

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,

process, and outcome indices of quality. This includes information of the following types: Clinical data, beneficiary experiences, changes in physical and mental health, benefit administration information and CMS administrative data. Data underlying Star Ratings measures may include survey data, data separately collected and used in oversight of MA plans' compliance with MA requirements, data submitted by plans, and CMS administrative data.

(2) MA organizations are required to collect, analyze, and report data that permit measurement of health outcomes and other indices of quality. MA organizations must provide unbiased, accurate, and complete quality data described in paragraph (c)(1) of this section to CMS on a timely basis as requested by CMS.

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§ 422.164 Adding, updating, and removing measures.

(a) *General.* CMS adds, updates, and removes measures used to calculate the Star Ratings as provided in this section. CMS lists the measures used for a particular Star Rating each year in the Technical Notes or similar guidance document with publication of the Star Ratings.

(b) *Review of data quality.* CMS reviews the quality of the data on which performance, scoring and rating of a measure is based before using the data to score and rate performance or in calculating a Star Rating. This includes review of variation in scores among MA organizations and Part D plan sponsors, and the accuracy, reliability, and validity of measures and performance data before making a final determination about inclusion of measures in each year's Star Ratings.

(c) *Adding measures.* (1) CMS will continue to review measures that are nationally endorsed and in alignment with the private sector, such as measures developed by National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA), or endorsed by the National Quality Forum for adoption and use in the Part

C and Part D Quality Ratings System. CMS may develop its own measures as well when appropriate to measure and reflect performance specific to the Medicare program.

(2) In advance of the measurement period, CMS will announce potential new measures and solicit feedback through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act and then subsequently will propose and finalize new measures through rulemaking.

(3) New measures added to the Part C Star Ratings program will be on the display page on *www.cms.gov* for a minimum of 2 years prior to becoming a Star Ratings measure.

(4) A measure will remain on the display page for longer than 2 years if CMS finds reliability or validity issues with the measure specification.

(d) *Updating measures*—(1) *Non-substantive updates.* For measures that are already used for Star Ratings, CMS will update measures so long as the changes in a measure are not substantive. CMS will announce non-substantive updates to measures that occur (or are announced by the measure steward) during or in advance of the measurement period through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act. Non-substantive measure specification updates include those that—

(i) Narrow the denominator or population covered by the measure;

(ii) Do not meaningfully impact the numerator or denominator of the measure;

(iii) Update the clinical codes with no change in the target population or the intent of the measure;

(iv) Provide additional clarifications: (A) Adding additional tests that would meet the numerator requirements;

(B) Clarifying documentation requirements;

(C) Adding additional instructions to identify services or procedures; or

(v) Add alternative data sources or expand modes of data collection.

(2) *Substantive updates.* For measures that are already used for Star Ratings,

in the case of measure specification updates that are substantive updates not subject to paragraph (d)(1) of this section, CMS will propose and finalize these measures through rulemaking similar to the process for adding new measures. CMS will initially solicit feedback on whether to make substantive measure updates through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act. Once the update has been made to the measure specification by the measure steward, CMS may continue collection of performance data for the legacy measure and include it in Star Ratings until the updated measure has been on display for 2 years. CMS will place the updated measure on the display page for at least 2 years prior to using the updated measure to calculate and assign Star Ratings as specified in paragraph (c) of this section.

(e) *Removing measures.* (1) CMS will remove a measure from the Star Ratings program as follows:

(i) When the clinical guidelines associated with the specifications of the measure change such that the specifications are no longer believed to align with positive health outcomes; or

(ii) A measure shows low statistical reliability.

(iii) The measure steward other than CMS retires a measure.

(2) CMS will announce in advance of the measurement period the removal of a measure based upon its application of this paragraph (e) through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act in advance of the measurement period.

(f) *Improvement measure.* CMS will calculate improvement measure scores based on a comparison of the measure scores for the current year to the immediately preceding year as provided in this paragraph (f); the improvement measure score would be 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.

(1) *Identifying eligible measures.* Annually, the subset of measures to be included in the Part C and Part D improvement measures will be announced

through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act. CMS identifies measures to be used in the improvement measures if the measures meet all of the following:

(i) CMS will include only measures available for the current and previous year in the improvement measures and that have numeric value scores in both the current and prior year.

