HEALTHCARE INDUSTRY GROUP

The Intersection of Risk Adjustment and Stars

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Setting the Stage – Financial Position

In the February 2023 Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, the Centers for Medicare & Medicaid Services (CMS) proposed Version 28 (V28) of the Part C Hierarchical Condition Count (CMS-HCC) model. Based on industry feedback regarding the operational and financial changes necessary to move from the Version (24) model, the final rule phased in the model over a three-year period. The V28 model will be full in effect for Payment Year 2026 (also called Contract Year [CY] 2026). As a predictive model, 2026 Medicare Advantage per member per month (PMPM) payments are based on 2025 dates of service (DOS).

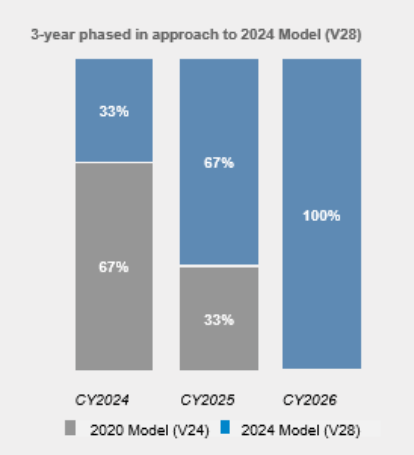

Figure 1: CY2026 uses 100% V28 payment (based on 2025 DOS)

While many payers and downstream risk-bearing provider organizations have been challenged by the Part C model shift to V28, there are more changes on the horizon because CMS has a fiduciary responsibility to manage the Medicare program. As outlined in the *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, "… [O]ne of the critical functions … is to inform policymakers and the public about the size of any trust fund deficits that need to be resolved to avert program insolvency." Given the Medicare program still faces a substantial shortfall, further legislation is necessary to ensure that funds do not run out, which is now projected to happen in 2036.

Painting a Vision for Healthcare

In 2008, the Institute of Healthcare Improvement (IHI) published the Triple Aim which seeks to: 1) improve the (patient) experience of care, 2) improve the health of populations and 3) reduce the patient per capita costs. Over time, IHI has added provider/healthcare worker welfare and equity-centered aspects to its model.

CMS appears aligned to this vision. For example, the CMS Innovation Center was established to "develop and test health care payment and service delivery models to improve patient care, lower costs, and align payment systems to promote patient-centered practices." And both recent and impending regulatory changes across risk adjustment and Star ratings are moving directionally toward the same Triple Aim.

Focused Efforts – Revenue Drivers

Given the current financial position of the Medicare program, it's imperative that health plans (and downstream, risk-bearing provider entities) deeply understand not only the risk adjustment and Star ratings programs, but the intersection of these programs — which together make up the primary revenue drivers for care funding.

Most payer and risk-bearing provider organizations historically have built three distinct competencies for risk adjustment, including Part C (medical), Part D (drug/pharmacy) and Star ratings (which also includes Part C and Part D elements). Each area has governing regulations, a unique technical infrastructure/model, operational needs and varied cost structures; each area also serves as a revenue driver — providing the underlying funding mechanism to pay for the cost of care.

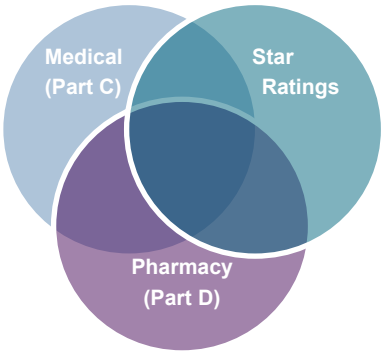

Figure 2: MA revenue driver

The opportunity to move toward the healthcare vision lies in creating connective tissue between these three areas, as well as with other teams/departments that are responsible for the cost side of the equation, such as provider network, medical management and operations.

In this article, we'll explore one highly prevalent condition: diabetes mellitus. According to the *CMS Diabetes Strategy – Impact Report 2024*, diabetes and prediabetes impacts 44 million Americans, or three out of every four people 65 years and older; 3 million of those people do not even know they have the condition.

While there is enough data to write an entire book on the diabetic population intersections, this article scratches the surface by providing a few insights in each competency category.

