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# 2022 Star Ratings Update: Current Landscape & a Look to the Future

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2022

# Today's Speakers

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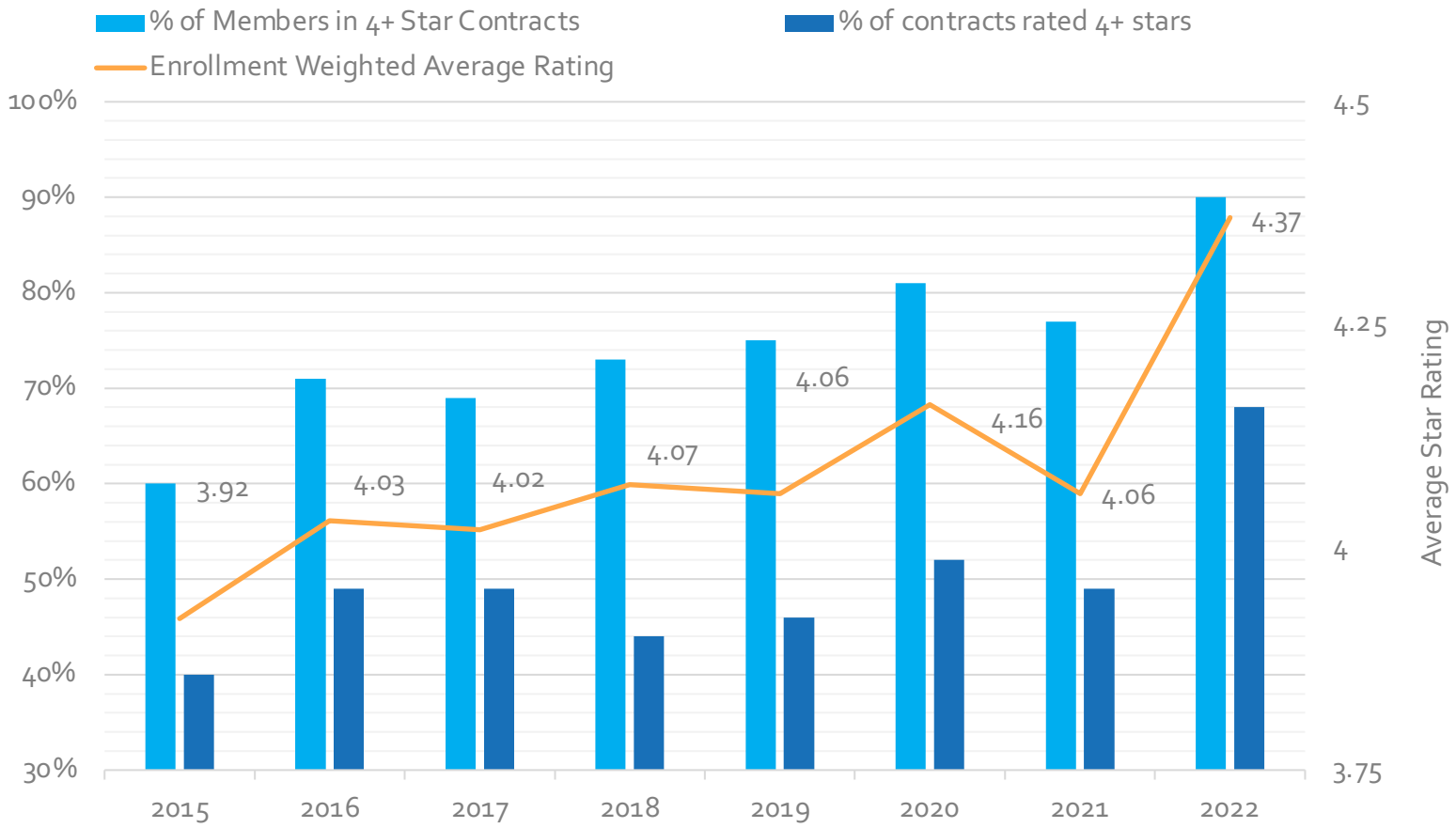
# 2022 Star Ratings Technical Updates

