Unlocking Quality Performance: Addressing Unmet Needs in Health Plan Care Management

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RISE®

Star Rating improvement: Impact on revenue

In 2025, Medicare Advantage plans receive an average annual bonus of

$372 per enrollee[1]

Increased Star Ratings yield significant revenue per member[2]:

3 to 3.5 Stars	**$500**
3.5 to 4 Stars	**$540**
4 to 4.5 Stars	**$210**

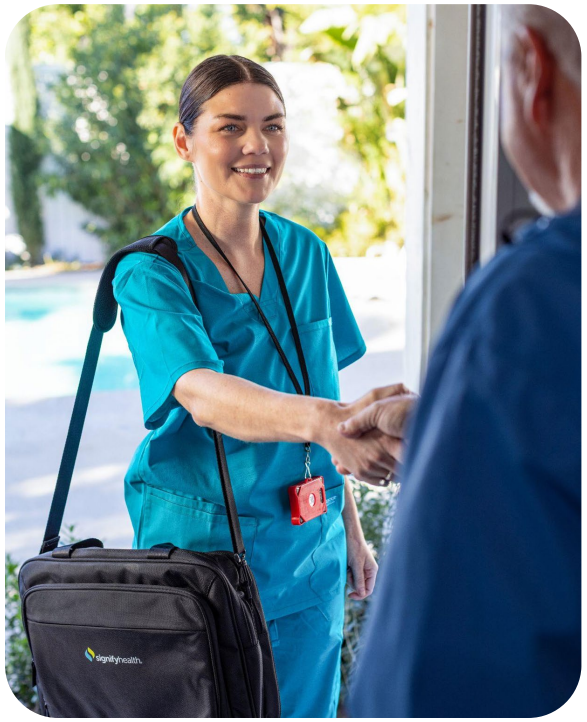
8%-12%

average increase in membership enrollment from 1 Star improvement in membership enrollment[3]

References available in the appendix.

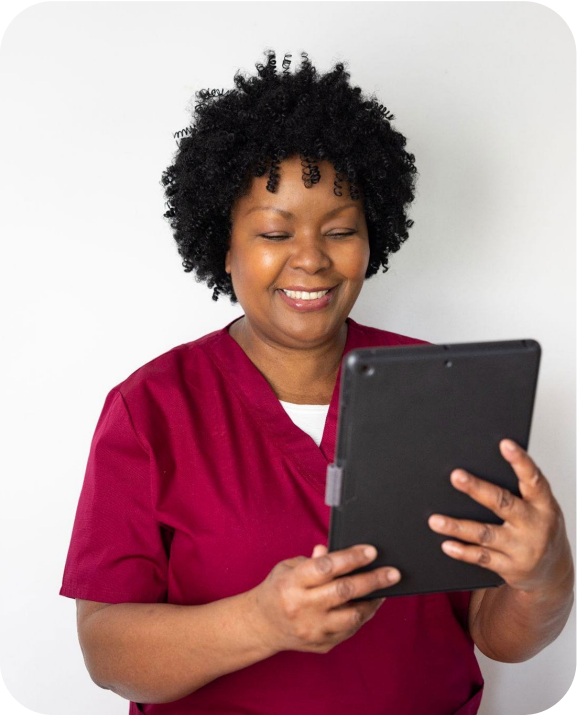
Level set on the fundamentals

MA plans (Part C) receive an overall star rating and a rating for five specific categories[4]



1. **Staying healthy**: Measures whether members got a flu shot or underwent various cancer screenings, and whether physical health improved after two years.
2. **Managing chronic conditions**: How often members with conditions such as diabetes or rheumatoid arthritis got the recommended tests and treatments.
3. **Member experience with the health plan**: Members rate overall satisfaction with plan.
4. **Member complaints and change in plan's performance**: Measures how often members have problems and choose to leave the plan. It also shows if the plan's performance has improved.
5. **Customer service**: Evaluates how well the provider handles customer requests.

MA Star ratings performance measures drawn from five sources[4]



1. **HEDIS®** (Healthcare Effectiveness Data and Information Set), created by NCQA (National Committee for Quality Assurance), is a set of performance measures designed to assess a plan's clinical effectiveness, accessibility to members, and use of resources.
2. **CAHPS** (Consumer Assessment of Healthcare Providers and Systems) is a survey developed under the aegis of the Agency for Healthcare Research and Quality and CMS to assess a patient's experience of care.
3. **HOS** (Health Outcomes Survey) is a survey sponsored by CMS that gathers health status data from Medicare beneficiaries.
4. **CMS** administrative data support measures such as call center performance, volume of complaints, and beneficiary disenrollment.
5. **Part D** measures developed by the Pharmacy Quality Alliance are now included among the measure for MA-PDP plans.

