OLIVER WYMAN

Health and Life Sciences

POINT OF VIEW

STAR CROSSED: WHY DOCS TRUMP HEALTH PLANS IN CMS STAR SCORES

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An analysis of Medicare Advantage data reveals an important lesson for health plans: Doctors determine quality scores, and to a great extent, geography determines doctor scores.

Healthcare today, with the help of a push from the Affordable Care Act (ACA), is moving toward much greater transparency and a sharper focus on cost and quality. One of the most significant initiatives in this area is the Star Rating program for Medicare Advantage plans (MA), in which a battery of objective and patient-reported metrics are converted into a publicly published score, with major consequences for how health plans are reimbursed and how they are permitted to market themselves. The program is vital to MA plans; if an MA plan run by a large Blue fails to achieve the 5 percent bonus, it stands to lose hundreds of millions of dollars in reimbursement and find itself hard pressed to offer the rates and benefits offered by other, more successful MA plans.

But we believe that *all* health plans should be paying close attention to the Star Rating program, in part because there

How important is the underlying quality of the local delivery system to Star Rating scores?

is discussion that a similar approach may be brought to bear for plans sold on public exchanges. Transparency and quality are the future for healthcare, and what happens in MA today will certainly be a clue to what happens in the individual and group markets tomorrow.

The Star Rating program raises many difficult questions for health plans: What metrics should we focus on? Where should we concentrate our efforts to provide more value for our members and maximize our quality? Is a broad, multi-initiative approach best, or would it be more efficient to use highly targeted solutions at the local level? The puzzle is made even more complex by the observation – noted in publications from the Kaiser Family Foundation and our own client work – that MA star quality ratings vary dramatically by county and state. Throughout the country, there are regions like Minnesota and Massachusetts where the average plan rating is significantly above average and a high percentage of MA enrollees are in plans with four or more stars, and there are other regions (like the New York metropolitan area) where star scores are below average and few four-star plans are available.

Exhibit 1: Metrics used to calculate the composite county, provider quality and payer quality Stars scores

Metrics incorporated in the provider quality score	C01 – Breast Cancer Screening C02 – Colorectal Cancer Screening C03 – Cardiovascular Care, Cholesterol Screening C04 – Diabetes Care, Cholesterol Screening C05 – Glaucoma Testing C06 – Annual Flu Vaccine C09 – Monitoring Physical Activity C10 – Adult BMI Assessment C07 – Improving or maintaining physical health C08 – Improving or maintaining mental health C11 – Care for older adults: Medication Review C12 – Care for older adults: Functional Status Assessment C13 – Care for older adults: Pain Screening C14 – Osteoporosis Management in Women who had a fracture C15 – Diabetes Care: Eye Exam C16 – Diabetes Care: Kidney Disease Monitoring C17 – Diabetes Care – Blood Sugar Controlled C18 – Diabetes Care – Cholesterol Controlled C19 – Controlling Blood Pressure C20 – Rheumatoid Arthritis Management C21 – Improving Bladder Control C22 – Reducing the Risk of Falling C23 – Plan All-Cause Readmissions C24 – Getting Needed Care C25 – Getting Appointments and Care Quickly C27 – Rating of Health Care Quality C29 – Care Coordination
Metrics incorporated in the payer quality score	C26 – Customer Service C28 – Rating of Health Plan C30 – Member Complaints about the Health Plan C31 – Beneficiary Access and Performance Problems C32 – Members Choosing to Leave the Plan C33 – Health Plan Quality Improvement C34 – Plan Makes Timely Decisions About Appeals C35 – Reviewing Appeals Decisions C36 – Call Center – Foreign Language and TTY Availability

Note: All metrics used to calculate the composite county Star score

How important is the underlying quality of the local delivery system to Star Rating scores? How much impact do health plans have on scores? What key metrics are most closely linked to higher Star performance? To find out, Oliver Wyman analyzed the relationship between the underlying performance and quality of local delivery systems and the average health plan Star Rating score at the county level using data for all US MA plans. Again, the data were taken from Medicare Advantage, but the broader goal was to gain a better understanding of the relationship between provider quality and payer quality ratings.

METHODOLOGY

We used the CMS's 2014 Health Plan Quality and Performance Ratings for Medicare Part C to calculate 1. a composite Star Rating score, 2. an average provider quality score, and 3. an average payer quality score for every county in the United States. The composite Star Rating score incorporated all 36 Part C quality measures, while the scores for payers and providers included data only from the metrics that were predominantly driven by them. (See Exhibit 1.)

