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Navigating the intersection of risk adjustment and the Medicare Star Ratings program

In the ever-evolving health care landscape, changes are on the horizon for the Centers for Medicare and Medicaid Services (CMS) Star Ratings Quality Measures program.[1] With the 2026 Star Ratings release, CMS will factor risk adjustment metrics into overall Star performance.

The integration of risk adjustment with quality measures will require health plans to break down silos. These efforts will foster collaboration and leverage data to improve performance. With major shifts underway, achieving and sustaining 4+ Stars will require organizations to further evolve an enhanced member-centric approach.

The evolution of the Star Ratings program

CMS introduced the Star Ratings program in 2007[2] to empower consumers with transparent information about plan performance. The program aimed to make it easier for consumers to make informed health care decisions.

The Star Ratings program has evolved significantly since then. It now serves as an assessment tool to measure the quality of care provided by Medicare Advantage (MA) and Part D prescription drug plans.

During its earliest stages, Star Ratings primarily focused on measuring clinical quality indicators such as preventive care, chronic disease management and patient satisfaction. CMS incentivizes quality improvement with financial bonuses to MA plans and certain value-based providers for delivering high-quality care.

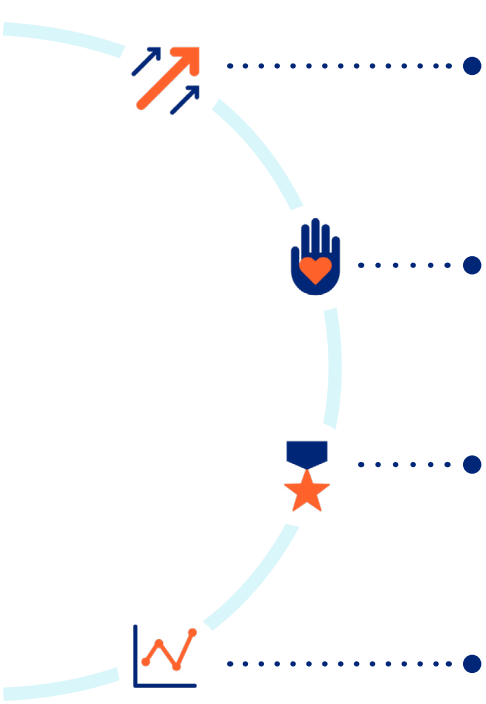
CMS continually adjusts the Star Ratings program by introducing new measures, altering existing measures and adjusting the rating methodology. These updates aim to better align with evolving health care standards and the needs and wants of members.

1. Centers for Medicare & Medicaid Services. 2024 Medicare Advantage and Part D Final Rule (CMS-4201-f).
2. Sprague L. The Star Rating System and Medicare Advantage Plans. National Health Policy Forum. May 5, 2015.

Moving beyond clinical indicators

Today, the Star Ratings program includes a more expansive set of measurement domains to drive quality improvement including member experience and satisfaction, customer service, complaint resolution and overall member ratings. Incorporating these aspects of the health care experience is intended to provide a more holistic evaluation of plan performance.

The Star Ratings program has also embraced a stronger emphasis on social determinants of health (SDOH) and health equity in recent years. CMS started considering SDOH measures, such as access to transportation, housing stability and food insecurity, to create a more comprehensive assessment of a plan's impact on member health. Health Equity Index (HEI) measurements – based on 2024 and 2025 measurement years – will be included in the 2027 Star Ratings release and will replace the program's Reward Factor.



Health Equity Index (HEI) could provide **a lift of up to a half a star** (0.0 to 0.4) towards overall performance

Health Equity Index (HE) measurement is embedded in every Star measure performance to **deliver a whole-person** model of care

HEI will **replace the current Reward Factor** (R Factor) for 2027 Stars or 2025 measurement year

HEI will be measured across 2 measurement years for **2 key demographical cohorts**: Low Income Subsidy/Dual Eligibility (LIS/DE) and Disability

The integration of risk adjustment

Another significant milestone in the program's evolution was the integration of medication adherence measures into the Star Ratings framework. Medication adherence includes assessing how well plans helped beneficiaries follow their prescribed medication regimens, especially for chronic conditions. This pivotal adjustment recognizes the critical role of proper medication management in overall health care outcomes and cost savings. And with the way Star Ratings has traditionally triple-weighted medication adherence, this addition significantly influences plan performance.

