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2025 Star Ratings: Unpacking the Data

December 2024

Today’s speakers

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Today's agenda

1. Introductions
2. Last call for 2026 Star Rating
3. Planning for new measures and 2027 Star Rating
4. Leveraging quality improvement and HEI
5. Adjusting goals and long-term planning
6. Questions

Upcoming changes to Stars

	Stars 2025 Measurement year 2023	Stars 2026 Measurement year 2024	Stars 2027 Measurement year 2025
Scoring methodology		**Patient Experience (CAHPS) & Complaints & Access Measures:** Weighting reduced from 4x to 2x	**Health Equity Index:** HEI replaces R-Factor (MY2024 & MY2025)
HEDIS	**Breast Cancer Screening:** Converted to ECDS (low impact)	**Colorectal Cancer Screening:** Converts to ECDS (no hybrid option)	**Colorectal Cancer Screening:** Expand the age band to include 45-49
	Plan All Cause Readmissions: Weighting increased to 3x	**Diabetes Care – Blood Sugar Controlled**: Significant methodology changes	**Medication Reconciliation Post-discharge:** Removed as stand-alone measure
		Kidney Health Evaluation for Patients With Diabetes: New measure added at 1x weight	**Care for Older Adults – Functional Status Assessment:** Returning measure 1x weight
			Care for Older Adults – Pain Assessment: Retired measure
			Eye Exam for Patients with Diabetes Removed the hybrid data collection method
CAHPS	**CAHPS All Measures:** Survey will include new web methodology	**CAHPS All Measures:** Measure weights shift to 2x	
	Getting Appointments and Care Quickly: Remove '15-minute wait' question		
HOS		**Improving or Maintaining Health Measures:** Two returning (Fall 2024) at 1x weight	**Improving or Maintaining Health Measures:** Weight increases from 1x to 3x
Part D		**All (3) Medication Adherence:** Change to denominator methodology – CE	**Concurrent Use of Opioids and Benzodiazepines:** New measure
		SUPD-Statin Use/Diabetes: Change to denominator methodology – CE	**Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults:** New measure
			MTM Program Completion Rate for CMR: Moved to display

CMS Proposed Rule (11.26.24)

Proposing to remove guardrails beginning with MY2026

New measures (MY2026)	Updated measures (MY2027)
• Initiation and Engagement of Substance Use Disorder Treatment (IET) (Part C) • Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D)	• Breast Cancer Screening (Part C) • Plan Makes Timely Decisions about Appeals (Part C) • Reviewing Appeals Decisions (Part C)

HEI reward changes

- MY2027/SY2029: Updated calculation approach for plans required to move DSNP members to a separate DSNP plan from existing MA contract.
- MY2025/SY2027: Clarification in consolidation of contracts that the combined enrollment from the consumed and surviving contracts from the most recent year
- Clarify I-SNPs only contracts must have data for at least half the measures required for calculation required for I-SNP only contracts
- Starting SY2029: Changes to how HEI scores calculated when there are PLD and summary level data discrepancies
- Clarification of how the improvement measure hold harmless for the highest rating is determined based on the rounded rating before the addition of the HEI reward, if applicable

Additional proposed changes

- Vaccine cost sharing
- Insulin cost sharing
- Part D Coverage of anti-obesity medications
- Updates to Medicare Prescription Payment Plan
- Provider directory access in the Medicare Plan Finder
- Broadened definition of marketing materials for review by CMS
- Codification of timely submission requirements for PDE records
- Pharmacy network transparency to pharmacies
- Fair contract termination criteria for both pharmacies and PBM
- Increased clarification of supplemental benefits use through debit cards
- Updates to non-allowable supplemental benefits for the chronically ill (SSBCI)
- Updated criteria to define chronically ill and transparency with the public
- Risk adjustment data updates to include codes as appropriate
- Further define the meaning and application of internal coverage criteria
- Equitable access to behavioral health benefits
- Update Medicare Advantage Network Adequacy reporting and exceptions rationale
- Reduce fragmentation of materials and communications for dually eligible members including ID cards, HRA completion
- Codify when HRAs and ICPs should be completed and involvement of enrollee advisory groups for the MOC
- MLR adjustments to exclude administrative costs, align provider incentive programs, and updates to audit and appeals process.
- Require pharmacies to be enrolled in the Medicare Drug Price Negotiation Program's Medicare Transaction Facilitator Data Module
- Update of Health Equity Analysis of UM Policies and Procedures – report by each item or service, not aggregated
- Artificial intelligence guardrails to promote equitable and culturally competent care for enrollees
- Codify definition of CBO and transparency in directories of CBO, in home services, hybrid, and direct furnishing entities
- Four proposed modifications to MA organization determinations to enhance enrollee protections in inpatient settings