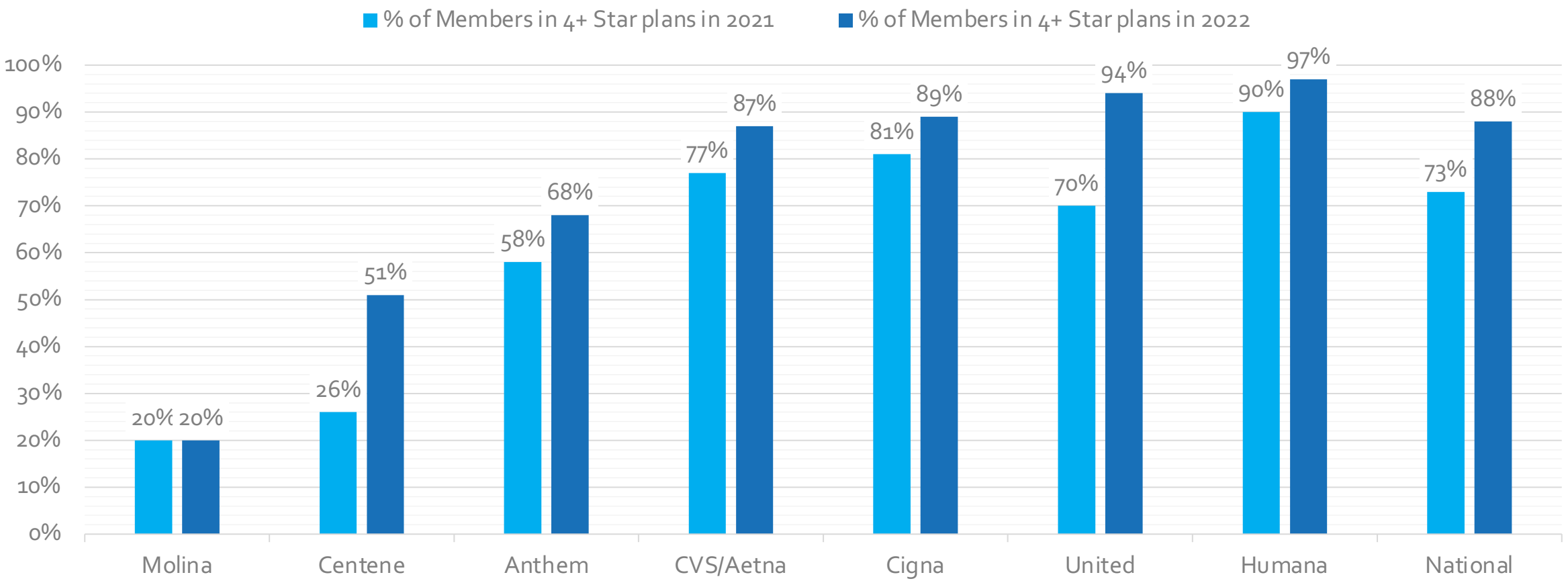
- MA-PD Star Ratings consisted of **38 unique measures**
- **No new measures** introduced in 2022 Star Ratings
- **6 measures retired** from 2022 Star Ratings:
  - *Retired Permanently: Adult BMI Assessment, Part D Appeals measures*
  - *Retired to Display: Improving or Maintaining Physical Health, Mental Health, Care for Older Adults Functional Status Assessment*
- **Many permanent changes introduced:**
  - *HEDIS® measures expanded to allow telehealth and exclude members using palliative care services*
  - *HOS Survey timeline permanently changed*
  - *MPF Price Accuracy specifications updated*
  - *Mean Resampling implemented for cut point calculations*
- **Significant "one-time" pandemic relief provided:**
  - *Most measures received the "better of" their 2021 or 2022 measure ratings (all except FL/TTY, HOS, MPF Price Accuracy)*
    - *MA contracts reverted to 2021 ratings on an average of 4.5 out of 23 Part C measures eligible for adjustment*
    - *MA-PD contracts reverted to 2021 ratings on an average of 2.8 out of 9 Part D measures eligible for adjustment*
  - *Delayed implementation of cut point guardrails to allow cut points to change by >5% if 2020 national performance declined during the pandemic*
  - *Improvement measure "Hold Harmless" provisions expanded to prevent Improvement measures from decreasing summary or overall ratings*
- Only **3 contracts decreased** their overall rating

# The 2022 MA-PD Star Ratings

- **68%** of MA-PD contracts earned 4+ Star in 2022 ratings
- **74** MA-PD contracts earned a **5 Star overall rating**
- **90%** of MA-PD enrollees are currently in contracts with 4+ Star in 2022 ratings



# How Did the Nationals Do?



# 20% of Measure Ratings Used "Better Of" Relief, Reverting Some Plans to MY2018 Results

| Part C Measure Examples | Change in Nat'l Average | Change in Avg Rating* |
|---|---|---|
| Special Needs Plan Care Management | +2.87 | +0.2 |
| Statin Therapy for Patients with Cardiovascular Disease | +2.46 | +0.4 |
| Medication Reconciliation Post-Discharge | +2.4 | +0.5 |
| Rating of Health Plan | +1.13 | +0.3 |
| Rating of Health Care Quality | +0.96 | +0.3 |
| Annual Flu Vaccine | +0.43 | +0.2 |
| Care for Older Adults Pain Assessment | -2.49 | -0.1 |
| Care for Older Adults Medication Review | -2.65 | +0.1 |
| Breast Cancer Screening | -3.56 | +0.4 |
| Diabetes Care – Blood Sugar Controlled | -3.91 | +0.1 |
| Diabetes Care – Eye Exam | -4.49 | 0 |
| Osteoporosis Management in Women who had a Fracture | -8.39 | 0 |

| MA-PD Measure Examples | Change in Nat'l Average | Change in Avg Rating* |
|---|---|---|
| MTM Program Completion Rate for CMR | +6.46 | +0.3 |
| Medication Adherence for Cholesterol | +3.89 | +0.3 |
| Medication Adherence for Diabetes Medications | +3.43 | 0 |
| Statin Use in Persons with Diabetes | +2.61 | +0.3 |
| Medication Adherence for Hypertension | +2.46 | +0.7 |
| Rating of Drug Plan | +1.38 | +0.4 |
| Getting Needed Prescription Drugs | +1.00 | +0.3 |



*After application of "better of" EUC relief

# 2020's Public Health Emergency Pervaded 2022 Star Ratings Performance

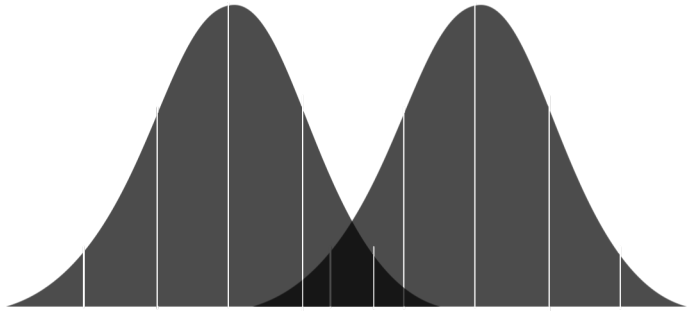
## Everyone performed better….

