The Medicare Environment in 2024

Presentation to the Association for Community Affiliated Plans (ACAP)

April 2024

EXPERTS WITH IMPACT™

FTI CONSULTING™

TODAY'S SPEAKERS

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FTI Consulting at a Glance

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(1) Number of total shares outstanding as of February 15, 2024, by the closing price per share on February 22, 2024.

Healthcare Payers | Capabilities Overview

MEDICARE ADVANTAGE AND RISK ADJUSTMENT

- Special Needs Plans' Model of Care, Operational, Implementation support and execution
- Market strategy
- FFS and HCC coding training, interim staffing and audit support
- Auditing/Reconciling claims
- Encounters for reimbursement
- Creating/Auditing RAF payment projections and adjustments
- Target patients for recapture
- Development of data stores and “bridge applications”
- Ensuring effective governance practices
- Reviewing and developing controls, best practice policies and procedures
- Support for disputes and investigations conducted by CMS, OIG, DOJ and other regulators
- Expert witness support and testimony

COMMERCIAL AND ACA MARKETPLACE

- ACA risk adjustment and operational risk assessments
- Prevailing fee studies
- IBNR reserve setting
- Market expansion strategies and utilization benchmarks/road maps
- ACO financial and strategic planning
- Actuarial MLR and rate support
- Managed Care contract negotiations
- “Black Box” network fee analysis
- M&A diligence analysis and audit and compliance reviews
- Employee health plan assessments
- Value Based Care initiatives

MANAGED MEDICAID

- Management and operational consulting including capabilities assessments
- End to end competitive procurement support
- Regulatory and policy analysis
- Mental Health Parity
- Health equity and health-related social needs
- Vendor procurement
- Managed Medicaid rate setting strategic support
- Reporting and analytics evaluations
- Contracting strategic consulting
- Advisory services to support pathway to Managed Medicaid programs
- Provider-owned Managed Medicaid and PACE strategies
- Strategies to support identification, stratification and prioritization of chronic illness and high-cost patients

Agenda

The Medicare Environment in 2024

- Regulatory and Enforcement Environment
- The New Risk Model - v28
- Dual Eligible Environment
- Model of Care
- Health Equity Index
- Key Star Ratings Changes
- Q&A

Poll Question

Which of the following do you have?

A. Medicare Advantage Plan

B. Dual Eligible Special Needs Plan (D-SNP)

C. Both

D. None

Regulatory and Enforcement Environment

Recent Enforcement Actions

Public DOJ Investigations *(Examples)*

- United Health Group
  - Allegations related to chart reviews, deletions
- Independent Health
  - Allegations related to addenda
- Elevance
  - Allegations related to chart reviews, deletions
- Kaiser
  - Allegations related to chart reviews, addenda, queries
- Plans, vendors, and providers are targets

Known Focus Areas

- Retrospective Chart Reviews
- In Home Assessments
- "Two-Way" Review
- Addenda
- High Risk Diagnosis Codes (OIG RADV and toolkit)

Recent Settlements and Corporate Integrity Agreements

- In fiscal year 2023, healthcare fraud remained a leading source of FCA settlements and judgments (DOJ Press Release)
  - Approximately $1.9 billion in recoveries in 2023
- Cigna ($172 M settlement and 5 Year CIA)
  - Allegations related to chart reviews, in-home assessments, and deletions
- Martins Point Healthcare ($22.5M settlement)
  - Allegations related to chart reviews
- Note: Freedom Health 2017 Settlement and CIA was the first health plan CIA related to MA

Medicare Advantage remains a DOJ top enforcement priority and DOJ continues to reinforce it as a priority

OIG Workplan

Medicare Advantage

- **Medicare Part C High-Risk Diagnosis Codes Tool Kit (Revised - 2024):**
  - 2023 Released toolkit focus on 8 categories of high-risk codes
  - Update the toolkit
- **Audits of Medicare Part C Health Risk Assessment Diagnosis Codes (2025)**:
  - Focus is on enrollees whose diagnoses, reported only on HRAs
  - Also updating 2023 report on HRAs (2024)
- **Medicare Advantage Organizations' Efforts To Reduce Racial and Ethnic Health Disparities (2025):**
  - Identify the actions that MAOs have developed to reduce racial and ethnic disparities in access to care, quality of care, and health outcomes

Medicaid Managed Care

- **States' and MCOs' Compliance With Mental Health Parity Requirements (2024)**
  - States and their MCOs conducted the required analyses and met MH/SUD parity requirements
- **Medicaid Managed Care Organizations' Denials**
  - Two prior reports focused on MCOs and states
  - Update focused on denying access to requested medical and dental services, behavioral health services, and associated drug prescriptions that required prior authorization
- **State Medicaid Agencies' Perspectives of Managed Care Plans' Referral of Fraud (2025):**
  - "OIG and CMS have ongoing concerns about States' and plans' efforts to combat fraud, including a lack of fraud referrals."
  - Volume and quality of the fraud referrals made by MCOs, incentives for MCOs to refer fraud
- **Maternal Health Care (2025):**
  - Evaluating Availability of Maternal Health Care Providers in Medicaid Managed Care

