Align. Measure. Perform. (AMP)

Medicare Advantage Program Star Ratings & Recognition Methodologies, Measurement Year 2024

Background

IHA's Align. Measure. Perform. (AMP) Medicare Advantage program uses standard measurement to promote healthcare quality in Medicare Advantage, providing aggregated performance data that allow participants to understand how they're performing compared to the market and their peers. We partner with the California Office of the Patient Advocate to publicly report Medicare Advantage performance results using the measures and methodologies that the Centers for Medicare & Medicaid Services (CMS) uses for its star ratings system. Additionally, we recognize top performing providers and those demonstrating the greatest year-to-year improvement through our annual recognition awards. recognition awards.

This document describes the methodology for assignment of star ratings and for our recognition awards for Provider Organizations (POs) participating in the AMP Medicare Advantage program.

Assigning star ratings

A. Measure selection: AMP Medicare Advantage includes clinical measures used by the CMS Star Ratings program for health plans that are claims-based, able to be calculated using administrative data sources, and determined to be feasible for provider organization reporting. For measurement year (MY) 2024, the AMP Medicare Advantage measure set consisted of 13 measures that are a subset of the Medicare Stars measures that plans report to CMS. All measures are subject to IHA's vetting and validation process before being used for public reporting.

B. Calculating provider organization results:

- Health plan-submitted rates are aggregated for a provider organization across all contracted plans that participate in IHA's AMP Medicare Advantage program: Blue Shield of California, Kaiser Permanente, SCAN Health Plan, Sharp Health Plan, UnitedHealthcare, and Wellcare by Health Net. POs also have the opportunity to self-report data for aggregation. Both PO- and health plan-submitted rates are audited.
- Submitted rates must have a minimum denominator of 30 to be considered valid with the exception of the Plan All-Cause Readmissions (PCR) measure, which requires a minimum denominator of 150. To protect sensitive utilization data, where applicable, a health plan reporting threshold is also applied.

- If a measure has both a valid aggregated health plan-submitted rate and a valid PO-submitted rate, the better rate is reported.
- Results are subject to a participant review and appeals period. This fair and neutral appeals process ensure data accuracy and completeness.

C. Applying cut points to individual measures: IHA applies the same methodology and cut points identified by CMS. Stars are assigned to individual measures according to the cut points determined by CMS for that measure.

- Results for the "Plan All-Cause Readmissions" measure are reported by CMS such that a lower rate reflects a better outcome. However, this measure has been inverted to show that a higher rate reflects a better outcome.

D. Assigning overall star rating: To determine the overall star rating, IHA applies the methodology identified by CMS:

- Performance on the set of clinical quality measures is combined to calculate an Overall Provider Organization Medicare Advantage Star Rating. The score is calculated by taking a weighted average of the measure-level star ratings that are available for a PO. Intermediate outcome measures are given a weight of three times as much as process measures per CMS.
- The weighted average of the available individual measure star ratings is rounded to the nearest half-star for the overall scoring.
- POs that have reportable scores for at least half of the measures qualify for an overall star rating, while those that have reportable scores for fewer than half of the measures are not assigned an overall star rating.

Provider Organization Recognition

A. Medicare Advantage Five-Star and 4.5-Star Recognition: IHA recognizes provider organizations that earn an overall star rating of 4.5 and 5 using the approach identified above.

B. Medicare Stars Most Improved: IHA determines the "Medicare Stars Most Improved" recognition by identifying POs who improved their overall Medicare Star rating by a ½ star or more from the previous year. Please note that all measures, regardless of measure set changes between the two years, are used for comparing improvement in overall star ratings. IHA analyzes year-over-year score changes to monitor for any dramatic impacts that may require adjustment. Furthermore, a PO must have a valid rate for both measurement years to qualify.

MY 2024 AMP Medicare Advantage Measure Set

IHA used the following 13 measures to calculate an overall star rating for Medicare Advantage provider organizations:

1. Proportion of Days Covered by Medications: Renin Angiotensin System (RAS) Antagonists (PDCA)
2. Proportion of Days Covered by Medications: Statins (PDCS)
3. Statin Therapy for Patients with Cardiovascular Disease (SPC)
4. Eye Exam for Patients with Diabetes (EED)
5. Kidney Health Evaluation for Patients with Diabetes (KED)
6. Glycemic Status Assessment for Patients with Diabetes: Poor control >9.0% (GSD)
7. Proportion of Days Covered by Medications: Oral Diabetes Medications (PDCD)
8. Statin Use in Persons with Diabetes (SUPD)
9. Controlling High Blood Pressure (CBP)
10. Osteoporosis Management in Women Who Had a Fracture (OMW)
11. Breast Cancer Screening (BCS-E)
12. Colorectal Cancer Screening: Ages 51-75 (COLE5175)
13. Plan All-Cause Readmissions (PCR)

In the AMP Medicare Advantage measure set, measures indicated as Testing, First-Year, or Info Only are also collected during the measurement year but are not factored into the overall star rating for Medicare Advantage provider organizations.