- ✓ Blues & Non-Blues
- ✓ PPOs & HMOs
- ✓ SNPs & Non-SNPs
- ✓ Nationals & Non-Nationals
- ✓ Large & Small Plans
- ✓ New & Mature Plans
- ✓ Plans in All Regions

## …though differences remain

**NON-PROFIT MA-PD PLANS**

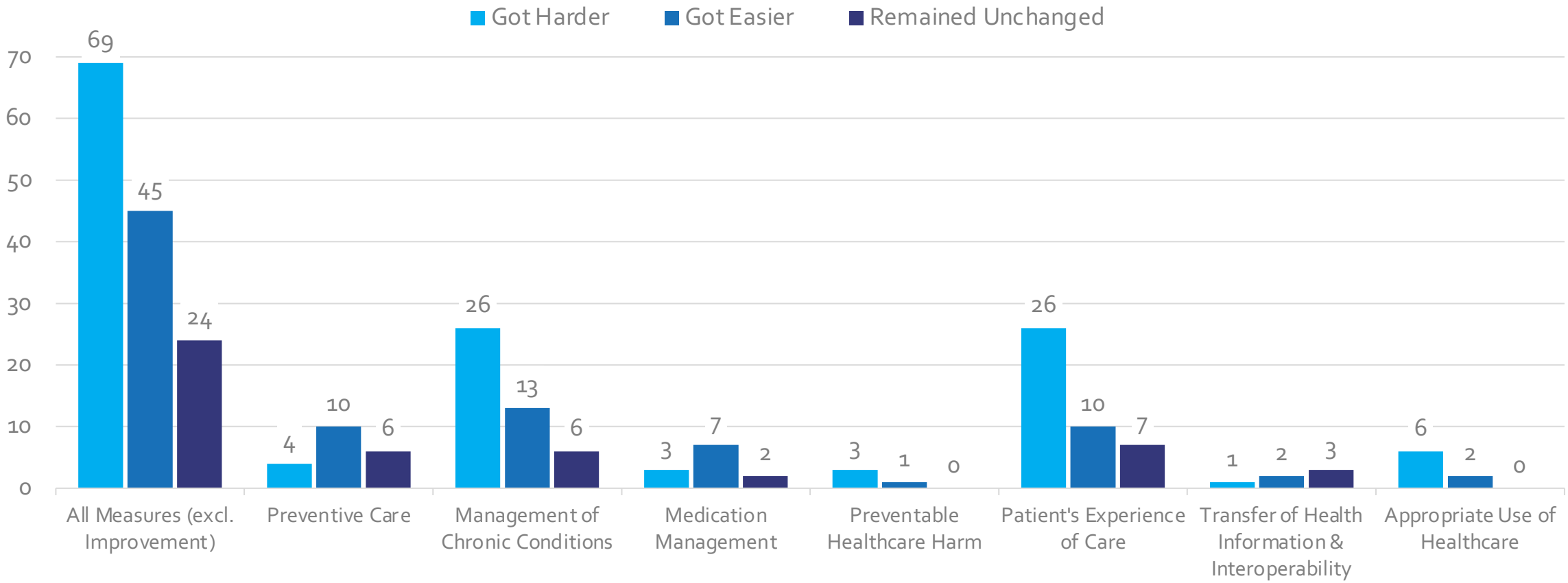
| Overall Rating | # of contracts |
|---|---|
| 2.5 stars | 0 |
| 3 stars | 3 |
| 3.5 stars | 23 |
| 4 stars | 37 |
| 4.5 stars | 45 |
| 5 stars | 40 |



**FOR-PROFIT MA-PD PLANS**

| Overall Rating | # of contracts |
|---|---|
| 2.5 stars | 2 |
| 3 stars | 22 |
| 3.5 stars | 99 |
| 4 stars | 115 |
| 4.5 stars | 51 |
| 5 stars | 34 |

# Most Cut Points Continued Rising




**CMS is aligning Star Ratings with the Meaningful Measures Framework.**

# 2022 will be a Year of Significant Change

## MY 2020 | 2022 Ratings

- Adult BMI Assessment permanently retired
- Part D Appeals measures permanently retired
- New MPF Price Accuracy specifications take effect
- Mean Resampling implemented
- HOS Survey Timeline permanently changed
- "Better of" 2021 or 2022 rating for all measures except FL/TTY, HOS, MPF Price Accuracy
- Expanded Hold Harmless for Improvement measures
- New HEDIS exclusions for palliative care
- HEDIS expansions to allow telehealth

## MY 2021 | 2023 Ratings

- Controlling Blood Pressure returns (1x-weight)
- Rheumatoid Arthritis Management permanently retired
- CAHPS & Administrative measures increase to 4x-weight
- Improving or Maintaining Physical Health & Improving or Maintaining Mental Health retired to Display
- Care for Older Adults – Functional Status Assessment retired to Display
- Statin Use in Persons with Diabetes decreases to 1x-weight
- "Better of" 2022 or 2023 rating for HOS measures
- Cut point guardrails implemented