(ii) CMS will exclude any measure for which there was a substantive specification change from the previous year.

(iii) CMS will exclude any measures that are already focused on improvement in MA organization performance from year to year.

(iv) The Part C improvement measure will include only Part C measure scores; the Part D improvement measure will include only Part D measure scores.

(v) CMS excludes any measure that receives a measure-level Star Rating reduction for data integrity concerns for either the current or prior year from the improvement measure(s).

(2) *Determining eligible contracts.* CMS will calculate an improvement score only for contracts that have numeric measure scores for both years in at least half of the measures identified for use applying the standards in paragraphs (f)(1)(i) through (iv) of this section.

(3) *Special rules for calculation of the improvement score.* For any measure used for the improvement measure for which a contract received 5 stars in each of the years examined, but for which the measure score demonstrates a statistically significant decline based on the results of the significance testing (at a level of significance of 0.05) on the change score, the measure will be categorized as having no significant change and included in the count of measures used to determine eligibility for the measure (that is, for the denominator of the improvement measure score).

(4) *Calculation of the improvement score.* The improvement measure will be calculated as follows:

(i) The improvement change score (the difference in the measure scores in the 2-year period) will be determined

for each measure that has been designated an improvement measure and for which a contract has a numeric score for each of the 2 years examined.

(ii) Each contract's improvement change score per measure will be categorized as a significant change or not a significant change by employing a two-tailed t-test with a level of significance of 0.05.

(iii) The net improvement per measure category (outcome, access, patient experience, process) would be calculated by finding the difference between the weighted number of significantly improved measures and significantly declined measures, using the measure weights associated with each measure category.

(iv) The improvement measure score will then be determined by calculating the weighted sum of the net improvement per measure category divided by the weighted sum of the number of eligible measures.

(v) The improvement measure scores will be converted to measure-level Star Ratings by determining the cut points using hierarchical clustering algorithms in accordance with § 422.166(a)(2)(i) through (iii).

(vi) The Part D improvement measure cut points for MA-PDs and PDPs will be determined using separate clustering algorithms in accordance with §§ 422.166(a)(2)(iii) and 423.186(a)(2)(iii) of this chapter.

(g) *Data integrity.* (1) CMS will reduce a contract's measure rating when CMS determines that a contract's measure data are inaccurate, incomplete, or biased; such determinations may be based on a number of reasons, including mishandling of data, inappropriate processing, or implementation of incorrect practices that have an impact on the accuracy, impartiality, or completeness of the data used for one or more specific measure(s).

(i) CMS will reduce HEDIS measures to 1 star when audited data are submitted to NCQA with a designation of "biased rate" or BR based on an auditor's review of the data or a designation of "nonreport" or NR.

(ii) CMS will reduce measures based on data that an MA organization must submit to CMS under § 422.516 to 1 star when a contract did not score at least

95 percent on data validation for the applicable reporting section or was not compliant with CMS data validation standards/substandards for data directly used to calculate the associated measure.

(iii) For the appeals measures, CMS uses statistical criteria to estimate the percentage of missing data for each contract using data from MA organizations, the independent review entity (IRE), or CMS administrative sources to determine whether the data at the IRE are complete. CMS uses scaled reductions for the Star Ratings for the applicable appeals measures to account for the degree to which the IRE data are missing.

(A)(1) The data reported by the MA organization on appeals, including the number of reconsiderations requested, denied, upheld, dismissed, or otherwise disposed of by the MA organization, and data from the IRE or CMS administrative sources, that align with the Star Ratings year measurement period are used to determine the scaled reduction.

(2) If there is a contract consolidation as described at § 422.162(b)(3), the data described in paragraph (g)(1)(iii)(A)(1) of this section are combined for the consumed and surviving contracts before the methodology provided in paragraphs (g)(1)(iii)(B) through (O) of this section is applied.

(B) [Reserved]

(C) The reductions range from a one-star reduction to a four-star reduction; the most severe reduction for the degree of missing IRE data is a four-star reduction.

(D) The thresholds used for determining the reduction and the associated appeals measure reduction are as follows:

(1) 20 percent, 1 star reduction.

(2) 40 percent, 2 star reduction.

(3) 60 percent, 3 star reduction.

(4) 80 percent, 4 star reduction.

(E) 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.

(F) [Reserved]

(G) The scaled reduction is applied after the calculation for the appeals