Prescription Drugs

- **Audit of Diabetes Drugs (2025):**
  - Part D
  - Medicaid
- **Medicaid MCO PBM Pricing (2024):**
  - Spread pricing
  - Oversight of Medicaid MCOs to ensure accountability over amounts paid to PBMs
- **States' Collection of Rebates for Drugs Dispensed to Medicaid MCO Enrollees (2024)**
  - Evaluated a number of states previously (e.g. TX, IA, NV, WA, HI, NJ, AZ, NM)
  - Determine whether States are collecting prescription drug rebates from pharmaceutical manufacturers for Medicaid MCOs
  - Drugs dispensed by Medicaid MCOs were excluded from this requirement until March 23, 2010

The New Risk Model – v28

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Recent Notable MA Changes (CY 2024, CY 2025 Final Rule and Other Potential Changes)

CY 2024 Change to Risk Adjustment

- Three year-phase in of Risk Adjustment Model V28 (hybrid V24/V28 model in interim)
  - Significant changes in Risk Scores for prevalent conditions, including:
    - Constraining the values of all Diabetes (same value for Uncomplicated and with Complication)
    - Constraining values of CHF
  - Removing approximately 2,200 diagnoses codes from risk adjustment, including:
    - Protein Calorie Malnutrition (HCC 21) and Angina Pectoris (HCC 88)
- Changes to complexity and breadth of Risk Adjustment Data Validation (RADV) audits and Related Financial Impact
- Notable V28 Impact and Other Changes Affecting D-SNP Plans
  - Estimated to have unfavorable risk score impact on dual members and members with the greatest number of HCCs
  - Risk score impact expected to vary significantly by Geography and Plan
  - Changes to threshold for FIDE SNPs to qualify for frailty adjustment and frailty factor member-level weights

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CY 2025 Final Rule

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Other Potential Program Changes

- Telehealth Coverage: Consolidated Appropriations Act of 2024 did not include extension of Medicare telehealth flexibilities set to expire at the end of 2024

Poll Question

Who is collaborating with your state(s) on the State Medicaid Agency Contract?