## MY 2022 | 2024 RATINGS

- Controlling Blood Pressure increases to 3x-weight
- Plan All-Cause Readmissions returns (1x-weight)
- Transitions of Care added (1x-weight)
- Medication Reconciliation Post-Discharge retired
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions added (1x-weight)
- Diabetes Care – A1c Testing & Nephropathy permanently retired by NCQA
- Diabetes measures separated: HbA1c Control for Patients with Diabetes (HBD), Eye Exam for Patients with Diabetes (EED)
- Tukey Outlier Deletion Model implemented
- R&I definition of "Qualified Individuals" prevents use of HEDIS data for reward program administration
- Expanded age range & removal of hybrid reporting option for Colorectal Cancer Screening measure
- EO13985 (Advancing Racial Equity & Support for Underserved Communities) added to Readiness Checklist; SES stratification added to COL, CBP, HBD
- Star Ratings for Biosimilars legislation proposes addition of new Star measures

Codified, known program changes

Proposed program changes not yet finalized



**As of November 3, 2021**

# CAHPS, CAHPS, CAHPS: The Name of the Game in MA!

## "CAHPS Gaps" Differ Significantly from "Traditional Gaps"

### Dissatisfied Members

Cannot be fixed with general marketing or communications.

1. Identify by multiple means
2. Resolve the specific issue for the specific member
3. Tell the member you solved their problem (and how you solved it)
4. Identify processes or systemic issues that surface while addressing specific member problems, so the issue does not perpetuate CAHPS risk

### 'OK' Members

Raising this group's rating on specific composite(s) has the greatest impact on a plan's CAHPS Star Ratings due to sheer volume. These members are often overlooked, but it's easier to move "good" to "great" than "awful" to "good."

### Unengaged & Under-Engaged Members

Members who don't call, don't access the care they need, and don't fill prescribed medications still compete surveys. They may not tell you about problems in access to care or issues with benefits. Look for access attempts (e.g., rejected medication fills, denied authorizations) and self-reported problems using proxy surveys.

### High Utilizers

Members with high disease burden have lower satisfaction scores. Population health strategies beyond highest risk/MLR Case Management designed to manage medical spend is critical. For example, members in SNP plans commonly improve CAHPS measure ratings through ongoing engagement and coordination of care, medications, and services.

# 2022: A Year of Change to People, Process & Technology

## People

Who are we performing interventions with?

Are we successfully reaching enough people for the right reasons?

Are we leveraging the right balance of high- and low-touch channels for equity, scalability, and sustainability?

## Process

How are we monitoring and supporting members' ability to get the appointments, care, and medications they need with ease and seamlessly?

Will old processes work with new measures?

Are interventions scalable across all members and fast enough for success?

## Technology

Are we using all available tools commonly used in the market?

Are virtual, telehealth, and RPM being optimized?

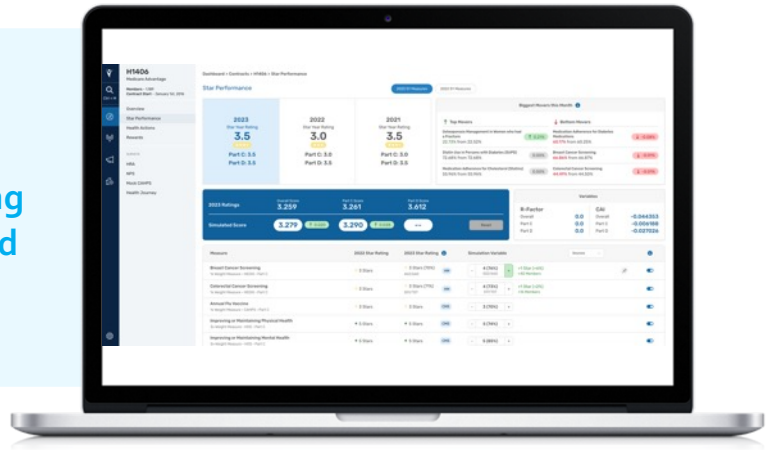
Are internal, provider, and member tools modern and adaptable enough to accomplish new and emerging Star needs?

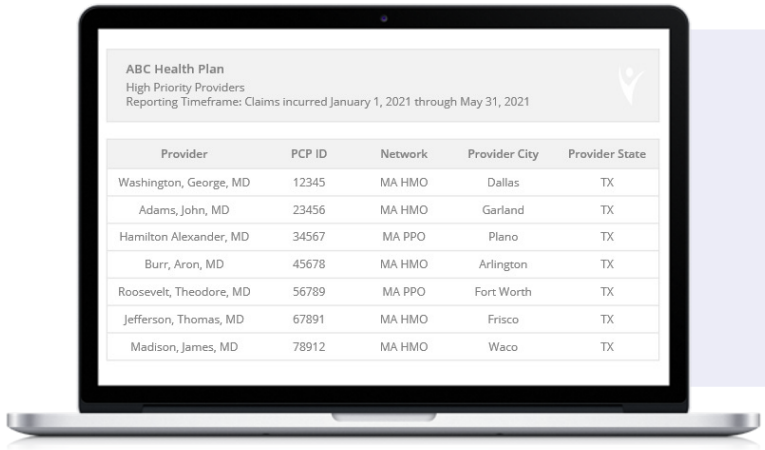
Are we facilitating whole-person engagement and care?

