

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 the 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 D improvement measure 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 measure if the measures meet all 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) The Part D improvement measure will include only Part D measure scores.

(iv) 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 (iii) 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 § 423.186(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).

(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 measures based on data that a Part D organization must submit to CMS under § 423.514 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/sub-standards for data directly used to calculate the associated measure.

(ii) [Reserved]

(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) and (ii) of this section, including a contract's failure to adhere to CAHPS reporting requirements.

(h) *Review of sponsors' data.* (1) A Part D plan sponsor 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 for the applicable Star Ratings year.

(2) A Part D plan sponsor 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) [Reserved]

(3) Beginning with the 2025 measurement year (2027 Star Ratings), Part D sponsor may request that CMS review its contract's administrative data for Patient Safety measures provided that the request is received by the annual deadline set by CMS for the applicable Star Ratings year.

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§ 423.186 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 hierarchical clustering of the current year's data. Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchical clustering, Tukey outer fence outliers are removed. 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. 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 hierarchical 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 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 D summary ratings.* (1) CMS will calculate the Part D summary ratings using the weighted mean of the measure-level Star Ratings for Part D, weighted in accordance with paragraph (e) of this section and with the applicable adjustments provided in 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 a summary rating calculated.

(ii) The Part D 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 section and with the applicable adjustments provided in 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.

(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) Through the 2025 Star Ratings, patient experience and complaint measures receive a weight of 4. Starting with the 2026 Star Ratings and subsequent Star Ratings years, patient experience and complaint measures receive a weight of 2.

(iv) Through the 2025 Star Ratings, access measures receive a weight of 4. Starting with the 2026 Star Ratings and subsequent Star Ratings years, access measures receive a weight of 2.

(v) Process measures receive a weight of 1.

(2) *Rules for new and substantively updated measures.* New measures to the Star Ratings program will receive a weight of 1 for their first year in the Star Ratings program. Substantively updated measures will receive a weight of 1 in their first year returning to the Star Ratings after being on the display page. In subsequent years, a new or substantively updated 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 D 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.* Through the 2026 Star Ratings, this rating-specific reward factor is added to both the summary and overall ratings of contracts that qualify for this 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 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 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 will be 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 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 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 described in paragraph (f)(1) of this section (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.

(I) For the first 2 years following a consolidation, for the surviving contract of a contract consolidation involving two or more contracts for health or drug services of the same plan type under the same parent organization, the enrollment data for the month of December for the measurement period of the Star Ratings year are combined across the surviving and consumed contracts in the consolidation.

(2) 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.

(3) 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.

(4) 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) A MA–PD contract 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) A PDP contract may be adjusted only once for the CAI for the Part D 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 measures 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 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 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 Rating's 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 contacts 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.

(3) *Health equity index.* Starting with the 2027 Star Ratings year and subsequent Star Ratings years, CMS applies a health equity index rating-specific factor to both the summary and overall ratings of contracts that qualify based on an assessment of contract performance on quality measures among enrollees with certain social risk factors (SRFs).

(i) The health equity index (HEI) is calculated separately for the overall rating for MA-PDs and cost contracts including the applicable Part C and D measures; Part C summary rating for MA-only, MA-PD, and cost contracts including the applicable Part C measures; Part D summary rating for MA-PDs and cost contracts including the applicable Part D measures; and Part D summary rating for PDPs including the applicable Part D measures.

(A) The SRFs included in the HEI are receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid (LIS/DE), or having a disability. Enrollees will be identified as LIS/DE or as having a disability as specified in paragraph (f)(2)(i)(B) of this section. If a person meets the LIS/DE criteria for only one of the two measurement years included in the HEI, the data for that person for just that year are used. Measures that are case-mix adjusted in the Star Ratings are adjusted using all standard case-mix adjusters for the measure except for those adjusters that are the SRFs of interest in the index, are strongly correlated with the SRFs of interest, or are conceptually similar to the SRFs of interest.

(B) The HEI is calculated by combining measure-level scores for the

subset of enrollees with SRFs of interest included in the HEI across the two most recent measurement years using a modeling approach that includes year as an adjustor to account for potential differences in performance across years and to adjust the data to reflect performance in the second of the 2 years of data used. Measure-level scores are used for contracts that have data for only the most recent of the 2 years, but measure-level scores are not used for contracts that have data for only the first of the 2 years.

(ii) In determining the HEI scores, a measure will be excluded from the calculation of the index if the measure meets any of the following:

(A) The focus of the measurement is not the enrollee but rather the plan or provider.

(B) The measure is retired, moved to display, or has a substantive specification change in either year of data used to construct the HEI.

(C) The measure is applicable only to SNPs.

(D) At least 25 percent of contracts are unable to meet the criteria specified in paragraph (f)(3)(iv) of this section. For Part D measures, this criterion is assessed separately for MAPDs and cost contracts, and for PDPs.

(iii) The Star Ratings measures that remain after the exclusion criteria in paragraph (f)(3)(ii) of this section have been applied will be included in the calculation of the HEI. CMS will announce the measures being evaluated for inclusion in the calculation of the HEI under this paragraph (f)(3) of this section through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act.

(iv) For a measure to be included in the calculation of a contract's HEI score, the measure must meet both of the following criteria:

(A) The measure must have a reliability of at least 0.7 for the contract when calculated for the combined subset of enrollees with the SRF(s) specified in paragraph (f)(3)(i)(A) of this section across 2 years of data.