1. Part C Risk Adjustment

Issue: In the V24 CMS-HCC model, diabetes mellitus (DM) was mapped to three separate Hierarchical Condition Categories (HCC), with different coefficient[1] values based on the severity of the condition. In moving to V28, DM conditions still map to multiple HCCs; however, the coefficient value is constrained — now having the same value across all DM HCCs, regardless of severity. As a highly prevalent condition, the overall impact of this change is a decrease in payment.

[1] CMS coefficient values are utilized to calculate PMPM payments. Demographic factors (e.g., age, sex) and specific condition category factors are actuarially calculated using a linear regression model and used to predict a beneficiary's total expected medical cost.

Illustrative Example: HCCs/Member

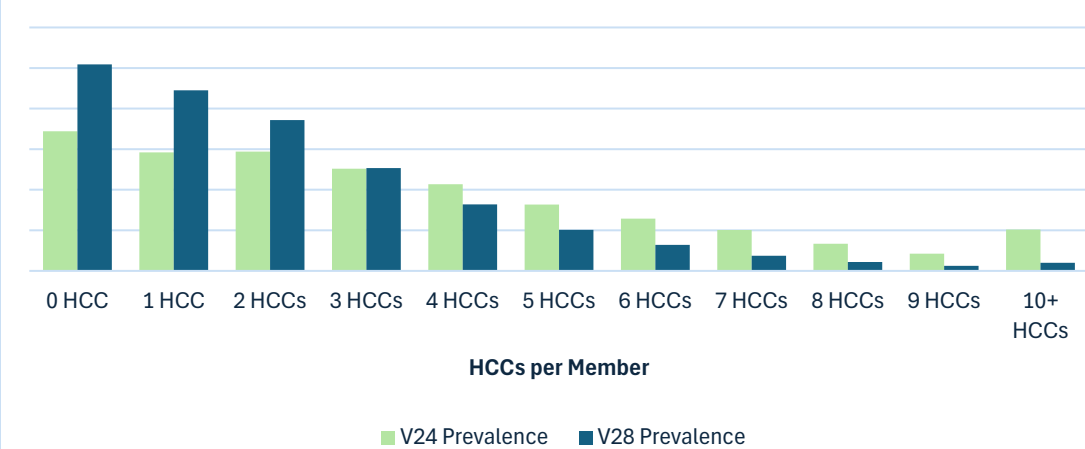

Figure 3: While the V28 model contains more HCCs, it has fewer underlying diagnosis codes. The overall impact in one dataset reviewed showed a significant increase in the number of beneficiaries with fewer (0–2) HCCs and a decrease in those with ≥4, representing a negative financial impact of ≥15% over the three-year blended phase-in period.

Action: Organizations should continue to promote **accurate, complete and timely documentation and coding.** As the industry shifts to more use of artificial intelligence, natural language processing and machine learning, documenting illness severity can help identify other potential comorbidities. Organizations should conduct sample audits to ensure these enhanced analytics are working as anticipated in finding and presenting charts for coding. These enhanced analytics can also uncover disease interactions and increase alternative payment condition counts, both of which are part of the model. Data also helps determine the best clinical pathway, which is an organizational matrix opportunity for the clinical/medical management team. Creating more strategic alignment between teams (e.g., using similar analytics, reducing member touch points, etc.) will be key in reducing costs and abrasion going forward.

Impact: Accurate, complete and timely documentation and coding not only will ensure all conditions are captured, aligning payment to the underlying cost of care, but will also help mitigate audit risks by removing unsupported diagnoses codes; this is important given OIG audits of Medicare Advantage payments and the Risk Adjustment Data Validation Rule (RADV) Final Rule, which allows for extrapolation audits beginning with PY2018 (2017 DOS).

2. Part D Risk Adjustment

Issue: The Inflation Reduction Act of 2022 (IRA) will continue to change the Part D landscape for the foreseeable future. While there is a lot to unpack in IRA, we'll again focus on diabetics. Insulin use impacts 5 –10 percent of beneficiaries. CMS capped beneficiary cost-sharing at $35 per month. As we move into 2025, all drugs — including insulin — will have no beneficiary cost share in the catastrophic phase, and beneficiary true out-of-pocket (TrOOP) cost will be capped at $2,000. Beneficiaries can also "opt in" to the Medicare Prescription Payment Plan (M3P).