# New Measures & Weights Require Recalibration of Tools & Investments Across All Measures

**01.**

Real-time monitoring across all clinical and survey measures



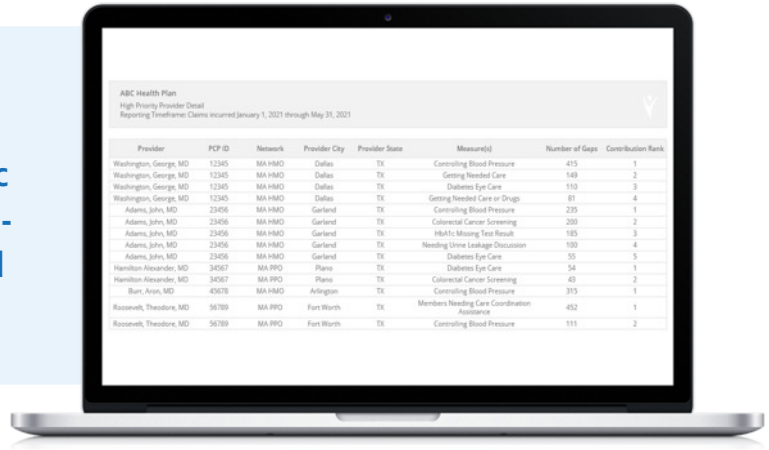


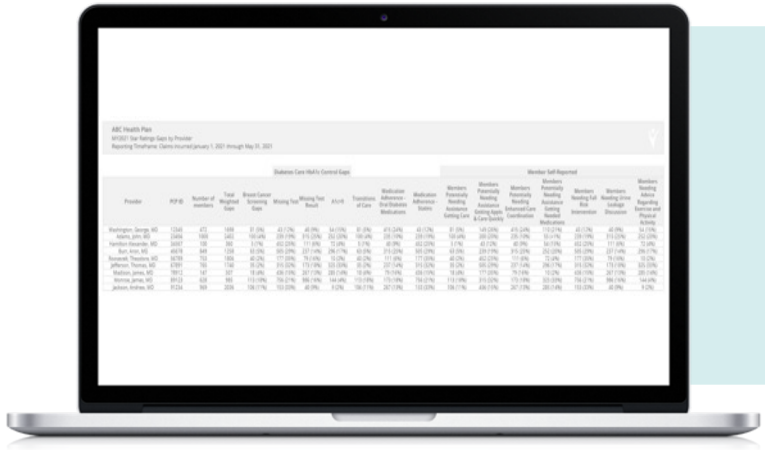

**02.**

Identify the high-ROI provider interventions

**03.**

Identify the specific measures that high-ROI providers need to improve

