American Academy
of Value Based Care

Medicare Star Diabetes Medication Adherence

Quick Reference Guide

2025

Medicare Star Diabetes Medication Adherence — Quick Reference Guide

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1. MEASURE SNAPSHOT

CMS Part D Star Measure: D08 – Medication Adherence for Diabetes Medications (MA-DM)

CMS Definition: Percentage of Medicare Part D beneficiaries aged **≥18 years** who receive **two or more fills** of a **non-insulin diabetes medication** (e.g., metformin, SGLT2 inhibitors, GLP-1 receptor agonists [oral], DPP-4 inhibitors, TZDs, sulfonylureas) and maintain **≥80% Proportion of Days Covered (PDC)** during the measurement year.[1,2]

Measure Weight: **Triple-weighted (3x)** under Star Ratings; MA **≈30% of total Part D rating**

Exclusions: Members in hospice, palliative care, ESRD, advanced illness/frailty programs, or long-term care facilities, **MA-DM specific exclusion:** Beneficiaries w/ diagnosis of **Gestational Diabetes** during the measurement year, **only one fill** of an eligible non-insulin diabetes medication during the measurement year or only filled **insulin** or other injectable treatments, as the measure focuses only on non-insulin oral agents.[1,2]

2025 Financial Impact: **$12.7 billion** in total Quality Bonus Payments (QPBs) across all MA-PD contracts[3]; **$372–$438 per enrollee annually** (depending on plan performance tier)[3]

Star Thresholds[1,4]

- **Adherent Patient:** PDC ≥80%
- **4-Star Plan:** >80% members adherent (historical 4 Star minimum)
- **5-Star Plan:** >88% members adherent (historical standard)
- Achieving 5 stars requires very high medical adherence(MA), typically requiring that over 90% of its members achieve the ≥80% PDC threshold
- 2024 analysis of the **2025 Star Ratings cutpoints** demonstrated high and rising thresholds for MA[4]
  - MA-DM with >90% adherence in 2024, in 2025 many plans needed >92% adherence to earn 5 Stars

CMS Cut Points:[1]

Prescription Drug Plan Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	<83%	83% – <86%	86% – <89%	89% – <92%	≥92%
PDP (Prescription Drug Plan)	<85%	85% – <87%	87% – <89%	89% – <92%	≥92%

Current Industry Performance (2024 → 2025 Trend)[1,4-6]

- National Performance Averages for D08: MA-PD 87% Star average 3.1, PDP 87% Star Average 2.7
- In 2025, **62%** of enrollees are in **4+ star contracts**, **down from 79% in 2023**

- **Only 1.8%** of members are in **5-star contracts**, reflecting increased adherence variability and plan stratification risk
- **MADM showed one of the steepest performance drops**, largely due to:
  - Rising cut points (up to 92% for 5 Stars)
  - Higher medication costs (SGLT2i/GLP-1 oral)
  - Increased social-risk effects incorporated through HEI

Rating Impact and Revenue

Star Rating	Benchmark Bonus	Rebate	Marketing Rights
5 stars	5% increase + QBP	70%	Year-round enrollment
4.5 stars	5% increase + QBP	70%	Standard windows
4 stars	5% increase + eligible for QBP	65%	Standard windows
<4 stars	None	50-65%	Limited

2. PDC CALCULATION

Formula[2]

$$PDC = \frac{Total\ days\ with\ medication\ available}{Days\ in\ measurement\ period} \times 100$$

Success Threshold: ≥80% PDC

Calculation Rules (Non-Negotiable)[1,2]

	Specification (2025 CMS/PQA Standard)	Operational Note
Measurement Start Date, Index prescription start date (ISPD)	ISPD is the first date a target medication was filled in the measurement year. The treatment period starts on the IPSD and ends on the earliest of: the last day of enrollment, death, or the end of the measurement year	Ensures sufficient observation window for annual PDC
Member Eligibility	Becomes eligible at 2nd fill within measurement year	Confirms chronic use vs trial
Data Source	**Part D Pharmacy claims only** (paid by plan)	Samples, cash-pays, 340B fills excluded
Supply Overlap	Overlapping days shift forward (no double-count)	Avoids inflated PDC (>100% errors)
	Specification (2025 CMS/PQA Standard)	Operational Note

