Star Ratings: New Rules for the Member Experience

pager

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The old rules for scoring high and gaining big in the Medicare Advantage (MA) Star Ratings program are out the door. The Centers for Medicare and Medicaid Services, better known as CMS, have proposed new rules that put the pressure on health plans to rethink their strategies for increasing Star Ratings and prioritize member experience like never before. This white paper will cover:

- How member experience scores are increasing in importance – by 2023, member experience scores will comprise 57% of the overall weight of Star Ratings for that year.[1]
- The benefits of high Star Ratings scores for health plans, and how plans can improve and maintain their scores given the upcoming changes to the Star Ratings program.
- The importance of – and strategies for – improving virtual care coordination and the digital member experience to enhance Star Ratings scores.
- How Pager's technology and services can help plans drive up member experience and ratings.

1. *Carlton, Stephanie, et al. "New Stars Ratings for Medicare Advantage Prioritize Customer Experiences." McKinsey & Company, 15 Oct. 2020, www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/new-stars-ratings-for-medicare-advantage-prioritize-customer-experiences.*

What are Medicare Advantage Star Ratings?

Medicare Advantage (MA) enrollment has doubled over the past decade, with projections to reach 34 millions lives by 2023.[1] MA plan economics are directly impacted by the Star Ratings program, which is a five-star quality-based incentive program that links MA payments to health plan performance based on 42 quality measures across five categories.[2] Each measure is weighted between one to three times. Star Ratings, as well as scores on individual performance measures, are published annually by CMS.

An MA plan's Star Rating is considered one of the most accurate indicators of the plan's value because it brings together ratings of care received from health care providers, health outcomes, health plan operations, and member satisfaction scores to offer a comprehensive view of each plan. The Star Ratings Program is aligned with the priorities set out in the CMS National Quality Strategy, which include safety; person- and caregiver-centered experience and outcomes; care coordination; clinical care and effectiveness; population and community health; and efficiency and cost reduction. Data sources for the measures include:

- Healthcare Effectiveness Data and Information Set (HEDIS): A widely used data set maintained by the National Committee for Quality Assurance (NCQA) and used by 90% of all healthcare providers in the U.S. to assess a plan's clinical effectiveness, accessibility to members, and use of resources

- Consumer Assessment of Healthcare Providers and Systems (CAHPS): Surveys of health plan members conducted annually to assess a patient's experience of care

- Health Outcomes Survey (HOS): Collected patient-reported measures from members enrolled in Medicare Advantage plans

- Part D measures: Developed by the Pharmacy Quality Alliance for plans covering drug services, the overall score for quality of those services includes measures in four categories

- CMS Data: Administrative data exchanges with CMS and their independent review entity, Maximus, including Measures Capturing Access and Patients' Experience and Complaints

2. Centers for Medicare and Medicaid Services. "*Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies." 15 Jan 2021. https://www.cms.gov/files/document/2022-announcement.pdf.*

How are Star Ratings measured?

The Star Ratings are measured by a variety of indicators that fall into the following six broad categories:[2]

01 Outcome measures

These reflect improvements in a member's health. Outcomes measures are key for assessing care quality.

Example: *"Improving or Maintaining Physical Health" is an outcome measure.*

02 Intermediate outcome measures

These reflect actions taken which can help improve a member's health status, and are supportive of outcome measures.

Example: *"Diabetes Care – Blood Sugar Controlled" is an intermediate outcome measure. The related outcome would be better health for members with diabetes.*

03 Patients' experience and complaints measures

These reflect members' perception of the care they received.

Example: *"Rating of Health Care Quality" is a patient experience measure.*

04 Access measures

These reflect whether there are potential barriers to receiving care.

Example: *"Plan Makes Timely Decisions about Appeals" is an access measure that indicates whether members of a plan receive a timely response when they made an appeal request about their plan's decision to refuse payment or coverage.*

05 Process measures

These reflect the ways care is provided. Process measures indicate whether a service is provided, but not the outcome of that service.

Example: *"Monitoring Physical Activity" is a process measure.*

06 Improvement measures

These measure the improvement, if any, in the health plan or drug plan's performance.

Example: *"Health Plan Quality Improvement" is a process measure.*

Calculating Star Ratings

Each Medicare contract of a health plan is assigned a number of stars for each individual quality measure, which then are averaged to get an overall summary score for the contract.

Star Ratings are publicly released in October of each year. Plans are able to appeal their ratings, and eligible plans begin to receive quality bonus payments in late fall. In spring, the Medicare Plan Finder is updated for any changes resulting from appeals. Then, in the fall of the following year, collection of measures data begins again.

