OLIVER WYMAN

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POINT OF VIEW

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WINNING ON STARS

IT STARTS AND ENDS WITH PROVIDERS

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Reimbursement cuts and competitive activity are placing increasing strain on Medicare Advantage margins, underscoring the criticality of Stars as a profit-driver. Concurrently, comparable quality programs are proliferating across other managed care markets (exchange, Medicaid, etc.).

As Stars becomes an even greater priority—and as risk-bearing entities transition more broadly towards a world where quality of care is a key determinant of financial viability—critical questions arise. Where must one focus to optimize performance? How can one drive holistic, sustainable, and continued improvement? Oliver Wyman has unveiled several key insights.

MARSH & McLENNAN COMPANIES

Stars performance has become critical for Medicare Advantage (MA) carriers. For many, the five percent reimbursement bonus for strong performance dictates whether or not the plan will remain financially viable. Top-performing plans (with five-star contracts) receive an added benefit: they can enroll members throughout the entire year, beyond the standard annual enrollment period. On the other end of the spectrum, plans that receive less than three stars for three years face termination of their CMS contracts.[1] Today, the Stars program is truly do-or-die.

CMS Star Ratings are do-or-die for health plans. And this year, the bar is higher than ever

The latest round of rule changes has made four- and five-star ratings both harder to achieve and harder to plan for. As the Stars program evolves and plans continue to raise the bar, it is becoming more and more vital to invest strategically in improving scores—and to clearly understand where and how to invest in order to maximize impact and ROI.

RAISING THE BAR

As four-star ratings have become more important to MA plans, they have become more difficult to earn and maintain. The April 2015 call letter included a number of provisions that will affect future Stars scoring—and each of them effectively raises the bar:

No predetermined four-star thresholds: In previous years, CMS set predetermined four-star thresholds on roughly two-thirds of the Part C Stars measures. Starting in 2016, CMS will instead determine cut points on a relative basis. As a result, minimum four-star performance requirements have increased on most measures, making it even more challenging for plans to achieve and maintain a high rating.[2]

Furthermore, removal of predetermined four-star thresholds adds a greater degree of uncertainty as plans manage Stars improvement strategies. Previously, a plan could monitor its performance throughout the year and know with confidence whether or not it was on track to reach four stars on a measure—and adjust its strategy accordingly.

Changes to the measures: CMS continues to change the standard measure set, requiring continual innovation from plans to adapt. In some cases, the changes respond to evolving standards of care; in others, the agency is concerned with the reliability of data. The

1 2015 CMS Call Letter.

2 Oliver Wyman analysis of 2015 and 2016 Stars Technical Notes.

changes for 2016 are modest[3], but CMS's clear intention to continue its fine-tuning poses a challenge for health plans. Many MA plans throughout the country have made meaningful investments in changing the behavior of their provider networks and improving data collection across a specific set of measures. When CMS changes the measures, the effort starts again from scratch.

Even plans that are well-positioned today must continue to invest in their Stars performance

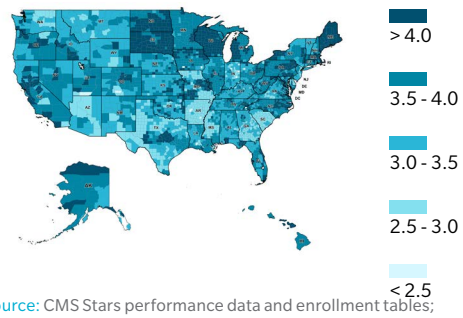
CMS wants to see continued, holistic improvement in the quality of care. It has made that view crystal clear—subtly, through the evolution of the underlying measure set, but also explicitly, by making the improvement measure the program's most heavily weighted metric.[4] Even plans that are well-positioned today must continue to invest in their Stars performance if they hope to be successful in the future.

Where do plans need to focus when investing in Stars? How can they maximize ROI? Oliver Wyman's annual and county-level analysis provides several key insights.

