DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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CENTER FOR MEDICARE

DATE: November 13, 2018

TO: Medicare Advantage Compliance Officers

FROM: Amy Larrick Chavez-Valdez
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SUBJECT: 2020 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances

Background

The Affordable Care Act of 2010 amends sections 1853(n) and 1853(o) of the Act[1] to require CMS to make quality bonus payments (QBPs) to Medicare Advantage (MA) organizations that achieve at least 4 stars in a 5-star quality rating system. The Affordable Care Act also amends section 1854(b)(1)(C) of the Act to change the share of savings that MA organizations must provide to enrollees as the beneficiary rebate, mandating that the level of rebate is tied to the level of an MA organization's QBP rating. As a result, beginning in 2012, quality as measured by the Star Ratings directly affected the monthly payment amount MA organizations receive from CMS.

Under 42 C.F.R. § 422.260, CMS has made an administrative review process available to MA organizations for payment determinations based on the quality bonuses. The 2020 QBP appeals process will start November 13, 2018 with the posting of the preliminary QBP ratings in HPMS. MA organizations may request an administrative review of their Star Ratings for QBP determinations and rebate retention allowances. The following explains the process for requesting a review of these ratings.

Star Ratings to be Used for QBP Determinations

The Star Ratings for the 2020 QBP determinations are the Star Ratings released October 2018 on the Medicare Plan Finder (MPF) tool at http://www.medicare.gov for those contracts that had enough data to calculate an overall rating.

The methodology for determining the Star Ratings is described in the Medicare 2019 Part C & D Star Ratings Technical Notes. With the release of the Star Ratings on the MPF tool, the data were also posted at http://go.cms.gov/partcanddstarratings

Only MA organizations are included in the QBP ratings. The MA organization types are:

[1] References to "the Act" are to the Social Security Act.

Organization Type	Offers Part D
Employer/Union Only Direct Contract Local CCP	✓
Employer/Union Only Direct Contract PFFS	✓
Local CCP	✓
MSA	
PFFS	✓*
Regional CCP	✓
RFB Local CCP	✓
RFB PFFS	✓

* PFFS are not required to offer drug benefits.

QBP Rating Rules

For contracts that receive a numeric Star Rating, the QBP rating is assigned as follows:

- For MA contracts that offer Part D, the QBP rating is the numeric overall Star Rating.
- For MA contracts that do not offer Part D (MA-only, MSA, and some PFFS contracts), the QBP rating is the numeric Part C summary rating.

For contracts that did not have a numeric Star Rating, the QBP rating is determined based on the message the contract received on MPF:

- Contracts with the message "Not enough data available" on MPF are considered low enrollment contracts for assignment of the QBP rating.
- Contracts with the message "Plan too new to be measured" on MPF are considered new contracts for assignment of the QBP rating.

Low enrollment contracts are those that have been in existence long enough (prior to 1/1/2017) to receive a Star Rating but do not have enough enrollment to reliably report Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcomes Survey (HOS) data. Contracts with 500 or more enrollees as of July 2017 are included in the 2019 Star Ratings on MPF, and these ratings will be used for 2020 QBPs.

New contracts for the 2020 QBP ratings are contracts with an effective date after 1/1/2017:

- Any new contract in a parent organization that contains MA contracts with numeric Star Ratings is assigned the enrollment-weighted average rating of all other MA contracts in the parent organization that will be active as of April 2019.
- If there are no MA contracts in the parent organization with numeric Star Ratings in November 2018, we look at MA Star Ratings for the previous three years. So for the 2020 QBP we look back to November of 2016 (i.e., 2017 Star Ratings).
    - If there were MA contract(s) in the parent organization with Star Ratings in the previous three years, the QBP rating is the enrollment-weighted average of the old MA contracts' ratings from the most recent year rated (including terminated contracts). We use the November enrollment from the corresponding year. The look back only includes active contract data published to the MPF.
    - If there were no MA contract(s) in the parent organization with numeric Star Ratings in the previous three years, the contract is rated as a new contract under a new parent organization.

Any changes in a contract's parent organization which occur from the annual verification (due by March 15) will be reflected in the final QBP ratings released in April 2019. The same parent organization rules outlined above are applied to the contract using the new parent organization information. Once the QBP ratings are finalized in April 2019, no additional parent organization changes are possible for QBP purposes.

