WHITE PAPER

MEDICARE ADVANTAGE STAR RATINGS – 2024 MEASUREMENT YEAR CHANGES

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2024 Measurement Year – What's New for Stars?

Note that this white paper assumes the reader has a technical understanding of the Centers for Medicare and Medicaid Services (CMS) Part C and D Medicare Part C and D Star Rating program.[1]

The new measurement year brings new challenges for Medicare Advantage (MA) plans navigating the Centers for Medicare and Medicaid Services (CMS) Star Rating program designed to measure and incentivize high quality of care to MA members.

All program changes effective with measurement year 2024 are likely to bring new challenges and increased financial pressure on many MA organizations.

The last couple of Star Rating cycles have been marked by significant program upheaval and subsequent adjustments by the MA plans. Following an all-time high performance in 2022, the Star Ratings have been on a steady decline resulting in large reductions in quality bonus and rebate payments. This downward trend is primarily the effect of the sweeping methodological changes finalized by CMS in April 2023, rather than evidence of declining performance by MA health plans.[2]

We expect the trend to continue with several more major changes starting in the current measurement year. First, the recently elevated Patient Experience and Access measures are set to decrease in weight, reducing their Star Rating importance and evening out the playing field among participating measures. Second, measurement year 2024 is the first year to inform the new Health Equity Index reward, scheduled to replace the reward factor in the 2027 Star Ratings (2028 Payment Year). Third, the first Star Rating measure is transitioning from hybrid to electronic reporting methodology, which historically has rendered much lower rates.[3]

This paper describes the new methodological changes impacting the 2024 measurement year, analyzes the downstream implications on Star Ratings and the associated revenue streams, and highlights the adjustments the health plans need to make to prevent further Star Rating decreases.

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[1] https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data

[2] Cut to the Point: A Summary of 2024 Star Rating Cut Point Changes and 2024 Medicare Advantage Star Ratings: (Tu)Key Takeaways

[3] NCQA Special Report: Reporting Results for Measures Leveraging Electronic Clinical Data for HEDIS® November 2021

Decrease of Patient Experience and Access Measure Weights

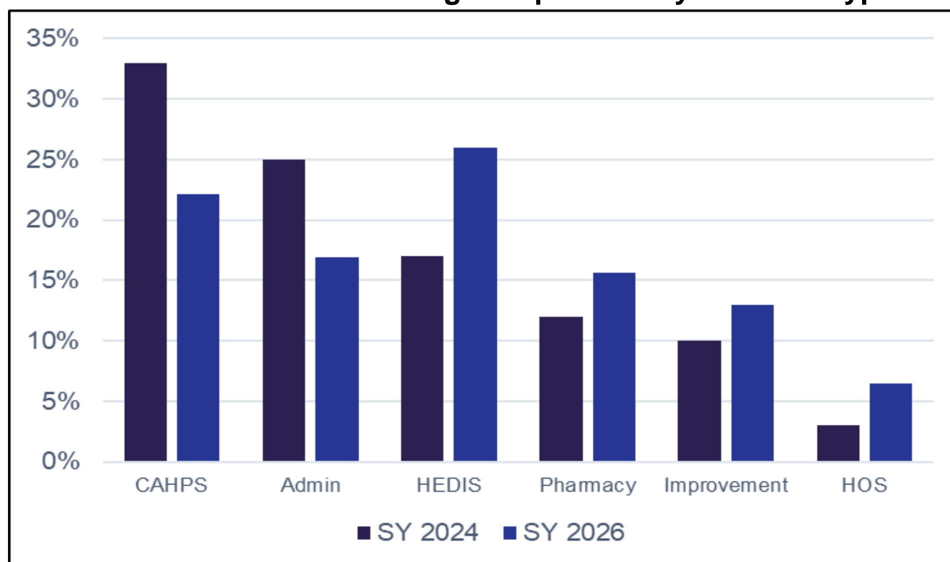
The “Patients’ Experience and Complaints Measures” and “Measures Capturing Access”, composed of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and operational type measures, have undergone numerous weighting changes in recent years, ranging from 1.5 in the 2020 Star Ratings (2021 Payment Year) to as high as 4.0 in the 2023 Star Ratings (2024 Payment Year). As a result, they have accounted for the majority of the Overall Star Rating for the last few years (55 to 58 percent). After remaining at 4.0 for three consecutive years, the weight will be reduced back to 2.0 and their percent of total weight will decline by 20 percent in the 2026 Star Ratings (2027 Payment Year), as shown in Table 1 below.