Hospital or SNF Days	Excluded from denominator if covered stay >7 days	Avoids penalizing temporary non-access
Class Aggregation	**ALL** eligible non-insulin diabetes classes are aggregated into **ONE single "Diabetes" class.**	Therapy switch counts as continuous adherence e.g. Patient switches from metformin to an SGLT2 inhibitor to a DPP-4 inhibitor, their adherence is considered continuous
End of Measurement	Dec 31 or disenrollment date (whichever comes first)	Defines final denominator for PDC calculation

Included Medication Classes[1]

- Biguanides (Metformin, Metformin XR)
- Sulfonylureas (Glipizide, Glyburide, Glimepiride)
- DPP-4 inhibitors (Sitagliptin, Saxagliptin, Linagliptin, Alogliptin)
- SGLT2 inhibitors (Empagliflozin, Dapagliflozin, Canagliflozin, Ertugliflozin)
- Thiazolidinediones (Pioglitazone, Rosiglitazone)
- Meglitinides (Repaglinide)
- Oral glucose-dependent insulinotropic polypeptide/glucagon-like peptide 1 (GIP/GLP-1) receptor agonists (Semaglutide oral)

Injectable GLP-1 receptor agonists, insulins, and non-oral formulations are excluded from MA-DM.

3. CRITICAL BARRIERS & EVIDENCE-BASED SOLUTIONS[7-11]

Primary Adherence Barriers

Barrier	Patient Impact	Evidence-based Intervention
Forgetfulness/Routine disruption	≈35–40% of nonadherence in chronic disease cohorts; highly prevalent among older adults with T2DM	**90-day fills,** medication synchronization, automated refill reminders, pill organizers
Medication cost burden (SGLT2i, oral GLP-1 agents)	~1/3 cite affordability issues; diabetes meds among highest OOP burden in Part	**Avoid denials w/ Prior Authorization (PA)** review; $0-copay or tier-reduction programs; MTM cost review; low-income subsidy programs; generic substitution when appropriate
Adverse effects (GI side effects, urinary infections, hypoglycemia with SUs)	A leading cause of discontinuation in T2DM; GI and GU effects reduce tolerance to metformin/SGLT2i	**Switch within class or to alternative class; slow titration (e.g., metformin); pharmacist follow-up for AE mitigation**
Therapy complexity /polypharmacy	25–40% of older adults with diabetes take 5–10 medications daily; increased regimen complexity → Lower PDC	Reduce regimen complexity; once-daily agents; deprescribing where safe; MTM for reconciliation

Barrier	Patient Impact	Evidence-based Intervention
Access & logistics barriers	15–20% limited pharmacy access	Mail-order or home delivery enrollment
Low health literacy	Strong predictor of poor MADM performance in LIS	Culturally tailored education; teach-back method; simplified instructions

Disparity Gaps Requiring Targeted Action

Population Segment	Patient Impact	Interventions
Black and Hispanic beneficiaries	7–10 percentage-point lower adherence even in ≥4-star plans	Community pharmacist partnerships, trust-building outreach, BP self-monitoring support, $0-copay/tier-reduction/subsidy programs; MTM cost review
American Indian/ Alaska Native beneficiaries	lowest adherence rates, with gaps as large as **16%**	Bilingual refill messaging, family-centered education; $0-copay/tier-reduction/subsidy programs; CHR (Community Health Representative) collaboration
Southern states (CMS regions 4,6,8,9)	~13% higher non-adherence rates	Mail-order enablement, low-cost generic campaigns
Low-trust index (all groups)	One of the strongest adherence predictor	Continuity with same prescriber/pharmacy, motivational interviewing, pharmacist follow-up calls
Low-income subsidy (LIS) & dual-eligible beneficiaries	Cost-driven nonadherence disproportionately high; SGLT2i/GLP-1 classes amplify gaps	Subsidy optimization; MTM cost review; lower-cost therapeutic alternatives; refill coordination; HEI-focused outreach

4. HIGH-YIELD INTERVENTIONS TO IMPROVE MADM PERFORMANCE

High-Yield System-Level Interventions

Action/Strategy	Evidence Summary	Estimated PDC Increase	Operational Cue
Convert to 90-day supplies	Reduces refill gaps and improves continuity; strongly recommended by CMS and PQA for adherence-sensitive meds	+15–20%	Target members ≥2 fills behind schedule; consider 100-day supply, with health plan approval
Activate auto-refill & sync	Reduces refill gaps ≈60%; *refill disruption* Is a leading cause of PDC failure	+25–30%	Auto-enroll at the point of sale or MTM call