While these are great program additions for seniors who are often on a fixed income, there are financial and operational implications for payers, risk-bearing entities, pharmacies and pharmacy benefit managers (PBM).

Action: **Accurate, complete and timely documentation and coding** are also critical in the Part D or Rx-HCC model. Unlike Part C, coefficient values remain variable for DM based on whether a beneficiary has DM with or without complications. Using provider group targeting analytics, organizations can highlight groups that may benefit from additional provider education efforts. Deeper analysis into provider documentation and coding reviews will help provide specific feedback and increase engagement.

Organizations should also have a basic understanding of M3P. For 2025, CMS is using a $600 pharmacy threshold based on a single prescription/visit to help identify Part D enrollees who may benefit from monthly billing from the Part D sponsor, which allows costs to be spread throughout the year. And while insulin is capped, many of the GLP-1 agonists used to treat DM type 2 would hit the pharmacy threshold. Understanding your current population is the first step. A deep dive may help uncover beneficiaries who would not only benefit from the M3P program, but also those with medication adherence challenges. Using a clinical pharmacist and/or licensed clinical social worker (LCSW) may be needed to explore different medications and/or underlying SDoH barriers. It will be important to also follow the new administration to determine if any of the IRA provisions are altered.

Impact: The Kaiser Family Foundation (KFF) released a publication in June of 2024 estimating that 800,000 beneficiaries with insulin-dependent diabetic mellitus (IDDM) had access to a $35 capped insulin prior to the IRA change. After implementation, the volume was estimated to be more than 3.3 million people. That translates to a beneficiary savings of more than 1 billion dollars that is absorbed by the U.S. healthcare system (e.g., payers, risk-bearing providers, PBMs, etc.).

3. Star Ratings

Issue: Similar to risk adjustment, Star ratings include both Part C (medical) and Part D (drug) measures. The HEDIS® measures for diabetes have historically included Diabetes Care Eye Exam, Diabetes Care and Blood Sugar Controlled and Statin Use in Persons with Diabetes, which are weighted 1X, 3X and 1X, respectively, for Measurement Year (MY) 2024. Kidney Health Evaluation for Patients with Diabetes is a new measure for MY2024 (2026 Star Rating) with a weight of 1X. In Part D, Medication Adherence for Diabetes Medications is weighted 3X. That's a total weight of 9X for MY2024 for diabetic-labeled measures alone (>11 percent of the total Star rating) and does not include comorbid measures often associated with the condition (e.g., hypertension, hyperlipidemia).

Action: In addition to focusing on Part C and D measure outcomes which also requires **accurate and complete data collection**, data should be reviewed through a health equity lens.

Data collected in both MY2024 and MY2025 will be utilized for the **Health Equity Index** calculation, which replaces the Reward Factor in Star Year 2027. The initial underlying measurement emphasizes dual eligible (DE), low-income subsidy (LIS) and disabled populations. Beneficiaries in these groups often live in environments adversely impacting their care — from socioeconomic status to food deserts.

One action that can be helpful is using the *Mapping Medicare Disparities* tool. The following illustration shows Medicare Fee for Service (MFFS) beneficiaries in 2022 and highlights DM prevalence rates in California. In Del Norte County, located in the northwestern corner of the state, prevalence rate changes based on selected parameters and is highest in 65+ year-olds who are dual-eligible, disabled and of Hispanic heritage. Health plans and risk-bearing entities should be not only managing cut points toward overall Star ratings, but also analyzing results for LIS, DE and disabled populations separately and create programmatic strategies to address Health Equity disparities.