Last call for 2026 Star Rating

Achieving success with a final push

HEDIS measures

- Did you maximize in year data collection and interventions?
- Supplemental data collection ends February 28, 2025.
- Are you still making outreach calls to members to close gaps in care?
- Do you have a dashboard to demonstrate statistical improvement/QI?

Admin measures

- Do you have a process for call auditing your TTY/FL processes?
- Do you know the status of CTMs for your plan?
- How did AEP impact members choosing to leave the plan?

Annual Wellness Visit (AWV) completion rates

- Is this rate higher than last year?
- Is there an access or availability concern?
- What are you doing to ensure members get the care they need before the end of the year?
- Outreach to members without a visit for 2024.

In what way do these interventions influence your potential to achieve quality bonus payments for Star Rating 2026?

Colorectal Cancer Screening measure sequence of changes

Measurement year 2021

The U.S. Preventive Services Task Force (USPSTF) updated its colorectal cancer screening guidelines:

- Recommends that adults at average risk begin screening at age 45, instead of 50, based on the increasing number of cases among younger adults.

Measurement year 2024

Removal of hybrid data source

- Information for this measure can now only be collected by claims, or digital reporting.

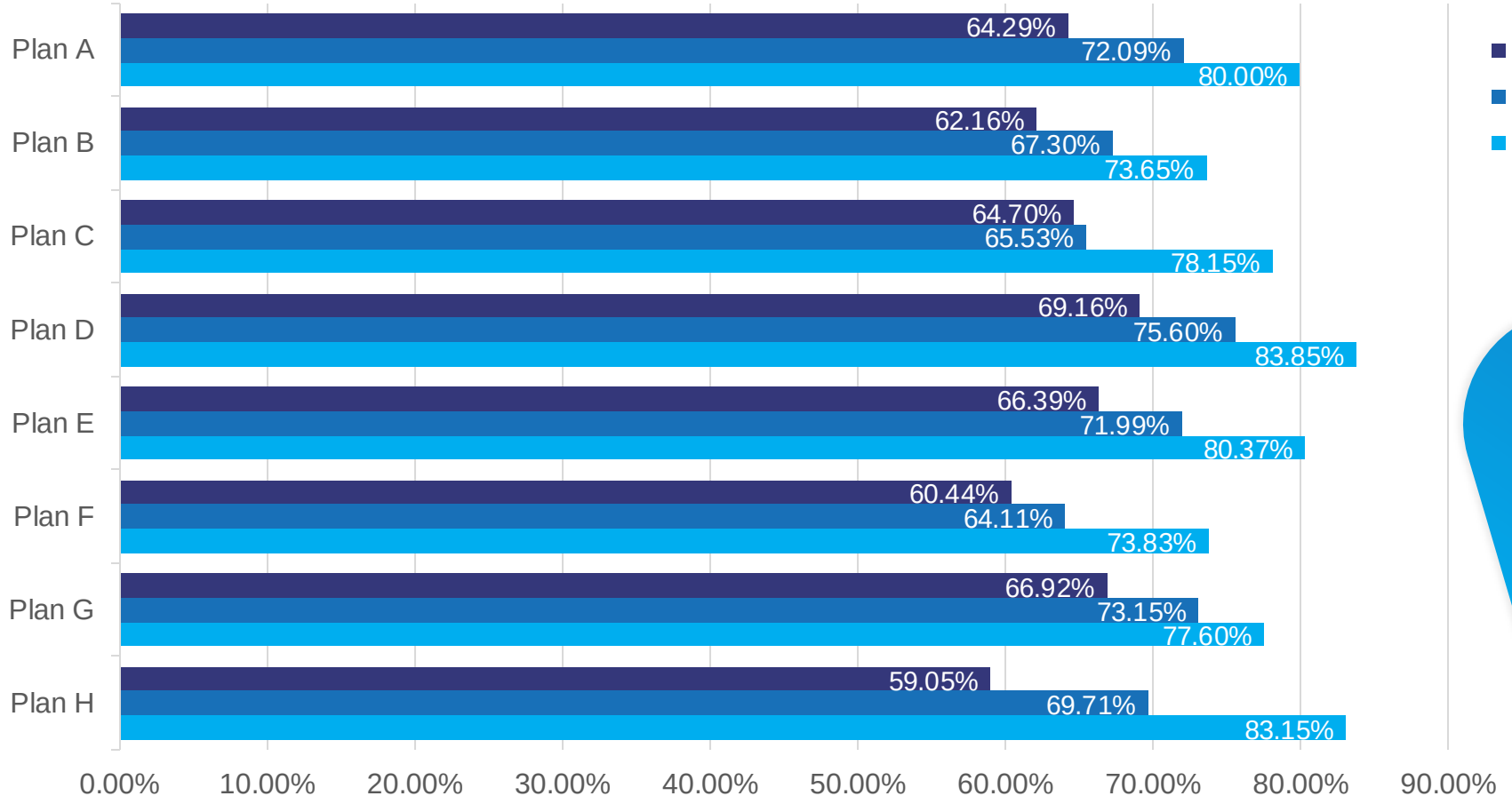
Measurement year 2025

CMS Star Rating program expands the age band to include 45-49.

- Potential large impact to denominator and compliance rates

How do you compare?

COL MY23 rates vs MY24 sept. YTD COL rate for eight MA plans



The current rates are trailing behind last year's, and health plans will need to make up the difference

NCQA transition to digital

2024

Colorectal cancer screening (COL)

2025

Eye Exam for patients with Diabetes (EED)

2026