Action/Strategy	Evidence Summary	Estimated PDC Increase	Operational Cue
Enroll in text/app reminders	~10% lower adherence even in ≥4-star plans	+15–20%	Use HIPAA-compliant SMS or EHR alert
Generic substitution review	~13% higher non-adherence rates	+20–25%	Pharmacist review at every refill
PDC Discrepancy Reconciliation	Corrects issues where pharmacy data shows a short supply or early refill, but the clinical record suggests continuous use. Crucial for maximizing accurate PDC scores.	+5–10%	Flag claims where Days Supplied <80 or where a refill is **significantly delayed** past the expected end date; reconcile with clinical notes

Targeted Clinical & Behavioral Interventions

Action / Strategy	Target Cohort (How to Select)	Typical 30-day PDC Effect	Implementation Notes
Pharmacist MTM (telephonic/embedded)	Prior gaps, polypharmacy, near-miss cohort	**↑↑ adherence** **↑↑ persistence** ↑↑ on-time refills ↓ gap-days	Use weekly check-ins for high-risk; document barrier, action, outcome(MEAT)
Smart pill bottles /digital monitors	Forgetfulness-flagged, cognitively at-risk, caregivers engaged	**↑ adherence** ↓ late refills ↑ reminders ↓ manual calls	Limit to high-risk decile; pair with SMS/app reminders
Copay assistance /LIS navigation	OOP cost > plan benchmark; prior abandonments; LIS-eligible	**↑–↑↑ adherence via affordability** ↓ abandonment ↑ paid claims ↑ 90-day fills	Build navigator script; close loop with pharmacy on successful enrollment
Mail-order auto-enrollment	Members with travel /transport barriers; stable regimens	**↑–↑↑ adherence via fewer gap opportunities** ↓ gap days ↑↑ on-time refills ↑ delivery success	Offer at refill or MTM; confirm address/stability; align with 90-day supply
90-day supply conversion + refill synchronization	Any member with ≥2 fills and non-complex titration	**↑↑ adherence by reducing refill friction** ↓ Refill freq ↓ Stockouts ↑ PDC ≥80%	Default to 90-day when clinically appropriate; sync all chronic meds
Text/app reminders (HIPAA-compliant)	All non-adherent without cost or clinical barriers	**↑ adherence as an adjunct** ↓ late refills ↑ reminder response	Pair with synchronization /auto-refill; culturally/linguistically tailored messaging

5. WORKFLOW OPTIMIZATION[7-11]

Efficient adherence improvement requires coordinated action across clinical teams, pharmacies, and patients. High-reliability workflows reduce refill gaps, strengthen documentation, support HEI performance, and improve Star Ratings.

A. Clinical Workflow Optimization

- Embed **PDC dashboards and auto-alerts** for <80% or post-discharge members
- Enable **standing refill protocols** (90-day supply, mail-order conversion, automatic synchronization) for all clinically appropriate diabetes medications
- Review **near-miss (PDC 75–79%)** patients in weekly cross-team huddles
- Use **monthly multidisciplinary review** to close high-risk gaps, especially among LIS and dual-eligible members

B. Pharmacy Engagement Strategies

- Create **preferred pharmacy partnerships** with adherence incentives. Trigger **pharmacist MTM calls** for URGENT/PRIORITY tiers
- Schedule **10–14-day pre-refill outreach** to prevent gaps
- Integrate **community-pharmacy notes** into care-management platforms

C. Patient Education & Engagement

- Apply **brief motivational interview style scripts** that normalize barriers (cost, GI effects, regimen complexity)
- Provide **plain-language, bilingual handouts** explaining "PDC ≥80%" and why consistent diabetes control prevents complications (retinopathy, neuropathy, kidney disease).
- Tie adherence to **A1C stability and complication prevention**, which patients often understand more clearly than PDC metrics.
- **Celebrate adherence milestones** at each refill contact for reinforcement

D. Simplification of Medication Regimens

- **Streamline regimens** by selecting **once-daily agents** when clinically appropriate (metformin XR, many DPP-4/SGLT2 inhibitors)
- **Align refill schedules** across chronic conditions (diabetes, hypertension, statins) to reduce confusion and pharmacy trips
- **Deprescribe duplicates** or no longer indicated meds to cut pill burden
- Prefer **once-daily formulations** for eligible patients

