

**EXECUTIVE BRIEFING**

# 2022 outlook: Plethora of ‘granular’ changes will drive MAOs’ stars strategy

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With continued emphasis on member experience, several new Part C measures and a directional shift to closing health care inequities, 2022 stands to be a landmark year in terms of changes to Medicare Advantage organizations’ star ratings strategies, industry experts tell AIS Health, a division of MMIT. “There is so much earth-shattering change on the horizon that most plans are just not thinking about,” cautions Melissa Newton Smith, executive vice president, consulting and professional services with Healthmine, Inc. “We’re worried that COVID took up way too much airtime and that plans have lost sight of the forest through the trees in MA a little bit.” While plans in recent years have had to grapple with only a few technical changes at a time, the 2022 measurement year — which determines the 2024 star ratings — brings an unprecedented amount of change “at a detailed, granular level” that will require a major shift in plans’ star ratings approaches, observes Smith. Changes include the addition of two new measures — Transitions of Care and Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions — the return of Plan All-Cause Readmissions, and an increased weighting for Controlling Blood Pressure. Moreover, this is the second measurement year in which the patient experience measures — i.e., those based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) and CMS administrative data — will have an increased weighting of 4, up from a value of 2 in 2020. “This shift in weightings is also consistent with what the plans are trying to achieve in terms of member retention and member engagement, so they’re already seeing that they need to start being more proactive in the way they engage members starting at the point of sale,” remarks Cary Badger, principal with HealthScape Advisors LLC. “We’re seeing elevated levels of churn of the membership and elevated levels of lapsing (i.e., when a member changes their mind before the effective date of coverage), and those weigh heavily on the minds of our clients because acquisition costs are pretty high,” continues Badger. “So we’ve been spending a lot of time with clients looking at ways to try to balance that equation of acquisition vs. retention vs. a positive experience, and they all kind of fit together and in full view of the CAHPS survey.” That survey, which is conducted from March to May, will reflect the patient experience in late 2021 and early 2022 and impact the 2024 star ratings. But by the time the survey comes out, “it’s almost a little bit late” to impact member churn, points out Alexis Seeder Levy, a managing

director with HealthScape. Because members' experience early on with a plan often correlates with what enrollment platform they used, HealthScape has helped clients identify the differences between sales channels and work on different outreach strategies to improve satisfaction rates. "So as an example, members coming from the EMO [electronic marketing organization] channel may make more complaints and be more dissatisfied, and that can impact CAHPS survey results," says Seeder Levy. "So looking at the various channels members come from and having very specific ways to interact with those members — to make sure they understand what they bought, that they're engaged with the plan, that they're happy with the plan — that's going to help with better CAHPS survey results in the future." This could result in, for example, different onboarding strategies depending on the channel through which the member enrolled. "For a member who came through the EMO channel, it's not going to be enough just to send them the standard welcome letter. They may need a welcome letter and a follow-up call to ensure that they received the letter, get them scheduled for a wellness visit and make sure the member understands their benefits," adds Seeder Levy. "You're probably going to need to take a bit of that higher touch with certain members than others, where you might know that they came through a direct agent with the plan who sat down with the member at the point of sale and did a lot of direct education on a plan's benefits."

### **New R&I Rules Took Effect on Jan. 1**

Complicating all of these efforts are changes to the definition of "qualifying individuals" in rewards and incentives programs that mean plans can no longer rely on HEDIS denominator and/or numerator status to target R&I participants and improve related star measures. Those changes took effect on Jan. 1, and noncompliance can result in sanctions, CMS clarified in a January 2021 rule. "People at health plans have a lot of competing priorities, stars being a high priority, and there has been an overwhelming preponderance of plans in MA that created these programs with a fairly narrowly appointed group of activities that focus on stars," explains Smith. "Given the robust adoption of rewards programs in MA in recent years, this type of clarity was inevitable," she continues. "CMS had to get clearer from a beneficiary protection standpoint to ensure that rewards programs continue to serve their purpose of motivating desirable health behaviors while stopping short of being cash inducements — either to enroll or remain with a plan and/or to respond to member experience surveys positively. It's a fine line, and one which we expect to see dramatically evolve in 2022 and 2023 as plans react to the clarity." Moreover, there has been some research indicating that the star ratings historically have not driven measurable quality differences between MA and FFS, and a recent Health Affairs study comparing performance on nine claims-based measures for MA and commercial enrollees found no "consistent differential improvement in quality for MA" vs. the comparison group. "There are plenty of arguments that could be made regarding the methods and assumptions used to develop this particular assessment," remarks Smith. "However, as even directionally relevant and/or potentially credible assessments such as this continue to surface, they add strength to MedPAC's longstanding recommendation that the program be significantly overhauled to better ensure it drives the desired improvements in quality, experience and cost. We see numerous options available [for] CMS to accomplish this without destabilizing the MA market."

## Health Equity Will Drive Future Changes

Meanwhile, “CMS is aggressively pushing progressive change” and has put health equity at the top of its agenda, says Smith. CMS Administrator Chiquita Brooks-LaSure “has openly told the nation that every decision she makes is going to be made through a lens of, ‘how does this advance health equity?’” With 2022 marking the introduction of race and ethnicity stratifications to five HEDIS measures and additional HEDIS modifications expected over the next several years, plans should prepare for more accountability down the road, advises Smith. “What if CMS stops incentivizing us on the gross contract level performance but starts to incentivize us on the degree to which we’re closing gaps based on race, ethnicity, language spoken? Those are all topics that most plans have dusted under the rug and tried mathematically to ignore at every turn possible. It’s no longer a directional idea to pursue, it’s going to be CMS’s way of seeing how well we’re doing,” adds Smith. As a result, plans should be considering investments in “the right technology, data interoperability, [and] meaningful provider engagement.” *By Lauren Flynn Kelly*