METHODOLOGY

As in last year's analysis[5], we took CMS's 2015 Health Plan Quality and Performance Ratings for Medicare Part C and, for every county in the United States, calculated: an average overall Part C Star rating (illustrated in Exhibit 1), an average Part C Star rating only on measures related to provider performance (see Exhibit 2), and an average Part C Star rating only on measures related to health plan performance and member experience. To calculate county-level scores, we first created a raw county score for each CMS metric using performance data from local MA contracts and adjusting for (1) a contract's total enrollment in a county and (2) the county's contribution to the overall size of the MA contract. We then replicated CMS's process for translating individual measure scores into an overall Star rating to calculate the overall, provider-driven, and payer-driven ratings for each county.

Exhibit 1: 2015 County Average Part C Ratings – All Measures



Source: CMS Stars performance data and enrollment tables; Oliver Wyman analysis

3 Four distinct measures were added, two of which appear in both the Part C and D measure sets. Five measures were removed (one temporarily).

4 Health/Drug Plan Quality Improvement now has weight of 5.0. Highest weight of any other measure is 3.0.

5 A. Jensen, M. Graf. "Star-Crossed: Why Docs Trump Health Plans in CMS Stars Scores" (2014).

Success on payer-driven measures is table stakes. Plans can't differentiate themselves on that alone

Exhibit 2: Metrics used to calculate the overall, provider-driven, and payer-driven county average Star ratings

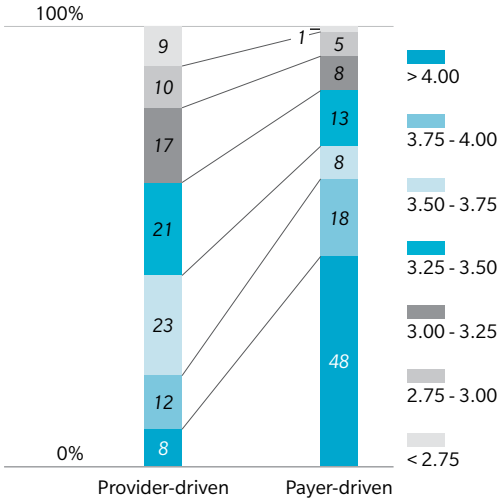
Metrics incorporated in the provider quality score	C01	Colorectal Cancer Screening
	C02	Cardiovascular Care – Cholesterol Screening
	C03	Diabetes Care – Cholesterol Screening
	C04	Annual Flu Vaccine
	C05	Improving or Maintaining Physical Health
	C06	Improving or Maintaining Mental Health
	C07	Monitoring Physical Activity
	C08	Adult BMI Assessment
	C09	Special Needs Plan (SNP) Care Management
	C10	Care for Older Adults – Medication Review
	C11	Care for Older Adults – Functional Status Assessment
	C12	Care for Older Adults – Pain Assessment
	C13	Osteoporosis Management in Women who had a Fracture
	C14	Diabetes Care – Eye Exam
	C15	Diabetes Care – Kidney Disease Monitoring
	C16	Diabetes Care – Blood Sugar Controlled
	C17	Diabetes Care – Cholesterol Controlled
	C18	Controlling Blood Pressure
	C19	Rheumatoid Arthritis Management
	C20	Improving Bladder Control
	C21	Reducing the Risk of Falling
	C22	Plan All-Cause Readmissions
	C23	Getting Needed Care
	C24	Getting Appointments and Care Quickly
	C26	Rating of Health Care Quality
	C28	Care Coordination
Metrics incorporated in the payer quality score	C25	Customer Service
	C27	Rating of Health Plan
	C29	Complaints about the Health Plan
	C30	Members Choosing to Leave the Plan
	C32	Plan Makes Timely Decisions about Appeals
	C33	Reviewing Appeals Decisions
Excluded metrics	C31	Health Plan Quality Improvement

Note: All metrics were used to calculate the overall county average Star rating

WHOSE STARS ARE THEY?