2026 Star Ratings were based on 33 measures[5]

Table 1. 2026 Star Ratings Part C Measures and Measure Weights

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

*Measure has a weight of 1 for the 2026 Star Ratings because it is considered a new measure.

Three new measures were added for 2026 Star Ratings (Part C)

1. Improving or Maintaining Physical Health
2. Improving or Maintaining Mental Health
3. Kidney Health Evaluation for Patients with Diabetes

References available in the appendix.

Poll question 1

How would you rank the 6 specific rating categories in terms of priority focus?

(1 being your organizations top priority, 6 being the lowest priority)

1. Staying healthy
2. Managing chronic conditions
3. Member experience with the health plan
4. Members rate overall satisfaction with plan
5. Member complaints and change in plan’s performance
6. Customer service

Roadmap for 2026

Barriers to closing quality gaps and meeting measures

Member engagement and access

- Disengaged from their care
- Access and affordability barriers
- Low utilization of preventive care
- Low health literacy

Data Gaps and Interoperability

- Siloed across different providers, systems (EHRs, claims)
- Difficulty collecting and integrating data from external sources (Supplemental files)

Provider Alignment and Workflow

- Overwhelmed clinicians unable to perform screenings and properly document
- Quality gap closure efforts not incorporated into clinical workflow

Member Attrition and Churn

- Members switching plans makes it difficult to track and complete long-term care plans for quality measures

Complexity of Measures and Regulations

- Measures are updated annually, requiring continuous adaptation and investment
- Rigorous auditing adding administrative burden

Resource Constraints

- Staffing limitations to conduct assessments, interventions
- Budgetary constraints to fund gap closure improvement programs
- Limitations in traditional settings

Poll question 2

How would you rank these 5 categories of potential quality gap closure barriers in order of importance to your organization?

(1 being the gap closure barrier your prioritizing the most, and 5 being the lowest priority)

1. Member engagement and access
2. Data Gaps and Interoperability
3. Provider Alignment and Workflow
4. Member Attrition and Churn
5. Complexity of Measures and Regulations

[If there is another barrier not covered here please submit it in the Q&A]

The Impact on Care Delivery and Health Outcomes

Root causes of MA member disengagement from care

Administrative Burdens

Prior authorization requirements and claims denials can cause members to abandon treatment[6]

Provider Networks

Many MA plans, particularly HMOs, have limited networks of participating doctors and hospitals[7]

Financial Strain

High out-of-pocket costs, which can lead them to delay or forego necessary medical care and prescription medications[8]

Health Literacy and Communication

Difficulty understanding complex health information and plan communications making it difficult to navigate their benefits[9]

Social Determinants of Health

Economic stability | Social support | Neighborhood environment | Social isolation | Transportation[10]

Medical Complexity

Multiple chronic conditions and medical needs make it challenging to for some to manage their health and stay engaged with their care plan[8]

References available in the appendix.

Root causes of provider misalignment and workflow gaps with MA members

Misaligned Incentives

Traditional fee-for-service (FFS) model, still prevalent in many health plans, creates a fundamental misalignment

Administrative Burden

- Electronic Health Records (EHR) and Quality Measures
- Billing and Claims Processing

Lack of Coordinated Data Sharing

- Identifying and Prioritizing Care Gaps
- Coordinating Care with Specialists
- Addressing Social Determinants of Health (SDOH)

71% of practices receive FFS payments[11]

Fewer than half **(46%)** receive value-based payments[11]

References available in the appendix.

The growing prevalence of chronic conditions

About **93%** of older Americans (age 65 or older) have at least one chronic condition[12]

Nearly **80%** of older Americans have two or more chronic conditions[12]

Leading causes of death among older adults in the U.S.[12]

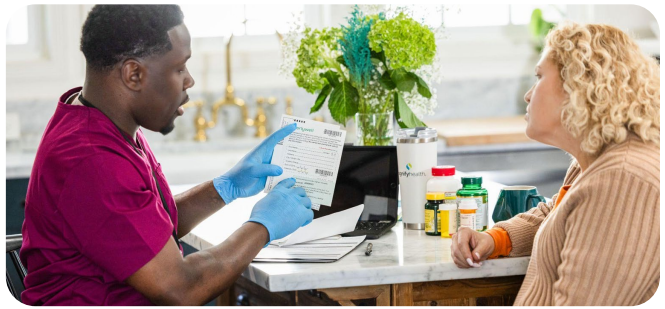
- Heart disease
- Cancer
- COVID-19
- Stroke
- Chronic lower respiratory diseases
- Alzheimer's disease
- Diabetes

References available in the appendix.