Table 1: Patient Experience and Access Measure Weights by Star Rating Year

	2020	2021	2022	2023	2024	2025	2026
Measure Weight	1.5	**2**	2	**4**	4	4	**2**
Domain Weight	24	**32**	28	**56**	56	56	**28**
Total Star Weight	75	**80**	68	**96**	100	102	**77**
% of Total Weight	32%	**40%**	41%	**58%**	56%	55%	**36%**

The weight change will create large shifts in the importance and relative weight of other measures. As patient experience and access measures decrease in weight, other measures will proportionally increase even though their measure weight remains the same. Among them, the Healthcare Effectiveness Data, and Information Set (HEDIS) measures will rise the most, capturing almost one third of the total weight.[4]

Chart 1: Overall Star Rating Composition by Measure Type

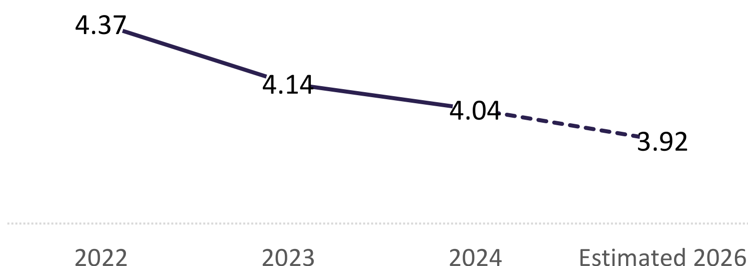


[4] See Appendix B for a full list of the measures, measure types, and measure weights used throughout this report. All statistics throughout the report exclude duplicative measures for Part C and Part D ratings.

To estimate the impact of the measure weight changes on the overall Star Ratings, we recalculated the 2024 Star Ratings (2025 Payment Year) performance of all experience-rated contracts using 2026 Star Ratings (2027 Payment Year) measure weights.[5] Our results suggested that significantly more contracts will see their Star Ratings decrease than increase, dragging down the enrollment-weighted industry average from 4.04 in 2024 to 3.92 in 2026.

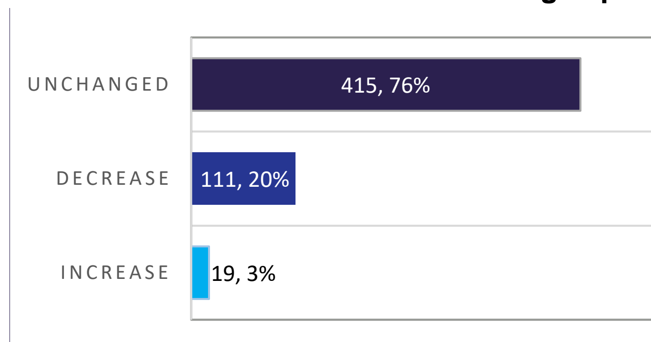
The two-year downward Star rating trend is likely to continue with the weight of Patient Experience and Access measures cut in half.

Chart 2: Enrollment-Weighted Average Star Rating by Star Rating Year



Had these measure weights been in place for the 2024 Star Ratings, 111 MA contracts – or 20 percent, enrolling 29 percent of members[6] – would have seen their Star Rating drop by half a star. Only 3 percent of contracts with 3 percent of enrollees would have seen a Star Rating lift by the same amount.

Chart 3: Rounded Overall Star Rating Impact



For most impacted contracts the shift in rating would have triggered an adjustment in Star Rating associated revenue.[7] An additional 12 high-performing contracts may have seen decreases in premium

[5] The model does not account for the three new measures to be added to the program in 2026 Star Ratings due to lack of 2024 Star Ratings experience. Appendix A further describes the methodology used for this simulation.

[6] November 2023 enrollment by contract was used throughout this report.

[7] Star rating revenue changes only when a contract goes in and out of 3.5 (+/- 15% rebate), 4.0 (+/- 5% bonus), or 4.5 (+/- 5% rebate) star ratings.

dollars as they would have lost the ability to market and enroll members year-round, a perk reserved for 5-star rated plans.