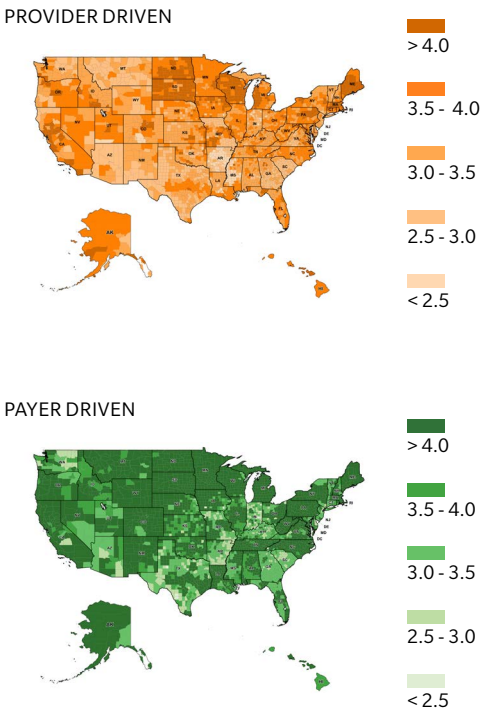
Historically, MA plans placed an outsized focus on Stars measures they believed were more easily controllable—the ones centered on member experience. Many plans delivered a consumer-centric approach to Stars improvement, and in turn many succeeded in ramping up performance on these metrics. As a result, national scoring on these "payer-driven" measures has become high and homogeneous. According to our research, roughly 50 percent of U.S. counties average 4.0 or higher on the payer-oriented measures (see

Exhibit 3: Distribution of Counties by Avg. Star Rating – Provider- vs. Payer-Driven



Source: CMS Stars performance data and enrollment tables; Oliver Wyman analysis

Exhibit 4: 2015 County Average Part C Star Ratings – Provider-Driven Measures vs. Payer-Driven Measures



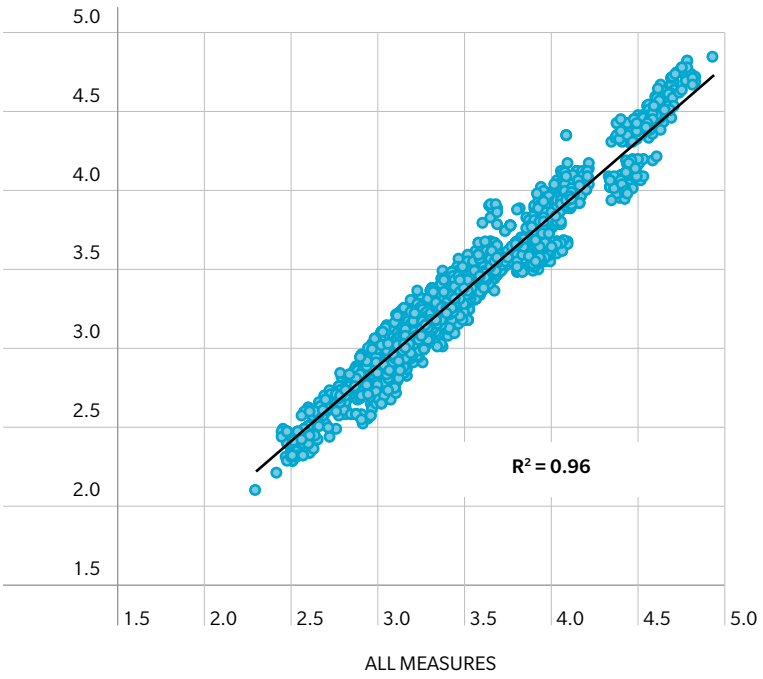
Source: CMS Stars performance data and enrollment tables; Oliver Wyman analysis

Exhibits 3 and 4). Success on payer-driven measures has become table stakes; plans generally do not—and cannot—differentiate themselves on this domain alone.

The opposite is true for the provider-driven measures—procedures and tests conducted, outcomes achieved, etc. On these measures, average performance is relatively low and much more variable . It is on these measures that health plans generally differentiate themselves, for better or for worse, from their competitors.

As in last year's analysis, provider quality has a disproportionate impact on overall Stars scoring. In 2014, there was a nearly perfect correlation ($R^2 = 0.92$) between average provider-driven Part C Star ratings and overall Part C Star ratings across all counties in the United States. In 2015, the correlation grew even stronger ($R^2 = 0.96$) (Exhibit 5). Even though provider-driven measures only make up about 74 percent of the total Part C scoring weight[6], they essentially determine the score by themselves. Ultimately, a health plan's Star rating is defined primarily by the behavior of its providers.

