MILLIMAN WHITE PAPER

# Leveraging operational excellence: Enhancing Medicare Star Ratings through effective adaptation

Rachel Ferguson, MHA
Bryce Platt, PharmD
Hayley Rogers, FSA MAAA

Milliman

## Given the impending changes to the Medicare Advantage Star Ratings, Medicare Advantage organizations (MAOs) should proactively act to preserve or improve their current ratings. With the increasing headwinds, it is imperative that MAOs explore strategies for maximizing effectiveness within tighter margins.

This white paper serves as a continuation of the insights presented in the three-part Milliman series on the evolution of the Medicare Advantage Star Rating system and its financial implications for MAOs[1,2,3].. This paper explores potential operational implications and strategic approaches to adapt to the significant changes in the Medicare Star Rating system. The healthcare industry is experiencing rapid evolution, characterized by regulatory changes and heightened competitiveness. This document is structured to cover a range of potential ideas that MAOs can use to respond to the changes in the Star Rating system, by strategically reassessing and modifying their operational practices to counter the potential negative impact on their financial stability.

These topics include:

- **Operational considerations:** Exploring strategies for MAOs to reduce the impact of Star Rating changes on their revenue, along with necessary operational adjustments in response to the evolving system.
- **Investment in individual measures:** Understanding baseline metrics and how internal, vendor, and provider interactions influence Star Ratings, including strategic allocation of resources toward the most impactful measures.
- **Provider engagement with vendors:** Assessing the performance of vendors, their ability to sustain and improve Star Ratings, and the impact they have on the Healthcare Effectiveness Data and Information Set (HEDIS) metrics.
- **Benchmarking and learning:** Highlighting the importance of learning from successful peers and implementing benchmarking practices to enhance both operational effectiveness and Star Ratings.
- **Leveraging the Health Equity Index (HEI):** Exploring how the HEI can improve outcomes for specific populations, like those with low incomes or dual eligibility, its positive effects on Star Ratings, and how to identify and customize approaches to their needs.
- **Data collection and visibility:** Highlighting the need for comprehensive data collection systems and clear visibility into performance metrics.
- **Preventive services case study:** Specific strategies for mammography screenings and other preventive services, which may effectively elevate Star Ratings through focused health initiatives.
- **Appointment-based model (Part D):** Discussing the positive impact on both health outcomes and star ratings of enhancing medication adherence through the appointment-based model.

[1] Rogers, Hayley M., Smith, Matthew H., & Yurkovic, Mike (October 2023). “Future of Medicare Star Ratings: The Reimagined CMS Bonus System.” Milliman White Paper. Retrieved February 16, 2024, from https://www.milliman.com/en/insight/future-of-medicare-star-ratings-reimagined-cms-bonus-system
[2] Rogers, Hayley M., Smith, Matthew H., Nelson, Philip, & Yurkovic, Mike (October 2023). “The Future Is Now: 2024 Star Ratings Release.” Milliman White Paper. Retrieved February 16, 2024, from https://www.milliman.com/en/insight/the-future-is-now-2024-star-ratings-release
[3] Rogers, Hayley M., Smith, Matthew H., & Yurkovic, Mike (November 2023). “The Next Stage of Star Ratings Evolution: 2025 Proposed Rule and Beyond.” Milliman White Paper. Retrieved February 16, 2024, from https://www.milliman.com/en/insight/the-next-stage-of-star-ratings-evolution-2025-proposed-rule-cms

# Background: Evolution of Medicare Advantage Star Rating system

The release of the 2024 Star Ratings revealed unexpected lower ratings for many health plans due to the removal by the Centers for Medicare and Medicaid Services (CMS) of Tukey outliers in measure cut points, indicating the start of significant changes to the Medicare Advantage (MA) Star Rating system. CMS indicates that these changes are intended to reward quality, enhance stability, and foster health equity, but they are expected to lead to funding reductions in the MA program.

The following are new and upcoming methodology changes coming to the MA Star Rating system.