Lead Screening for Children (LSC)

2027

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

2028

Prenatal and Postpartum Care (PPC)

Controlling Blood Pressure (CBP)

Blood Pressure Control for Patients with Diabetes (BPD)

2029

Transitions of Care (TRC)

Care for Older Adults (COA)

NCQA plans to transition away from the hybrid reporting method by MY 2029. When a hybrid measure shifts to ECDS or administrative specifications, the sampling methodology is removed, and data are reported for the full population. For some measures, the ECDS measure will be introduced before removing the hybrid measure, allowing organizations to submit both versions as part of the transition.

Reduction of CAHPS and Administrative measure weights to 2x

Star Rating 2026

Some stakeholders felt the effect of the 4x-weighting on these measures was undue compared to other CMS quality programs.

This change will reduce the impact of patient experience, complaints and appeals measures from about 58% to 40% of the overall Star Rating.

While this change will reduce the weight of CAHPS and Administrative measures in the Star Rating calculation, the impact will be felt in other domains.

Health plans should be assessing how this weighting change will impact future projections and performance, while adjusting goals and strategy quickly.

Identify and action CAHPS gaps in care immediately to impact the overall 2026 Star Rating

- Increase and accelerate capture of member feedback
- Re-survey post-resolution and track CAHPS gap closures
- Add short proxy surveys (1-2 questions) to all member touchpoints
- Analyze and identify responses to identify trended segments of problems
- Treat every suboptimal member response to a CAHPS question as a “CAHPS Gap in Care”
- Build plan and group specific mitigation projects as problems are identified

Who can you help to improve CAHPS with outreach calls?