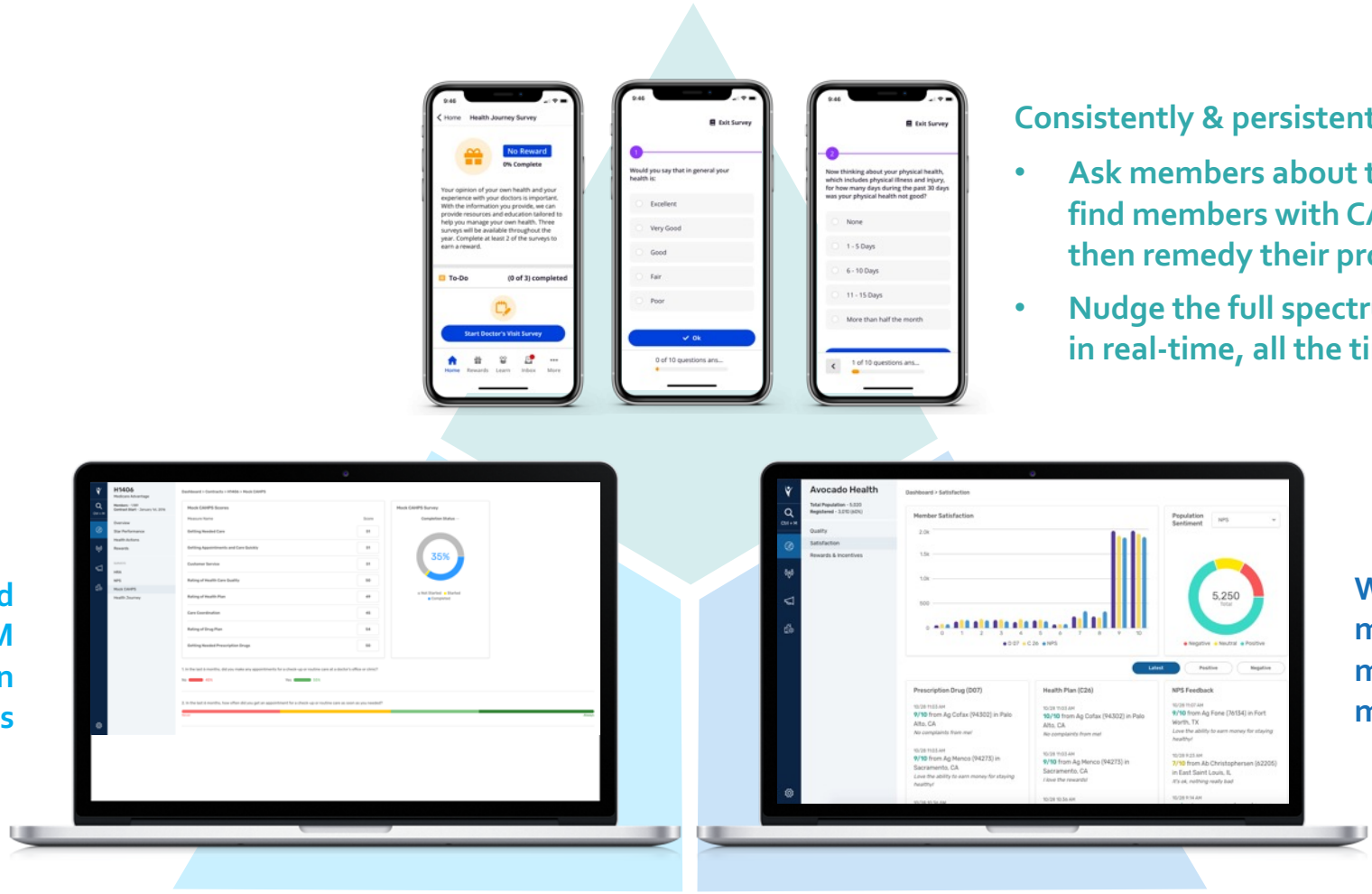




**04.**

Monitor status and speed of improvements

# Don’t Leave CAHPS Up to Chance:
# CMS Expects Digitized Engagement & Activation



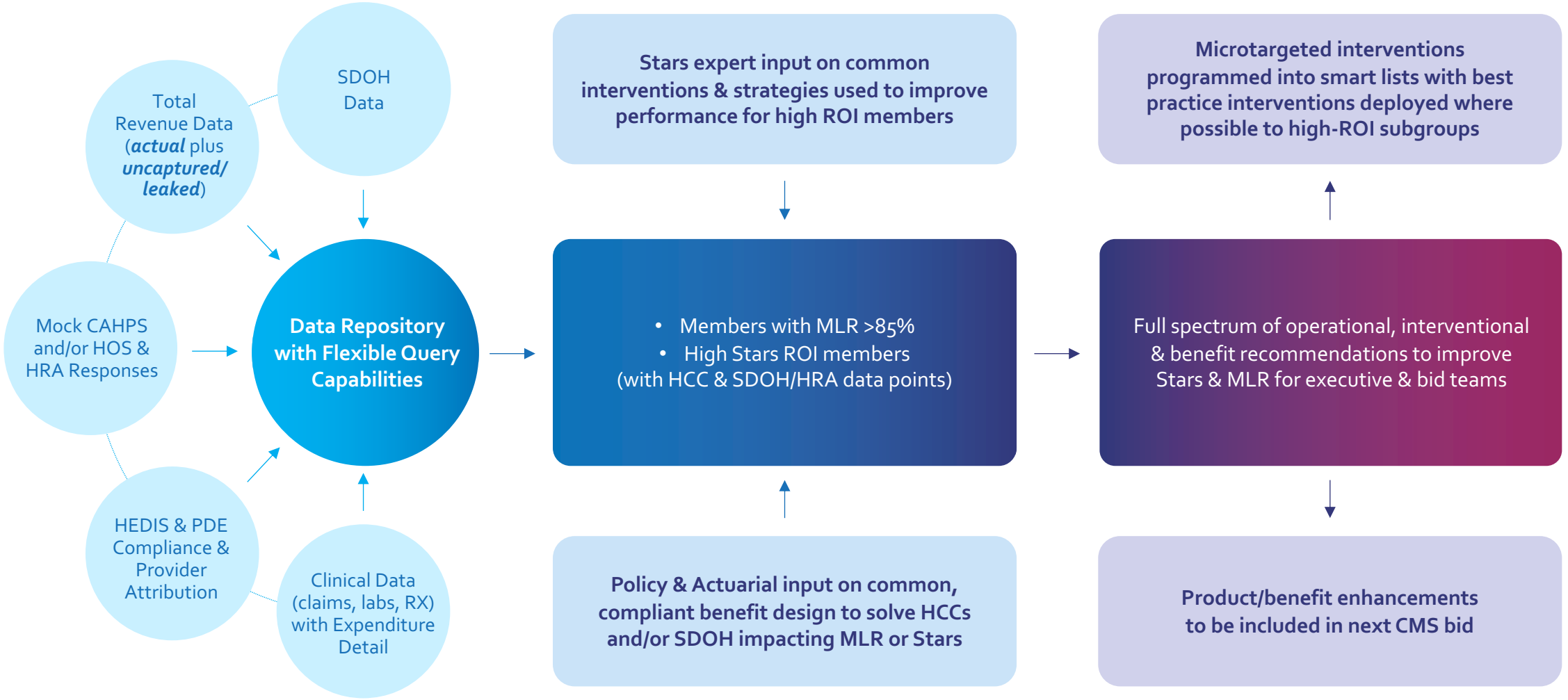
**Consistently & persistently:**

- Ask members about their experiences to find members with CAHPS problems, then remedy their problems
- Nudge the full spectrum of health actions in real-time, all the time