These tripled-weighted medication adherence measures become risk-adjusted for 2026 based on certain sociodemographic characteristics[3] – a move by CMS to account for the health status and diversity of a plan's enrolled population. Adjusting for members' complex health needs incentivizes health plans to cater to diverse patient populations and address health disparities more effectively.

3. Centers for Medicare & Medicaid Services. Advanced Notice to Medicare Advantage Organizations, Prescriptoin Drug Plan Sponsors, and Other Interested Parties.

1 Put members at the center

The perfect health care experience is different for everyone. That's the essence of Star Ratings. CMS built the program around a member-centric approach to care.

Plans with the most success listen to members' voices, understand demographics and design programs that target specific populations – sometimes down to the individual member.

At every turn, health plans should ask themselves if they are helping a member or those providing their care.

2 Break down siloes

Many health plans have siloed quality, analytics and risk management teams. In the coming years, coordination between these groups will be critical for increasing the complete and accurate reporting of Star Ratings measures and performance. Quality teams, for example, should take advantage of risk adjustment strategies to target the new medication adherence Star Ratings measures. Many of the components required to calculate HEI – now integrated into Star Ratings – come from risk adjustment files

3 Invest in member engagement

Member experience continues to weigh heavily within Star Ratings. And engagement before, during and after procedures can impact experience. Consider a more coordinated approach to member interactions. Avoid multiple touch points and overlapping outreach by designating a "quarterback" for each patient's care. Thoughtful care planning can improve outcomes, lower abrasion and enhance member experience and engagement.

4 Let engagement drive equity

Health plans should build on member experience and engagement work to drive health equity. CMS has publicly released a batch of health equity data, and plans have received their own HEI performance data for the past 2 years. Health plans can use plenty of available data to influence their HEI.

5 Prioritize data accuracy and completeness

Closing data gaps and improving accuracy should be a top priority for health plans. Flawed or incomplete data could temporarily inflate performance ratings, leading to a correction down the road. It may also negatively influence Star Ratings or put organizations at risk for negative audit findings. From a budgetary perspective, health plans should know where they stand and solve issues within a plan year to get proper credit for performance.

Risk adjustment and Star Ratings: Assessing and addressing

Risk adjustment is all about currently assessing the current health status of members and populations. Star Ratings (quality) is about addressing the quality and member experience of the same members.

The essence of care [4,5]

Diabetes and kidney disease

Health quality researchers identified one zip code in South Carolina as an extreme outlier in toe, foot and leg amputation rates among people with diabetes. That location also had a higher amputation rate among Black and low-income patients. Data showed significant SDOH factors, including limited food and public transportation access. Outdated clinical decision-making and delayed screenings also contributed to the problem. Fast forward: Once researchers identified the root causes, providers with more up-to-date clinical knowledge stepped in to offer research-backed care, including more advanced medication management and screenings.

Depression

When one provider organization that prided itself on its clinical quality learned their providers hadn't seen a patient with polychronic conditions in a year, they began to investigate. They discovered that depression and other medication conditions prevented this patient from leaving their home. Long before in-home assessments were common, the organization's medical director initiated home visits to ensure ongoing care and chronic disease management for this home-bound patient.

Medication adherence

A fixed-income senior with diabetes began cutting pills in half to make them last longer. Halving his dosage allowed him to save on prescription costs and avoid trips to the pharmacy, which were nearly impossible due to the onset of dementia. With the right SDOH analytics, seniors can be paired with a case manager to ensure medication adherence.

How can Optum help

The integration of risk adjustment and Star Ratings is imminent. To prepare, health plans need to foster collaboration, optimize data use and leverage expertise. These proactive efforts will achieve higher quality care and improve member outcomes.

As a consultant or solutions partner, Optum can help health plans stay on top of evolving risk adjustment and quality models. We offer risk adjustment and Star Ratings services, as well as data and analytics solutions for every health care program.

Optum can drive better risk and quality outcomes for members, health plans and providers. To learn more, visit optum.com/risk

4. Amputee Coalition. Fact Sheet. April 2016.
5. South Carolina Department of Health and Environmental Control. Eliminating Health Disparities.

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