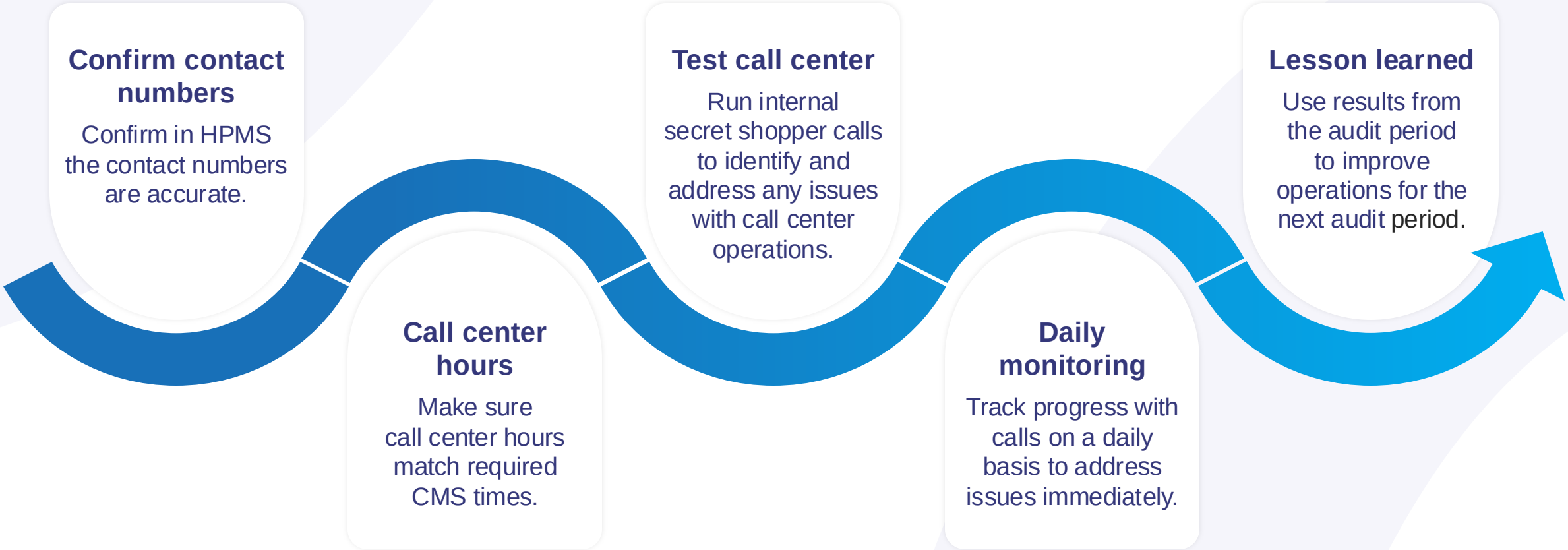
- Members responding negatively to pulse/proxy CAHPS questions
- Frequent CS callers, grievers, complainers, appealers
- Members without a visit
- Members targeted for in-home visits by risk adjustment
- Members with CTMs, denied PAs/claims

- Members experiencing negative 2025 formulary or benefit changes
- Members with outlier MLR (high or low)
- Members with LIS but no MCD
- Members with Rx claims showing past/pending Rx expiration for Med Adherence measures

- Members with ED/IP utilization and no follow up
- Members with rejected/ denied or reversed claims
- Members with claims in multiple states
- Unattributed/auto-attributed members
- Members using urgent care/retail clinics
- Members using ED without PCP appts

- Members with transition fill but no alternative
- Members seeing specialists but no PCP
- Members with NO specialists visit despite referral or conditions indicating need
- Member with RTS pharmacy edits, STs, PAs/auths, requesting tier exceptions

Call Center – Foreign Language Interpreter and TTY Availability



Planning for new measures and 2027 Star Rating

New Part D measures

Concurrent Use of Opioids and Benzodiazepines (COB):

The percentage of beneficiaries, 18 and older, with concurrent use of prescription opioids and benzodiazepines (BZDs) during the measurement period.

- The denominator is any beneficiary with at least 2 prescriptions of an opioid medications with unique dates of service **and at least 15 cumulative days supply** of opioids.
- The numerator is any beneficiary from the denominator with at least 2 prescription claims of a benzodiazepine with unique days of service and concurrent use of opioids
- Exclusions for beneficiaries receiving palliative care and those with diagnosis of cancer or sickle cell disease.

Use of Multiple Anticholinergic Medications (Poly-ACH):

The percentage of beneficiaries, 65 and older, with concurrent use of 2 or more anticholinergic (ACH) medications during the measurement period.

- The denominator is any beneficiary (65 years old or older) with at least 2 prescriptions with unique dates of service of the same medication in the targeted drug classes of ACH.
- The numerator is any beneficiary from the denominator with concurrent use of 2 or more ACH medications.

Both measures rely on 2 prescription claims with unique dates of service (overlap of at least 30 cumulative days)

New Part D measures

Implementation and impact

Implementation

- Set up clinical systems such as: point of sale (POS) drug utilization review (DUR) edits and retrospective DUR review
- Evaluate institution of a non-overridable or allow the fill to be overridable by a pharmacist after clinical consultation with the prescriber with regular retrospective reviews.
- Find members that were historically noncompliant with measures.