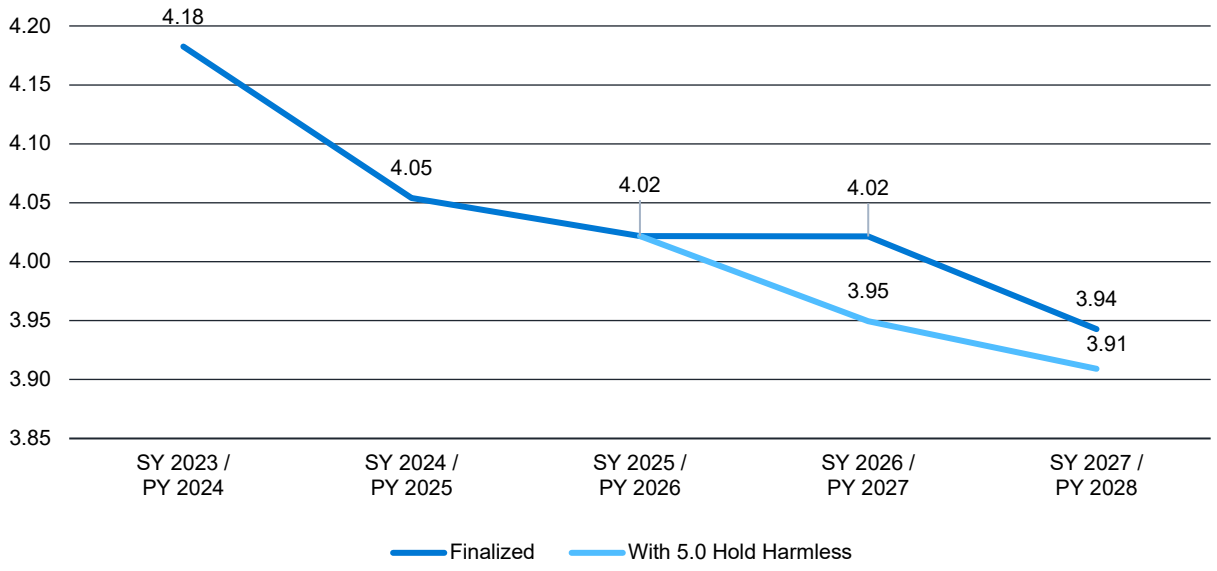
- **Tukey outlier removal:** CMS began excluding Tukey outliers from all cut point calculations in the 2024 Star Ratings (2025 payment year) for all non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, in an attempt to stabilize annual cut point shifts caused by low-performing contracts. Despite regulations suggesting a gradual implementation with 5% guardrails, the change had an immediate and comprehensive effect, as CMS recalculated the 2023 cut points without including Tukey outliers. CMS projected it would save $935 million in 2025, increasing to $1.5 billion by 2030.[4] Contracts with Star ratings between 3.5 and 4.0 Stars are expected to absorb the CMS savings through revenue reductions related to star ratings.
- **HEI rewards system:** Starting in 2027, the Medicare Advantage Star Ratings will adopt a new HEI rewards system, prioritizing social risk factor (SRF) populations. This system will benefit contracts providing high-quality healthcare to low-income, dual-eligible, and disabled populations. CMS simulations indicate that this change could save the government $670 million by 2028.[5] primarily by reducing rebates for 4.5-Star contracts.
- **Measure and weight changes:** Beginning with the 2026 Star Ratings (2027 payment year), CMS will reduce the weight of patient experience, complaints, and access measures from four to two, increasing the importance of claim-based measures from 30% in plan year (PYr) 2024 to 53% in PYr 2027.[6] This shift includes removing measures, adding measures, and modifying specifications for existing measures. CMS estimates this change will lower program expenses for the government by $330 million in 2027, reaching $580 million by 2033.[7]
- **Hold harmless and other unfinalized rules:** Medicare Star Ratings are calculated both with and without improvement measures; for contracts already over 4.0 Stars, CMS uses the higher score to reflect the challenge of continuous improvement at higher performance levels. CMS proposed raising the threshold from 4.0 to 5.0 Stars for the 2026 Star Ratings, potentially saving the government $2.1 billion in 2027[8] with cost savings coming from reduced revenues for existing 4.0- and 4.5-Star contracts. While not finalized in the 2024 Final Rule, CMS intends to implement this change in the future.

[4] See Tukey Outlier CMS Cost Savings, Table 12, in the 2021 Final Rule, available at https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program
[5] See Table 1 in the 2024 Final Rule, available at https://public-inspection.federalregister.gov/2023-07115.pdf.
[6] Claim-based measures include HEDIS, HEDIS Health Outcomes Survey (HEDIS-HOS), Prescription Drug Event (PDE), PDE/Medicare Plan Finder (MPF) and Part C/D Plan reporting data types. Non-claim-based measures include CAHPS, HOS, Complaint Tracking Module (CTM), Medicare Beneficiary Database Suite of Systems (MBDSS) Independent Review Entity (IRE) and Call Center data types.
[7] CMS, 2024 Final Rule, op cit.
[8] CMS, 2024 Final Rule, op cit.