E. Use of Technology & Reminders

- Auto-enroll **sub-80%** PDC members in **SMS/app reminders**
- Offer **smart caps** or **digital packaging** for forgetfulness/cognitive risk
- Send **portal or IVR confirmations** pre-refill; track completion monthly

- Analyze reminder data to adjust outreach volume

Risk Stratification Protocol

Tier	Improvement in Adherent Cohorts	Response Time	Recommended Actions
URGENT	PDC <40% OR Discharged <7 days OR ≥3 missed fills OR >10 active meds	<24 hours	Pharmacist call; refill + barrier review; coordinate with discharging provider; document MEAT & refill action
PRIORITY	PDC 40–60% OR cost concern OR recent side effect OR new therapy <90 days	48–72 hours	Outreach for refill sync, copay/LIS check, or ARB switch if ACE cough. Add reminder enrollment
ROUTINE	PDC 60–79% OR stable but suboptimal OR single barrier	Weekly review	Auto-refill setup; 90-day conversion; mail-order or reminder text; monitor PDC ≥80% progress
MAINTENANCE	PDC ≥80% AND no current barriers AND stable >6 months	Monthly	Reinforce adherence success; review at annual wellness or med sync cycle; document continued stability

Re-score all members monthly; automatic escalation if ≥10% PDC drop or hospital discharge event detected.

Sample Outreach Script

Initial Greeting & Normalize Common Barriers

"Hi [Name], this is [Your Name] calling from [Health Plan/Pharmacy].
I'm calling about your *diabetes medication*. I noticed there may be a gap in your refills, and I want to help make sure you have what you need to stay on track."

"Many of our members tell us that things like cost, side effects, or simply forgetting can make it hard to refill on time. What has your experience been?"

Follow-up flow:

1. **Listen → validate → summarize barrier**
2. **Offer tailored solutions** (e.g., 90-day supply, mail-order, copay help)
3. **Confirm next refill date + preferred pharmacy**
4. **Document resolution** (date/time, intervention type, new PDC trajectory)

6. DOCUMENTATION REQUIREMENTS

Accurate, time-stamped documentation is the single most important determinant of Star measure validation. Every adherence encounter should clearly show the who, what, when, and outcome — structured for traceability and MEAT compliance.[1]

Must-Have Elements

Element	Documentation
Member identifiers	Member ID + full medication name, strength, and dose
Current PDC status	Calculated % with start/end dates of measurement period
Barriers identified	List specific causes (cost, forgetfulness, side effects, access)
Interventions	Each action with an implementation date (e.g., auto-refill, 90-day mail, ARB switch)
Follow-up plan	Defined timeline (e.g., "Next PDC check in 30 days")
Outcome metrics	Post-intervention PDC or refill confirmation noted

Documentation Examples

COMPLIANT: "Member #12345 — metformin XR 500 mg daily; PDC 44% (1/1–6/30/25).Barriers: $47 copay → cost-related nonadherence; occasional GI upset; inconsistent morning routine.
Actions (7/1): LIS/copay review completed; switched to lower-cost generic formulation; titration plan reviewed for GI tolerability; 90-day mail-order initiated; enrolled in SMS refill reminders.

Follow-up: Next PDC check scheduled 8/1."

INSUFFICIENT: "Counseled on diabetes medication importance."

Clinical Documentation Optimization

- Use SOAP or **MEAT** structure for every contact:
  - *Monitor:* current PDC, refill gap, or BP trend
  - *Evaluate:* reason for non-adherence
  - *Assess:* patient readiness, barrier type
  - *Treat/Track:* intervention + timeline
- Auto-populate **PDC fields from claims data** in EHR to reduce error
- Attach **intervention type codes** (e.g., "MTM-1," "MAIL-90," "COPAY-AID") for audit traceability

Audit-ready documentation transforms adherence outreach from "soft counseling" into verifiable, revenue-protecting Star performance evidence.

7. PERFORMANCE MANAGEMENT

Continuous, data-driven monitoring ensures adherence programs stay aligned with CMS cut-points and financial targets. This measure is **100% determined by claims data** (pharmacy fills). There is **no manual chart review** or provider submission that can change the score. If the member didn't fill it, the score drops.