A new approach is needed to help enable appropriate screenings and preventive care

- Only **50%** of Medicare beneficiaries with diabetes are getting their eyes examined[13]
- Regular eye exams and timely treatment can delay or prevent up to **90%** of diabetes-related blindness[14]

- **1 in 7** U.S. adults have chronic kidney disease (CKD)[15]
- **34%** of people aged 65 years or older have CKD adults with diabetes has CKD[15]
- Among people with CKD, **61%** are not receiving the recommended testing[16]



- Approximately **7 in 10** Americans aged 65 to 75 are up-to-date with colorectal cancer (CRC) screening, with rates declining significantly after age 75[17]

References available in the appendix.

A New Approach to HEDIS® & CMS Stars Performance

In-home visits allow the time to provide education, close gaps and coordinate appropriate care

Bridging gaps between members, their PCP and Health Plan

Empowering members conveniently in their home to engage their health care

Supplementing providers relationship with health plan members

Supporting health plans member engagement and provider alignment strategies

Educate members of their current health condition(s) and ways to manage

Close gaps accessible in the home with applicable screenings and tests

Triage case management needs with comprehensive documentation and notifications

Facilitate care coordination between members' and their Primary Care Provider (PCP), or help them find a new PCP to close open gaps

Three visit options for closing quality gaps in the home

In-Home Health Evaluation + DPS Add-ons

Flagship In-Home Health Evaluation (IHE) plus Diagnostic and Preventive Services (DPS)

Quality Focused Follow-up Visit

Follow-up visit focused on closing open care gaps not addressed during the IHE

Standalone In-Home Quality Focused Visit

Standalone in-home visit focused on closing quality gaps for members (Initial IHE not required)

DPS Labs and Diagnostics Add-ons available:

Modular add ons

- Diabetic Eye Exam (DEE)
- Hemoglobin A1c (HbA1c)
- Fecal Immunochemical Test (FIT)
- Urine Albumin-to-Creatinine (uACR) / Estimated Glomerular Filtration Rate (eGFR)

Each visit results in complete and accurate documentation of all labs and diagnostics performed

Signify Health's Quality Focused Visit impacts

Core Quality Services

- BMI, Height, Weight
- REaL (race, ethnicity, language)
- Vitals
- Blood Pressure
- Blood Glucose Capture
- SDOH
- Mental Health Screening
- Alcohol Use, Smoking
- DME Dependency
- Immunization History
- Women's Health
- PCP Record and Scheduling
- Case Management Referrals

Diagnostic Labs and Preventive Services

Modular add ons

Contracted at the IHE add-on rate

- **DEE**
- **HbA1c**
- **KED** uACR, eGFR
- **FIT**

58%	HEDIS® Measures impacted
74	Post-IHE Member NPS
54%	Member scheduling rate
97%	DEE completion rate
40%	DEE abnormal results
23%	A1c abnormal rate
43%	Post-IHE FIT kit return rate

Signify Health. Data on file.

Post-visit data sharing and follow-up

Care coordination

- Where applicable member identification for case management referral
- Confirm or facilitate member connection with a PCP

Documentation and result notifications

Shared with the health plan
- Evaluation PDF
- HEDIS® Supplemental file
- Member and evaluation reporting

Shared with the PCP
- Summary of the visit
- Lab test results

Shared with the member
- Lab test results
- Care outreach for any abnormal results

Built to improve health plan performance on HEDIS® and CMS Star Ratings

Expanded Reach & Eligibility

Comprehensive quality services offering allows for broader member eligibility enabling you to reach more members for critical quality interventions

Flexible and Modular

Choose the service engagement that best aligns with your quality goals and budget

Direct Impact on Quality Metrics

Designed to improve your HEDIS® and CMS Star Ratings by efficiently identifying and closing key quality gaps

Enhanced Member Experience & Engagement

Tailored services administered conveniently in the member's home which helps reduce member abrasion while delivering a positive, comprehensive, and engaging healthcare experience

Driving Members Back to Primary Care

Connecting your members to a PCP facilitating continuity of care and proactive health management

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THANK YOU