Impact to health plan

- Measures relate to prescribing pattern, focus on engaging the prescribers and changing prescribing behavior, to achieve good results.
- All plans have an idea of where their score and the average plans scores are so they may gauge the amount of effort they need to put in to improve their own score.
- Ensure any UM system control criteria is approved by CMS.

New Part D measures

Resources and rationale

Resources

- Allocate clinical resources to focus on these measures.
- Prepare provider and member education materials to reach out to members that are historically noncompliant.
- Engage with PBM to identify PA criteria and formulary changes (QL, step therapy) that could be instituted

Rationale

- COB-Concurrent use of benzodiazepines and opioids increases risk of respiratory depression, overdose, and death.
- Poly-ACH- Concurrent use of multiple anticholinergic medications increases risk of cognitive decline especially in people over age 65.

Return to HOS measures

- Beginning with the Health Outcomes Survey (HOS), administered in summer 2024, two measures are returning:
  - Improving and Maintaining Physical Health
  - Improving and Maintaining Mental Health
- Star Rating 2027 these will be 3-weighted measures, this survey will field July-November 2025. Plans only have 8 months to begin interventions.
- CMS is also considering adding an additional HOS measure with a 3x-weight related to Activities of Daily Living.

These returning measures will increase the HOS composition of the Star Rating from 3% in Star Year 2026 to 11% in Star Year 2027

Strategies for HOS

Star Rating 2027 performance will be based on sample of member who were enrolled in 2023 and remain enrolled in 2025. Create a focused project to identify, prioritize, and intervene with members.

Identify

- Members enrolled in 2023
- Screen with HRAs and Pulse surveys
- Analyze claims
- Use HEDIS depression screening measure

Prioritize

- Members with depression or are socially isolated
- Members challenged with Activities of daily living
- Use predictive analytics

Intervene

- Direct engagement
- Care navigators
- Community services
- Physical therapy
- Mental health counseling
- Leverage digital technology for outreach.

Leveraging QI measures and HEI

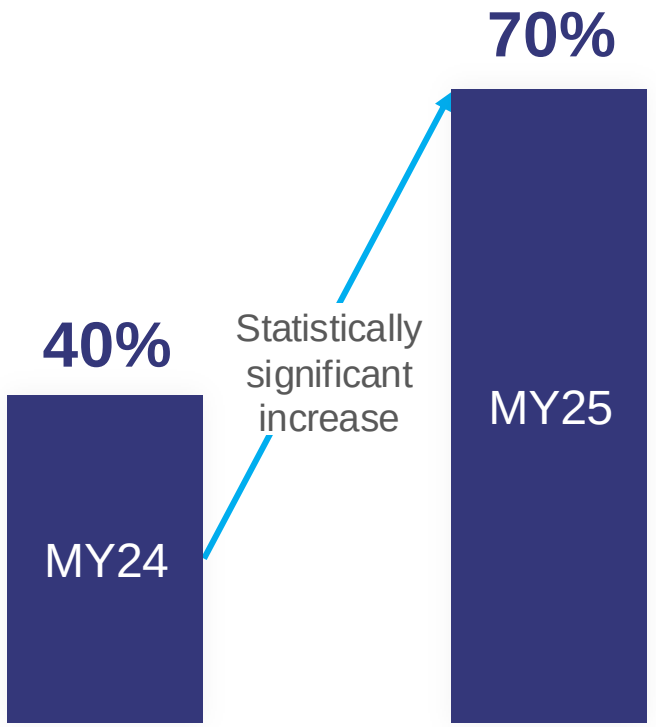
QI Measures reward “improvement”

Leverage the two five weighted measures

Demonstrating statistically significant improvement among Part C and Part D measures helps trigger health plan and drug plan quality improvement (both weighted 5x)

If individual measures are not performing at 5 Stars but you improve, this can help increase the summary and overall ratings

Use the CMS calculators to test if your current performance is on track to a high QI measure rating



Health Equity Index

Developed to reward MA plans and PDP contract for excellent performance among enrollees with specified social risk factors (SRFs).