Numeric	Graphic	Description
5	★★★★★	Excellent
4	★★★★	Above Average
3	★★★	Average
2	★★	Below Average
1	★	Poor

October
Ratings publicly released; appeal period opens

Late Fall
Eligible plans begin to receive Quality Bonus Payments (QBP)

Spring
Medicare Plan Finder (MPF) is updated with any changes resulting from appeals

Fall
Collection of measures begins again

Why do Star Ratings matter?

For health plan members, looking at Star Ratings can help identify plans that have:

- **An increased focus on preventive services for early detection of disease.** Plans are awarded better ratings based on their offerings of disease screenings and preventive services, meaning members of highly rated MA plans are more likely to receive these services.

- **Greater emphasis on access to and quality of care.** MA plans are incentivized by patient experience and access measures to provide members with easy access to high quality care services.

- **Better customer service.** With certain patient experience measures focused specifically on care coordination and customer service, members of MA plans with high Star Ratings are more likely to have access to high quality customer service.

For health plans, the biggest benefits include:

- **Options for member self-enrollment.** A health plan with a higher Star Rating is more desirable to members shopping for a MA plan. The Medicare Plan Finder (MPF) marks plans according to whether they have a high or low Star Rating, and does not allow users to enroll online in a low performing plan. Members must contact low-performing plans directly to enroll.

- **Bonus payments.** Plans receiving a score of 4+ are eligible for quality bonus payments that can be reinvested back into MA plans to lower member premiums and increase supplemental benefits, incentivizing plans to continue to offer positive member experiences.

- **Full-year marketing and extended enrollment options.** 5-Star plans can market their plans year-round, while plans with lower scores can only do so during the CMS-specified enrollment period, meaning those high-performing plans may be more likely to see higher enrollment.

- CMS will terminate contracts that have failed to achieve 3.0 Star rating for Part C or Part D for three consecutive years.

How Star Ratings Are Changing

In early 2020 in response to the COVID-19 pandemic, CMS paused ongoing data collection surveys used to calculate the 2021 Star Ratings. CMS instead used 2019 measurement year data for HEDIS and 2018 measurement year data for CAHPS measures to determine 2021 CMS Star Ratings.

New codes have been added to recognize telehealth visits for measurement in the 2022 Star Ratings in certain cases, including for rheumatoid arthritis management, breast cancer screenings, and comprehensive diabetes care, to name a few.[3]

In addition to the changes made for the 2021 and 2022 Star Ratings resulting from the COVID-19 pandemic, there are several important measure and weight changes in effect for the 2022 and 2023 plan years, which CMS is implementing in order to put a stronger emphasis on member experience. Although member experience measures have been a component of Star Ratings for years, health plans have historically been less successful in making improvements in this regard when compared to other industries.

High Performing Plan

Low Performing Plan

The Medicare Plan Finder (MPF) marks plans according to whether they have a high or low Star Rating

3. *Blue Peak Advisors. "Early Release Of Medicare Advantage And Part D Advance Notice: Part C & D Star Rating Changes." 18 Dec 2020. https://bluepeakadvisors.com/early-release-of-medicare-advantage-and-part-d-advance-notice-part-c-d-star-rating-changes/.*

Key Star changes for 2022	Key Star changes for 2023	Key Star changes for 2024

• **Retiring measures:**
  • Adult BMI Assessment
  • Appeals Auto-Forward
  • Appeals Upheld
	• **Returning measures:**
	  • Controlling High Blood Pressure (1x)
		• **New measures:**
		  • Transitions of Care
		  • Follow-Up After ED Visit for Patients with Multiple Chronic Conitions

	• **Retiring measures:**
	  • Rheumatoid Arthritis Management
		• **Returning measures:**
		  • Plan All-Cause Readmissions (1x)

• **Temporarily removed:**
  • Plan All-Cause Readmissions
  • Controlling Blood Pressure
	• **Temporarily removed:**
	  • Plan All-Cause Readmissions
		• **Temporarily removed:**
		  • Improving or Maintaining Physical Health
		  • Improving or Maintaining Mental Health