Using internal models that replicate Star Rating methodologies, we conducted simulations to evaluate the effects of the aforementioned methodology changes. These assessments were done under two scenarios: keeping the current hold harmless threshold at 4.0 Stars and increasing it to 5.0. Figure 1 displays the estimated impacts of these changes, utilizing September 2023 membership data and the latest Star Ratings for each contract.

Our projections indicate a historical decline in average Star Ratings, which could fall to as low as 3.91 by the 2027 Star Ratings (2028 payment year). Such a decrease would represent the lowest national average since the conclusion of the Quality Bonus Payment demonstration in 2014.

**FIGURE 1: ESTIMATED MEMBER-WEIGHTED AVERAGE STAR RATING BY STAR RATING YEAR (SY) AND PAYMENT YEAR (PY)**




To demonstrate the potential effects of Star Rating changes on individual contracts, Figure 2 presents the revenue impacts on plans according to their Star Ratings and bid-to-benchmark ratios (which inversely reflect their savings as a percentage of the benchmark).

**FIGURE 2: % CHANGE IN CMS REVENUE BY BID-TO-BENCHMARK RATIO AND 2023 TO 2024 STAR RATING SHIFT**

| Bid to Benchmark Ratio | < 3.5 | 4.0 to 3.5 | 4.5 to 4.0 | New/Low to 3.5 | New/Low to 4.0 |
|---|---|---|---|---|---|
| **0.60** | -7.0% | -4.8% | -2.3% | -3.4% | 1.4% |
| **0.70** | -5.0% | -4.8% | -1.6% | -3.4% | 1.4% |
| **0.80** | -3.2% | -4.8% | -1.1% | -3.4% | 1.4% |
| **0.90** | -1.6% | -4.8% | -0.5% | -3.4% | 1.4% |
| **1.00** | 0.0% | -4.8% | 0.0% | -3.4% | 1.4% |

The actual revenue impact of Star Rating changes will be dependent on the service-area benchmarks, the influence of double-bonus counties, or counties capped by benchmarks established before the Affordable Care Act (ACA). For a more detailed understanding and application of this information, refer to the "Impact of Area and Savings Levels" section in The Future Is Now: 2024 Star Rating Release, which offers additional guidance and notes on using the table to estimate the financial effects of upcoming Star Rating changes on MA revenue.

# Case study: Preventive services (Part C)

Improvement of preventive services is a key strategy to boost Star ratings for MAOs. To highlight one preventive service, the breast cancer screening measure evaluates the percentage of female beneficiaries within a certain age group who have received mammograms for breast cancer screening with the overarching goal to drive the highest percentage of eligible female members to undergo preventive mammography screenings as recommended by evidence-based guidelines.[9] Mammograms have an 87% sensitivity rate; correctly identifying cancer in 87% of women with breast cancer.[10] Breast cancer screening presents an opportunity for MAOs to not only positively influence their overall Star ratings and member health, but also to reduce overall expenditures, due to the following financial realities:

- In the United States, breast cancer has the highest treatment cost of any cancer and accounts for 14% of all cancer treatment costs.[11]
- The average per-patient costs for medical services were highest for the end-of-life phase (the year before death from cancer), at $76,100, followed by the initial care phase (first year after diagnosis), at $35,000, and continuing care phase (time between initial care and end-of-life), at $3,500[12]
- The costs are higher for patients whose cancer is more advanced at diagnosis, largely due to the cost of chemotherapy and noncancer treatments.[13]

Many MAOs increase utilization of preventive services by:

- **Performing outreach and education:** Campaigns targeting preventive services can be in the form of printed materials, webinars, social media content, or verbal telephonic call drives. Breast cancer screening, primarily through mammograms, is a key component of Part C quality and performance ratings and reflects the emphasis on early detection and prevention of breast cancer.
- **Implementing incentive programs or rewards:** Incentive programs and rewards are a strategy used to encourage members to prioritize preventive services and programs can be designed to offer rewards like gift cards, wellness discounts, or premium reductions for members who participate in and complete recommended preventive treatment. In addition to the incentive value, these programs can foster a sense of value and appreciation for members' time and commitment to maintaining their health.
- **Prioritizing integrated care coordination:** Integrated care coordination includes data analytic tools to ensure that screenings and interventions are incorporated into routine visits and other technological solutions like health information exchanges, telehealth services, and personalized digital health tools. By integrating preventive care into the broader care continuum, MAOs can better prioritize prevention and wellness. Integrated care coordination can increase preventive services by establishing relationships between primary care providers, specialists, and other providers to facilitate preventive care more easily.