The HEI reward will be implemented beginning with the 2027 Star Ratings (MY2024 and MY2025)

Currently summarizes performance among LIS/DE and disabled status enrollees across multiple Star Ratings measures into a single score. This score is translated into a reward added to the overall and summary Star Ratings for contracts that qualify

CMS structured the HEI to ensure the right incentives by including criteria that:

1. Considers the sample size
2. Considers percentage of enrollees with SRFs
3. Determines a minimum score that must be achieved on index to receive a reward

To avoid rewarding contracts that serve very few enrollees with SRFs, CMS included thresholds for the minimum percentage of enrollees with LIS, or who are DE or disabled. Based on the number of enrollees with a specified SRF, contracts are eligible for either a ½ or full reward

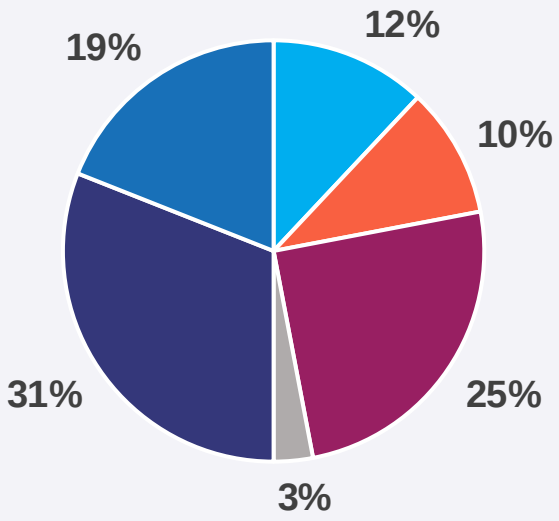
Health Equity Index replaces R-Factor

	2024 contract year	2025 contract year	2026 contract year	2027 contract year
Stars 2025	**Reward Factor** Included in published Stars 2025 scoring			
Stars 2026	**Measurement Period** R-Factor performance impacting Stars 2026	**Reward Factor** Included in published Stars 2025 scoring		
Stars 2027	**HEI: 2-Year Measurement Period** The HEI combines 2 years into one score: Stars 2027 will be based on performance in 2024 and 2025		**Health Equity Index** Included in published Stars 2027 scoring	
Stars 2028		**HEI: 2-Year Measurement Period** The HEI combines 2 years into one score: Stars 2028 will be based on performance in 2025 and 2026		**Health Equity Index** Included in published Stars 2028 scoring