Impact of Subpopulation on Diabetes Mellitus

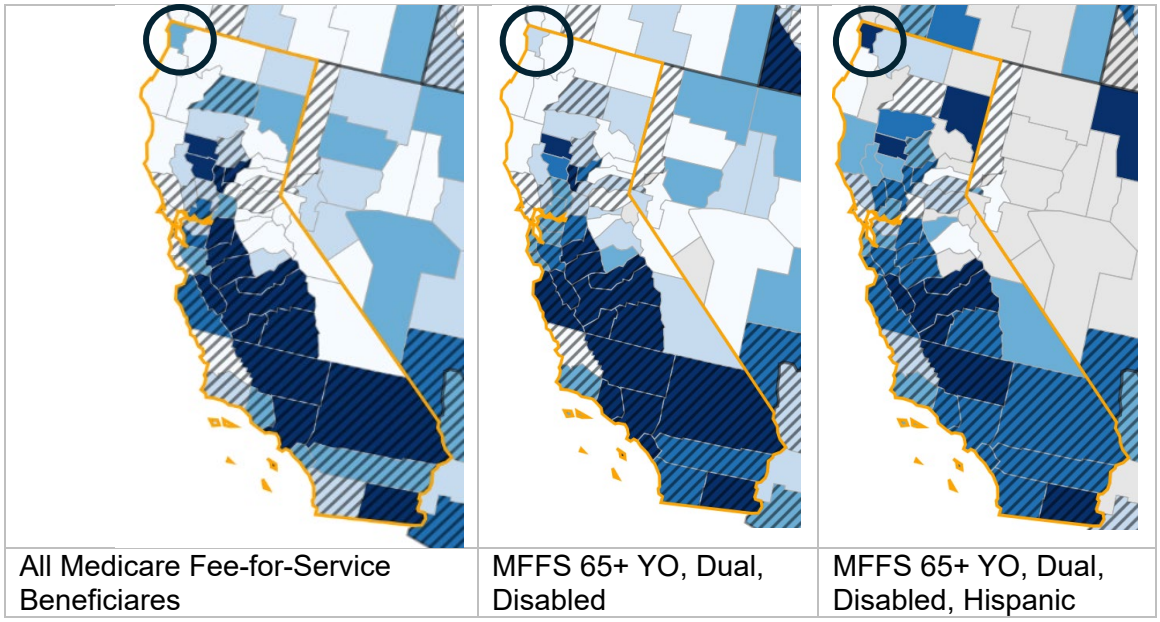

Figure 4: Drill down on 2022 diabetes mellitus prevalence in Medicare Fee-for-Service (MFFS) subpopulation. Del Norte County, California, highlighted.

Impact: Benchmarking your current population against national trends can help you understand beneficiary selection patterns and identify opportunities for programmatic improvement of outcomes for subpopulations.

Final Thoughts

Diabetes is just one example that touches each of the three primary revenue-driver/competency areas. Key takeaways (aligned to the Triple Aim):

- **Improve the patient experience of care:** Capture accurate, complete and timely data on beneficiaries, including social determinants of health information and beneficiary preferences (e.g., communication preference). Reduce beneficiary abrasion by combining outreach calls and addressing both 1) chronic conditions like DM and 2) quality measures like diabetic retinal eye exams during the same visit.
- **Improve the health of populations:** Explore the CMS Health Equity site, which is filled with data and programmatic tips to identify and address care disparities. Health plans with more than three years of data can access their CMS Health Equity Summary Score (HESS) reporting, which is comprised of several measures (including several DM measures) that "…assess disparities across and within race and ethnicity groups and populations that are dually eligible for Medicare and Medicaid and/or who are eligible for the low-income subsidy."
- **Reduce the patient capita costs:** Given that CMS will likely continue to make changes to risk adjustment and Stars revenue to maintain the Medicare Trust Fund, focus on administrative cost takeouts, ensure medical cost-of-care drivers are aligned with the market and increase efficiency through tools and technology.

How We Can Help

Regardless of where you are on the continuum, A&M can help. We have experts and thought leaders in:

- Part C and D risk adjustment (e.g., targeting analytics, accurate and complete data capture and submission, sample chart reviews for provider education).
- Star ratings (e.g., Star ratings performance improvement — including Health Equity Index, care gap closure strategy and execution, and MA Part C and D data validation audits).
- Pharmacy benefit management (PBM and pharmacy services strategy and solutioning, financial and operational performance improvement, and membership migration).

On a broader level, A&M can help provide strategic guidance on how to better bring these key revenue drivers together to harness financial improvements, create operational efficiencies and improve member experience.

Regarding the financial and regulatory environment, A&M also helps health plans and managed care organizations manage through financial distress, maximize growth, mitigate risks and achieve cost effectiveness through expertise in areas like turnaround management, corporate transformation, tax advisory, valuation and digital transformation — particularly when companies are facing complex challenges or need to make significant changes to their operations or strategy

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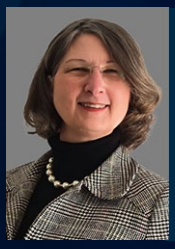

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