The Introduction of the Health Equity Index (HEI) Reward

The replacement of the reward factor with the Health Equity Index (HEI) reward will further exacerbate the declining trend, judging by the CMS simulation of this change on 2021 Star Ratings data,[8] where 13.4 percent of contracts lost half a star and less than two percent gained half a star. Additionally, the additive increase to star ratings from the HEI reward will be much lower than the increase from the reward factor in recent years – roughly 0.1 points on average compared to 0.3. Overall, this change is estimated to decrease star rating associated revenue by $670 million in the 2027 Star Ratings (2028 Payment Year).

Even though the shift from reward factor to HEI reward will not occur until 2027, the health equity index starts to matter as early as this year. This is due to the index's two-year lookback period. The 2027 HEI reward will summarize the relevant performance data from measurement years 2024 and 2025 into a single score. As the reward factor is still in place for 2026 Star Ratings (2027 Payment Year), the MA plans will need to devise and execute on strategies for both rewards during this overlapping measurement year.

The dual reward strategy may prove elusive for most plans. Both rewards offer the same opportunity for improved star ratings as they can add up to 0.4 points to the overall score, but the criteria to get to 0.4 are vastly different. While the reward factor benefits contracts with consistent, high performance across all measures and members, the HEI reward benefits contracts with higher prevalence and performance among the population with social risk factors (SRFs) including those with low-income, dual-eligible, and/or disabled status.

Not surprisingly, the MA contracts expected to earn the HEI reward are quite different from those historically earning the reward factor. Our analysis shows that the two rewards are inversely correlated. Plans currently receiving the reward factor are unlikely to receive the HEI reward as they tend to enroll a lower proportion of members afflicted by social risk factors, as apparent by their low categorical adjustment index (CAI) final adjustment category (FAC).[9] As depicted in table 2 below, highlighted in orange, two thirds of the contracts who received a reward factor of 0.3 or higher in the 2024 Star Ratings are unlikely to meet the median enrollment breakpoint, which we estimate to fall somewhere within final adjustment category 3. For these health plans, building capabilities to receive the HEI reward will take time and they may have to rely on improved performance elsewhere to attain their star rating goals in the meantime. Conversely, contracts not currently receiving a reward factor, found in the top half of the final adjustment category (highlighted in blue) may be better positioned to qualify for the HEI reward. They are highly likely to meet the enrollment threshold and have more experience in serving this population.

[8] Medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[9] Categorical Adjustment Index Final Adjustment Category is derived from the distribution of MA Health Plans from Level 1 being the lowest and Level 7 the highest concentration of this population.

Table 2: SY 2024 Reward Factors by CAI FAC

		Reward Factor				
	CAI FAC	0	0.1	0.2	0.3	0.4
	1	40	11	12	14	27
	2	76	19	14	4	26
60%	3	58	6	11	0	11
	4	56	7	6	0	8
	5	32	1	1	0	0
	6	47	3	4	3	6
	7	27	4	5	1	5

Transition to Digital Measurement Reporting

Aligned with the CMS national quality strategy to improve quality outcomes and reduce burden by placing a greater emphasis on the use of electronic data for quality measurement and improvement, NCQA is transitioning HEDIS from traditional to digital quality measurement (dQMs). The transition is targeted to complete circa 2030, when HEDIS reporting as we know it now will no longer exist. Simply put, the "hybrid" approach to reporting measures heavily reliant on clinical data, which allows plans to draw a sample of patients for measure calculation, will go away. Instead, plans will have to report and collect clinical data on all eligible patients. That amounts to high volume of scarce clinical data, making digital data collection an imperative.

Over the years, health plans have relied heavily on hybrid methodology to collect and abstract relevant clinical data from Electronic Health Records, not typically received on a claim. The small sample size makes the chart chase and abstraction manageable and leads to increased rate performance, known as the "hybrid lift". With the removal of hybrid, and essentially the sample-based rate, the clinical data will need to be collected and abstracted for the entire eligible population rather than a handful of members, making the current laborious process unwieldy, especially for larger size health plans. Unless some serious and reliable automation strategies are put in place, health plans will likely see a lower chart retrieval and declining performance.