By engaging with members through focused initiatives, MAOs can raise awareness about the importance of preventive care. This can include cascading information about local available services, highlighting the benefits of screenings and vaccinations, and emphasizing the role that preventive care has on overall health.

An MAO that can achieve a high preventive screening rate demonstrates its commitment to promoting prevention, saving women's lives, and there is an implied return on investment as a mammogram and treatment after early detection is much less costly than advanced cancer treatment.[14]

Breast cancer screening has a Star rating weight of one, and there are similar approaches for similarly weighted or higher-weighted preventive services measures. Motivating factors for preventive services vary across the population. By looking at both the reasons why

[9] American Cancer Society. American Cancer Society Guidelines for the Early Detection of Cancer. Retrieved February 16, 2024, from https://www.cancer.org/cancer/screening/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html#:~:text=Breast%20cancer%201%20Women%20ages%2040%20to%2044,years%2C%20or%20can%20continue%20yearly%20screening.%20More%20items.
[10] Komen.org. Accuracy of Mammograms. Retrieved February 16, 2024 from https://www.komen.org/breast-cancer/screening/mammography/accuracy/#:~:text=Screening%20mammography%20is%20good%20at%20finding%20breast%20cancer%2C,50%20than%20in%20younger%20women%20%5B%2011%20%5D.
[11] Ibid.
[12] Ibid.
[13] Blumen, H. et al. (February 9, 2016). Comparison of Treatment Costs for Breast Cancer, by Tumor Stage and Type of Service. *Am Health Drug Benefits*. Retrieved February 16, 2024, from https://pubmed.ncbi.nlm.nih.gov/27066193/.
[14] Ibid.

members may not want to receive preventive care and the barriers to doing so, MAOs can help increase members obtaining preventive care and screenings, and therefore increase their ratings. Figure 3 contains reasons that members may not receive a mammogram, ways MAOs can strategically focus their attention on those reasons, and the financial investment rating:

