DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

DATE: November 29, 2021

TO: Medicare Advantage Organization Compliance Officers

FROM: Amy Larrick Chavez-Valdez
Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: 2023 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances

This memorandum provides guidance on the determination of quality bonus payment (QBP) status and the administrative process available for review of those determinations.[1] In addition, this memorandum provides procedural instructions for MA organizations to seek review under 42 C.F.R. § 422.260.

Background

Sections 1853(n) and 1853(o) of the Act[2] require CMS to make QBPs to Medicare Advantage (MA) organizations that achieve at least 4 stars in a 5-star quality rating system. In addition, section 1854(b)(1)(C) of the Act ties the share of savings that MA organizations must provide to enrollees as the beneficiary rebate to the level of an MA organization's QBP rating.

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 2023 QBP appeals process starts November 29, 2021 with the posting of the preliminary QBP ratings in HPMS. MA organizations may request an administrative review of their 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 2023 QBP determinations are the 2022 Star Ratings released October 2021 on the Medicare Plan Finder (MPF) tool at http://www.medicare.gov for those contracts that had enough data to calculate an overall rating.

[1]The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.
[2] References to "the Act" are to the Social Security Act.

The methodology for determining the Star Ratings is described in 42 C.F.R. §§ 422.160 through 422.166 and 423.180 through 423.186 and the Medicare 2022 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:

Organization Type	Offers Part D
Local CCP	✓
MSA	
PFFS	✓*
Regional CCP	✓

* PFFS are not required to offer drug benefits.

QBP Rating Rules

For contracts that receive a numeric Star Rating, the QBP rating is the highest rating as defined at 42 C.F.R. § 422.162 and 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, the QBP rating is the numeric Part C summary rating.

For contracts that do not have a numeric Star Rating, the QBP rating is determined based on whether the contract is a new MA plan or low enrollment contract, as defined at 42 C.F.R. § 422.252. The message the contract received on MPF is specific to the type of contract:

- 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, as defined at 42 C.F.R. § 422.252, are those that have been in existence long enough 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.

Under 42 C.F.R. § 422.252, a new MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 3 years.

The following rules are used to assign QBP ratings for a new contract; these were first adopted in the 2012 Advance Notice and Rate Announcement.[3] These rules are now codified at 42 CFR § 422.166(d)(2)(vi). As explained in the final rule that appeared in the Federal Register on January 19, 2021 (" Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly") (86

[3] In addition, this policy was addressed in a proposed rule for CY 2012 that appeared in the Federal Register on November 22, 2010 (''Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes'') (75 FR 71190, 71219) and the related final rule that appeared in the Federal Register on April 15, 2011 (76 FR 21432, 21486 through 21490).

FR 5864, 5929 through 5931), we codified existing and current policy without change. We follow the same steps as in prior years for calculating the QBPs after publication of the final rule.

For the 2023 QBPs, for any new contract(s) under an existing parent organization, we apply the following rule:

(i) We identify the parent organization of the new contract in November 2021.

(ii) For preliminary QBP ratings, we identify the MA contracts held by that parent organization in November 2021. We use the numeric Star Ratings issued in October 2021 for those MA contracts that are held by the parent organization in November 2021 that we anticipate will still be in existence and held by that parent organization in April 2022.

(iii) Using the enrollment in those other MA contracts as of November 2021, we calculate the enrollment-weighted average of the highest Star Rating(s) of those MA contracts.

(iv) In April 2022, we update the enrollment-weighted average rating to take into account any changes to the parent organization of the existing contracts; this includes the ratings of any contract(s) that the parent organization acquired since November 2021. The updated enrollment-weighted average rating continues to use the November 2021 enrollment in the contracts held by the parent organization in April 2022. This updated rating is used as the 2023 QBP rating for the new MA contract(s) for that parent organization for payment in 2023. This final QBP rating will be released to the MA organization for the new contract(s) in April 2022.

For any new contract(s) under a parent organization that has no MA contracts in November 2021, we apply the following rule:

(i) We identify the MA contracts held by that parent organization in November 2020. If the parent organization had other MA contracts in November 2020, we use the numeric Star Ratings issued in October 2020 for those MA contracts that were held by the parent organization in November 2020.

