

## Preparing for star ratings in 2012

### Laying the foundation for success



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The Centers for Medicare & Medicaid Services (CMS) are raising the stakes in measuring whether Medicare Advantage plans are delivering quality care with the implementation of a new star rating system. The new system rewards only plans that achieve certain benchmarks for multiple quality measures. Plans that earn more than three stars and fewer than four stars will receive partial Quality Bonus Payments (QBPs) from 2012 through 2014. But starting in 2015 they will lose all opportunity for bonus payments, while those that achieve four or more stars will earn a QBP of 5 percent. This puts Medicare Part C and Part D plans under intense pressure to formulate a clear strategy for achieving and maintaining quality.

To move toward better quality ratings, plans need to fully understand the basic tenets of the star program, select a customized approach to identifying their core capabilities, establish best practices, and determine how to improve lagging scores on specific star quality measures.

#### **Promoting quality: the long-term goal of star ratings**

The star system considers 53 quality measures—36 for Part C, and 17 for Part D—which include providing preventive services, managing chronic illness, and providing good customer service as measured by low consumer complaints.

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The data that determine the quality ratings are drawn from:

- Administrative claims data and chart reviews—Healthcare Effectiveness Data and Information Set (HEDIS) and medication adherence
- Member satisfaction and member experience surveys—Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Surveys (HOS)
- CMS monitoring and oversight—Appeals timeliness, call center performance, enrollment processing, etc.

Several CMS “call letters” issued in 2011 made adjustments to the initial program and QBP demonstration project. Accordingly, the introduction of three new medication adherence measures, each with a triple weight, makes Part D matter more than ever. Indeed, CMS is emphasizing an outcomes-based, “member-centric” movement that integrates Parts C and D.

In terms of member experience, plans need to understand that they often have more opportunities to touch the member through prescription drug services than through clinical encounters. For example, the average member has six to nine physician visits per year, providing six to nine opportunities for the plan to provide quality services to that member. However, the average member also has four prescriptions filled each month, which gives the plan 48 opportunities to succeed or fail. Plans cannot overlook these opportunities and must not treat Parts C and D as separate domains because members do not differentiate between clinical services or medication services. To members, they are both part of one plan.

Plans have to look at all the moving parts in both Part C and Part D and look for synergies—such as bringing together medication therapy management and disease management programs—that could lead to better overall quality and have an impact on high blood pressure or other conditions. This approach could have a positive effect on multiple star measures.

### Targeting five key domains to drive improvement

To manage a broad array of measures and moving CMS targets for yearly evaluation, plans first need to look at big-picture goals instead of devoting significant resources to specific interventions. Plans need to replace a “measure-owner” approach whereby a specific department is responsible for making sure a particular measure (e.g., mammogram reminder postcards) is carried out—with an overall strategy for plan operations that focuses on core capabilities.

Then, when devising best practices, plans can focus on approach rather than specifics. Taking this approach will allow the plan to expand core competencies and remain flexible amid ongoing CMS changes.

During the past two years, OptumInsight™ has completed Medicare Advantage star system engagements covering 49 states and more than 100 contracts, working with a variety of plan types (HMO, SNP, PPO, and PFFs) that have earned 2.5 to 4.5 stars. Through this experience, OptumInsight has identified five domains that can be used as levers to drive quality improvement:

- **Data and reporting**—Data collection, organization, and reporting allow plans to optimize member and provider outreach efforts. Without management-focused reporting that integrates data regarding utilization, pharmacy, risk adjustment, HEDIS, and operations, plans are unable to evaluate their real-time quality status or the results of quality improvement initiatives and interventions or facilitate continuous improvement.
- **Organization and strategy**—A sound infrastructure and a macro star strategy allow the plan to make the necessary investments in growth, process management, people, and technology (see graphic on page 3). Best practices in this domain include organizational knowledge building, statistical prioritization algorithms, organization alignment and investment, market selection and growth models, and benefits design. OptumInsight uses a proprietary national data set that links star data, CMS administrative data, NCQA data, and census data to create a predictive model for use in the analysis of each contract and its subregions.
- **Operations improvement**—Although CMS has indicated that longer-term operational measures will have declining importance while clinical measures will be weighted more heavily, most plans are continuing to commit resources to achieve five stars on operational measures. Operational excellence is particularly integral to Part D, in which administrative measures predominate. In the operations domain, pharmacy benefit management optimization, mock member satisfaction surveys, complaint and call center reviews, vendor management and procurement, and operational metric alignment are among the best practices.
- **Provider engagement**—The selection, growth, and alignment of high-performing providers has never been more important for payers than today. Plans want to reach members through providers as the centers of care, but typical broad-access networks make that difficult. Only 20 to 30 percent

of current members are aligned with physicians or physician organizations that can handle interventions, which can then be reinforced through plan investments in other areas, such as data capture and submission, feedback, and reporting. In this domain, selective primary care expansion, clinical network relations, provider communications and incentives, and narrowed and preferred networks are among the best practices to improve star ratings.