A. Considerable collaboration

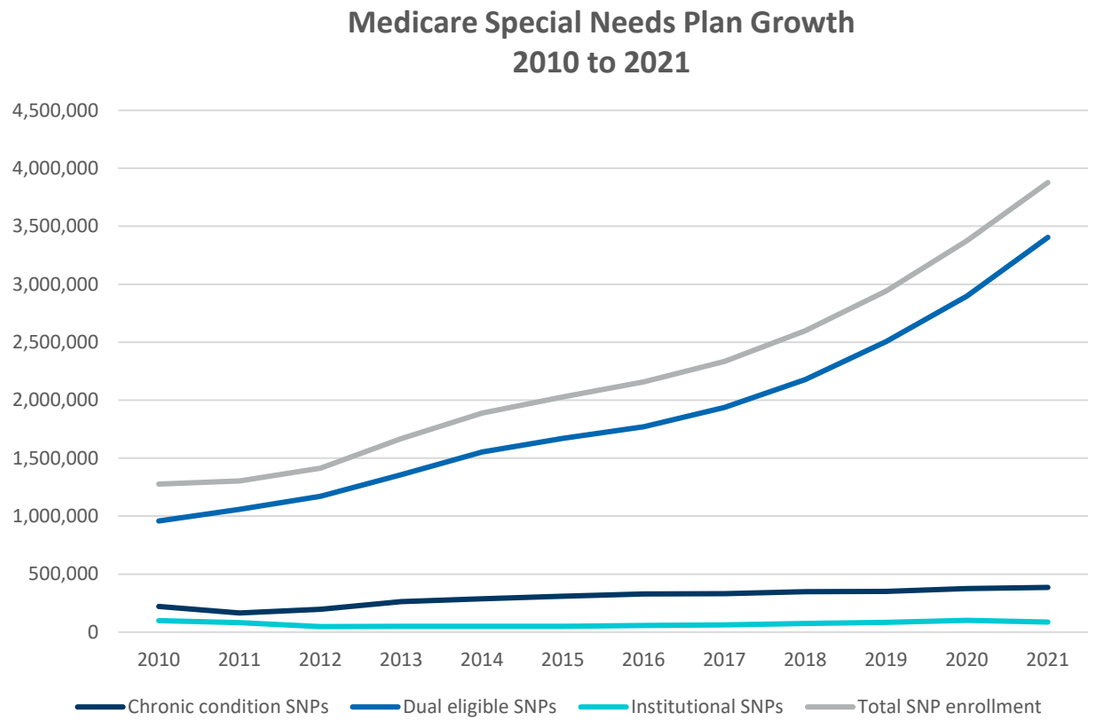
B. Some collaboration

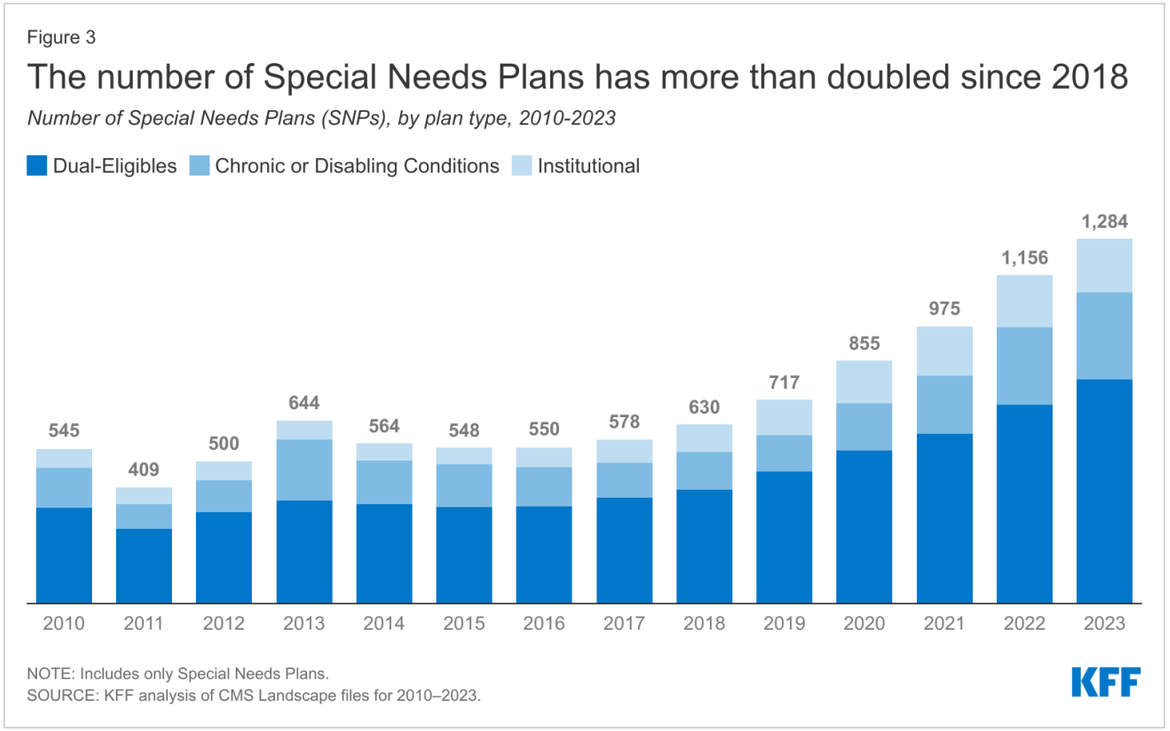
C. No collaboration

Dual Eligibles Environment

Medicare Special Needs Plan Growth

There has been significant growth in special needs plans beginning in2019. This trend is expected to continue as Congress and CMS policies favor more integration for Dual Eligibles.





https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-special-needs-plans

Federal Initiatives Impacting Dual Eligibles

Both the federal Executive and Legislative branches of government have initiatives that strongly promote integration of Medicare and Medicaid services for Dual Eligibles, increase Dual Eligible outcomes, and reduce the number of Look Alike MAOs.

Initiative	Origin	Description
Delivering Unified Access to Lifesaving Services Act of 2024	US Senate	▪ Requires each state, with support from CMS, to select, develop and implement a comprehensive, integrated health plan for dual-eligible beneficiaries. States can create a new system or build off of existing coverage options. ▪ Reduces beneficiary confusion by reducing "look-alike" plans which target dual eligible beneficiaries for enrollment but don't provide any coordination,
Health Equity Index	CMS	▪ Plans who meet the Health Equity Index metrics will be eligible for up to .4 increase to Star ratings. This replaces the Reward Factor for consistently high performing MAO. ▪ Full .4 increase is available for MAO with >50% Dual Eligibles. This can create new competition through targeting Dual Eligibles into plans and the establishment of new D-SNPs.
Reduction of DSNP Look Alike Medicare Advantage Plans	CMS (and Duals Act)	▪ Since 2022, CMS will not approve new DSNP Look Alike MAOs. ▪ Beginning 2025, DSNP Look Alike MAOs with 70% or more Dual Eligibles will be required to transition them to other MAO plans (unless in existence for under 1 year or with fewer than 200 members).

https://www.cassidy.senate.gov/wp-content/uploads/2024/03/Duals-Legislation-One-Pager-Final.pdf
https://www.cms.gov/files/document/cy25dsnplookaliketransitionmemo040524g.pdf

Developing a Model of Care

There are three primary steps to developing a model of care that is not unlike developing a Medicaid RFP response. The good news is that you are not competing with other plans to get CMS approval.