Transparency and quality are the future. Medicare Advantage today shows what's next for commercial.

To calculate county level scores, we first created a raw county score for each CMS metric, utilizing the available MA contracts in each county and adjusting for a contract's total enrollment in a county and the county's contribution to the overall size of the given MA contract. We then replicated CMS's process for translating individual metric scores into an overall Star Rating score to calculate the composite, payer, and provider scores for each county.

FINDINGS

Our analysis uncovered four key insights:

PROVIDER METRICS ARE THE DRIVING FORCE: Provider metrics account for approximately two-thirds of the 36 Part C metrics, and 73 percent of the total weight of a Part C Star Rating score. But in practice, we found, provider metrics account for approximately 90 percent of total variation in Star Rating scores. Slightly less than 10 percent is attributable to the seven metrics predominantly controlled by payers. (See Exhibit 2.) Average provider quality and the underlying capabilities of the local delivery system were also found to be highly predictive of a county's overall average Star Rating score. Even some payer metrics, such as C24 ("getting needed care") or C27 ("overall rating of healthcare quality") are actually intimately related to care delivery and are not as "payer-controllable" as they may appear to be. While this finding certainly underlines the importance of careful network design and management, we think it also points to a more basic insight: In most cases, the average quality of care delivery in a given geography is the single most important factor in

Providers determine about 90 percent of a Star Rating score. Payers control a bit less than 10 percent.

determining quality scores. And that means it is critically important for health plans to include quality as a major factor when they prioritize their geographic markets and construct their networks.

YOU CAN'T IGNORE PAYER METRICS: At first glance, it may appear that we are arguing that payer-related metrics are unimportant. That is not the case. Our point is that payers do not control a full 27 percent of their Star Rating score, as CMS's weighting system suggests. But they do directly control roughly 10 percent, and that is still an important number, and they heavily impact the remaining 90 percent via the provider network they create and the engagement strategies they employ. While strong payer-related metrics will not be enough to overcome a low-quality, low-performance delivery system, they can be the deciding

Exhibit 2: Provider quality is highly predictive of a plan's STAR rating

CORRELATION BETWEEN COMPOSITE COUNTY AND PROVIDER -RELATED STAR RATING SCORES – 2014 MA DATA

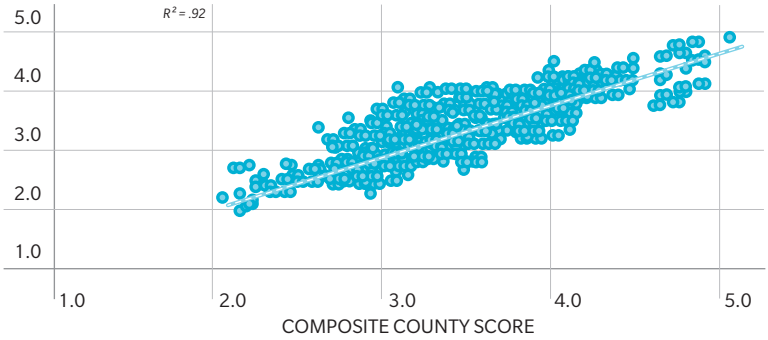
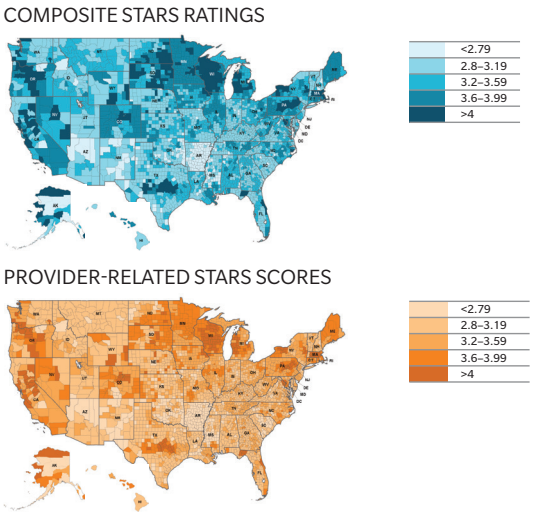


Exhibit 3: Provider Star Rating scores are highly predictive of a county's overall Star Rating score



factor in many marginal cases. This implies that payers should continue to improve consumer experience metrics through careful budgeting and highly targeted efforts, rather than broad based programs.