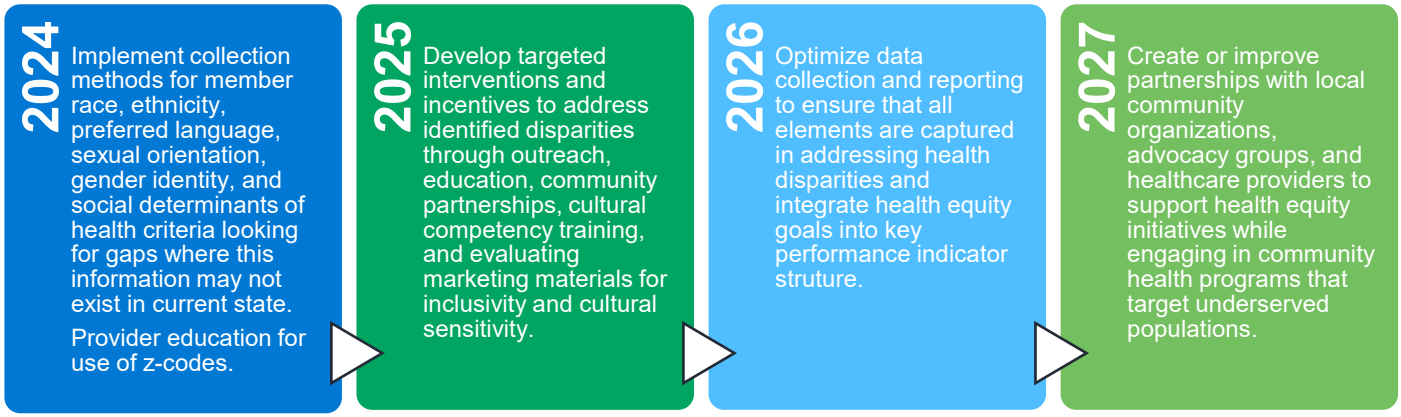
**FIGURE 3: INCREASING MAMMOGRAPHY ADHERENCE STRATEGIES**

| Reasons members may not receive a mammogram | Ways an MAO can address that reason to encourage breast cancer screenings | Financial investment* (low/medium/high) *vary based on plan size. |
|---|---|---|
| Fear and anxiety regarding the procedure itself, associated pain and discomfort, or nervousness regarding the results | Marketing campaigns addressing the procedure end-to-end, including what to expect, the purpose, and the benefits that the results provide. Candidly addressing the pain and discomfort and using actual members who benefited from early detection are also potential strategies. These campaigns should consider social determinants of health and cultural beliefs. | Low (<$50,000) |
| Misconceptions about the procedure's effectiveness | Providing clear statistics through marketing campaigns or answering common member questions like "What if my results are inconclusive?" or "What if I don't have a lump or any symptoms that I am worried about?" | Low (<$50,000) |
| Previous negative experiences with mammograms | Telephonic campaigns to talk to members with standardized and compassionate verbiage to anticipatorily discuss negative experiences. | Medium ($50,000-$100,000) |
| Time constraints and inconvenience | MAOs can partner with local mobile mammography vendors and use specialized vehicles to bring services to the members rather than members to the service. This approach offers convenience and provides an initiative-taking approach for members who may face geographical or economic barriers to traditional mammography services. | Medium ($50,000-$100,000) |
| Long wait times or difficulty scheduling | In addition to expanding their networks to broaden covered mammography facilities, MAOs can expand their networks to broaden covered mammography facilities while using technology like self-scheduling services. This helps ensure that members can schedule without long hold times over the phone and can modify their appointments, as needed. | High ($100,000+) |

The actions presented in the next aspect of the program address the intent of the HEI reward program, which will look at underserved populations based on race, ethnicity, socioeconomic status, and other social determinants of health. Unfortunately, many disparities exist in breast cancer screening as women living in rural areas are significantly less likely than women living in urban areas to have been appropriately screened for breast cancer. Additionally, CMS beneficiaries who are proficient in English with a combined income of $25,000 or more had a higher breast cancer screening rate compared with beneficiaries who were not proficient in English and had a combined income of less than $25,000. By reducing screening disparities and collecting comprehensive data to assess the disparities, breast cancer early detection can be improved and MAOs can structure preventive health strategies to improve their Star Ratings in conjunction with improving health equity.[15]

[15] CMS (October 2022). Breast Cancer Screening Disparities in Medicare Beneficiaries. Data Snapshot. Retrieved February 16, 2024, from https://www.cms.gov/files/document/bcs-october2022-datasnapshot.pdf.

**FIGURE 4: SAMPLE HEALTH EQUITY INDEX PREPARATION ROADMAP**




One of the most important aspects to convey is that operational changes take considerable time to see positive impacts on Star Ratings and associated revenue. If we look at the example of breast cancer screening, an MAO may choose to invest and execute several campaigns in 2024 to increase mammography screenings:

- New mammography program initiatives are implemented in 2024
- The HEDIS mammography measurement year is January 1, 2024 to December 31, 2024
- The HEDIS mammography reporting year is 2025 with results typically released in Q2 2025 or later
- CMS releases the 2026 Star Ratings in October 2025 in time for open enrollment for calendar year 2026, including the measure results for breast cancer screening.
- The 2026 Star Ratings affect the CMS revenue received in calendar year 2027

The call to action is for MAOs to invest in preventive strategies immediately as new mammography initiatives implemented in 2024 will be reflected in the 2026 Star Rating, which will be used in the 2027 bids, therefore impacting MAOs' 2027 revenue. MAOs will need new strategies and focus in 2024 to keep preventive care Star ratings stable or improved in 2027.

Note that not all Star Rating metrics are based on the same measurement period.