- MOC content must align with the NCQA Scoring Guidelines for the applicable contract year.
- Define the response strategy including what to commit to and how not to over-commit.
- Listen to the CMS Model of Care trainings
- Proof points, win themes, and differentiators are not needed for CMS approval.

- The NCQA Scoring Guidelines detail how they will assign a score for each Model of Care Element.
- Not unlike a procurement mock scoring process, an independent review of the MOC narrative to the Scoring Guidelines is important to maximize points.
- The Model of Care Attachment A (Matrix) should also be reviewed as the requirements can differ slightly from the Scoring Guidelines

- The Model of Care Matrix must be submitted with the Model of Care.
- The Matrix cross walks the Model of Care elements to a page number and section for easy reference for NCQA during their scoring process.

Model of Care Elements

The Model of Care (MOC) is a CMS requirement for approval of Medicare Advantage Special Needs Plans (SNP) that allows MCOS to focus on a subset of the Medicare population and establishes more robust requirements.

Chapter 1: Description of the Population to be Served

- Description and attributes of the D-SNP population
- The specific health conditions among duals in the service area
- Health disparities and social determinants of health factors
- Most vulnerable enrollees - sub population with the D-SNP

Chapter 2: Care Coordination Model

- Staff structure and deployment
- Health Risk Assessment approach with high-level discussion of the tool
- Annual face-to-face care coordination encounter
- Individualized Care Plan
- Interdisciplinary Care Team
- Care Transition Protocols

Chapter 3: Provider Network

- The specialized expertise that the Plan provider network offers to meet the needs of the population presented above
- Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols
- Training for the provider network related to CPGs, the MOC, transition protocols and expectations related to provider involvement in care coordination

Chapter 4: Quality Measurement and Performance Improvement

- Quality Performance Improvement Plan
- Goals and health outcomes to assess the MOC and plan performance
- Measuring member experience
- Ongoing Performance Improvement Evaluation
- Communication of the Quality outcomes and program evaluation

Chapter 1 Considerations: Dual Eligible Demographics and Characteristics: National View

CMS requires a D-SNP to describe the attributes of a given plan's D-SNP population, including health disparities and HSRNs. Then the most vulnerable population within the D-SNP must be identified. CMS places emphasis on ensuring the data collected is not generic, but specific to the D-SNP's population.

Demographic Characteristics of Dual Eligible and Non-Dual Medicare and Medicaid Beneficiaries, CY 2021

Demographic characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Gender						
Male	41%	48%	37%	41%	41%	47%
Female	59	52	63	59	59	53
Race/Ethnicity						
White/non-Hispanic	53%	60%	50%	52%	58%	82%
Black/non-Hispanic	21	25	19	20	24	9
Hispanic	18	12	20	18	15	6
Other	8	3	11	10	4	3
Residence						
Urban	79%	76%	81%	81%	75%	80%
Rural	21	24	19	19	25	20

Additional Characteristics of Dual-Eligible Beneficiaries, CY 2021

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	53%	44%	58%	46%	69%	83%
1–2 ADL limitations	23	31	19	25	21	12
3–6 ADL limitations	24	25	23	29	10	6
Self-reported health status						
Excellent or very good	24%	21%	25%	22%	27%	53%
Good or fair	59	62	58	59	59	39
Poor	11	13	10	11	10	4
Unknown	6	4	7	7	4	4
Living arrangement						
Institution	11%	6%	13%	15%	1%	3%
Alone	37	34	39	34	46	27
Spouse	13	9	15	13	14	50
Children, nonrelatives, others	39	51	32	39	39	21
Education						
No high school diploma	33%	26%	36%	34%	31%	7%
High school diploma only	31	38	28	31	32	23
Some college	31	33	30	29	36	69
Other	5	3	6	6	1	1

https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf Page 35 and 36

Chapter 2 Considerations: Care Coordination Tools, Processes and Skill Sets

Every D-SNP member must be in care coordination and have an individualized care plan (ICP) even if the member does not complete the health risk assessment. This impacts care coordination workflows and staffing.

Care Coordination Staff Skills

- Broader experience in behavioral health, substance use disorder and/or Waiver services
- Understanding of Medicaid and Waiver benefits, knowledge of community agencies to address health-related social needs (HRSN)

Collaboration with Community Case Managers

- Medicaid Waiver Programs
- Adult Protective Services
- Agencies addressing health-related social needs

Broader Support of Members

- Tracking of Medicaid Eligibility dates
- Assisting to complete Medicaid renewals
- Reporting potential changes in eligibility to ND HHS such as incarceration and death
- Identifying and referring members that appear to qualify for Waiver services

Revision of Tools

- Health Risk Assessment
- Stratification definitions and conditions
- Care Plan elements
- ICT meeting documents

Enhancements to EHRs

- Member self-serve options to complete HRA, review ICP, etc.
- Bi-directional communication with Care Coordination staff
- Communication with ICT members
- Facilitate information sharing for care transitions
- Capture types of care coordination encounters to support CMS reporting

Chapter 3 Considerations: Provider Network

Provider Network considerations may include increased demand for several types of services impacting contracting, credentialing, VBP arrangements and supplemental benefits. There are enhanced requirements related to clinical practice guidelines and transitions of care.