The enrollment used in the calculations is the enrollment the contract is paid for in November of the year the Star Ratings are released. Since the 2019 Star Ratings were released in the fall of 2018, the November 2018 enrollment is used for both the preliminary 2020 QBP ratings (released in November 2018) and the final 2020 QBP ratings (released in April 2019). The enrollment data are posted publicly here: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html.

Under 42 C.F.R. § 422.162, 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 that are approved on or after January 1, 2019, CMS will update the QBP status of the surviving contract using the enrollment-weighted means of what would have been the QBP ratings of the surviving and consumed contracts based on contract enrollment in November 2018. The updates will be available in spring 2019 for bid submissions.

Viewing QBP Ratings

All MA contracts with Star Ratings data (those with numeric Star Ratings and new contracts under existing parent organizations) should view their Star Ratings for QBP purposes in HPMS by selecting Quality and Performance in the navigation bar, then Performance Metrics, then Costs, then MA QBP Rating. Contracts should ensure that 2020 is selected on the "Select a Report Period" page and then click the Next button. Use the link at the top of the page to download the Request for Reconsideration Form. QBP details for contracts without Star Ratings data (low enrollment contracts and new contracts under new parent organizations) were finalized in the 2019 Rate Notice published in April 2018. These contracts are not part of the appeals process since they have no data to appeal.

During the Star Ratings preview periods, MA organizations had the opportunity to raise questions about the calculation of the Star Ratings and the underlying data. CMS anticipates that issues addressed during the preview periods will reduce the number of MA organizations requesting an administrative review of QBP determinations. Note, however, that asking questions during the preview periods is not part of the formal appeals process.

Administrative Review Process for QBP Determinations

Section 422.260 provides for a two-step administrative review process that includes a request for reconsideration and a request for an informal hearing on the record after an adverse reconsideration decision. Both steps are conducted at the contract level. The first step allows the MA organization to request a reconsideration of how its Star Rating was calculated and/or what data were included in the measure(s). If the MA organization is dissatisfied with CMS' reconsideration decision, the contract may request an informal hearing to be conducted by a hearing officer designated by CMS.

Scope of an Administrative Review

Under § 422.260(c)(3)(ii), an administrative review cannot be requested for the following: the methodology for calculating the Star Ratings (including the calculation of the overall Star Ratings), cut-off points for determining measure thresholds, the set of measures included in the Star Rating system, and the methodology for determining QBP determinations for low enrollment and new plans. Therefore, requests for reconsideration and an informal hearing may be filed for QBP purposes only under a limited set of circumstances.

Permissible bases for requests for both types of reviews include a calculation error (miscalculation) or a data inaccuracy (incorrect data). A calculation error could impact the individual measure's value or the overall Star Rating. Requests should focus on issues that could result in increased star values, as increased measure values that result in the same Star Rating do not change an MA organization's QBP rating. MA organizations are reminded that administrative reviews for measures for which the organization already receives 5 stars will not result in an increase in an organization's QBP rating, and could result in the rating going down if a calculation error or data inaccuracy is identified.

If an MA organization believes the wrong set of data was used in a measure (i.e., wrong timeframe for the data or wrong measure selected), this is considered a calculation error. A request for review based on data inaccuracy may only be filed for a subset of measures. Attachment A includes information about whether a contract may request a review based on data inaccuracy (incorrect data) for each of the measures included in the Star Ratings. The contract may not request a review based on data inaccuracy for the following data sources:

- HEDIS measures since they were audited prior to submission to CMS;
- Measures based on beneficiary feedback, including data collected through CAHPS, HOS, and CTM;
- Plan-reported data, including SNP Care Management, Medication Therapy Management, Prescription Drug Event data, and Plan Finder pricing and pharmacy data;
- Measures where there is a data issue because the contract did not follow standard operating procedures (e.g., CTM data); and
- Contract enrollment data from HPMS or MARx since CMS information is the system of record for enrollment.

Note: Before an MA organization requests an administrative review, it is important to consider that a change in data values for a measure may not necessarily change the Star Rating for that measure or the overall Star Rating for the contract. Since Star Ratings for a measure are based on cut points, a significant change in the data is usually required in order for a contract to move from a lower Star Rating to a higher one. Even if there is a change in the Star Rating for one or more measures, the contract's overall Star Rating may not change because the change to a single measure is not often significant enough to move it to the threshold for the next higher overall Star Rating. Please review the cut points for Part C and D measures in the Medicare 2019 Part C & D Star Ratings Technical Notes. This information will help an organization determine whether requesting an administrative review will be beneficial.

