PQA-Prepared Summary of Points of Interest
April 21, 2022

CMS Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

PQA distributed a summary of points of interest from the CMS Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies to membership in February 2022. This follow-up communication highlights key points noted in the CY2023 Announcement, with new information (since the Advance Notice) noted in shaded text boxes. There were no substantial changes in the Announcement regarding PQA measures from what CMS proposed in the Advance Notice.

For further details on any of the points below, we have indicated page numbers/sections and encourage you to refer to the full language from the document, which can be accessed here.

PQA will review all comments received on its measures and, where appropriate, will engage the PQA Measure Update Panel and Quality Metrics Expert Panel as part of the measure maintenance process to determine any necessary revisions.

Health Equity in MA and Part D Programs (p. 1)

In the CY 2023 Advance Notice, CMS described agency efforts to advance health equity including collecting more and improved data on beneficiaries’ race, ethnicity, and social determinants of health; developing quality measures and methodological enhancements that better measure and strengthen methods of addressing health disparities; and driving value in the Medicare program to make sure that the Medicare dollar is spent effectively and efficiently on programmatic changes that will close health equity gaps. CMS solicited feedback on these efforts and the role plans can play in meeting these challenges.

[p. 1]

• Commenters expressed support for CMS’s focus on promoting health equity. CMS plans to conduct a thorough review of comments to examine further actions CMS might take, including coordinating across programs that CMS oversees, to reduce barriers to health equity.

CONDENSED SUMMARY

• Reminder: The Statin Use in Persons with Diabetes (SUPD) measure will change from a weight of 3 to a weight of 1 for the 2023 Star Ratings.

• For the SUPD measure, CMS will implement the narrowing of the liver disease exclusion and the removal of dapagliflozin and empagliflozin single ingredient products from the measure for the 2022 measurement year (2024 Star Ratings).
• The Risk Adjustment Processing System (RAPS) prescription drug hierarchical condition categories (RxHCC) codes will be removed from all PQA-endorsed Part D measures, including the medication adherence measures, SUPD measure, and display measures, for the 2022 measurement year (2024 Star Ratings).

• CMS is still undergoing testing of the three medication adherence measures for sociodemographic status (SDS) risk adjustment, discontinuing member-years of enrollment and using continuous enrollment, and removing the inpatient and skilled nursing facility stay adjustment. Additional information from the testing would be provided through the rulemaking process, if CMS decides to propose these changes to fully align with the PQA-endorsed specifications.

• Palliative care will be added as an exclusion to the opioid display page measures for the 2022 measurement year (2024 display page).

• CMS plans to add the Initial Opioid Prescribing Long Duration (IOP-LD) measure to the display page for 2023 (2021 data) and 2024 (2022 data). Once they gain more experience with the IOP-LD measure, CMS will consider adding the measure to the Star Ratings through future rulemaking.

• CMS will begin reporting the Persistence to Basal Insulin (PST-INS) measure in the Patient Safety reports for the 2022 measurement year, and the measure will be added to the display page for 2024 (2022 data) and 2025 (2023 data). CMS appreciates the comments received, which will be carefully considered; adding measures to the Star Ratings must be proposed through the rulemaking process.

• CMS will begin sharing confidential stratified reports with contracts through the Health Plan Management System (HPMS) this spring (2022). CMS plans to start by stratifying scores for a subset of Star Ratings measures by Low-Income Subsidy (LIS)/dual eligibility (DE) versus non-LIS/DE and disabled versus non-disabled. National performance scores will be provided for comparison, which can be used by contracts to inform and target their quality improvement efforts.

• CMS will continue to explore additional variables for stratification and consider including stratified reporting as part of the display measures on CMS’s Part C and D Star Ratings webpage and on the Medicare.gov Plan Finder tool in the future to help make the data accessible to beneficiaries in their reviews and selections of plans.

• To provide Part C and D sponsors with information about how their contracts perform on the health equity index, CMS plans to make contract-specific index information available in HPMS later this year. Addition of a health equity index to the Part C and D Star Ratings would need to be adopted through the rulemaking process.