The impact of the digital measurement transition on Star Ratings remains to be seen but could be substantial. Unlike other adjustments, this will require an overhaul of existing data collection strategies and processing as well as building new capabilities and expertise. The biggest unknown stems from the shift in data model and measure execution. The dQMs leverage the new data exchange standard, Fast Interoperability Healthcare Resource (FHIR), and are calculated using Clinical Quality Language (CQL). In theory, the rates should remain the same as the measure logic will not change. Nevertheless, because data gaps are treated the same as care gaps in HEDIS, the inevitable gaps in data especially with the change to population-based rates and new data environment are likely to lead to lower performance. Abetted by the overall industry inexperience and lack of know-how with FHIR and CQL, the rates may see decline during the earlier years, especially for those plans still building up their digital measurement readiness.

The sunset of hybrid reporting will be slow-footed, allowing the health plans time to adjust. The first true readiness test begins this measurement year with the transition of the Colorectal Cancer Screening measure as a first Star measure to move away from hybrid for the 2026 Star Ratings (2027 Payment Year). NCQA previously reported a significant hybrid performance lift for the Colorectal Cancer Screening measure across MA plans, ranging between 5 and 10 percent.[10] For the MA stragglers still relying on hybrid reporting, this could translate into a substantial decline in the measure star rating.

The overall impact of one process measure with a weight of 1.0 is expected to be small. However, it should not be overlooked as more and more heavily weighted measures, such as Diabetes Care – Blood Sugar Controlled, are to join the electronic reporting world soon. The Tukey outlier deletion methodology made the cut points for HEDIS measures harder to achieve. Combined with their increased relative weight in the current Star Ratings program, discussed earlier in the paper, the impact of the transition to digital measurement deserves early and rapt attention.

Conclusion

The 2024 measurement year is full of weighty measurement changes, each one of them expected to create strong headwinds in upcoming star rating cycles. For many plans, this may translate to lower star ratings and reduced quality payments unless they make swift adjustments. For others, these changes might be favorable but require actions to make the most out of them. In a climate of constant change, it's imperative for organization to advance their Star Rating analytics, know which camp they will fall into due to the impending changes, and be able to redraw the Star Rating roadmap accordingly. Likewise, health plans need to equip themselves with tools that will give them more than monthly retrospective accountability reports and enable them to slice and dice their performance year-round and frequently, informing strategies and producing actionable to do lists.

Please contact Lisa Winters at Lisa.Winters@wakely.com or Daniela Simpson at Daniela.Simpson@wakely.com with any questions or to follow up on any of the concepts presented here.

[10] Leveraging Clinical Data for Measurement of Colorectal Cancer Screening, NCQA, February 2022

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

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Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

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Appendix A: Methodology

Methodology Overview

Wakely used the published 2024 Star Ratings Data Tables[11] to evaluate the impact of the reduction in Patient Experience and Access measure weights. These tables include measure level data (ex. a contract scoring 83% on the Breast Cancer Screenings measure), measure level Star Ratings (ex. a contract receiving 4 stars out of 5 on the Breast Cancer Screenings measure), Part C and D cut points for each measure, and Overall Star Ratings. We replicated the CMS calculations for the 2024 Overall Star Ratings for every contract by calculating raw Overall Star Ratings (weighting each measure with the CMS defined measure weight) and then adjusting for Part C and D Improvement Measure "hold harmless" provisions, Reward Factors, and the Categorical Adjustment Index (CAI).

With all contracts aligned in their starting point – the published 2024 Overall Star Rating – the 2024 Star Ratings measure weights were replaced with the expected 2026 Star Ratings measure weights, allowing us to calculate simulated 2026 Overall Star Ratings with the new measure weights.

Better of 2023 and 2024 Measure Level Star Ratings

In the 2024 Star Rating year, several contracts qualified under the 25% rule as being subject to an "Extreme and Uncontrollable Circumstance" (EUC). These contracts received measure level Star Ratings that are the better of 2021 and 2022 performance for all measures except the Part C and D Call Center – Foreign Language Interpreter and TTY Availability measures.

The 2024 Star Ratings Data Tables publish the "better of" measure-level values for EUC-qualified contracts. If the "better of" value is based on 2021 performance, the associated Star Rating would be the result of mapping that value using the 2023 cut points; therefore, the published measure values for EUC-qualified contracts cannot all be mapped correctly using the published 2024 cut points. The published measure-level Star Ratings were used in the calculation of the simulated 2026 Star Ratings for EUC-qualified contracts.