Request for Reconsideration

As stated above, the administrative review is a two-step process that begins with a request for reconsideration. **This review is not intended to repeat the preview periods in giving contracts another opportunity to raise general questions about how CMS calculates the Star Ratings, nor is it intended to review how every measure was calculated.** Instead, this review affords an MA organization the opportunity to request review of specific measure values that may affect the calculation of the contract's QBP. The request for reconsideration must specify the given measure(s) in question and the basis for reconsideration. The alleged error could impact an individual measure's value or the overall Star Rating. The request must include the specific findings or issues with which the contract disagrees and the reason for the disagreement, and it should also include specific examples of the miscalculation and/or data inaccuracy if relevant. The request for reconsideration may include additional documentary evidence that the MA organization would like CMS to consider. The burden is on the MA organization to prove an error was made in the calculation of the QBP.

In conducting the reconsideration, the reconsideration official will review the QBP determination, the evidence and findings upon which it was based, and any other written evidence submitted by the organization or by CMS before the reconsideration determination is made. CMS will inform the MA organization of the reconsideration official's decision through electronic mail. The reconsideration official's decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided with the reconsideration official's decision.

Request for a QBP reconsideration is made by completing **the Excel version of the form shown in Attachment A**, "Request for Reconsideration" available in HPMS by selecting Quality and Performance in the navigation bar, then Performance Metrics, then Costs, then MA QBP Rating. To complete the form, macros must be enabled in Excel. The contract must email the completed Excel form to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on November 29, 2018**. The file should include the contract number as part of the file name. A request for reconsideration must be submitted by the date and time above in order to reserve the right to later request an informal hearing.

Informal Hearing

Instructions for requesting an informal hearing will be provided with the reconsideration decision. An informal hearing request may not be made unless a reconsideration was first requested and the decision sent to the MA organization. The informal hearing request must pertain only to the measure(s) and value(s) in question that precipitated the request for reconsideration. Requests must include a statement that describes the error(s) that the MA organization asserts CMS made in its QBP determination and how correction of those errors could result in the organization's qualification for a QBP or a higher QBP. The MA organization must provide clear and convincing evidence that CMS' calculations of the measure(s) and value(s) in question were incorrect; in other words, the burden is on the MA organization to prove an error was made in the calculation of the QBP.

CMS will attempt to complete all informal hearings by early April; however, decisions could be issued as late as May 15 of the year preceding the year in which the QBP is to be applied, especially in cases where the results of the informal hearing require a recalculation of star values for many

contracts. CMS is aware a May 15 deadline is necessary to afford MA organizations time to incorporate their QBP status into their plan bids, due by the first Monday in June. The hearing officer's decision is final and binding on both the MA organization and CMS**.**

Changes from the Administrative Review Process

If the hearing officer's decision is in favor of the MA organization, relief would be recalculation of the MA organization's QBP. Recalculation could cause the requesting MA organization's QBP to go higher or *lower*. In some instances, the recalculation may not cause the Star Rating to rise above the cut-off for the higher QBP rating. When the reconsideration official or hearing officer's decision requires that a measure be systematically recalculated for all contracts, all other affected contracts (i.e., contracts of other MA organizations) would receive the recalculation if it results in a higher Star Rating, and any resulting changes would be made to the Star Ratings and QBPs for all affected contracts. Contracts' 2019 Star Ratings, which are used for 2020 QBPs, will not be decreased by CMS as a result of a systematic re-calculation; however, the issue will be addressed in the next year's Star Ratings.

Any questions regarding this memo may be submitted to QBPAPPEALS@cms.hhs.gov.

Please do not send messages requiring CMS to login to another site to access the questions or message content. If you need to share personally identifying information (PII) with us, please contact us with a regular email to discuss a safe way to transfer the secure data.

Attachment A

Request for Reconsideration

Note: The QBP administrative review process is a two-step process which includes: 1) a request for reconsideration, and 2) a request for an informal hearing after CMS has rendered its reconsideration decision. Both steps are conducted at the contract level. This first step affords an MA organization the opportunity to request a reconsideration of how its Star Rating, for the given measure in question, was calculated. This is not an opportunity for an MA organization to question how every measure was calculated. A request for reconsideration must be submitted by the date and time specified below in order to reserve the right to later request an informal hearing on the record.