Specialists	Behavioral Health and SUD	Essential Providers	Digital Solutions	Supplemental Benefits
▪ Contracting with specialists that treat the Dual Eligible and most vulnerable populations ▪ Supplemental tools to meet network standards (i.e., telehealth) ▪ Value-based arrangements ▪ Consider hospital at home	▪ Added pressures to BH/SUD network capacity even when the access and availability requirements are met ▪ CCBHCs and other safety net providers for BH/SUD will be important to include in the networks	▪ Federally qualified health centers ▪ Community Behavioral Health Centers ▪ Tribal health organizations	▪ Remote patient monitoring ▪ Telemedicine and telehealth services	▪ Supplemental benefits to ensure health equity and health related social needs are met ▪ Examples: NEMT that supplements the Medicaid benefit; peer support; flex cards that support food, housing, and utilities, OTC, etc

Chapter 2 & 3 Considerations: Transitions of Care

CMS places emphasis on smooth transitions of care for Dual Eligibles. Both the Care Coordination and Provider MOC chapters have requirements related to transition of care.

Care Coordination

- Definitions of Care Setting
  - Home (place of residence), home health care, acute care, skilled nursing facility, custodial nursing facility, rehab facility, and outpatient/ambulatory care/surgery centers
- Coordination communications across all providers – regardless of par/non par status
- Member and caregiver access to all members health records
- Education about indicators that their condition has improved or worsened, and how they will demonstrate understanding of changes in their condition and use appropriate self-management activities

Provider Network

- Description of how D-SNP provides oversight of network providers to ensure they follow the required care transition protocols outlined in MOC Chapter 2 (Care Coordination)
- Training requirements on the MOC, including transitions of care and how the care plan will transfer across providers
- Training is for all providers the members regulatory see, regardless of network affiliation

Chapter 4 Considerations: Quality Improvement Program

The Quality Improvement Program must be tailored to measure outcomes for the D-SNP specific population and especially for the most vulnerable populations. It's unclear how the CMS Health Equity Index Measures will fit into the MOC framework.

- Selection of Measures
  - MOC Chapter 4 requires that the D-SNP select quality measures that are tailored to the described populations in MOC Chapter 1
  - Detailed reporting on measuring goals and outcomes is required
  - This may mean staffing and data enhancements

- Quality Program documentation
  - All documentation, including the Quality Improvement Program, Work Plan, Annual Program Evaluation, and the Quality Improvement Committee must have specific references to the D-SNP and members
  - The documentation should isolate and report on specific D-SNP performance measure results (CAHPS, HOS, HEDIS)

- In future years, D-SNPs are required to develop Performance Improvement Plans and Chronic Care Improvement Plans

State Medicaid Agencies are Regulating D-SNPs More Closely

States are leveraging the State Medicaid Agency Contract (SMAC) to regulate D-SNPs. It's important for D-SNPs to review SMACs closely and develop a collaborative relationship with the Medicaid agency to ensure a well-crafted SMAC.

One recently reviewed draft SMAC requires the D-SNP to submit the Model of Care for state approval before it is submitted to CMS.

This added scrutiny will add complexity to Model of Care design and implementation.

Seen in a recent draft SMAC and other potential requirements:

- ✓ State mandates the required most vulnerable populations.
- ✓ Enhanced care coordination requirements impacting MOC Chapter 2, including quarterly face-to-face interactions between the care coordinator and member.
- ✓ Enhanced provider network requirements, such as targets for the percentage overlap of Medicare and Medicaid networks.
- ✓ Enhanced reporting requirements that may include both state-specific reports and/or an obligation to provide state Medicaid agencies with copies of Medicare Part C reports, quality reports, and others.
- ✓ Required reporting more frequently than CMS requirements.
- ✓ Increased visibility related to compliance such as requirements obligating the Plan to share CMS correspondence such as notifications of noncompliance and sanctions with State Medicaid Agencies.
- ✓ State influence on the overall MOC document.

Poll Question

How prepared is your organization to adapt to changes like Health Equity Index and Star Ratings changes?