(ii) Using the enrollment in those other MA contracts as of November 2020, we calculate the enrollment-weighted average of the highest Star Rating(s) of those MA contracts.

(iii) This is used as the 2023 QBP rating for the new MA contract(s) for that parent organization for payment in 2023. This final QBP rating will be released to the MA organization for the new contract(s) in April 2022.

For any new contract(s) under a parent organization that has no MA contracts in November 2020 and 2021, we apply the following rule:

(i) We identify the MA contracts held by that parent organization in November 2019. If the parent organization had other MA contracts in November 2019, we use the numeric Star Ratings issued in October 2019 for those MA contracts that were held by the parent organization in November 2019.

(ii) Using the enrollment in those other MA contracts as of November 2019, we calculate the enrollment-weighted average of the highest Star Rating(s) of those MA contracts.

(iii) This is used as the 2023 QBP rating for the new MA contract(s) for that parent organization for payment in 2023. This final QBP rating will be released to the MA organization for the new contract(s) in April 2022.

For the 2023 QBPs, if there were no MA contract(s) for the parent organization with numeric Star Ratings in the previous three years (i.e., November 2019, 2020, and 2021), the contract is treated as a new MA plan in accordance with 42 C.F.R. § 422.258(d)(7) for payment purposes.

Any changes in a contract's parent organization that occur from the annual verification (due by March 15, 2022) will be reflected in the final QBP ratings released in April 2022. 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 2022, no additional parent organization changes are possible for QBP purposes. The QBP rating is applied to each plan benefit package under the contract.

The enrollment used in the calculations is the enrollment in the contract used for payment by CMS in November of the year the Star Ratings are released. Since the 2022 Star Ratings were released in the fall of 2021, the November 2021 enrollment is used for both the preliminary 2023 QBP ratings (released in November 2021) and the final 2023 QBP ratings (released in April 2022). 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(b)(3), 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, 2022 and for which 2023 is the first year of the consolidation, CMS will update the QBP status of the surviving contract using the enrollment-weighted average of what would have been the QBP ratings of the surviving and consumed contracts based on contract enrollment in November 2021. The updates will be available in spring 2022 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 Reports, then Costs, then MA QBP Rating. Contracts should ensure that 2023 is selected as the "Report Period" and then click "Create Report" to view their QBP ratings. Select "Download in Excel" 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) are not part of the appeals process because such contracts have no data to appeal and their QBPs are assigned based on 42 C.F.R. § 422.258(d)(7)(iv) and (v).

During the 2022 Star Ratings preview periods in August and September 2021, 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 contract's 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 MA organization may request an informal hearing to be conducted by a hearing officer designated by CMS.

Scope of an Administrative Review

Under 42 C.F.R. § 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 an 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 are unlikely to 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., following a different timeframe than the one in the measure specifications as adopted in the applicable final rule and subject to updates as permitted by 42 C.F.R. § 422.164(d)), 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. Generally, the contract may not request a review based on data inaccuracy for the following data sources:

- HEDIS measures, which were audited prior to submission to CMS;
- Measures based on beneficiary feedback, including data collected through CAHPS, HOS, and the Complaints Tracking Module (CTM);
- Plan-reported data, including SNP Care Management, Medication Therapy Management, Prescription Drug Event data, and Plan Finder pricing and pharmacy data;
- Contract enrollment data from HPMS or MARx because CMS information is the system of record for enrollment; and
- Other federal data sources (e.g., FEMA).

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 2022 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 under 42 C.F.R. § 422.260(c)(1)

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.

Per 42 C.F.R. § 422.260(c)(1)(i), 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; we recommend including 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.

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 Reports, then Costs, then MA QBP Rating. The contract must email the completed Excel form to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on December 14, 2021**. 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. **Please ensure you receive confirmation from the mailbox that your request was received.**

Informal Hearing under 42 C.F.R. § 422.260(c)(2)

The MA organization seeking an appeal of the reconsideration official's decision regarding its QBP status must do so by providing written notice to CMS within 10 business days of the issuance of the reconsideration decision; 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.