ATTACHMENT VI. UPDATES FOR PART C AND D STAR RATINGS (begins on p. 78)

REMINDERS FOR 2023 STAR RATINGS (p. 78)

In the CY 2021 final rule (85 FR 33796), CMS finalized an increase in the weight of patient experience/complaints and access measures from 2 to 4 for the 2023 Star Ratings. They also updated the Part D Statin Use in Persons with Diabetes (SUPD) measure weighting category from an intermediate outcome measure with a weight of 3 to a process measure with a weight of 1 for the 2023 Star Ratings. The COVID-19 interim final rule (IFC) (CMS-1744-IFC), issued on March 31, 2020, delayed the application of guardrails until the 2023 Star Ratings. Please see the final rule and IFC for further information on
these changes for the 2023 Star Ratings, as well as the “Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs” proposed rule (CMS-4192-P) which appeared in the Federal Register on January 12, 2022.

Section 1. General Content

Measure Updates for 2023 Star Ratings (pp. 79-85)

Part C & D Improvement Measures and Categorical Adjustment Index (pp. 79-83)

- The PQA measures that will be used to calculate the 2023 Star Ratings Improvement measure and Categorical Adjustment Index (CAI) are listed in Table VI-1 in the Rate Announcement, and noted below.
- CMS will only include measures in the improvement calculations at the contract level if numeric value scores are available for both the current and prior years.
- The methodology for the CAI is described in the annual Medicare Part C & D Star Ratings Technical Notes available on the CMS webpage at https://go.cms.gov/partcanddstarratings.

Table VI-1: Measures Included in 2023 Star Ratings Improvement and 2023 CAI Value (Excerpt: PQA Measures)

<table>
<thead>
<tr>
<th>Part C or D</th>
<th>Measure</th>
<th>Measure Type</th>
<th>Weight</th>
<th>Improvement Measure</th>
<th>CAI</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Medication Adherence for Diabetes Medications</td>
<td>Intermediate Outcome</td>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Medication Adherence for Hypertension (RAS antagonists)</td>
<td>Intermediate Outcome</td>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Intermediate Outcome</td>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>MTM Program Completion Rate for CMR</td>
<td>Process</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Statin Use in Persons with Diabetes</td>
<td>Process</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Extreme and Uncontrollable Circumstances Policy (pp. 83-85)

- Extreme and uncontrollable circumstances such as natural disasters can directly affect Medicare beneficiaries and providers, as well as the Part C and D organizations that provide beneficiaries with important medical care and prescription drug coverage. An affected contract is identified based on whether its service area is within an “emergency area” during an “emergency period” as defined in section 1135(g)(1) of the Act and within a geographic area designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s).
- Under the 25 percent rule, contracts with at least 25 percent of their service area in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance area in 2021 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of
calculating the 2023 Star Ratings (thus, for 2023 Star Ratings, affected contracts will receive the higher of their measure-level ratings from 2022 or 2023 for the applicable measures).

- The numeric scores for contracts with 60 percent or more of their enrollees living in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance are excluded from: (1) the measure-level cut point calculations for non-CAHPS (Consumer Assessment of Healthcare Providers and Systems) measures; and (2) the performance summary and variance thresholds for the reward factor.\(^1\)
- As part of the 2023 Part C and D proposed rule, CMS has proposed to amend the relevant statute\(^2\) to specifically address the 2023 Star Ratings for HEDIS measures derived from the 2021 Health Outcomes Survey (HOS) only, by adding § 422.166(i)(12) to remove the 60 percent rule for affected contracts.
  - This would ensure that CMS is able to calculate the Star Ratings cut points for the three HEDIS measures derived from the HOS survey and is able to include these measures in the determination of the performance summary and variance thresholds for the reward factor for the 2023 Star Ratings, since the disaster adjustment due to COVID-19 for measures from the HOS survey is delayed one year given timing of survey administration and recall periods.

