following measures, unless the exemption in paragraph (i)(6)(iii) of this section applies.

(A) Part C Call Center—Foreign Language Interpreter and TTY Availability.

(B) Part D Call Center—Foreign Language Interpreter and TTY Availability.

(iii) CMS adjusts the measures listed in paragraph (i)(6)(ii) of this section using the adjustments listed in paragraph (i)(6)(i) of this section for contracts affected by extreme and uncontrollable circumstances where there are continuing communications issues related to loss of electricity and dam-

age to infrastructure during the call center study.

(iv) When a contract is an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance with regard to separate extreme and uncontrollable circumstances that begin in successive years, it is a multiple year-affected contract. A multiple year-affected contract receives the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure (using the corresponding measure score for the Star Ratings year selected).

(7) *Exclusion from improvement measures.* Any measure that reverts back to the data underlying the previous year's Star Rating due to the adjustments made in paragraph (i) of this section is excluded from both the count of measures and the applicable improvement measures for the current and next year's Star Ratings for the affected contract. Contracts affected by extreme and uncontrollable circumstances do not have the option of reverting to the prior year's improvement rating.

(8) *Missing data.* For an affected contract that has missing data in the current or previous year, the final measure rating comes from the current year unless any of the exemptions described in paragraphs (i)(2)(ii), (i)(3)(ii), and (i)(4)(ii) of this section apply.

(9) *Cut points for non-CAHPS measures.* (i) CMS excludes the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance from the clustering algorithms described in paragraph (a)(2) of this section.

(ii) The cut points calculated as described in paragraph (i)(9)(i) of this section are used to assess all affected contracts' measure Star Ratings.

(10) *Reward Factor.* (i) CMS excludes the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance area at the time of

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the extreme and uncontrollable circumstance from the determination of the performance summary and variance thresholds for the Reward Factor described in paragraph (f)(1) of this section.

(ii) All affected contracts are eligible for the Reward Factor based on the calculations described in paragraph (i)(10)(i) of this section.

(11) *Special rules for the 2022 Star Ratings only.* For the 2022 Star Ratings only, CMS will not apply the provisions in paragraph (i)(9) or (10) of this section and CMS will not exclude the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance from the clustering algorithms or from the determination of the performance summary and variance thresholds for the Reward Factor.

(j) *Special rules for 2021 and 2022 Star Ratings only.* (1) For the 2021 Star Ratings:

(i) The measures calculated based on HEDIS data are calculated based on data from the 2018 performance period.

(ii) The measures calculated based on CAHPS data are calculated based on survey data collected from March through May 2019.

(iii) The measure-level change score calculation described at § 422.164(f)(4)(i) is not applied for HEDIS and CAHPS measures and the measure-level change score used for the 2020 Star Ratings is applied in its place for all HEDIS and CAHPS-based measures.

(iv) The provisions of § 422.164(g)(1) and (2) are not applied for the failure to submit HEDIS and CAHPS-based measures.

(v) In the event that there are extraordinary circumstances resulting from the COVID-19 pandemic that compromise CMS resources to the extent that CMS cannot calculate or issue 2021 Star Ratings by October 2020, CMS will adopt the 2020 Star Ratings as the 2021 Star Ratings.

(2) For the 2022 Star Ratings:

(i) In the event that the threat to health and safety posed by the COVID-19 pandemic compromises the ability to collect the Health Outcomes Survey in 2020, CMS will adopt the 2021 Star

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Ratings and measure scores for the measures that come from the Health Outcomes Survey as the 2022 Star Ratings and measure scores for the measures that come from the Health Outcomes Survey.

(ii) [Reserved]

[83 FR 16725, Apr. 16, 2018, as amended at 84 FR 15830, Apr. 16, 2019; 85 FR 19290, Apr. 6, 2020; 85 FR 33907, June 2, 2020; 85 FR 54872, Sept. 2, 2020]

Subpart E—Relationships With Providers

SOURCE: 63 FR 35085, June 26, 1998, unless otherwise noted.

§ 422.200 Basis and scope.

This subpart is based on sections 1852(a)(1), (a)(2), (b)(2), (c)(2)(D), (j), and (k) of the Act; section 1859(b)(2)(A) of the Act; and the general authority under 1856(b) of the Act requiring the establishment of standards. It sets forth the requirements and standards for the MA organization's relationships with providers including physicians, other health care professionals, institutional providers and suppliers, under contracts or arrangements or deemed contracts under MA private fee-for-service plans. This subpart also contains some requirements that apply to noncontracting providers.

§ 422.202 Participation procedures.

(a) *Notice and appeal rights.* An MA organization that operates a coordinated care plan or network MSA plan must provide for the participation of individual physicians, and the management and members of groups of physicians, through reasonable procedures that include the following:

(1) Written notice of rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions.

(2) Written notice of material changes in participation rules before the changes are put into effect.

(3) Written notice of participation decisions that are adverse to physicians.

(4) A process for appealing adverse participation procedures, including the right of physicians to present information and their views on the decision. In