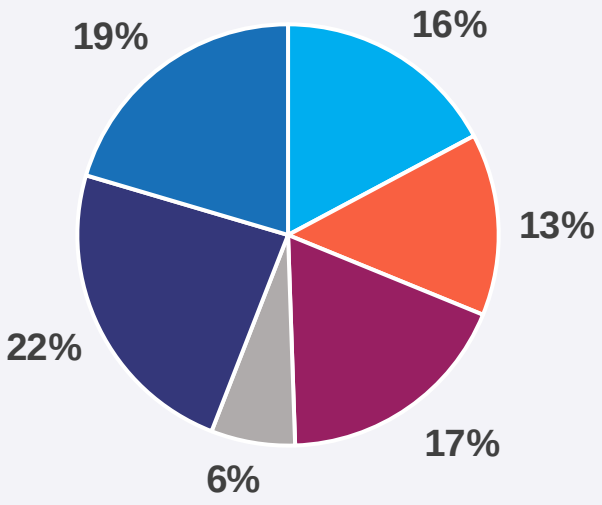
Adjusting goals and long-term planning

Star Rating changes

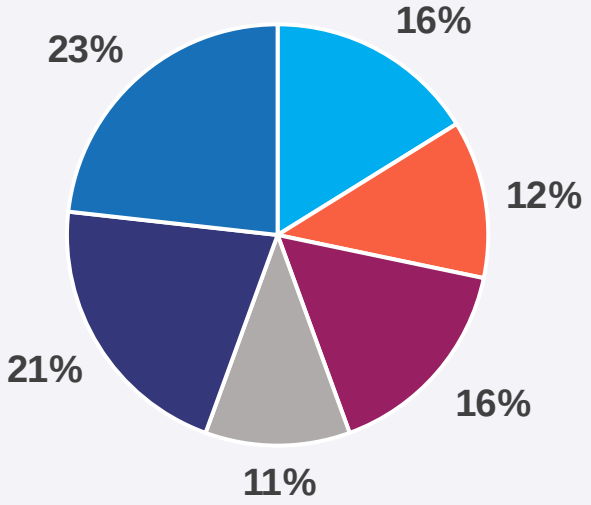
Stars 2025 domain breakdown



Stars 2026 domain breakdown



Stars 2027 domain breakdown

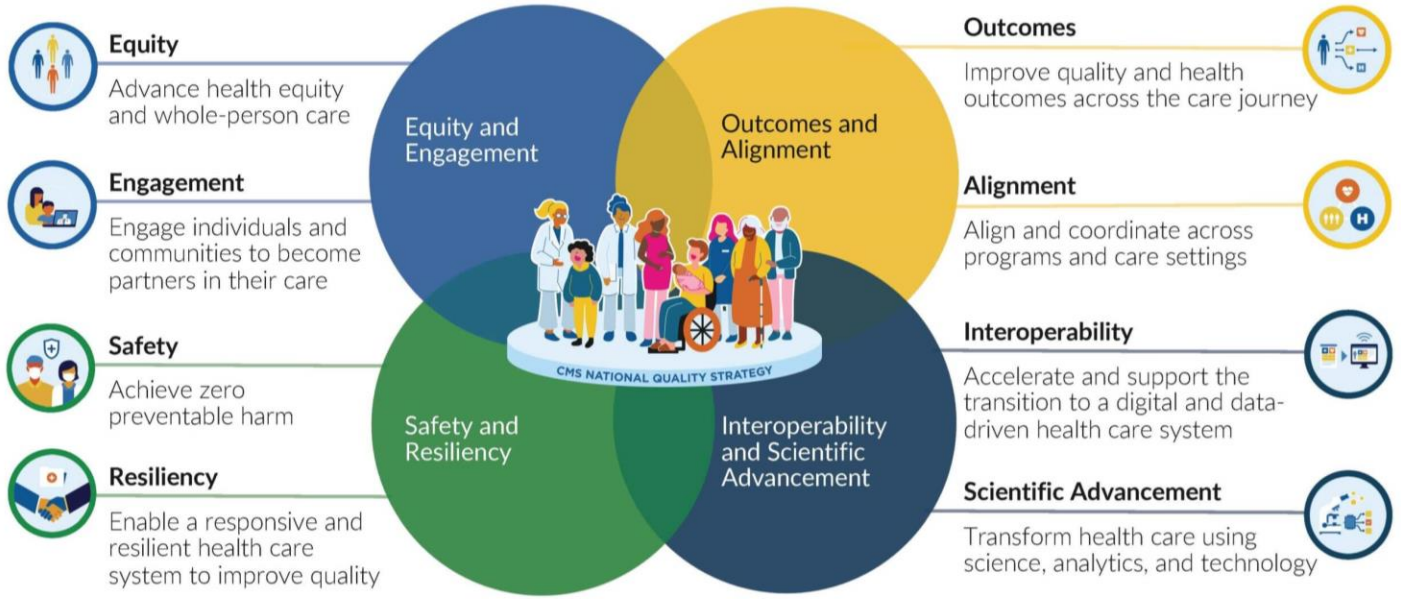


Pharmacy QI ADMIN HOS CAHPS HEDIS

Universal measures

CMS quality strategy goals

- CMS operates more than 20 quality programs.
- Each has its own set of quality measures they are held accountable for.
- Some measures are consistent across our programs, many are not.
- CMS's goal is for the Universal Foundation to include measures for assessing quality along a person's care journey from infancy to adulthood, and for important care events, such as pregnancy and end-of-life care.
- Many of the Universal Measures are currently within the Star Rating program and others are either display or proposed for the Star Ratings program.



Universal Measure Set for Adults

- Focuses provider attention
- Reduces burden
- Identifies disparities in care
- Prioritizes development of interoperable digital quality measures
- Allows for cross-comparisons across programs
- Helps identify measurement gaps

Current star measures

- Colorectal Cancer Screening
- Plan All-Cause Readmissions
- Consumer Assessment of Healthcare Providers and Systems
- Breast Cancer Screening
- Controlling High Blood Pressure
- A1c Control

Current display measures

- Screening for Depression and Follow-up Plan
- Initiation and Engagement of Substance Use Disorder Treatment
- Adult Immunization Status

How to prioritize and execute strategies

Assessment of current performance: Evaluate current internal performance with addition or removal of measures and determine performance impact Identify gaps or areas needing improvement.