[p. 84]

- Most commenters supported the rating adjustments made under the extreme and uncontrollable circumstances policy.
- Some commenters suggested an expanded policy, such as continuing the COVID-19 adjustments (implemented for the 2020 measurement year for the 2022 Star Ratings) to the 2021 measurement year for the 2023 Star Ratings and expanding adjustments across multiple years and to disasters that have occurred but are not declared as a public health emergency by the Secretary.
- Changes to the extreme and uncontrollable circumstances policy would have to be implemented through rulemaking. CMS will take these comments into consideration as they develop future policies for the ratings program beyond the 2023 Star Ratings.

### Section 2. PQA Measure-Related Content

#### Changes to Existing Star Ratings Measures in 2023 (pp. 86-95)

CMS solicits feedback on new measure concepts as well as measure updates through the annual Advance Notice and Rate Announcement process. CMS also provides advance notice regarding measures considered for implementation as future Star Ratings measures. New measures and measures with substantive specification changes must be added or updated through rulemaking and must remain on the display page for at least two years prior to becoming a Star Ratings measure. In addition, CMS uses the Advance Notice and Rate Announcement process to announce non-substantive specification changes. CMS encourages stakeholders to provide comments directly to measure developers during their public comment periods. For example, NCQA and PQA regularly solicit public comments on new measures, changes to existing measures, and measure retirements.

1. **Statin Use in Persons with Diabetes (SUPD) Measure (Part D) (pp. 86-87)**

---

\(^1\) As described at §§ 422.166(i)(9)(i) and (i)(10)(i).

\(^2\) § 422.166(i).
- As discussed in the CY 2023 Advance Notice, PQA modified several exclusions related to the SUPD measure in the 2022 PQA Measure Manual.
- PQA refined the liver disease exclusion to include only beneficiaries with a diagnosis of cirrhosis during the measurement year since liver disease without cirrhosis is not contraindicated in recent guidelines.
- PQA removed dapagliflozin and empagliflozin single ingredient products from the measure because dapagliflozin and empagliflozin are sodium-glucose cotransporter 2 (SGLT2) inhibitors, which were recently approved for use in reducing the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure (New York Heart Association class II-IV) with reduced ejection fraction.
  - The SUPD measure denominator includes beneficiaries with diabetes mellitus (DM), which is determined by prescription claims for diabetes medications. Therefore, dapagliflozin and empagliflozin cannot be used as a proxy for DM diagnosis since they are now indicated for use in heart failure without DM.
- These changes are non-substantive updates because they are updates with no change to the intent of the measure or the target population.

[p. 87]
- Overall, commenters were supportive of the PQA updates to remove dapagliflozin and empagliflozin single ingredient products from the SUPD measure.
- A few commenters suggested that the SUPD measure drug exclusions should also be applied to the Medication Adherence for Diabetes Medications measure or the Medication Adherence for Cholesterol (Statins) measure as applicable for consistency.
- Some commenters also expressed concern with refining the liver disease exclusion to include only a diagnosis of cirrhosis since other forms of severe liver disease with diabetes comorbidity can be progressive leading to hepatotoxicity with statin use and therefore may be inappropriate.
- CMS will share comments received with PQA, the steward for the SUPD and Medication Adherence measures.
- CMS will implement the narrowing of the liver disease exclusion and the removal of the dapagliflozin and empagliflozin single ingredient products from the measure for the 2022 measurement year (2024 Star Ratings).

2. Medication Adherence for Diabetes Medications/Medication Adherence for Hypertension (RAS Antagonists)/Medication Adherence for Cholesterol (Statins)/Statin Use in Persons with Diabetes (SUPD) Measures (Part D). (pp. 87-88)
- PQA removed the Risk Adjustment Processing System (RAPS) RxHCC codes from all of its measures, including the medication adherence and SUPD measures in the 2022 PQA Measure Manual for better alignment of the diagnosis codes used for exclusions.
- Therefore, the RxHCC codes for identifying end stage renal disease (ESRD) will no longer be used to identify ESRD diagnosis in the PQA measures.
  - PQA will maintain the diagnosis codes for the exclusions in the PQA Value Sets.
- These changes are non-substantive updates since clinical codes for quality measures are routinely revised as the value sets are updated. The updates to the clinical codes do not change the intent of the measure or the target population.