# Deep dive: Appointment-based model (Part D)

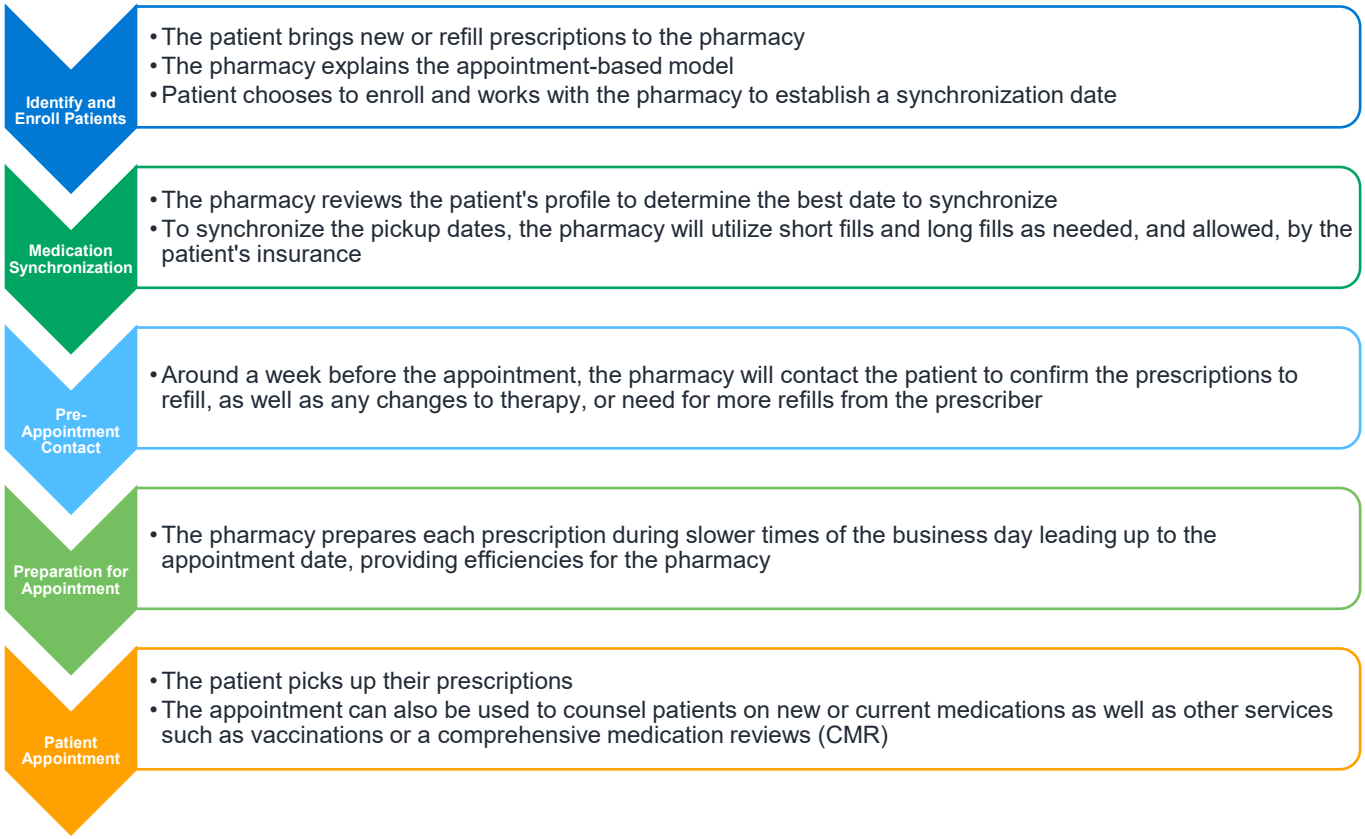
A foundational program for improving medication adherence (and providing efficiencies for the pharmacy network) is medication synchronization as part of an appointment-based model (ABM). The ABM is defined as pharmacist coordination of a patient's regimen in such a way that all chronic medications are refilled on the same day of the month. Enrolled patients visit their pharmacists once monthly (or every 90 days if all a patient's medications are 90-day fills), by appointment, where the pharmacist conducts a short medication review with the patient, identifies any need for medication reconciliation, asks about over-the-counter treatments, and answers any questions from the patient. This time is also spent discussing other goals the patient may have, such as smoking cessation or routine vaccinations.

Key differences between an ABM and autofill program:

- Preemptive outreach to the patient before the appointment date to update any changes in their medications
- Makes sure there are refills available from the prescriber
- Meets with the patient on the appointment date to discuss other health goals

By this definition, mail-order pharmacies are not currently running ABM programs, but have the potential to easily convert to the ABM by adding outreach and a scheduled audio or video call with the patient to discuss their goals. This would also improve patient satisfaction with mail-order pharmacies, which have received mixed reactions from patients. See Figure 5 for more details on the ABM process.

