drips

Measures Look Fine
Members Are Still Falling Through

A framework for Medicare Advantage plans to coordinate outreach around the member

Plans Are Scored by Measure
Members Need to Be Engaged as a Whole

Each decision a plan makes across Stars, quality, pharmacy, care management, and operations is defensible on its own. No single program owns the order in which those decisions reach the member.

That creates three consequences:

1. **Open gaps do not have equal priorities.**

   The highest-weighted measure is not always the highest-priority action once claims, revenue, member context, and likelihood to act are considered.

2. **Programs can make the right decisions but create the wrong sequence.**

   Outreach for an HRA, refill, AWV, and screening may each be appropriate. The member receives all four, in whatever order they happen to land, and that order is often nobody's metric.

3. **A member reply can change what another program should do next.**

   A transportation issue, medication cost concern, or missing PCP is routing information. If it stays inside a single campaign, context is lost.

The Scale of the Measure and Member Challenge

69%

of Medicare beneficiaries have **two or more chronic conditions**[1]

43

separate quality and performance measures in the 2026 Star Ratings[2]

60%

AWV completion nationally in 2022, meaning 40% of eligible members still without a visit[3]

The question is not whether each program is making the right decision. It is whether those decisions add up to the right next action for the member.

[1] CMS, *Multiple Chronic Conditions Measures Overview* (2017 data year).
[2] CMS, *2026 Star Ratings Fact Sheet.*
[3] CMS, *Medicare Current Beneficiary Survey 2022..*

The 90-Day Member-Level Review

Assess Your Member Experience

Pull 90 days of outreach, open needs, member responses, and completed actions, indexed by member ID rather than campaign. Then assess five things across the member journey:

FOCUS	ASK	IF YOU CAN'T ANSWER, LOOK FOR
Visibility	How many members have three or more open gaps, and which programs are contacting them?	*Your highest-risk members competing against your easiest-to-reach members.*
Prioritization	When two programs want the same member, what decides which action comes first?	*Priority that reflects Stars weight alone, not claims, revenue, or likelihood to act.*
Handoff ownership	When a member reveals a barrier mid-conversation, who owns the next action?	*Information trapped in the campaign where it surfaced, so the member starts over.*
Multi-need impact	In the last 90 days, how many interactions closed more than one open need?	*Coordinated outreach credited to a single measure, undercounting its value.*
Completed action	Are you measuring scheduled, or completed actions?	*Performance numbers that track intent instead of the gap between scheduled and done.*

> ***"Our commercial members age-in to Medicare, and we treat them like a new person entirely. The member is n=1 but we don't communicate as if they are."***
>
> **— VP Risk Adjustment, Medicare Advantage[4]**

Success Story: **Regional Health Plan**

2-4x Goal Achievement From Drips Member Outreach

A regional health plan partnered with Drips to scale AI-driven SMS and voice member engagement, improving quality measures and reducing manual burden.

Drips focused on driving member action across multiple programs including annual preventative visits (AWV/APV), medication adherence, and preventative screenings.

Drips Impact

$5-$7M
estimated annual gross margin impact across programs

17K
preventative visits completed, 262% over goal

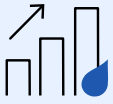
2,100+
care gaps closed, 462% over goal

390%
over goal, improved Rx refill performance

Annualized PMPM estimate based on performance to date (~8 months of program activity)
Over goal compares Drips performance to regional health plan internal targets

Engagement at Scale

- **11X** increase in engaged members (YoY)
- **250K** members engaged annually
- **21%** of conversations continue beyond 3 messages



2-4X
higher program results vs. goal

What to Take Back to Your Team

1. **Index outreach by member ID first.**
   It exposes overlap, competing priorities, and stalled handoffs program-level reporting misses.

2. **Report gaps closed per encounter.**
   Crediting one measure undercounts what coordination accomplished.

3. **Write down who wins when two programs want the same member.**
   Unwritten rules default to whichever outreach is already scheduled.

4. **Name one owner per handoff and measure reply-to-completion time.**
   Track the reply through to completion.

5. **Segment by barrier, not measure.**
   Why a member hasn't acted shapes outreach better than which measure is open.

Where Drips Fits

Drips Connect starts with a question, reads how the member responds, and moves the conversation to the next right action instead of following a fixed script.

Compliance proven

Every conversation is governed against HIPAA, TCPA, FCC, and CMS.

Outcomes driven

We design, launch, and continuously improve the program, so your team can focus on what matters.

Conversation powered

When a member's situation changes, the conversation changes with it, adapting in real time toward the outcome.

About Drips

Drips is conversational outreach for Medicare Advantage and Medicaid plans: it starts with a question and ends with a completed action, closing gaps across HRAs, AWVs, care gap closure, and medication adherence. Built on nearly 850M+ regulated-industry conversations over 10 years, with zero compliance violations, Drips turns replies into results.

Learn more at **drips.com**