Use daily, weekly, and monthly review tiers to maintain focus and accountability across pharmacy, clinical, and quality teams.[1,3,4,7]

Daily Monitor List- Frontline Focus

Monitor List	Actionable Criteria	Operational Response
Near-miss members (PDC 75–79%)	Identify via daily PDC feed	Outreach within 48h; refill or mail-order enrollment (eligible for 5–10 pt lift)
Recent hospital discharges on RAS	≤7 days post-discharge	Verify med reconciliation + 90-day fill initiation
Upcoming refill windows	Fills due within 10 days	Trigger auto-refill or text reminder
Failed intervention follow-ups	No response within 7 days of outreach	Escalate to pharmacist/care coordinator

Focus on high-yield, high-risk members for rapid action

Weekly Dashboard Metrics

Metric	Target/Insight	Operational Response
Overall PDC trend	Track plan-level movement toward ≥88% adherence	Escalate cohorts trending <78%
Interventions completed vs pending	Ensure ≥90% follow-through within 5 days	Redistribute outreach workload
Cost per successful intervention	Target <$50 per member per quarter	Prioritize low-cost, high-yield methods (auto-refill, mail)
Provider-level performance	Identify top and bottom deciles	Targeted feedback, educational resources
Demographic gap analysis	Detect race/region PDC variance >5 pts	Deploy equity-focused outreach

Aggregate performance indicators for operational leaders

Monthly STAR Projections

Indicator	Calculation/Action
Current rate vs CMS cut-points	Compare to latest benchmarks
Members needed to "move the needle"	Estimate count to reach the next Star threshold
Revenue at risk	Project bonus variance per 1,000 members
Resource allocation ROI	Rank interventions by PDC impact per $ spent

Link performance metrics to financial and quality outcomes.

Consistent daily tracking, weekly analytics, and monthly Star projections convert adherence management into predictable financial performance — turning data visibility into sustained Star performance.

8. FINANCIAL MODELING

Investment Requirements (per 1,000 members)

Indicator	Calculation / Action	Estimated Annual Cost
Personnel	0.5 FTE Pharmacist ($65K) 1.0 FTE Pharmacy Tech ($35K) for adherence outreach and monitoring	$100K
Technology	Tools for PDC dashboards, refill alerts, SMS outreach, mail-order automation. Estimate count to reach the next Star threshold.	$50K
Materials	Member engagement packets; multilingual diabetes education; adherence reminder materials; Project bonus variance per 1,000 members	$10K
Resource allocation ROI	Rank interventions by PDC impact per $ spent	**≈$160K per 1,000 members**

Real-world example scenario

Scenario: A 50,000-member MA-PD plan launched a pharmacist-led adherence program in Q1 2025.

Investment: $8 million (total scaled).

Interventions: 90-day conversion, auto-refill activation +synchronization, and copay LIS navigation + tier reduction + copay assistance

Outcomes at 12 months:

- RAS PDC rose from 76% → 87%
- Plan Star rating improved from 3.5 → 4.5
- Annual quality bonus increase ≈ $18 million
- Net ROI ≈ 5.1× within the first year

Operational Insight: The plan retained over 96% of members year-over-year and cut avoidable hospital admissions by ~18%.

Targeted investment in MADM generates one of the highest ROIs across all Star Rating measures, often approaching a 5:1 return within the first year. This makes diabetes medication adherence a core lever for financial sustainability, clinical quality, and equity performance in Medicare Advantage.

In real-world Medicare Advantage programs, that translates to **multi-million-dollar quality bonuses and measurable reductions in avoidable hospitalizations**, making MADM one of the **highest-yield investments in the Star Ratings portfolio.**

9. REGULATORY REQUIREMENTS

A. Documentation Optimization[1,2,12-14]

Ensure the following documentation and system controls are in place to meet VBC comprehensive documentation standards:

- **Algorithm validation:** Quarterly auditing of PDC calculation logic to confirm no member exclusion, correct denominator/ numerator alignment, and timely claim capture
- **Data integrity:** Daily checks for claim feed completeness, missing days-covered fields; monthly reconciliation of pharmacy claim to PDC summaries
- **Documentation audit trail:** All intervention-outreach actions must be timestamped, linked to member ID, with barrier, action, and outcome clearly noted
- **Appeal process:** Dedicated team with documented **72-hour response protocol** for member/plan appeals of adherence status or PDC adjustments
- **Record retention:** Maintain all relevant data for **at least 10 years**, including claims, intervention logs, analytics output, and dashboards