(B) The measure-specific denominator criteria must be met for the contract using only the combined subset of enrollees with the SRF(s) specified in

paragraph (f)(3)(i)(A) of this section across 2 years of data.

(v) To calculate the rating-specific HEI score, the distribution of contract performance on each eligible measure for the subset of enrollees that have one or more of the specified SRFs will be assessed and separated into thirds, with the top third of contracts receiving 1 point, the middle third of contracts receiving 0 points, and the bottom third of contracts receiving –1 point. The rating-specific HEI will then be calculated as the weighted sum of points across all measures included in the index using the Star Ratings measure weight for each measure divided by the weighted sum of the number of eligible measures for the given contract. The measure weight for each measure is the weight used for the measure in the current Star Ratings year as specified in paragraph (e) of this section.

(vi) To have the HEI calculated, contracts must have at least 500 enrollees in the most recent measurement year used in the HEI and have at least half of the measures included in the HEI meet the criteria specified under paragraph (f)(3)(iv) of this section.

(vii) In order to qualify for the full HEI reward, contracts must have percentages of enrollees with the specified SRFs combined greater than or equal to the contract-level median in the most recent year of data used to calculate the HEI and a rating-specific minimum index score of greater than zero. In order to qualify for one-half of the HEI reward, contracts must have percentages of enrollees with SRFs greater than or equal to one-half of the contract-level median up to, but not including, the contract-level median percentage of enrollees with SRFs in the most recent year of data used to calculate the HEI and a rating-specific minimum index score of greater than zero. One-half of the contract-level median and the contract-level median enrollment percentages are assessed separately for contracts that offer Part C and stand-alone Part D contracts.

(A) For contracts with service areas wholly located in Puerto Rico, the percentage of enrollees that are LIS/DE or disabled is calculated by adding the number of DE/disabled enrollees to the estimated LIS percentage calculated

by taking the percentage LIS/DE as calculated at §§ 422.166(f)(2)(vi) and (vii) and 423.186(f)(2)(vi) and (vii) and subtracting the percentage of DE enrollees.

(B) Contracts with service areas wholly located in Puerto Rico are excluded from the calculation of one-half of the contract-level median and the contract-level median.

(viii) For contracts that have percentages of enrollees with SRFs greater than or equal to the contract-level median enrollment percentage, the HEI reward added to the contract's summary and overall ratings will vary from 0 to 0.4 on a linear scale with a contract receiving 0 if the contract receives a score of 0 or less on the HEI and 0.4 if the contract receives a score of 1 on the HEI. For contracts that have percentages of enrollees with SRFs greater than or equal to one-half the median percentage of enrollees with SRFs up to, but not including, the contract-level median percentage of enrollees with SRFs, the HEI reward added to the contract's summary and overall ratings will vary from 0 to 0.2 on a linear scale, with a contract receiving 0 if the contract receives a score of 0 or less on the HEI and 0.2 if the contract receives a score of 1 on the HEI. The HEI reward is rounded and displayed with 6 decimal places. Contracts that cannot have a HEI score calculated (that is, contracts that are not scored on at least half of the measures included in the index) will not receive an HEI reward.

(A) 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 calculates the HEI reward for the surviving contract accounting for both the surviving and consumed contract(s). For the first year following a consolidation, the HEI reward for the surviving contract is calculated as the enrollment-weighted mean of the HEI reward of the consumed and surviving contracts using total contract enrollment from July of the most recent measurement year used in calculating the HEI reward. A reward value of zero is used in calculating the enrollment-weighted mean for contracts that do not meet the min-

imum percentage of enrollees with the SRF thresholds or the minimum performance threshold specified at paragraph (f)(3)(vii) of this section.

(B) For the second year following a consolidation when calculating the HEI score for the surviving contract, the patient-level data used in calculating the HEI score will be combined from the consumed and surviving contracts and used in calculating the HEI score.

(ix) The HEI reward is calculated separately for, and then added to, the overall rating, Part C rating for MA-PDs and MA-only contracts (and cost contracts), Part D rating for MA-PDs (and cost contracts), and Part D rating for PDPs after the addition of the CAI as specified in paragraph (f)(2) of this section and application of the improvement measures as specified in paragraph (g) of this section and before the final overall and Part C and D summary ratings are calculated by rounding to the nearest half star.

(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 D summary rating for PDPs), with the reward factor adjustment if applicable and the CAI adjustment, 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 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 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 D summary rating for PDPs) and Part D 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 PDPs, 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 D 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 a Part D plan sponsor for achieving a 5-star Part D 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 Part D plan sponsors 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 (8) 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 (8) 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) *New measure adjustments.* For affected contracts with at least 25 per-

cent 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.

(4) *Other Star Ratings measure adjustments.* (i) For all other Part D measures except those measures identified in this paragraph (i)(4)(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 of the Star Ratings for the Part D Call Center—Foreign Language Interpreter and TTY Availability measure, unless the exemption listed in paragraph (i)(4)(iii) of this section applies.

(iii) CMS adjusts the measure listed in paragraph (i)(4)(ii) of this section using the adjustments listed in paragraph (i)(4)(i) of this section for contracts affected by extreme and uncontrollable circumstances where there are continuing communications issues related to loss of electricity and damage 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).

(5) *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