

(5) A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(6) A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

(7) A description of the organization's policies and procedures with respect to the withholding or removal of accreditation organization's standards or requirements, and other actions the organization takes in response to non-compliance with its standards and requirements.

(8) A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.

(9) A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

(10) A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.

(11) The name and address of each person with an ownership or control interest in the accreditation organization.

(b) *Required supporting documentation.* A private, national accreditation organization applying or reapplying for approval must also submit the following supporting documentation:

(1) A written presentation that demonstrates its ability to furnish CMS with electronic data in CMS compatible format.

(2) A resource analysis that demonstrates that its staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(3) A statement acknowledging that, as a condition for approval, it agrees to comply with the ongoing responsibility requirements of § 422.157(c).

(c) *Additional information.* If CMS determines that it needs additional information for a determination to grant or deny the accreditation organization's request for approval, it notifies the organization and allows time for the organization to provide the additional information.

(d) *Onsite visit.* CMS may visit the accreditation organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents, and interviews with the organization's staff.

(e) *Notice of determination.* CMS gives the accreditation organization, within 210 days of receipt of its completed application, a formal notice that—

(1) States whether the request for approval has been granted or denied;

(2) Gives the rationale for any denial; and

(3) Describes the reconsideration and reapplication procedures.

(f) *Withdrawal.* An accreditation organization may withdraw its application for approval at any time before it receives the formal notice specified in paragraph (e) of this section.

(g) *Reconsideration of adverse determination.* An accreditation organization that has received notice of denial of its request for approval may request reconsideration in accordance with subpart D of part 488 of this chapter.

(h) *Request for approval following denial.* (1) Except as provided in paragraph (h)(2) of this section, an accreditation organization that has received notice of denial of its request for approval may submit a new request if it—

(i) Has revised its accreditation program to correct the deficiencies on which the denial was based;

(ii) Can demonstrate that the MA organizations that it has accredited meet or exceed applicable Medicare requirements; and

(iii) Resubmits the application in its entirety.

(2) An accreditation organization that has requested reconsideration of CMS's denial of its request for approval may not submit a new request until

the reconsideration is administratively final.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40324, June 29, 2000]

**§ 422.160 Basis and scope of the Medicare Advantage Quality Rating System.**

(a) *Basis.* This subpart is based on sections 1851(d), 1852(e), 1853(o) and 1854(b)(3)(iii), (v), and (vi) of the Act and the general authority under section 1856(b) of the Act requiring the establishment of standards consistent with and to carry out Part C.

(b) *Purpose.* Ratings calculated and assigned under this subpart will be used by CMS for the following purposes:

(1) To provide comparative information on plan quality and performance to beneficiaries for their use in making knowledgeable enrollment and coverage decisions in the Medicare program.

(2) To provide quality ratings on a 5-star rating system to be used in determining quality bonus payment (QBP) status and in determining rebate retention allowances.

(3) To provide a means to evaluate and oversee overall and specific compliance with certain regulatory and contract requirements by MA plans, where appropriate and possible to use data of the type described in § 422.162(c).

(c) *Applicability.* Except for § 422.162(b)(3), the regulations in this subpart will be applicable beginning with the 2019 measurement period and the associated 2021 Star Ratings that are released prior to the annual coordinated election period for the 2021 contract year and used to assign QBP ratings for the 2022 payment year.

[83 FR 16725, Apr. 16, 2018]

**§ 422.162 Medicare Advantage Quality Rating System.**

(a) *Definitions.* In this subpart the following terms have the meanings:

*Absolute percentage cap* is a cap applied to non-CAHPS measures that are on a 0 to 100 scale that restricts movement of the current year's measure-threshold-specific cut point to no more than the stated percentage as compared to the prior year's cut point.

*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 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.

*Case-mix adjustment* means an adjustment to the measure score made prior to the score being converted into a Star Rating to take into account certain enrollee characteristics that are not under the control of the plan. For example age, education, chronic medical conditions, and functional health status that may be related to the enrollee's survey responses.

*Categorical Adjustment Index (CAI)* means the factor that is added to or subtracted from an overall or summary Star Rating (or both) to adjust for the average within-contract (or within-plan as applicable) disparity in performance associated with the percentages of beneficiaries who are dually eligible for Medicare and enrolled in Medicaid, beneficiaries who receive a Low Income Subsidy, or have disability status in that contract (or plan as applicable).

*Clustering* refers to a variety of techniques used to partition data into distinct groups such that the observations within a group are as similar as possible to each other, and as dissimilar as possible to observations in any other group. Clustering of the measure-specific scores means that gaps that exist within the distribution of the scores are identified to create groups (clusters) that are then used to identify the four cut points resulting in the creation of five levels (one for each Star Rating), such that the scores in the same Star Rating level are as similar as possible and the scores in different Star Rating levels are as different as possible. 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.