A. Fully prepared – We have proactive strategies and resources in place.

B. Somewhat prepared – We are aware of the changes but still adjusting our strategies.

C. Not very prepared – We are currently assessing the implications.

D. Unprepared – We have not yet started planning for these changes.

E. Unsure at this time.

Health Equity Index

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Health Equity Index

- CMS, through its **Health Equity Framework** and **Final Rule[1],** is tying improvements to health disparities for enrollees with social risk factors (SRFs) and replacing the Medicare Advantage Reward Factor with the **Health Equity Index** reward
- The new HEI reward will replace the current reward factor that currently rewards consistently high performance by health plans
- The HEI reward will include data from the 2024 and 2025 measurement periods and **apply for the 2027 Star Ratings**
- The HEI reward focuses on improving care for enrollees with CMS defined **social risk factors (SRFs).** The initial set of social risk factors will include members who are:
  - Dually-Enrolled (DE), receiving Low-Income Subsidies (LIS), and/or beneficiaries with Disabilities
- HEI will focus on improvements on a **subset of STAR measures** for members with **social risk factors.**

Members with SRFs in Medicare Advantage vs. Traditional Medicare

SRF Groups	Medicare Advantage	Traditional Medicare
Dual Eligible (DE)/Low Income Subsidy (LIS) AND Disabled	12.6%	10.1
DE/LIS ONLY	12.6%	7.1
Disabled ONLY	10.6%	10.4
SRF Total	**35.8%**	**27.6%**

- HEI scores are awarded based on a plan's performance relative to peers for each HEI selected quality measure.
  - Plans are stratified by performance into thirds with points awarded based on performance on each HEI measure:

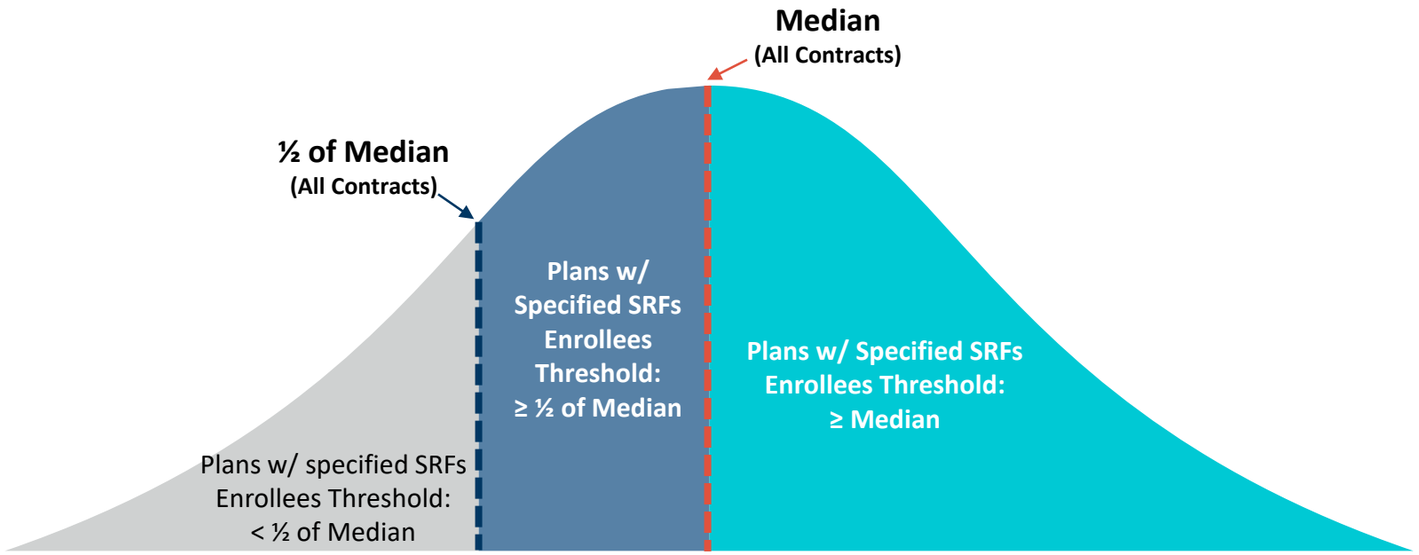
Bottom 1/3 of Plans = -1 point>>	Mid 1/3 of Plans = 0 Points	Top 1/3 of Plans = +1 point

  - Measures that will apply to HEI Scores have not been announced by CMS (as of February 2024).

[1] Federal Register on 04/05/2024.

Health Equity Index

% of Enrollees in a contract with Specified SRFs



HEI Reward Ranges:

Threshold for % of Enrollees with Specified SRFs	Amount of Reward
< ½ of the Median for all contracts	ZERO Reward
≥ ½ of the Median for all contracts	HEI Reward ranges from > 0 to 0.2*
≥ Median for all contracts	HEI Reward ranges from > 0 to 0.4*

**On a linear scale, with an HEI score > 0*

HEI calculation involves several steps, including:

- —Measuring scores for each contract
- —Adjusting for case-mix
- —Meeting reliability and minimum denominator criteria
- —Assigning points based on contract-level scores
- —Calculating the HEI Score as a weighted average of the assigned points
- —Evaluating Plan performance against National Performance Rates

Source: CMS Health Equity Conference in June 2023. CMS example of how the HEI scoring could work.