[pp. 87-88]
- All commenters supported the removal of the RxHCC codes from these measures.
Some commenters requested that CMS accept supplemental data sources to identify appropriate exclusions, but CMS does not accept supplemental data.

CMS will continue to use the Common Working File (CWF) and Encounter Data System (EDS) to identify diagnoses based on ICD-10 codes.

The RxHCC codes will be removed from the measures for the 2022 measurement year (2024 Star Ratings).

### 3. Medication Adherence for Diabetes Medications/Medication Adherence for Hypertension (RAS Antagonists)/Medication Adherence for Cholesterol (Statins) Measures (Part D). (pp. 90-91)

- As previously announced in the CY 2021 Rate Announcement, CMS is currently testing the risk adjustment for socioeconomic status (SES) or sociodemographic status (SDS) of the medication adherence measures according to the PQA measure specifications, which were endorsed by the National Quality Forum (NQF). According to PQA, the SDS recommendations are the following:
  - All three adherence measures should be risk adjusted for SDS characteristics to adequately reflect differences in patient populations.
  - The measures should be adjusted for the following beneficiary-level SDS characteristics: age, gender, dual eligibility/LIS status, and disability status.
  - The measures should be stratified by the beneficiary-level SDS characteristics listed above to allow health plans to identify disparities and understand how their patient population mix is affecting their measure rates.
- CMS included stratifications by age, gender, dual eligibility/LIS status, and disability status in the Medication Adherence patient safety reports to Part D sponsors beginning with the 2019 measurement year.
- CMS solicited initial feedback on the implementation of the SDS risk adjustment for these Star Ratings measures for consideration in developing future policy and rulemaking. Substantive measure changes must be proposed and finalized through rulemaking.
- Currently, Part D enrollment used in the measures is adjusted monthly based on member-years to account for beneficiaries who are enrolled for only part of the contract year (for example, if a beneficiary is enrolled in the Part D contract for six out of 12 months of the year, the beneficiary will count as only 0.5 member-years in the rate calculation). The proportion of days covered (PDC) calculation is adjusted for Part D beneficiaries’ stays in inpatient (IP) settings and stays in skilled nursing facilities (SNFs).
- Moving forward when applying the SDS risk adjustment for the medication adherence measures, CMS is considering whether to no longer use member-years of enrollment. Instead, CMS would align with PQA measure specifications of continuous enrollment as defined by the treatment period and exclude beneficiaries with more than 1-day gap in enrollment during the treatment period.
  - According to PQA, the treatment period begins on the earliest date of service for a target medication during the measurement year and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period should be at least 91 days.
  - Therefore, a beneficiary may meet the requirements of enrollment in more than one contract in a measurement year but will not be adjusted using the member-years methodology.
  - In addition, CMS would no longer adjust for IP or SNF stays once the SDS risk adjustment is applied to the medication adherence measures. The PQA specifications do not include IP/SNF adjustments.
• A majority of commenters supported SDS risk adjustment for the medication adherence measures.
  o Some commenters requested information on how the CAI will be affected by this update.
  o Commenters requested clarification on the update from member-years to continuous enrollment.
  o A few commenters expressed concern with the proposal to remove the SNF/IP stay adjustment and its impacts to the medication adherence measures.
• CMS is still undergoing testing of the SDS risk adjustment, discontinuing member-years of enrollment and using continuous enrollment, and removing the IP/SNF stay adjustment.
• If CMS decides to propose these changes to fully align with the PQA-endorsed specifications, additional information from the testing would be provided through the rulemaking process.