*Consolidation* means when an MA organization that has at least two contracts for health and/or drug services of the same plan type under the same parent organization in a year combines multiple contracts into a single contract for the start of the subsequent contract year.

*Consumed contract* means a contract that will no longer exist after a contract year's end as a result of a consolidation.

*Cut point cap* is a restriction on the change in the amount of movement a measure-threshold-specific cut point can make as compared to the prior year's measure-threshold-specific cut point. A cut point cap can restrict upward movement, downward movement, or both.

*Display page* means the CMS website on which certain measures and scores are publicly available for informational purposes; the measures that are presented on the display page are not used in assigning Part C and D Star Ratings.

*Domain rating* means the rating that groups measures together by dimensions of care.

*Dual-eligible (DE)* means a beneficiary who is enrolled in both Medicare and Medicaid.

*Guardrail* is a bidirectional cap that restricts both upward and downward movement of a measure-threshold-specific cut point for the current year's measure-level Star Ratings as compared to the prior year's measure-threshold-specific cut point.

*Health equity index* means an index that summarizes contract performance among those with specified social risk factors (SRFs) across multiple measures into a single score.

*HEDIS* is the Healthcare Effectiveness Data and Information Set which is

a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS data include clinical measures assessing the effectiveness of care, access/availability measures, and service use measures.

*Highest rating* means the overall rating for MA-PDs, the Part C summary rating for MA-only contracts, and the Part D summary rating for PDPs.

*Highly-rated contract* means a contract that has 4 or more stars for its highest rating when calculated without the improvement measures and with all applicable adjustments in § 422.166(f).

*HOS* means the Medicare Health Outcomes Survey which is the first patient reported outcomes measure that was 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.

*Low income subsidy (LIS)* means the subsidy that a beneficiary receives to help pay for prescription drug coverage (see § 423.34 of this chapter for definition of a low-income subsidy eligible individual).

*Mean resampling* refers to a technique where measure-specific scores for the current year's Star Ratings are randomly separated into 10 equal-sized groups. The hierarchical clustering algorithm is done 10 times, each time leaving one of the 10 groups out. By leaving out one of the 10 groups for each run, 9 of the 10 groups, which is 90 percent of the applicable measure scores, are used for each run of the clustering algorithm. The method results in 10 sets of measure-specific cut points. The mean cut point for each threshold per measure is calculated using the 10 values.

*Measurement period* means the period for which data are collected for a measure or the performance period that a measures covers.

*Measure score* means the numeric value of the measure or an assigned 'missing data' message.

*Measure star* means the measure's numeric value is converted to a Star Rating. It is displayed to the nearest whole star, using a 1-5 star scale.

*Overall rating* means a global rating that summarizes the quality and performance for the types of services offered across all unique Part C and Part D measures.

*Part C summary rating* means a global rating that summarizes the health plan quality and performance on Part C measures.

*Part D summary rating* means a global rating that summarizes prescription drug plan quality and performance on Part D measures.

*Plan benefit package (PBP)* means a set of benefits for a defined MA or PDP service area. The PBP is submitted by Part D plan sponsors and MA organizations to CMS for benefit analysis, bidding, marketing, and beneficiary communication purposes.

*Reliability* means 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"); it is reflected on a scale from 0 (all differences in plan performance measure scores are due to measurement error) to 1 (the difference in plan performance scores is attributable to real differences in performance).

*Restricted range* is the difference between the maximum and minimum measure score values using the prior year measure scores excluding outlier fence outliers (first quartile  $- 3 \times$  Interquartile Range (IQR) and third quartile  $+ 3 \times$  IQR).

*Restricted range cap* is a cap applied to non-CAHPS measures that restricts movement of the current year's measure-threshold-specific cut point to no more than the stated percentage of the restricted range of a measure calculated using the prior year's measure score distribution.

*Reward factor* means a rating-specific factor added to the contract's summary or overall ratings (or both) if a contract has both high and stable relative performance.

*Statistical significance* assesses how likely differences observed in performance are due to random chance alone

under the assumption that plans are actually performing the same.

*Surviving contract* means the contract that will still exist under a consolidation, and all of the beneficiaries enrolled in the consumed contract(s) are moved to the surviving contracts.

*Traditional rounding rules* mean that the last digit in a value will be rounded. If rounding to a whole number, look at the digit in the first decimal place. If the digit in the first decimal place is 0, 1, 2, 3, or 4, then the value should be rounded down by deleting the digit in the first decimal place. If the digit in the first decimal place is 5 or greater, then the value should be rounded up by 1 and the digit in the first decimal place deleted.