2025 – 2026 Changes to Monitor[1,2,12-14]

- The **Health Equity Index (HEI)** or equivalent measure is now a formal part of the Star Ratings framework for measurement year 2025 (impacting the 2027 rating) and will carry increasing weight
- **Cut-points raised** for many Part D adherence and outcome measures in 2026, meaning the bar for “4-star” and “5-star” is higher (by ~3-12 percentage points in some cases)
- **Telehealth interventions** and virtual pharmacist encounters are now explicitly counted as valid “interventions” under outreach/engagement components and should be captured in workflow logs
- **Increased CMS focus on disparity reduction** means plans must stratify adherence by demographics and SDOH (social determinants of health) and document targeted corrective actions

Implications for MADM Programs[1,2,12-14]

- **Prioritize Clinical Complexity Over Cost Alone:** Cost remains important, but for many nonadherent members (including many LIS beneficiaries) basic affordability interventions have already been applied. Remaining gaps often stem from regimen complexity and tolerability challenges, particularly with SGLT2 inhibitors and oral GLP-1 receptor agonists
  - Direct MTM and pharmacist time toward members with:
    - Polypharmacy (five or more chronic medications)
    - Complex diabetes medication schedules
  - Key focus areas
    - Regimen simplification using once-daily dosing when appropriate
    - Fixed-dose combination options when clinically appropriate
    - Active management of adverse effects such as metformin GI intolerance
- **Integrate Health Equity Index (HEI) as a Core Operational Requirement:** MA-DM resources should be concentrated on LIS beneficiaries, dual-eligible members, and Black and Hispanic beneficiaries. Plans must document meaningful cost and access interventions
  - Copay support for 90-day supplies
  - Preferred generic substitutions
  - Mail-order or home delivery for members facing transportation or stability barriers

- **Move From Auto-Refill to Full Medication Synchronization:** Make medication synchronization the default for members with stable regimens. Sync non-insulin diabetes medications, hypertension medications, and statins to one pickup date. Synchronization addresses forgetfulness, access barriers, and regimen complexity across all three triple-weighted adherence measures simultaneously
- **Proactively Manage the Near-Miss Cohort (PDC 70–79 Percent):With** MADM cut points approaching or exceeding 92 percent, converting near-miss members is essential for 4- and 5-Star attainment
- Flag members as the top-priority operational segment. These members often need only one timely refill to reach adherence. Assign the most intensive outreach such as pharmacist calls, MTM sessions, LIS navigation, and refill synchronization. Track weekly conversions from near-miss to adherent status to optimize Star Rating impact

KEY TAKEAWAYS

1. **MADM is triple-weighted and high stakes:** Medication Adherence for Diabetes Medications (MA-DM, D08) is a 3x weighted Part D Star measure, contributing **~30% of total Part D rating**
2. **Cut points are very high (and rising):** To earn 5 Stars, plans now typically need ≥92% of members adherent (PDC ≥80%)
3. **PDC is class-based and switch-tolerant**: PDC looks at all non-insulin diabetes pills as one class.
4. **Key barriers are cost, complexity, and disparities**: Most nonadherence is driven by cost (SGLT2i/GLP-1), regimen complexity, side effects, and access/logistics
5. **High-yield levers are well known and repeatable** 90-day supplies, auto-refill + med sync, mail-order, LIS/copay help, and pharmacist MTM consistently deliver the largest PDC lifts
6. **Workflow and risk tiers must be explicit:** Near-miss members (PDC 70–79%) are the most cost-effective group to convert to adherent
7. **Comprehensive Documentation** Every contact should show who/ what/ when/barrier /intervention /outcome using MEAT/SOAP structure and standard codes (MTM-1, MAIL-90, COPAY-AID, SYNC-Rx)
8. **Financial ROI is large and fast:** A focused MADM program (pharmacist-led, tech-enabled) can yield ≈5:1 ROI within one year
9. **HEI makes equity work non-optional:** Plans must stratify MADM by SRF groups, document targeted actions, and show gap closure across LIS, dual-eligible, and minority members to protect future Star ratings

MADM adherence remains the most profitable, measurable, and controllable driver of Star success. When coupled with equity-focused outreach and airtight documentation, it delivers unmatched ROI, sustained audit compliance, and long-term competitive advantage in the 2026 Part D environment.

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