**Facilitate self-reported CAHPS & PROM responses as “gaps in care” in provider EMRs**

**Work with enough members to improve the measure rating; track and monitor improvement**

# "Future Proofing" Your Bid is an Important Step



# Improving Health Equity: 4 Things You Can Do Today

- Health Equity is a top priority at CMS for MA, ACA, and Medicaid. Every decision is made after asking "how is this action advancing health equity?"
- Alignment with Executive Order 13985 elevated to Page 1 of Readiness Checklist
- CMS seeks to accelerate MA impact on health equity within the VBID Model, beginning with Health Equity Incubation Sessions in December
- NCQA phasing in race, ethnicity, and SES stratification beginning in MY2022
- NCQA has urged federal action to:
  - Mandate standardized, self-identified data collection of race and ethnicity data to monitor equity
  - Mandate federal programs to report data stratified by race, ethnicity, and other available demographics
  - Collect information on provider demographics to ensure those caring for beneficiaries reflect the demographics of the community

### Determine Your Status

Ensure analytics, P&Ps, and projects prevent, detect, and correct disparities in areas such as gender identity, race, disability, literacy, ethnicity, and language preferences. Confirm your approach is well-documented, being followed by vendors and FDRs, and will stand up to CMS audit.

### Gather the Data

Increase efforts to resolve longstanding data gaps regarding race and ethnicity data by adding data collection efforts to all member interactions in alignment with NCQA standards.

### Involve Everyone

Involve HR, Community Relations, Compliance, etc., to help staff be comfortable discussing sensitive topics and meaningfully support this work. Many employees shy away from these issues not because they are unwilling to address them, but because they are unsure what words to use and/or how to frame discussions in a legal and interpersonally comfortable manner.

### Use Stars for Accountability

Leverage Star measure accountability as the foundation for transparency and accountability to both identify and remedy performance disparities in clinical areas/issues CMS has defined as the most important to our shared pursuit of the Triple Aim.

# CMS is Already Updating Policies to Reduce Discrimination & Increase Compliance & Regulatory Oversight

## TECHNICAL UPDATE

New CMS Rewards & Incentive Program Regulations will Impact MY2022 Stars Tactics

- The 2021 Final Rule tightens the 2022 regulatory structure for Rewards & Incentives in Medicare Advantage
- MA plans must offer rewards uniformly and without discrimination to all enrollees who qualify for the incentivized service
  - Establishes agency expectations that the goal of MA rewards programs are to issue rewards to all Qualified Individuals who perform the eligible incentivized service
  - Formally defines "Qualifying Individuals" for reward programs:
    - For plan-covered health benefits as "any plan enrollee who would qualify for coverage of the benefit"
    - For non-plan-covered health benefits as "any plan enrollee"
  - Clarifies that all members receiving medical benefit coverage for an incentivized activity must be deemed eligible for the reward
- Prohibits Amazon gift cards and debit/reloadable cards (even with spending restrictions applied) in MA
- Clarifies that disputes regarding Rewards & Incentives in MA are Grievances, which must be handled in compliance with Section 30 of the Medicare Managed Care Manual
- Formalizes that noncompliance with CMS Rewards & Incentives program requirements may result in sanction

**The new regulations eliminate the ability to use HEDIS denominators and/or numerator status as the eligibility criteria to qualify for and/or earn rewards in Medicare Advantage.**

# Let's Look at a Real-World Example: Breast Cancer Screening

## Pre-2022 MA Rewards Strategy

*Offer a reward to members who are noncompliant on BCS as of 1/1.*

- Could offer rewards only to members in denominator and/or who began the year noncompliant on multi-year measurements
- Did not mandate reward eligibility for members whose exclusion from rewards programs CMS considers "discriminatory circumstances"
  - Female members receiving medically necessary mammograms who were not in denominator due to age or advanced illness
  - Male members receiving medically necessary mammograms
  - Female members whose past medical history requires annual mammograms

## New Rewards Strategy

*Must offer reward to all members for whom a mammogram is a covered benefit during the year.*

- Requires rewards to be available to all enrollees for whom a mammogram is covered as a plan benefit, regardless of HEDIS measure status, age, sex, health status, etc.
- Requires rewards to be made available to all enrollees for whom the plan covers (i.e., pays for) a mammogram under the plan benefit during the year including:
  - Men for whom mammograms are medically necessary
  - Members whose past medical history requires annual mammography
  - Female members under 50 and over 74 for whom mammogram is covered
  - Female members with advanced illness for whom mammogram is covered
- Still allows outreach, messaging, and interventions encouraging mammograms with females between 50 and 74 who have not had a mammogram in the last 27 months

***Combined with retirement of CDC-Nephropathy Screening and CDC-A1c Testing (and proposed changes to Colorectal Cancer Screening), this may require significant R&I program redesign to impact MY2022 Star Ratings***



* NOTE: Similar impacts exist for incentives offered for other services measured by HEDIS measures

# Though Policy Changes Require Rulemaking, CMS Can Accelerate "Stars Suppression"

Medicare Trustees predict the Medicare Hospital Insurance Trust Fund, which pays for inpatient hospital services, will run out in 2026 if no action is taken

MA plans were extremely profitable in 2020 due to massive drops in utilization because of COVID, which has increased national scrutiny on MA plans

MA cost-per-beneficiary is $321 higher than Original Medicare, which amounts to $7 billion of additional spending

MA spending is projected to rise to $664 billion by 2029, up from $348 billion this year; Medicare Drug Pricing remains under debate

Higher MA spending and arguable impact on quality has attracted CMS attention; the 2022 budget expressed support for reforming payments to private plans to extend the solvency of the Trust Fund and improve affordability for beneficiaries