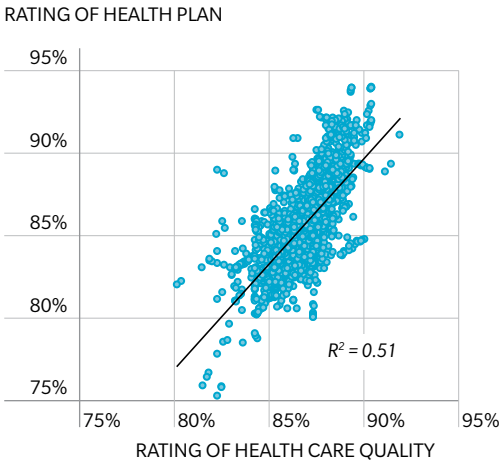
Exhibit 5: County Average Part C Star Ratings – All Measures vs. Provider-Driven Measures Only (2015)



Source: CMS Stars performance data and enrollment tables; Oliver Wyman analysis

6 As of 2015, including Health Plan Quality Improvement.

Exhibit 6: County Avg. Scores on Rating of Health Care Quality vs. Rating of Health Plan



Source: CMS Stars performance data and enrollment tables; Oliver Wyman analysis

Provider-driven measures are where plans must focus their energy and investment

The conclusion is clear: Provider-driven measures—and the network of physicians who influence them—are where plans must focus their energy and investment. Payer-driven member experience measures are still important (they make up roughly 17 percent of the overall Part C scoring weight[7]) but are secondary to clinical quality.

Interestingly, clinical quality may even affect scores on the member experience measures—the metrics traditionally viewed as payer-driven. There is a meaningful correlation between average scoring on members' "Rating of Health Care Quality" and "Rating of Health Plan" (see Exhibit 6). Patients tend not to distinguish their experiences with their doctor from their experience of their health plan—so that what happens in the physician office shows up in the payer-driven measures.

DEVELOPING STARS POWER

Any winning Stars strategy must include the following elements:

Understand the program. The Stars program is simple in its broad outlines, but complex in its details. Be sure you and your team maintain a robust understanding of the program and—equally important—keep close tabs on the regulatory environment to help predict future legislative changes and enable pre-emptive action.

Understand your market and your network. Different areas of the country have very different provider infrastructures. The particulars of your local provider market—baseline quality levels, performance variance across providers and measures, degree of market consolidation, and how far your providers have traveled along the path to risk—will all have significant implications for your strategy. A successful Stars strategy in Indiana, where baseline quality is low (roughly three stars) and the local provider market is highly fragmented, will look different than a strategy in Minnesota. Your own market position as a payer will also inform the ways in which you can drive change across your contracted providers—and the extent to which you can succeed on a given initiative. Greater market share often translates to a greater ability to influence and transform your network. If you are a high-share player outside of MA, integrating quality initiatives across other lines of business (for example, the Quality Rating System for ACA membership) can help put weight behind your programs.

7 As of 2015, including Health Plan Quality Improvement.

Deploy the right tools. There is no one-size-fits-all approach to driving clinical Stars performance. Network sculpting, incentives/penalties, member/provider interventions, and other mechanisms can all be effective, depending on the local provider landscape, your market positioning, and the measures you are trying to address.

There is no one-size-fits-all approach to driving clinical Stars performance

Monitor and report on performance. It is crucial to track and forecast your Stars performance in detail and in near-real time. Maintaining a robust understanding of your current performance and gaps enables strategic deployment of initiatives to address specific measures that need to be moved to maximize your overall rating. Furthermore, effective performance monitoring and reporting enables ROI tracking for the programs you deploy today—which in turn helps shape and refine your future Stars strategy.

CONCLUSION

If there is one thing we've learned in our work with health plans and their quality improvement strategies, it is the importance of taking a long view. Stars is just the beginning—comparable quality programs are proliferating in other managed care markets (exchange, Medicaid, etc.) with increasingly weighty financial implications. Continuous quality improvement is not a now-and-again concern; it is one of the cores of your business. It's time to ensure that you can meet the ever-increasing quality demands of tomorrow.

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