DISPLAY MEASURES (pp. 95-99)

4. Concurrent Use of Opioids and Benzodiazepines (COB)/Initial Opioid Prescribing for Long Duration (IOP-LD)/Use of Opioids at High Dosage in Persons without Cancer (OHD)/Use of Opioids from Multiple Providers in Persons without Cancer (OMP) (Part D) (p. 98)
• PQA updated the measure specifications to exclude beneficiaries in palliative care during the measurement period for all of the opioid measures.
  o Excluding palliative care aligns with the Centers for Disease Control and Prevention’s Guideline for Prescribing Opioids for Chronic Pain since beneficiaries receiving palliative care have unique therapeutic goals and the risks and benefits associated with opioid use in palliative care may be different from the broader population.
• PQA removed RAPS RxHCC codes from all measures, including the opioid measures. Therefore, the RxHCC codes for identifying cancer will no longer be used to identify cancer diagnosis in the opioid measures to better identify active cancer-related pain.
  o PQA will maintain the diagnosis codes for the cancer exclusions.
• As a reminder, starting in measurement year 2020, CMS began reporting the Initial Opioid Prescribing Long Duration (IOP-LD) in the Part D Patient Safety reports.
  o CMS plans to add the IOP-LD measure to the display page for 2023 (2021 data) and 2024 (2022 data).
  o Once they gain more experience with the IOP-LD measure, CMS will consider adding the measure to the Star Ratings through future rulemaking.

[p. 98]
• Commenters were supportive of the palliative care exclusion.
  o A commenter requested clarification on how palliative care will be identified for these measures when managed outside of hospice care. CMS uses the PQA Value Sets for the measures, including the palliative care ICD-10 code.
  o CMS will share comments regarding the palliative care exclusion with the PQA.
• Palliative care will be added as an exclusion to the opioid display page measures for the 2022 measurement year (2024 display page).
• All commenters supported the removal of the RxHCC codes from these measures.
CMS will continue to use the CWF and EDS to identify diagnoses based on ICD-10 codes.

The RxHCC codes will be removed from all display measures for the 2022 measurement year (2024 display page).

CMS appreciates the comments received suggesting which opioid measures should be added to the Star Ratings. These comments will be carefully considered; adding measures to the Star Ratings must be proposed through the rulemaking process.

5. Antipsychotic Use in Persons with Dementia, Overall (APD)/Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH) Measures (Part D) (pp. 98-99)

- Like the code changes discussed above for other Part D Patient Safety measures due to PQA Measure Manual updates, CMS will no longer use the RxHCC codes in APD and APD-LTNH for identifying dementia diagnosis.
  - CMS will continue to use the CWF and EDS to identify the diagnosis of dementia based on the PQA Value Set ICD-10 codes.

[p. 99]

- All comments received supported the removal of the RxHCC codes from these measures.
- The RxHCC codes will be removed from all display measures for the 2022 measurement year (2024 display page).

**Potential New Measure Concepts and Methodological Enhancements for Future Years (pp. 99--109)**

1. Persistence to Basal Insulin (PST-INS) Measure (Part D) (pp. 105-107)

- PQA developed and endorsed a new measure in 2021, Persistence to Basal Insulin (PST-INS), to address the lack of quality measures to assess insulin persistence in measurement programs.
  - The Medication Adherence measure for Diabetes measure excludes beneficiaries with a prescription claim for insulin.
- The PST-INS measure assesses the percentage of beneficiaries who are 18 years of age or greater who were treatment persistent to basal insulin during the measurement year. A higher rate indicates better performance.
- PST-INS is a new Part D measure included in the Patient Safety reports provided to sponsors.
- CMS will fully align with PQA’s PST-INS measure specifications, and CMS solicited comments on use of PQA’s continuous enrollment specification, not member-years adjustment in the Patient Safety Reports.
  - According to PQA, continuous enrollment is defined as the treatment period and excludes individuals with more than a 1-day gap in enrollment during the treatment period.
- To be included in the denominator, beneficiaries 18 years of age or greater would have one or more prescriptions for basal insulin during the measurement year. Additionally, the earliest date of service for a basal insulin medication during the measurement year is the index prescription start date (IPSD). Therefore, a treatment period begins on the date of the IPSD and extends through whichever comes first: the last day of the measurement year, death, or disenrollment. The treatment period must be at least 91 days during the measurement period.
- Beneficiaries with gestational diabetes, who are in hospice, with ESRD, who have one or more prescription claims for mixed insulin, or who have one or more prescription claims for regular insulin during the measurement year are excluded from this measure.
The numerator includes the number of beneficiaries with continued use of basal insulin through the treatment period (beneficiaries with all refills for basal insulin occurring on or prior to the expected refill date).