HEI Performance Impacts Two Aspects of Medicare Advantage Payments

Better HEI Scores Improve Quality Payments

Quality Bonus

- CMS incentivizes MA plans with a Quality Bonus Program (QBP), rewarding high-quality service with increased payments
- Increases a plan's base payment rate by a percentage, up to a maximum of 5%.
  - **Current:** Focus on overall plan performance (e.g., Reward Factor)
  - **Future:** Focus on health equity (e.g., HEI Reward)
    - Note: The HEI Reward would continue, like the legacy Reward Factor, to be added to the plan's weighted average raw star score prior to calculating the final star rating

Rebate

- CMS provides incentives to payers for providing care at lower-than-benchmark rates
- Rebates can only be used to provide beneficiaries with supplemental benefits such as vision or dental care or to lower plan premiums
  - **Higher star rating + lower bid:** Bigger rebate! A 4.5-star plan bidding under the benchmark receives a 5% larger rebate than a 4-star plan
  - **Lower star rating + higher bid:** Smaller or no rebate

Star Rating	Quality Bonus %	Rebate %
5.0	**5.0%**	**70%**
4.5	**5.0%**	**70%**
4	**5.0%**	**65%**
3.5	0.0%	65%
3	0.0%	50%
< 3.0	0.0%	50%
New Plan (No Rating)	3.5%	65%

Key Takeaways

- Stars are extremely important to payers – every improvement translates to $ millions in bonus.
- Rebates increase member benefits – High-quality plans that are successful at offering low-cost care unlock extra financial incentives.
- While not directly tied to HEI, operational efficiency, excellent customer service, and a strong provider network are crucial for long-term success. They're not just cost factors but investments in member satisfaction and loyalty, ultimately driving profitability.

Notes: 1. KFF Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least $12.8 Billion in 2023. Jeannie Biniek. August 9, 2023. https://www.kff.org/ebd3a22/

FTI Consulting's Predictions for Measures Likely to be included in HEI

CMS **has not announced** the quality measures that will be included as HEI measures; it is likely CMS will select at least some of the HEI measures from this list

Domain	Measure	Product Lines
Cardiovascular	Controlling High Blood Pressure (CBP)	Medicare, Commercial, Medicaid
Cardiovascular	Statin Therapy for Patients with Cardiovascular Disease (SPC)	Medicare, Commercial, Medicaid
Diabetes	Eye Exam for Patients with Diabetes (EED)	Medicare, Commercial, Medicaid
Diabetes	Hemoglobin A1c Control for Patients With Diabetes (HBD)	Medicare, Commercial, Medicaid
Diabetes	Kidney Health Evaluation for Patients with Diabetes (KED)	Medicare, Commercial, Medicaid
Prevention & Screening	Breast Cancer Screening (BCS-E)	Medicare, Commercial
Prevention & Screening	Colorectal Cancer Screening (COL-E)	Medicare, Commercial
Musculoskeletal	Osteoporosis Management in Women who had a Fracture (OMW)	Medicare
Managing Chronic Conditions	Monitoring Physical Activity	Medicare
Managing Chronic Conditions	Reduce the Risk of Falling	Medicare
Vaccines	Annual Flu Vaccine	Medicare
Member Experience	Getting Needed Care	Medicare
Member Experience	Getting Appointments and Care Quickly	Medicare
Member Experience	Customer Service	Medicare
Member Experience	Rating of Health Care Quality	Medicare
Member Experience	Rating of Health Plan	Medicare
Member Experience	Care Coordination	Medicare
Member Experience	Rating of Drug Plan	Medicare
Member Experience	Getting Needed Prescriptions	Medicare
Drug Safety	Medication Adherence for Diabetes Medications	Medicare
Drug Safety	Medication Adherence for Hypertension (RAS antagonists)	Medicare
Drug Safety	Medication Adherence for Cholesterol (Statins)	Medicare
Drug Safety	Statin Use in Persons with Diabetes	Medicare
Drug Safety	MTM Program CMR Completion	Medicare

Notes:

1. NCQA Blog- Stratified Measures: How HEDIS Can Enhance Health Equity. Tony Walsh. October 18, 2022. https://www.ncqa.org/blog/stratified-measures-how-hedis-can-enhance-health-equity
2. NCQA The Future of HEDIS®: Health Equity. October 6, 2022. https://www.ncqa.org/wp-content/uploads/2022/10/FOH-Using-HEDIS-to-Improve-Health-Equity-Oct-6-2022.pdf
3. NCQA Proposed Changes to Existing Measures for HEDIS MY 2024: Expansion of Race and Ethnicity Stratification in Select HEDIS Measures. Draft Document for HEDIS Public Comment. https://www.ncqa.org/wp-content/uploads/2023/02/02.-Race-Ethnicity.pdf
4. NCQA Social Need: New HEDIS Measure Uses Electronic Data to Look at Screening, Intervention. November 2022. https://www.ncqa.org/blog/social-need-new-hedis-measure-uses-electronic-data-to-look-at-screening-intervention/