Reward Factor

The reward factor adjustment varies from 0.0 to 0.4 and is added to a contract's Summary and Overall Star Ratings based on the variance and mean across all measure-level Star Ratings. When we adjusted to using the expected 2026 measure weights, we also brought these new weights into the reward factor calculation.

[11] https://www.cms.gov/files/zip/2024-star-ratings-data-tables-oct-13-2023.zip

Improvement Measure Hold Harmless

The “Hold Harmless” clause for Improvement Measures allows contracts rated 4.0 Stars or higher to receive the higher Overall Star Rating between with and without the Improvement Measures included. This provision was re-calculated with the measure-level Star Ratings using the expected 2026 measure weights.

Appendix B: Stars Measure Types

Measure	Measure Type	SY 2024 Weight	SY 2026 Weight
Part C: Breast Cancer Screening	HEDIS	1	1
Part C: Colorectal Cancer Screening	HEDIS	1	1
Part C: Annual Flu Vaccine	CAHPS	1	1
Part C: Improving or Maintaining Physical Health*	HOS	NA	1
Part C: Improving or Maintaining Mental Health*	HOS	NA	1
Part C: Monitoring Physical Activity	HOS	1	1
Part C: Special Needs Plan (SNP) Care Management	Admin	1	1
Part C: Care for Older Adults – Medication Review	HEDIS	1	1
Part C: Care for Older Adults – Pain Assessment	HEDIS	1	1
Part C: Osteoporosis Management in Women who had a Fracture	HEDIS	1	1
Part C: Diabetes Care – Eye Exam	HEDIS	1	1
Part C: Diabetes Care – Blood Sugar Controlled	HEDIS	3	3
Part C: Controlling Blood Pressure	HEDIS	3	3
Part C: Reducing the Risk of Falling	HOS	1	1
Part C: Improving Bladder Control	HOS	1	1
Part C: Medication Reconciliation Post-Discharge	HEDIS	1	1
Part C: Plan All-Cause Readmissions	HEDIS	1	3
Part C: Statin Therapy for Patients with Cardiovascular Disease	HEDIS	1	1
Part C: Transitions of Care	HEDIS	1	1
Part C: Follow-Up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	HEDIS	1	1
Part C: Getting Needed Care	CAHPS	4	2
Part C: Getting Appointments and Care Quickly	CAHPS	4	2
Part C: Customer Service	CAHPS	4	2
Part C: Rating of Health Care Quality	CAHPS	4	2
Part C: Rating of Health Plan	CAHPS	4	2
Part C: Care Coordination	CAHPS	4	2
Part C: Complaints about the Health Plan	Admin	4	2
Part C: Members Choosing to Leave the Plan	Admin	4	2
Part C: Health Plan Quality Improvement	Improvement	5	5
Part C: Plan Makes Timely Decisions about Appeals	Admin	4	2
Part C: Reviewing Appeals Decisions	Admin	4	2
Part C: Call Center – Foreign Language Interpreter and TTY Availability	Admin	4	2
Part C: Kidney Health Evaluation for Patients with Diabetes*	HEDIS	NA	1

Part D: Call Center – Foreign Language Interpreter and TTY Availability	Admin	4	2
Part D: Complaints about the Drug Plan	Admin	4	2
Part D: Members Choosing to Leave the Plan	Admin	4	2
Part D: Drug Plan Quality Improvement	Improvement	5	5
Part D: Rating of Drug Plan	CAHPS	4	2
Part D: Getting Needed Prescription Drugs	CAHPS	4	2
Part D: MPF Price Accuracy	Pharmacy	1	1
Part D: Medication Adherence for Diabetes Medications	Pharmacy	3	3
Part D: Medication Adherence for Hypertension (RAS antagonists)	Pharmacy	3	3
Part D: Medication Adherence for Cholesterol (Statins)	Pharmacy	3	3
Part D: MTM Program Completion Rate for CMR	Pharmacy	1	1
Part D: Statin Use in Persons with Diabetes (SUPD)	Pharmacy	1	1

New measures that do not have SY 2024 experience data were not included in the SY 2026 Overall Star Ratings projections. They were included in this table to tie to the total weights shown in Chart 1.