CMS tested the PST-INS measure using year of service 2020 prescription drug event (PDE) data based on PQA’s measure specifications of continuous enrollment and with contracts greater than 30 beneficiaries.

- Overall, 80 percent of the eligible population for all contracts was persistent to basal insulin treatment and the rates were similar between MA-PD (80.16 percent) and PDPs (79.63 percent).
- There was a total of 841 Part D contracts using 2020 PDE data; however, after adjusting the measure for contracts greater than 30 beneficiaries, there were 703 contracts that met the eligibility requirements of the denominator.
- The mean overall rates for all contract types was 81.43 percent while the mean rate for MA-PD contracts was 81.65 percent, and the mean rate for PDP contracts was 79.06 percent.

Commenters were generally supportive with the intent of the PST-INS measure, but some commenters expressed concerns.

- A few commenters strongly disagreed with the PST-INS measure. Commenters requested that measure results be fully tested and validated prior to adding the measure to the Star Ratings.
- Commenters acknowledged the importance of improving insulin use among the Part D Medicare population; however, concerns were expressed with the measure’s methodology since insulin therapy is complex and response can be variable.
- Some commenters suggested developing a measure based on glycemic control of hemoglobin A1C regardless of medication regimen.

Commenters also requested the following changes be considered for PST-INS:

- Denominator require two or more fills rather than a single fill
- Include social risk factors
- Stratify data by age and consider limiting the age to 65 since older adults with multiple co-morbidities should have different targets and less medications per Standards of Medical Care in Diabetes
- Exclude beneficiaries in palliative care or hospice care
- Consider adjustments for SNF/IP stays
- Account for discontinuations or dose reductions made by a provider

Additionally, commenters were concerned with how the Reference Table was developed and requested further information on how it was derived.

- Commenters encouraged CMS to use caution when selecting the representative or comprehensive dataset to develop the Reference Table.
- CMS reminds stakeholders that CMS will refer to the PQA measure specifications and the NDC Value Sets developed by PQA to calculate the contract-level rates for the PST-INS measure.
- CMS will share specification related comments and concerns received with the PQA.
- CMS will begin reporting the PST-INS measure in the Patient Safety reports for the 2022 measurement year, and the measure will be added to the display page for 2024 (2022 data) and 2025 (2023 data).
- CMS appreciates the comments received, which will be carefully considered; adding measures to the Star Ratings must be proposed through the rulemaking process.
Section 3. Additional (non-PQA) Medication Measure Related Content

Potential New Measure Concepts and Methodological Enhancements for Future Years (pp. 99-109)

Driving Health Equity (Part C and D) (pp. 99-100)

- The National Academies of Sciences, Engineering, and Medicine (NASEM) define social risk factors (SRFs) as factors related to health outcomes that are evident before care is provided, are not the consequences of the quality of care, and are not easily modified by healthcare providers, such as DE status and income. There are often disparities in health care and outcomes between and within groups with and without SRFs.
- Currently, within-group SRFs are addressed in the Part C and D Star Ratings through the CAI and, in some cases, through measure-level adjustment.
- While the current approach to addressing SRFs has focused on adjusting for the within-contract disparities to address mis-measurement of performance in order to not inappropriately penalize or reward health and drug plans for factors that are difficult for them to control, CMS is currently exploring ideas on how plan sponsors can better identify and then address disparities in care provided to members with a particular SRF, with the ultimate goal of reaching equity by eliminating health disparities or differences in contract performance by SRFs, consistent with efforts under Executive Order 13985 to advance health equity.
- For certain Star Ratings measures, research to date shows that it is more difficult for most plans to achieve the same level of care for groups that are socioeconomically disadvantaged, disabled, or more complex compared to those groups with fewer SRFs.
  - This may be due to many factors, such as transportation issues, lower health literacy, communication challenges, discrimination, residential instability, and/or reduced compliance to medical regimens.
- CMS’ work has focused on identifying within-contract differences in performance to improve accuracy of measurement to remove incentives for plans to avoid caring for particular groups of beneficiaries.
- As part of CMS’ current work, they are focused on creating incentives to reduce existing disparities related to DE/LIS and disability status. Efforts related to stratified reporting and the development of a health equity index to further drive efforts to reduce disparities are described below.