**FIGURE 5: THE APPOINTMENT-BASED MODEL PROCESS**




The medication adherence Star Ratings are all triple-weighted, giving them more impact on an MAO's or Medicare Advantage Prescription Drug (MAPD) plan's Star Ratings. Improvements in adherence may also indirectly improve several Part D measures such as Getting Needed Prescription Drugs, Rating of Drug Plan, Complaints about the Drug Plan, and even some Part C measures like Diabetes Care and Controlling Blood Pressure. See the table in the sidebar for a comprehensive list of the measures impacted by the

ABM. These measures impact 40.7% (44 / 108) of the weighted measures. For these reasons, a program based on improving medication adherence will not only improve a plan's Star Ratings but will also improve the health and satisfaction of its members.

The data supporting medication synchronization, and the ABM version in particular, is strong. A meta-analysis from 2021 found medication synchronization increases the likelihood for adherence to therapy, with the ABM having the largest effect on adherence.[16] Another study found that this effect can be an increase of 20% or more in proportion of days covered (PDC), increasing the likelihood of a patient being adherent 3.4 to 6.1 times compared to those not in an ABM program.[17]

**SIDEBAR: STAR MEASURES POTENTIALLY IMPACTED BY THE ABM**

| **PART C MEASURES** | WEIGHT |
|---|---|
| Annual Flu Vaccine | 1 |
| Care for Older Adults—Medication Review | 1 |
| Diabetes Care—Blood Sugar Controlled | 3 |
| Controlling Blood Pressure | 3 |
| Improving Bladder Control | 1 |
| Medication Reconciliation Post-Discharge | 1 |
| Plan All-Cause readmissions | 1 |
| Statin Therapy for Patients with Cardiovascular Disease | 1 |
| **Part D Measures** | **Weight** |
| Complaints about the Drug Plan | 4 |
| Members Choosing to Leave the Plan | 4 |
| Drug Plan Quality Improvement | 5 |
| Rating of Drug Plan | 4 |
| Getting Needed Prescription Drugs | 4 |
| Medication Adherence for Diabetes Medications | 3 |
| Medication Adherence for Hypertension (RAS antagonists) | 3 |
| Medication Adherence for Cholesterol (Statins) | 3 |
| MTM Program Completion Rate for CMR | 1 |
| Statin Use in Persons with Diabetes | 1 |

This effect is not limited to just the Star Rating measure medications (diabetes, renin angiotensin system antagonists [RASA], statins). Another study from 2022 found that the ABM produced significant improvements in adherence for all chronic disease categories.[18] This includes adherence to medications for mental health conditions. When patients are adherent to their mental health medications, their adherence to all chronic medications improves, potentially resulting in a positive catalyst to better outcomes and lower costs. These catalysts could lead to lower claims costs, while also increasing revenue due to higher Stars ratings.

The investment for an MAO or prescription drug plan (PDP) to implement the ABM is exceptionally low compared to the return on investment for all the Star measures mentioned in the sidebar.[19] Most pharmacy benefit managers (PBMs) already have a medication synchronization program they can offer to plans. However, those programs may be more like autofill programs. They may need to be modified to include advance outreach and appointments with a pharmacist. There are also multiple vendors that offer their networks of pharmacies for running the ABM. The financial model for these programs from PBMs and vendors can vary depending on the company and how confident it is in their results. The contracts can range from fee-for-service to get patients initially enrolled, to quality payments only for the patients who achieve adherence above the 80% PDC threshold.

> The effect of an ABM can be an increase of 20% or more in proportion of days covered (PDC), increasing the likelihood of a patient being adherent 3.4-6.1 times

[16] Nsiah, I., Imeri, H., Jones, A.C., Bentley, J.P., Barnard, M., & Kang, M. (July-August 2021). The impact of medication synchronization programs on medication adherence: A meta-analysis. *J Am Pharm Assoc* (2003);61(4):e202-e211. doi: 10.1016/j.japh.2021.02.005. Epub 2021 Feb 17. PMID: 33741277. Retrieved February 16, 2024, from https://pubmed.ncbi.nlm.nih.gov/33741277/.

[17] Holdford, D.A. & Inocencio, T.J. (November-December 2013). Adherence and persistence associated with an appointment-based medication synchronization program. *J Am Pharm Assoc (2003)*;53(6):576-83. doi: 10.1331/JAPhA.2013.13082. PMID: 24185429. Retrieved February 18, 2024, from https://pubmed.ncbi.nlm.nih.gov/24185429/.