Instructions: Use only the "Request for Reconsideration" form that can be found in HPMS. To download a copy of the form from HPMS, select Quality and Performance on the home page, then Performance Metrics. On the Performance Metrics page select Costs and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Each form may only be used for one contract. Complete the identifiable information including all contact information. **Please enable Macros in this form.** Mark an "X" next to the measure(s) that the MA Organization is questioning and requesting reconsideration. In the "Description of the Issue" specify any errors that the MA Organization asserts CMS may have made in calculating the contract's QBP determination. Save the information, please include your contract number in the filename and e-mail the completed form along with any additional documentary evidence to be considered to QBPAPPEALS@cms.hhs.gov by the due date.

Due Date: A Request for Reconsideration of QBP is made by completing the Excel version of this form downloaded from HPMS and e-mailing the form to QBPAPPEALS@cms.hhs.gov by 5:00 p.m. EST on **November 29, 2018**. No late requests will be accepted.

Contract Number (5 character CMS assigned code):	
Contact First Name (your first name):	
Contact Last Name (your last name):	
Contact Title (your job title):	
Contact Phone Number (your phone number, include extension if necessary):	
Contact email address (your email address):	

Overall Rating	Data Source	Request for Reconsideration Indicate with "X"		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
QBP/Overall Rating	Star Ratings		Not Appealable	

Part C Measures	Data Source	Request for Reconsideration Indicate with "X"		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
C01 - Breast Cancer Screening	HEDIS		Not Appealable	
C02 - Colorectal Cancer Screening	HEDIS		Not Appealable	
C03 - Annual Flu Vaccine	CAHPS		Not Appealable	
C04 - Improving or Maintaining Physical Health	HOS		Not Appealable	
C05 - Improving or Maintaining Mental Health	HOS		Not Appealable	
C06 - Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C07 - Adult BMI Assessment	HEDIS		Not Appealable	
C08 - Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C09 - Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C10 - Care for Older Adults – Functional Status Assessment	HEDIS		Not Appealable	
C11 - Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C12 - Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	

C13 - Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C14 - Diabetes Care – Kidney Disease Monitoring	HEDIS		Not Appealable	
C15 - Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C16 - Controlling Blood Pressure	HEDIS		Not Appealable	
C17 - Rheumatoid Arthritis Management	HEDIS		Not Appealable	
C18 - Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C19 - Improving Bladder Control	HEDIS / HOS		Not Appealable	
C20 - Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C21 - Plan All-Cause Readmissions	HEDIS		Not Appealable	
C22 - Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C23 - Getting Needed Care	CAHPS		Not Appealable	
C24 - Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C25 - Customer Service	CAHPS		Not Appealable	
C26 - Rating of Health Care Quality	CAHPS		Not Appealable	
C27 - Rating of Health Plan	CAHPS		Not Appealable	
C28 - Care Coordination	CAHPS		Not Appealable	
C29 - Complaints about the Health Plan	CTM		Not Appealable	
C30 - Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C31 - Health Plan Quality Improvement	Star Ratings		Not Appealable	
C32 - Plan Makes Timely Decisions about Appeals	IRE			
C33 - Reviewing Appeals Decisions	IRE			
C34 - Call Center – Foreign Language Interpreter and TTY Availability	Call Center			

Part D Measures	Data Source	Request for Reconsideration Indicate with "X"		Description of the Issue (Please enter as much text as necessary to describe the reason you believe there was a Miscalculation and/or that Incorrect data were used)
		Miscalculation	Incorrect Data	
D01 - Call Center – Foreign Language Interpreter and TTY Availability	Call Center			
D02 - Appeals Auto–Forward	IRE			
D03 - Appeals Upheld	IRE			
D04 - Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C29 above.
D05 - Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C30 above.
D06 - Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D07 - Rating of Drug Plan	CAHPS		Not Appealable	
D08 - Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D09 - MPF Price Accuracy	PDE data		Not Appealable	
D10 - Medication Adherence for Diabetes Medications	PDE data		Not Appealable	
D11 - Medication Adherence for Hypertension (RAS antagonists)	PDE data		Not Appealable	
D12 - Medication Adherence for Cholesterol (Statins)	PDE data		Not Appealable	
D13 - MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D14 - Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

Additional Comments (Please provide any additional information relevant to your request)				