SEVEN METRICS ARE KEY: Within the significance of the 27 provider-related metrics, we identified six that, along with the provider-oriented consumer complaint metric, most strongly predict the composite county Star Rating score. (See Exhibit 5.) Interestingly, none of them are specifically related to the problems and conditions of the elderly patients served by Medicare Advantage. Rather, they demonstrate the ability of providers and payers to coordinate care, apply consistent standards, and act proactively – which makes us expect that a similar set of metrics also play a strong role in identifying high-quality providers in the world of commercial health plans. The seven metrics provide a good starting point for any organization, whether the goal is to identify high-quality providers, prioritize improvement programs, engineer incentives, or track progress.

The most significant Star Rating metrics are not specifically related to problems of elderly patients.

CONSUMERS LINK THEIR PROVIDER AND PAYER EXPERIENCES: Perhaps the most important finding is that members think about a singular overarching healthcare experience and do not divorce payer components from provider components. The experience with a provider – good or bad – will likely show up in the payer's quality metrics. The point is demonstrated by Exhibit 4 which shows a relatively strong correlation between provider-related and payer-related Star Rating scores. The lesson is clear, whether applied to MA Star Ratings or broader questions of perceived quality: If you want members to think highly of your health plan, invest in guaranteeing that they have better experiences and greater satisfaction with the doctors they see and the care they receive. Patients don't think in silos, so you can't either. Payer-related, provider quality and member engagement efforts should all be coordinated into a single strategy to drive greater member value.

Exhibit 4: Payer-related metrics are still relevant as demonstrated by the correlation between the county Star Ratings score and payer quality scores

CORRELATION BETWEEN COMPOSITE COUNTY AND PAYER-RELATED STAR RATINGS SCORES – 2014 MA DATA

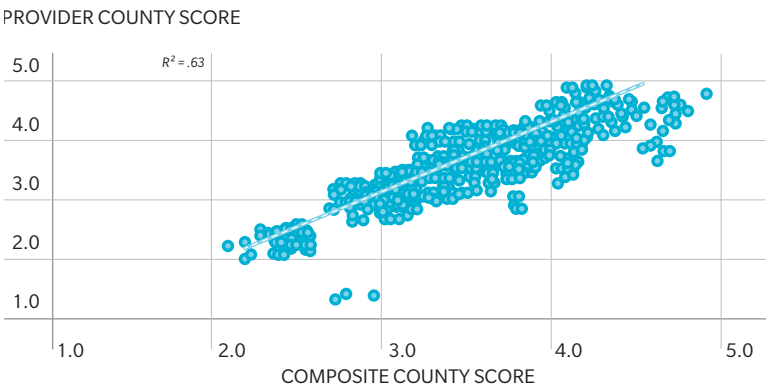


Exhibit 5: Specific variables are likely to drive a county's composite Star Rating score

METRICS DEMONSTRATING A STATISTICALLY SIGNIFICANT PEARSON POSITIVE CORRELATION WITH THE COMPOSITE COUNTY STARS SCORE (R >.6)	
1: Staying Healthy: Screenings, Tests and Vaccines	**Pearson Correlation Value, r**
C01 – Breast Cancer Screening	.685
C02 – Colorectal Cancer Screening	.751
C05 – Glaucoma Testing	.762
C06 – Annual Flu Vaccine	.651
2: Managing Chronic Conditions	
C17 - Diabetes Care – Blood Sugar Controlled	.708
C19 - Controlling Blood Pressure	.696
4: Complaints, Service problems and Health plan improvement	
C30 – Member Complaints about the Health Plan	.618

Sapphire: Payer specific metrics

CONCLUSION

What happens in the doctor's office, good or bad, will likely show up in a payer's quality metrics.

Outcomes and quality are becoming more and more important to health plans. For Medicare Advantage plans, a poor Star Rating score can already make the difference between profit and loss. All commercial health plans are likely to face a similar challenge over the next few years. In order to remain successful in the future, plans need to continue to shift to value and develop a more consumer-centric approach to healthcare by improving outcomes, helping members stay and become healthier, and ensuring positive care experiences. This is especially true because members clearly do not distinguish their feelings about their payer from feelings about their providers.

Our assessment is of course most immediately applicable in Medicare Advantage. There it can help plans determine where Star Rating scores are likely to be high or low, where contracted providers may be underperforming, and where plans should ultimately play. Healthcare is increasingly local, and MA plans need to assess and prioritize their markets – including the strength of the local delivery system. Plans should examine a variety of county-level characteristics such as demographics, MA market penetration and growth, provider capabilities and performance, and historical/forecast reimbursement rates to identify structurally sound counties where they will have the greatest likelihood of success. This process will help plans to deploy Star Rating improvement efforts more surgically and ultimately drive the enhanced performance of their MA portfolio.

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