[18] Cheng, A., Hughes, T.D., Chen, H.-H., Ozawa, S., & Ferreri, S.P. (October 2022). Beyond refill alignment: Evaluating the impact of appointment-based model. *Res Social Adm Pharm*;18(10):3751-3757. doi: 10.1016/j.sapharm.2022.05.004. Epub 2022 May 10. PMID: 35597711. Retrieved February 18, 2024, from https://pubmed.ncbi.nlm.nih.gov/35597711/.

It is crucial for MAPDs and PDPs to have a proven strategy to continually improve member adherence. Starting with the ABM as a foundation is a good approach. To this foundation, additional programs such as 30 to 90-day conversions, adherence barrier assessments, and concierge fills can be layered on. These strategies not only maintain medication adherence among members for better health outcomes, but also enhance Star Ratings for MAOs and PDPs for a low financial and operational investment.

# Closing remarks

The dynamic landscape of upcoming CMS Star Ratings underscores the pressing need for MAOs to implement strategic operational changes. Without a focus on operational changes, MAOs are at risk for:

- **Negative quality-of-care perceptions:** Quality-of-care perceptions are associated with Star ratings and decreases can be poorly perceived by beneficiaries, regulators, and the public. There is a risk that lower star ratings can lead to reduced enrollment and retention. Preserving an MAO's reputation is paramount while experiencing any decrease in Star ratings.
- **Contract renewal and scrutiny:** Impact on provider network relationships may be influenced by lower Star ratings. High-quality providers may not want to collaborate with a poorly performing MAO, potentially limiting quality services for members. Contract renewal concerns may arise as CMS evaluates contracts based on Star ratings and contracts may face more scrutiny from provider groups and other healthcare delivery systems. If low-quality ratings continue, plans will be identified by their low-quality ratings in the Medicare Plan Finder.
- **Poor vendor performance:** MAOs are typically not able to manage every responsibility and rely on vendors for a variety of functions, including conducting chart reviews, data aggregation, auditing coding, providing in-home assessments, and many others. MAOs rely on many of their vendors to provide a positive return on investment (ROI). Vendor ROI can be difficult to accurately measure and must be tailored to each client contract to provide a realistic value. Vendor ROI is dependent on a vendor's performance because a poorly performing vendor can have a direct negative impact on Star ratings. As a result, vendors should adhere to performance guidelines and MAOs need to have strong vendor oversight programs in place.

As Star Ratings change over the next several years, operational strategies will become pivotal to enhance the quality of care and sustain financial viability, especially knowing that strategies take years to see positive changes in ratings and revenue. MAOs that prudently invest in operational excellence are better positioned to navigate the evolving regulatory environment successfully, but they can also position themselves to excel with stakeholders such as patients and providers. This forward-thinking approach can lead to improved patient outcomes, better Star ratings, increased market share, and a stronger competitive position in the industry.

### LIMITATIONS AND DATA RELIANCE

We primarily relied on information and data provided by CMS, including both publicly released membership data and projections for model impacts. We also relied on other information provided by additional sources, primarily relating to policy analysis. Throughout this analysis, Milliman relied on data and other information provided by publicly available data sources. The estimates included in this paper are not predictions of the future; they are estimates based on the assumptions and data analyzed at a point in time. If the underlying data or other listings are inaccurate or incomplete, the results may also be inaccurate or incomplete. Milliman has not audited or verified this data and other information but has reviewed it for reasonableness.

This report is intended for informational purposes only. Milliman makes no representation or warranties regarding the contents of this report. Likewise, readers of this report are instructed that they are to place no reliance upon this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The views expressed in this research paper are made by the authors and do not represent the opinions of Milliman, Inc. Other Milliman consultants may hold alternative views and reach different conclusions from those shown.

**ACKNOWLEDGEMENTS**

The authors further acknowledge Lisa Mattie, RN and Matthew Hayes, FSA MAAA for their peer review during the writing of this report.

Milliman

Milliman is among the world's largest providers of actuarial, risk management, and technology solutions. Our consulting and advanced analytics capabilities encompass healthcare, property & casualty insurance, life insurance and financial services, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

**CONTACT**

Rachel Ferguson
rachel.ferguson@milliman.com

Bryce Platt
bryce.platt@milliman.com

Hayley Rogers
hayley.rogers@milliman.com