Data collection and infrastructure: Ensure robust data collection mechanisms are in place to capture relevant metrics. Establish or enhance data systems to collect, analyze, and report data accurately and in a timely manner. Implement data validation processes to ensure data integrity and reliability.

Provider engagement and education: Collaborate closely with healthcare providers to align practices and workflows with new requirements. Provide education and training sessions to providers on star rating changes, reporting protocols, and performance expectations/value-based care agreements.

Performance improvement initiatives: Develop targeted initiatives to improve performance on specific metrics.

Quality monitoring and reporting: Establish regular monitoring processes to track performance update stars scorecards to include display measures.

Communicate impact of changes: Engage internal key stakeholders and communicate to leadership potential impact to star rating.

Strategic planning: Develop a strategic plan that aligns organizational goals with Star Rating improvement objectives.

Focus on high-impact measures: Identify and prioritize measures that have the greatest impact on Star Ratings.

Ready to help you win

Tailored, cost effective member engagement that delivers results on the measures that matter

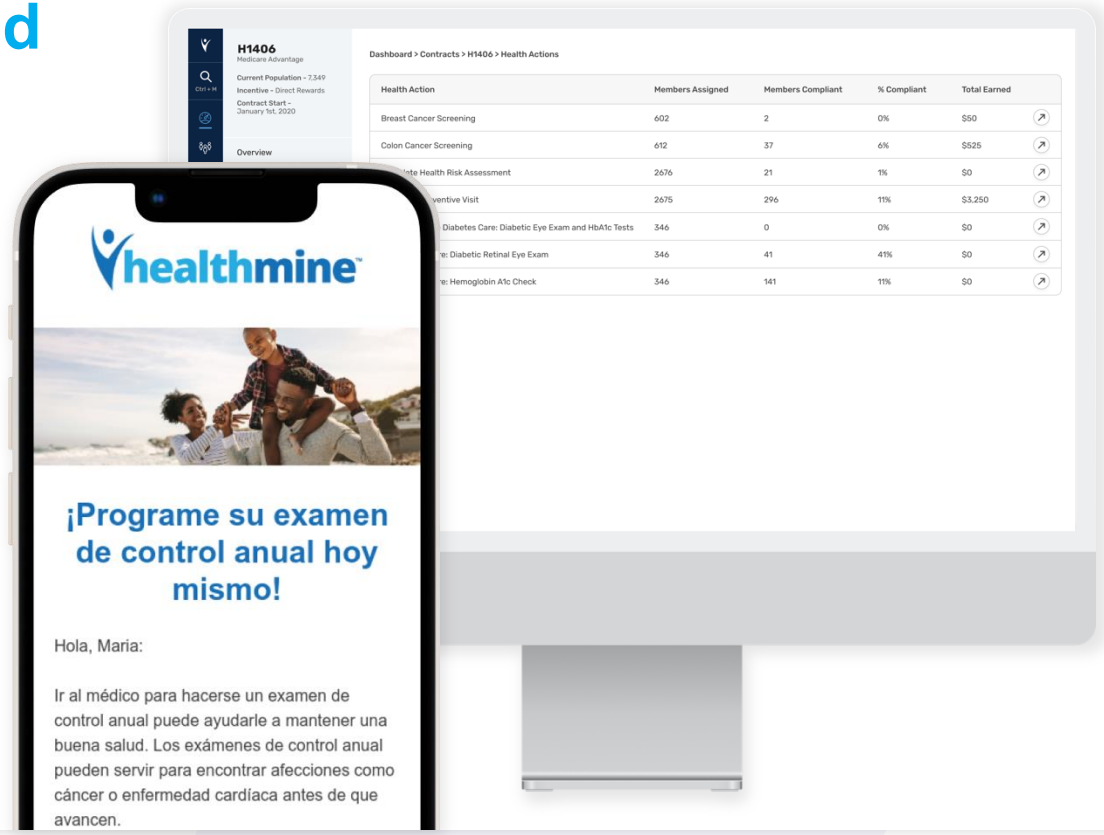
70% of Healthmine's clients maintained or improved their overall Star Rating

20% Flu shot completion improvement

16% Increase in breast cancer screenings

15% Increase in diabetic retinal eye exams

15% Increase in fall risk assessments



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