[p. 100]

- There was unanimous support for CMS’s efforts to advance health equity.
- Some commenters urged CMS to allow plans adequate time to implement necessary changes and to use a transition period for implementation of changes that will require significant operational adjustments or new resources.
- Many of the commenters supported CMS’s proposals to bridge the equity gap through future stratification of additional quality measures in the Star Ratings program, and the addition of important screening and referral measures.
- Commenters mentioned additional social risk factors for CMS to consider.
- CMS appreciates the support from commenters and will take the comments into consideration as they continue to work to advance health equity.
1. **Stratified Reporting (Part C and D). (pp. 100-101)**

- CMS is expanding efforts to report differences in contract performance on additional Star Ratings measures for subgroups of beneficiaries with SRFs, including providing stratified reporting by disability, LIS status, and DE status through confidential reports in the Health Plan Management System (HPMS) to organizations and sponsors.

- Currently, contract-level HEDIS and CAHPS data stratified by race and ethnicity are publicly available on CMS’s Office of Minority Health website (cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting). There are national-level results by race/ethnicity, gender, and rural/urban status.

- For the three Part D Medication Adherence measures, CMS provides Part D contracts with a contract-level analysis workbook that includes stratified data by gender, LIS status, DE status, disability status, and age group. Additionally, other Part D patient safety measure reports provided to Part D contracts are stratified by beneficiary LIS status for informational purposes only.

- Not all Star Ratings measures can be stratified. CMS will stratify by LIS/DE/disability status for both process and outcome measures, as well as CAHPS measures when appropriate.
  - Certain variables, like LIS or DE status, may not have enough data in a stratum (subgroup) from the sample to have sufficiently reliable estimates to provide useful information by contract.
  - Stratification may not be appropriate for some measures that focus on evaluating plan operations and are not specific to particular beneficiaries, such as call center measures.

[pp. 100-101]

- Nearly all commenters supported confidential stratified reporting, with some citing that it would provide useful insights to identify performance gaps and facilitate quality improvement, drive health equity, reduce health disparities, support increased transparency of plan accountability, incentivize plan improvement, inform allocation of resources, and support plan choice for beneficiaries with social risk factors.

- A few commenters requested a preview period if the stratified reports are made public so plans can gain experience and confidence in the data before the data are used by beneficiaries for plan selection.
  - Some commenters expressed reservations about making stratified reporting results public, although several said they would support if information is clear, meaningful, and can be easily understood.

- Commenters also recommended additional variables for stratification.

- **CMS appreciates the support for stratified reporting and will begin sharing confidential stratified reports with contracts through HPMS this spring.**
  - CMS plans to start by stratifying scores for a subset of Star Ratings measures by LIS/DE versus non-LIS/DE and disabled versus non-disabled.
  - National performance scores will be provided for comparison, which can be used by contracts to inform and target their quality improvement efforts.

- **CMS will continue to explore additional variables for stratification and consider including stratified reporting as part of the display measures on CMS’s Part C and D Star Ratings webpage (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrug CovGenIn/PerformanceData) and on the Medicare.gov Plan Finder tool in the future to help make the data accessible to beneficiaries in their reviews**
and selections of plans. These data would help promote plan accountability for their enrolled populations.