Key Star Ratings Changes

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Key Star Ratings Changes

Measurement Year (MY) 2024 (2026 Star Ratings)

Measurement Year 2024 (2026 Star Ratings)
CONFIRMED CHANGES

- **MY 2024 performance will be used in the 2027 Star Ratings Health Equity Index.**
- **CAHPS & Administrative measures to decrease to weight of 2x from 4x.**
- **Added 3 measures (first year @ 1x weight):**
  - **Improving/Maintaining Physical Health**
  - **Improving/Maintaining Mental Health**
  - **Kidney Health for Patients with Diabetes**
- Adjust Breast Cancer Screening for gender neutrality.
- Convert Colorectal Cancer Screening to ECDS (without a hybrid option).
- Use continuous enrollment for Medication Adherence & SUPD measures.
- Changes in Medicare FFS will add new MA-required coverage.

Key Takeaways:

1. Consider implementing a non-blinded mock survey that can be conducted to track the Member Experience with CAHPS/HOS-related questions.
2. Update internal reports/trackers to account for:
   - New Star Measures (e.g., Kidney Health for Patients with Diabetes) and measure weights (e.g., CAHPS & Admin weights @ 2x)
   - Stratified measure level rates for members in LIS, Dual Eligible, & Disabled to track HEI performance
3. Review synergy opportunities between SNP HATs, HEDIS, Adherence measures, and MTM to maximize performance.

Key Star Ratings Changes

Measurement Year (MY) 2025 (2027 Star Ratings) & Beyond

Measurement Year 2025 & 2026
CONFIRMED CHANGES

- **Health Equity Index will replace Reward Factor (MY 2024 & MY 2025 for Star Ratings Year 2027)**
- **Use Risk-adjusted Medication Adherence measures (MY 2026; first year @ 1x weight)**
- **Remove IP/SNF adjustments from Med Adherence measures (MY 2026)**
- **Both Improving/Maintaining Physical Health and Improving/Maintaining Mental Health measures increase to 3x weight**
- **Add the expanded age range 46-49 to Colorectal Cancer Screening**
- **Add exclusion for statin intolerance for Statin Use in Persons with Cardiovascular Disease measure**
- **Added measures (first year @ 1x weight):**
  - **COA-Functional Status Assessment; Concurrent Use of Opioids/Benzos; Poly-Rx Multi-Anticholinergics**
- **FIDE SNPs must have exclusively aligned enrollment (e.g., only enrollment of individuals in the affiliated Medicaid MCO contract; MY 2025)**
- **HIDE SNPs state contracts must apply to the entire service area for the D-SNP (MY 2025)**
- Part D Redesign, Inflation Reduction Act & $2,000 Out-of-Pocket cap
- Retired measures:
  - COA-Pain Assessment & Medication Reconciliation Post-Discharge (standalone version)
- Expand required MTM criteria & move MTM CMR Completion Rate measures to the Display page

Key Takeaways:

1. The shift to HEI may not be beneficial for some plans; it is imperative to review internally to see how you could be impacted by HEI.
2. Starting now in 2024, use Acumen reports to track the risk-adjusted impacts on medication adherence measures. It is recommended to build internal tools that mimic the CMS methodology for the best results.
3. Collaborate with the Pharmacy Team to ensure that the Medication Therapy Management (MTM) program eligibility is optimized to maximize cross-functional touchpoints, such as SNP and HEDIS.

Key Actions for MA Plans and D-SNPs

Strategic Priorities

- Elevate Patient Experience & Admin Efficiency:
  - 2x weight for CAHPS & Admin measures demands superior service and streamlined operations.
- Target New Health Outcome Measures:
  - Invest in clinical programs for Physical, Mental, and Kidney Health measures.
- Adapt to Reporting & Measure Changes:
  - Transition to ECDS; capitalize on cost savings from eliminated hybrid reporting.
- Focus on Health Equity:
  - Leverage MY 2024 performance for future Health Equity Index; identify & address unique disparities.

Financial Implications

- Anticipate Cost Increases:
  - New measures and weight changes require strategic investments in health outcomes.
- Seize Potential Savings:
  - Streamlined reporting offers cost-saving opportunities and optimizes processes.
- Invest in Data Systems Upgrades:
  - Essential for new reporting requirements and administrative measure shifts.

Specific Considerations for DSNPs

- Address Socioeconomic Challenges:
  - Tailor strategies to DSNP's unique health determinants and socioeconomic landscape.
- Innovate in Care Delivery:
  - Overcome infrastructure limitations with creative healthcare solutions.

Immediate, strategic action is critical to navigating the 2026 Star Ratings changes, with a significant focus on patient experience, health outcomes, and equity, specially tailored for the unique context of DSNPs.

Questions?

Thank You

For additional questions, please contact us:

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