*Tukey outer fence outliers* are measure scores that are below a certain point (first quartile  $- 3.0 \times$  (third quartile  $-$  first quartile)) or above a certain point (third quartile  $+ 3.0 \times$  (third quartile  $-$  first quartile)).

(b) *Contract ratings*—(1) *General*. CMS calculates an overall Star Rating, Part C summary rating, and Part D summary rating for each MA-PD contract, and a Part C summary rating for each MA-only contract using the 5-star rating system described in this subpart. Measures are assigned stars at the contract level and weighted in accordance with § 422.166(a). Domain ratings are the unweighted mean of the individual measure ratings under the topic area in accordance with § 422.166(b). Summary ratings are the weighted mean of the individual measure ratings for Part C or Part D in accordance with § 422.166(c), with the applicable adjustments provided in paragraph (f) of this section. Overall Star Ratings are calculated by using the weighted mean of the individual measure ratings in accordance with § 422.166(d), with the applicable adjustments provided in paragraph (f) of this section. CMS includes the Star Ratings measures in the overall and summary ratings that are associated with the contract type for the Star Ratings year.

(2) *Plan benefit packages*. All plan benefit packages (PBPs) offered under an MA contract have the same overall and/or summary Star Ratings as the contract under which the PBP is offered by the MA organization. Data

from all the PBPs offered under a contract are used to calculate the measure and domain ratings for the contract except for Special Needs Plan (SNP)-specific measures collected at the PBP level; a contract level score for such measures is calculated using an enrollment-weighted mean of the PBP scores and enrollment reported as part of the measure specification in each PBP.

(3) *Contract consolidations.* (i) In the case of contract consolidations involving two or more contracts for health or drug services of the same plan type under the same parent organization, CMS assigns Star Ratings for the first and second years following the consolidation based on the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s) as provided in paragraph (b)(3)(iv) of this section. Paragraph (b)(3)(iii) of this section is applied to subsequent years that are not addressed in paragraph (b)(3)(ii) of this section for assigning the QBP rating.

(ii) For the first year after a consolidation, CMS will determine the QBP status of a contract using the enrollment-weighted means (using traditional rounding rules) of what would have been the QBP Ratings of the surviving and consumed contracts based on the contract enrollment in November of the year the preliminary QBP ratings were released in the Health Plan Management System (HPMS).

(iii) In subsequent years following the first year after the consolidation, CMS will determine QBP status based on the consolidated entity's Star Ratings displayed on Medicare Plan Finder.

(iv) The Star Ratings posted on Medicare Plan Finder for contracts that consolidate are as follows:

(A)(I) For the first year after consolidation, CMS uses enrollment-weighted measure scores using the July enrollment of the measurement period of the consumed and surviving contracts for all measures, except survey-based measures, call center measures, and improvement measures. The survey-based measures will use enrollment of the surviving and consumed contracts at the time the sample is pulled for the rating year. The call center measures will use average enrollment during the

study period. The Part C and D improvement measures are not calculated for first year consolidations.

(2) For contract consolidations approved on or after January 1, 2022, if a measure score for a consumed or surviving contract is missing due to a data integrity issue as described in § 422.164(g)(1)(i) and (ii), CMS assigns a score of zero for the missing measure score in the calculation of the enrollment-weighted measure score.

(B)(I) For the second year after consolidation, CMS uses the enrollment-weighted measure scores using the July enrollment of the measurement year of the consumed and surviving contracts for all measures except for HEDIS, CAHPS, and HOS. HEDIS and HOS measure data are scored as reported. CMS ensures that the CAHPS survey sample includes enrollees in the sample frame from both the surviving and consumed contracts.

(2) For contract consolidations approved on or after January 1, 2022, for all measures except HEDIS, CAHPS, and HOS if a measure score for a consumed or surviving contract is missing due to a data integrity issue as described in § 422.164(g)(1)(i) and (ii), CMS assigns a score of zero for the missing measure score in the calculation of the enrollment-weighted measure score.

(v) This provision governing the Star Ratings of surviving contracts is applicable to contract consolidations that are approved on or after January 1, 2019.

(4) *Quality bonus payment ratings.* (i) For contracts that receive a numeric Star Rating, the final quality bonus payment (QBP) rating for the contract is released in April of each year for the following contract year. The QBP rating is the contract's highest rating from the Star Ratings published by CMS in October of the calendar year that is 2 years before the contract year to which the QBP rating applies.

(ii) The contract QBP rating is applied to each plan benefit package offered under the contract.

(c) *Data sources.* (1) CMS bases Part C Star Ratings on the type of data specified in section 1852(e) of the Act and on CMS administrative data. Part C Star Ratings measures reflect structure,