Per 42 C.F.R. § 422.260(c)(2)(v), 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. 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, the MA organization's QBP is recalculated using the corrected data and applying the rules at 42 C.F.R. §§ 422.160 through 422.166. **Recalculation could cause the requesting MA organization's QBP to go higher or *lower*.** In some instances, the recalculation may not result in the Star Rating rising above the cut-off for the higher QBP rating. Under 42 C.F.R. § 422.260(d), CMS may revise an MA organization's QBP status at any time after the initial release of the QBP determinations through April 1 of each year on the basis of any credible information, including information provided during the administrative review process that demonstrates that the initial QBP determination was incorrect. 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) are recalculated using the corrected data and applying the rules at 42 C.F.R. §§ 422.160 through 422.166; other affected contracts are assigned the recalculated Star Rating 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' 2022 Star Ratings, which are used for 2023 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 that 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 Reports, Costs, and then MA QBP Rating. One form must be submitted for each contract for which reconsideration is requested. Complete the identifiable information including all contact information. 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 **December 14, 2021**. 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 - Monitoring Physical Activity	HEDIS / HOS		Not Appealable	
C05 - Special Needs Plan (SNP) Care Management	Part C Plan Reporting		Not Appealable	
C06 - Care for Older Adults – Medication Review	HEDIS		Not Appealable	
C07 - Care for Older Adults – Pain Assessment	HEDIS		Not Appealable	
C08 - Osteoporosis Management in Women who had a Fracture	HEDIS		Not Appealable	
C09 - Diabetes Care – Eye Exam	HEDIS		Not Appealable	
C10 - Diabetes Care – Kidney Disease Monitoring	HEDIS		Not Appealable	
C11 - Diabetes Care – Blood Sugar Controlled	HEDIS		Not Appealable	
C12 - Rheumatoid Arthritis Management	HEDIS		Not Appealable	
C13 - Reducing the Risk of Falling	HEDIS / HOS		Not Appealable	
C14 - Improving Bladder Control	HEDIS / HOS		Not Appealable	

C15 - Medication Reconciliation Post-Discharge	HEDIS		Not Appealable	
C16 - Statin Therapy for Patients with Cardiovascular Disease	HEDIS		Not Appealable	
C17 - Getting Needed Care	CAHPS		Not Appealable	
C18 - Getting Appointments and Care Quickly	CAHPS		Not Appealable	
C19 - Customer Service	CAHPS		Not Appealable	
C20 - Rating of Health Care Quality	CAHPS		Not Appealable	
C21 - Rating of Health Plan	CAHPS		Not Appealable	
C22 - Care Coordination	CAHPS		Not Appealable	
C23 - Complaints about the Health Plan	CTM		Not Appealable	
C24 - Members Choosing to Leave the Plan	MBDSS		Not Appealable	
C25 - Health Plan Quality Improvement	Star Ratings		Not Appealable	
C26 - Plan Makes Timely Decisions about Appeals	IRE			
C27 - Reviewing Appeals Decisions	IRE			
C28 - 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 - Complaints about the Drug Plan	CTM	Not Applicable	Not Applicable	Not appealable, use Part C measure C23 above.
D03 - Members Choosing to Leave the Plan	MBDSS	Not Applicable	Not Applicable	Not appealable, use Part C measure C24 above.
D04 - Drug Plan Quality Improvement	Star Ratings		Not Appealable	
D05 - Rating of Drug Plan	CAHPS		Not Appealable	
D06 - Getting Needed Prescription Drugs	CAHPS		Not Appealable	
D07 - MPF Price Accuracy	PDE data		Not Appealable	
D08 - Medication Adherence for Diabetes Medications	PDE data		Not Appealable	
D09 - Medication Adherence for Hypertension (RAS antagonists)	PDE data		Not Appealable	
D10 - Medication Adherence for Cholesterol (Statins)	PDE data		Not Appealable	
D11 - MTM Program Completion Rate for CMR	Part D Plan Reporting		Not Appealable	
D12 - Statin Use in Persons with Diabetes (SUPD)	PDE data		Not Appealable	

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