- Member engagement**—Until provider engagement improves, plans need to invest in member-direct outreach. Clinical programs must be designed to align with the star system and ideally reach both acute care and chronic care members. For most plans, this approach represents a change in the way members are assigned to programs and the way resources are allocated. OptumInsight has used focus groups and quantitative research to define specific drivers for improving CAHPS and HOS performance and member satisfaction. Other best practices in this domain include consumer customization, care outreach gap closure, customer service concierges, member incentives, and pharmacy benefit streamlining.

**Tools to jumpstart quality progress**

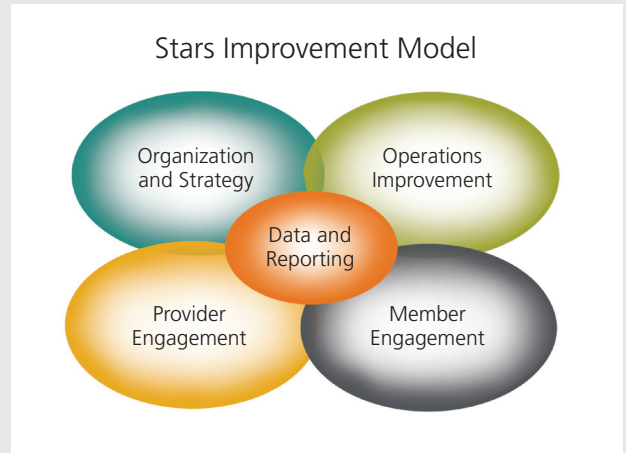
OptumInsight works closely with plans—and providers—to help plans position themselves for four-plus star ratings and QBPs. Together, we develop customized provider incentive and clinical quality programs that fit the needs of each organization and its marketplace.

This is clearly not a one-size-fits-all approach. Plans and providers need to meet each other with a realistic, fact-based understanding of performance in order to align financial and clinical objectives. OptumInsight’s approach supports conversations that yield improved performance for all participants.

OptumInsight also can facilitate collaborative efforts between a pharmacy benefit manager (PBM) and its health plan to focus on star measures and pinpoint where the interplay of pharmacy benefit management and health plan attributes drive Part D scores.

On the member engagement side, OptumInsight will show plans how to redesign their clinical programs and interventions to better mesh with the star system’s Part C measures. Further, OptumInsight has developed a fact-based approach to network

**Prioritizing organization and operations goals helps plans improve**



Plans that perform well under the star ratings system are those that are able to focus capacity on meaningful measures in advance and ignore other measures. Getting distracted by trying to get to four stars on every measure really just dilutes plan efforts, so focus is important here.

The graphic above describes best practices that OptumInsight has defined for its clients. For example, prioritizing among markets within a contract, among contracts, among providers, and among members will lead to a more well-rounded strategy than taking an intervention-based approach. Further, benefit design in the “organization and strategy” domain will help plans develop a tiering and pricing structure for Part D drugs so they remain competitive while still satisfying members.

In the “operations improvement” domain, mock member satisfaction surveys can help plans take the pulse of their members so they are not surprised by Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores. Pharmacy benefit management program optimization also is important due to the increase in weighting of Part D measures.

Plans—even small plans and those whose contracts are not up for renewal—have to get the attention of the PBM C-suite executives to escalate the conversation about meeting members’ Part D needs in a manner that boosts performance and improves star ratings. Plans need to spend a lot more time in this area if they are to achieve success with Part D quality measures.

stratification that informs the plan's member engagement and provider engagement strategies. This approach uses quantitative analysis to plot providers, groups, and their related membership into groupings that support logical outreach strategies.

Plans then can track and evaluate all of the initiatives they employ to improve or maintain their star ratings using an OptumInsight "dashboard" that allows plans to visualize their performance, break down measures by domain, and intuitively drill down into individual measures within that domain.

This dashboard leverages existing data extracts through web services integration and shows plan administrators their actual star ratings, raw scores, and cut points, so they can easily see what improvements they need to make to reach their goals. Plans also can use the dashboard to perform "what if" modeling to help them align initiatives and priorities.

Identifying and fine-tuning core capabilities to improve performance on quality measures may seem like an overwhelming task, but if plans examine their performance in the five domains that are critical to star improvement and utilize the sophisticated tools and expertise that OptumInsight has to offer, this mission will seem less daunting.

In terms of predicting future changes, there is no certainty, so plans must remain nimble. OptumInsight experts use up-to-date industry intelligence and develop business and data tools that provide plans and providers with the strategies that allow them to deliver quality today and plan ahead for tomorrow.

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