2. **Health Equity Index (Part C and D). (pp. 101-103)**
   - CMS is developing a health equity index as a methodological enhancement to the Star Ratings that summarizes contract performance among those with SRFs across multiple measures into a single score.
   - Data are readily available to include disability and LIS/DE in a health equity index. CMS is considering what other data are available and what other SRFs might be appropriate to include over time.
   - As CMS further explores this option, they are considering what other data are available and what other SRFs might be appropriate to include over time.
     - CMS is considering the feasibility and utility of incorporating the Area Deprivation Index (ADI) into the health equity index.
   - The goal is to improve health equity by incentivizing contracts to perform well for socially at-risk beneficiaries, consistent with the objectives of Executive Order 13895.
     - An index would provide additional incentives to plan sponsors to reduce any disparities through care improvements by focusing resources on more effective interventions for at-risk beneficiaries.
   - The health equity index would look at a subset of the Star Ratings measures, such as the measures included in the CAI and CAHPS measures.
     - Currently, CMS intends to combine data over two years to increase measure-level reliability.
     - The distribution of contract performance on each measure for each SRF would be separated into thirds, with the top third of contracts receiving 1 point, the middle third of contracts receiving 0 points, and the bottom third of contracts receiving -1 point.
     - The index could then be calculated as the weighted sum of points across all measures included in the index using the Star Ratings measure weights divided by the weighted sum of the number of eligible measures to calculate the index.
     - Contract performance on the index would vary from -1.0 (performance was in the bottom third for each included measure) to 1.0 (performance was in the top third for each included measure).
     - A contract would need to be measured on at least half of the measures included in the index to receive an index value.
   - CMS is also considering replacing the current reward factor added to the overall or summary ratings with the health equity index.
     - Contracts that have a minimum percentage of enrollees with SRFs, such as half the contract median percentage of enrollees with SRFs, and meet a minimum score on the index, such as a score greater than zero, could receive a reward factor that could vary with higher index scores receiving a larger reward factor.
     - Currently, the Part C and D Star Ratings program includes a reward factor that incentivizes consistently high performance across measures.
     - The health equity index reward factor could replace the current reward factor to incentivize contracts to reduce disparities in care.
   - CMS notes that the Office of Minority Health (OMH) has been working to create the Health Equity Summary Score (HESS), which would be a quality improvement tool with a similar goal of improving health equity.
• CMS sought feedback on the utility of such an index and any considerations in its development, as well comments on the potential removal of the current reward factor for consistently high performance.

[pp. 102-103]

• The majority of commenters supported including a health equity index in the Star Ratings.
  o Many commenters would like more details related to the methodology and simulations of the impact of adding a health equity index to the Star Ratings.
  o Some commenters also requested the index be implemented slowly to allow for time to review the methodology and allow plans time to adjust and prepare for the implementation of a health equity index.
  o Commenters also suggested possible changes to the methodology for calculating the health equity index mostly focused around additional SRFs to include in the index.

• There was mixed support for implementing a health equity index in place of the current reward factor since it could reduce Star Ratings for some contracts.
  o A few commenters asked for a phased approach to implementing a health equity index and removing the current reward factor.
  o A few commenters asked for clarification around how a health equity index would differ from the CAI and asked whether it would be appropriate to replace the CAI with a health equity index.

• A small number of commenters addressed including ADI in a health equity index. While a few commenters supported including ADI, most did not.
  o Several concerns were raised including that ADI does not distinguish between areas that have both extreme poverty and extreme wealth; and that is not fully representative of systemic disparities for historically marginalized communities.

• CMS appreciates the support for including a health equity index in the Star Ratings and will take the comments into consideration as they continue its development.

• CMS also noted that a health equity index has different goals and methodology from the CAI and therefore it would not be an appropriate replacement for the CAI.
  o The CAI adjusts for within-group SRFs that are outside of a plan’s control.
  o A health equity index would focus on between-contract differences in performance for groups with SRFs capturing differences in performance across contracts.
  o Thus, a health equity index would reward contracts for performing well among groups with SRFs with the goal of incentivizing improved performance for these populations, leading to reductions in disparities.

• To provide Part C and D sponsors with information about how their contracts perform on the health equity index, CMS plans to make contract-specific index information available in HPMS later this year. The addition of a health equity index to the Part C and D Star Ratings would need to be adopted through the rulemaking process.