The MA Quality Payment Relief Act is a brief proposed bill to remedy inclusion of QBPs in the benchmark cap calculation by changing 4 words in the SSA; the small change may enhance Part D and OTC benefits, access to fitness memberships and hearing aids, and nutrition and transportation programs to address SDOH

Beginning with MedPAC's 2019 annual report to Congress, systemic problems with the quality bonus program have been identified; MedPAC continues seeking to replace the QBP program altogether by implementing a new set of measures and structure for the MA Star Ratings system

While sweeping Part D or program changes could alter the Stars landscape dramatically, CMS is uninterested in destabilizing the market—and may use tactics like removal of highly rated measures, audits, data integrity challenges, and similar operational levers to deflate ratings and reduce spending

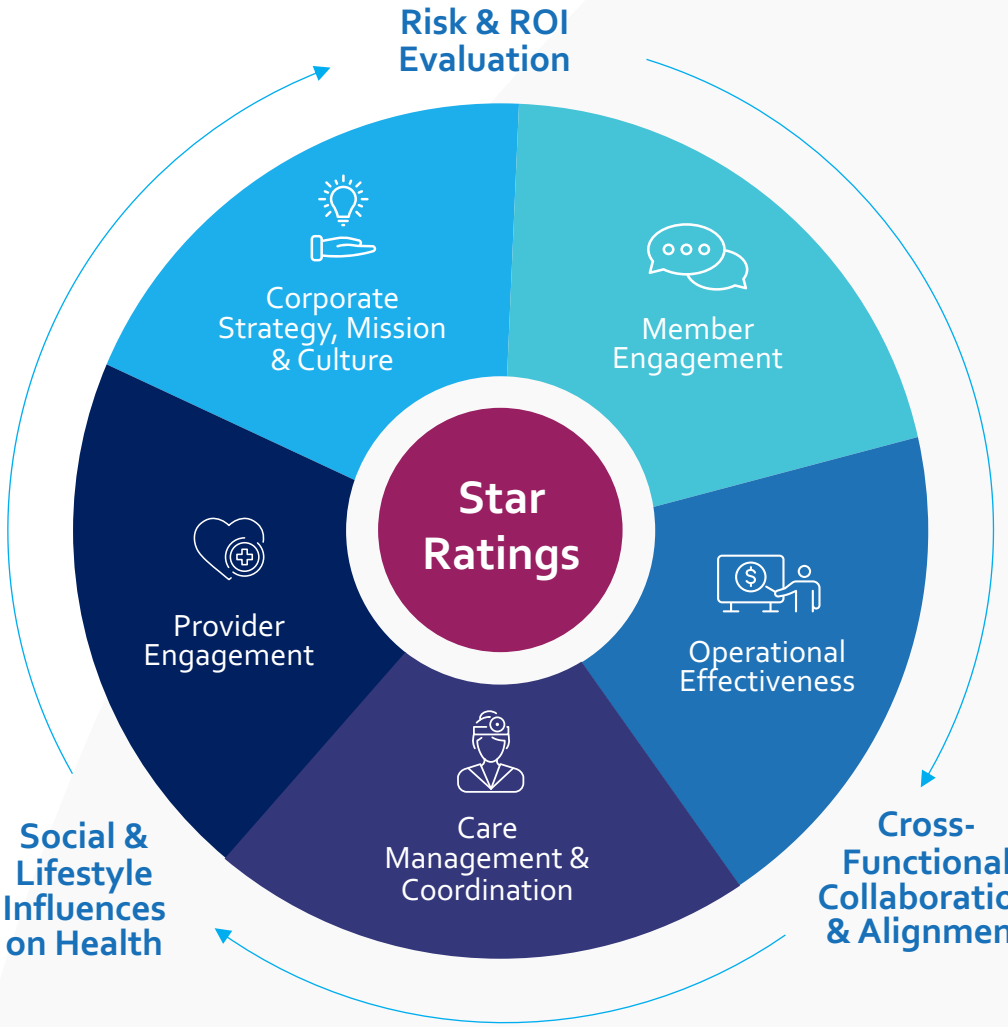
POLLING QUESTION

# What are your biggest pain points or barriers to running your Stars/quality programs in the most efficient and outcomes-driven manner?

| | |
|---|---|
| 14.5% | Access to real-time data on Stars performance (e.g., Medication Adherence trending) |
| 15.3% | Near-time member feedback on CAHPS measures |
| 13.7% | Consolidation of member data to surface longitudinal member record and whole-person care opportunities |
| 9.7% | Collaboration with provider network on gap closure and new Star measures (e.g., TRC, FMC, PCR) |
| 46.8% | All of the above |

# Emerging Issues to Watch

- Increasing focus by CMS on health equity and emphasis on elimination of discriminatory practices
- NCQA evolution to digital quality measurement and digital surveying
- NCQA urging of federal mandate requiring data collection for race and ethnicity
- Potential Part D structural and pricing changes, including proposed bill to add 5 biosimilars measures to Star Ratings
- Disparate goal between reducing cost and additional care needed to improve CAHPS and outcomes
- Impacts of data interoperability changes and increased adoption of digital, telehealth, and remote patient monitoring
- Impact of expanded insurance coverage on access, availability, and clinical capacity
- MedPAC's continued reiteration of the need for changes to Star Ratings and QBPs
- CMS' increasingly aggressive regulatory stance on MA Risk Adjustment
- Continued adoption of enhanced and creative supplemental benefits and Special Supplemental Benefits for the Chronically Ill



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