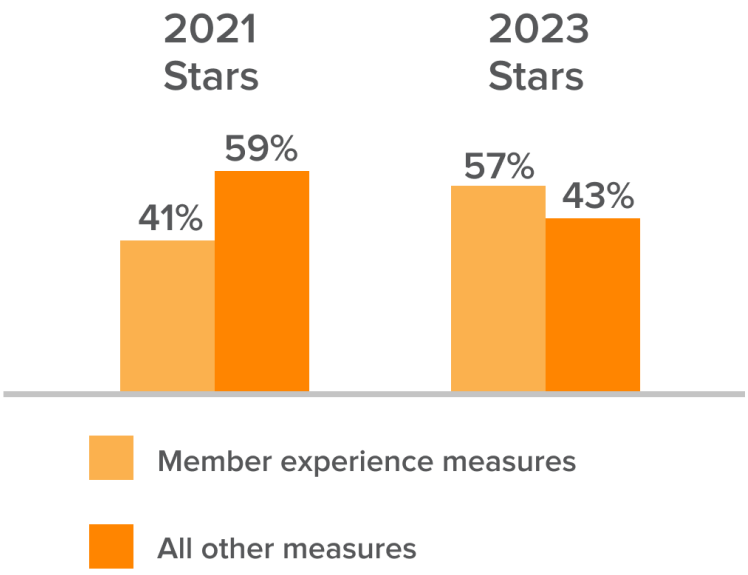
Notes:
• NCQA added codes for MY 2020 for several HEDIS/ telehealth measures
• Re-specified MPF Price Accuracy measure will be a new measure. CMS will calculate each contract's summary and overall Star ratings with and without the new MPF measure. The higher ratings will be used for 2022 Star Ratings.
• Kidney Health Evaluation for Patients with Diabetes added to display page
	Notes:
	• Statin Use in Persons with Diabetes (SUPD) permanently decreasing to 1x
	• Member experience measures increasing 2x to 4x
	• Beneficiaries included in the SUPD measure calculation for a diabetes medication at least 90 days prior to MY (exclusions apply)
	• Updated Part D Measures on 2023 display page:
	  • Use of Multiple CNS-Active Medications in Older Adults
	  • Use of Multiple Anticholinergic Medications in Older Adults
		Notes:
		• Controlling Blood Pressure returning to 3x
		• Potential new measures being considered:
		  • Provider Directory Accuracy (Part C)
		  • COVID-19 Vaccination (Part C)

How upcoming changes emphasize member experience

Another proposal laid out by CMS for the 2024 Star Ratings is that a member experience question to evaluate Net Promoter Score (NPS) be added to the CAHPS survey.[4] NPS is a metric focused on loyalty existing between an organization and a consumer, used across many industries and scored on a scale from -100 to 100. Consumers would be asked to answer the question "How likely is it that you would recommend [X organization] to a friend or colleague?" usually using a 0-10 scale, where the greater the value, the more likely there is a favorable recommendation. While health plans average an NPS score of 13,[5] Pager-led services within a health plan routinely average an NPS score of 80+.

Health plans must remain focused to ensure they have a plan to continue closing gaps in care and providing an excellent customer experience for members. Now more than ever, because of the measure weight changes for the 2023 Star Ratings, health plans must build a thoughtful approach for re-examining their current strategies to address member experience once operations return to business as usual.

Member Experience Measure Weighting



Applicable for non-SNP MAPD plans.

4. *Dockrey, Whitney. "CMS Medicare Proposed Rule and Changes to Star Measure Program." American Health Law Association. 27 Mar 2020. https://www.americanhealthlaw.org/content-library/publications/briefings/5ff125c0-7c43-4dd5-9adf-32ff287ce34b/cms-medicare-proposed-rule-and-changes-to-star-mea.*

5. *NICE Satmetrix. "U.S. Consumer 2018 Net Promoter Benchmarks at a Glance." NICE Satmetrix. https://info.nice.com/rs/338-EJP-431/images/NICE-Satmetrix-infographic-2018-b2c-nps-benchmarks-050418.pdf.*

It’s time to double down on member experience

One of the most important Star Rating changes within plan years 2021 and 2022 is the weight increase from 1.5x to 2x for member experience measures. This is because while member experience measures accounted for only 34% of the overall weight for 2020 Star Ratings, the measures will now account for 41% and 38% in 2021 and 2022, respectively.

By 2023, member experience measures will account for 57% of the overall weight of Star Ratings.

Additionally, because the member experience weight measures will increase from 2x to 4x for plan year 2023, the measures will result in accounting for 57% of the overall weight of Star Ratings for that year.

These changes mean that member experiences must increasingly be at the forefront of MA plans’ goals and strategies for the coming years.

Member experience measures include non-Flu CAHPS measures, Disenrollment, Appeals, Call Center, and Complaints measures, and are calculated based on a variety of data and member responses to CAHPS survey questions. Some determinants include:

+ **Access to care and information**: Members’ ability to easily access care and appointments, and to receive information from customer service
+ **Care coordination:** How well a plan coordinates members’ care and provides care coordination
+ **Member review of plan and care quality:** Member rating of their plan, drug plan, or healthcare received on a scale of zero to 10 in terms of quality
+ **Complaints and member departures:** Member complaints received or members’ decision to leave a health plan or drug plan
+ **Appeals:** Whether a health plan or drug plan makes timely decisions on appeals and how fair appeals are, according to independent review
+ **Access to prescriptions:** Member ability to easily access prescriptions, both by mail and from pharmacies

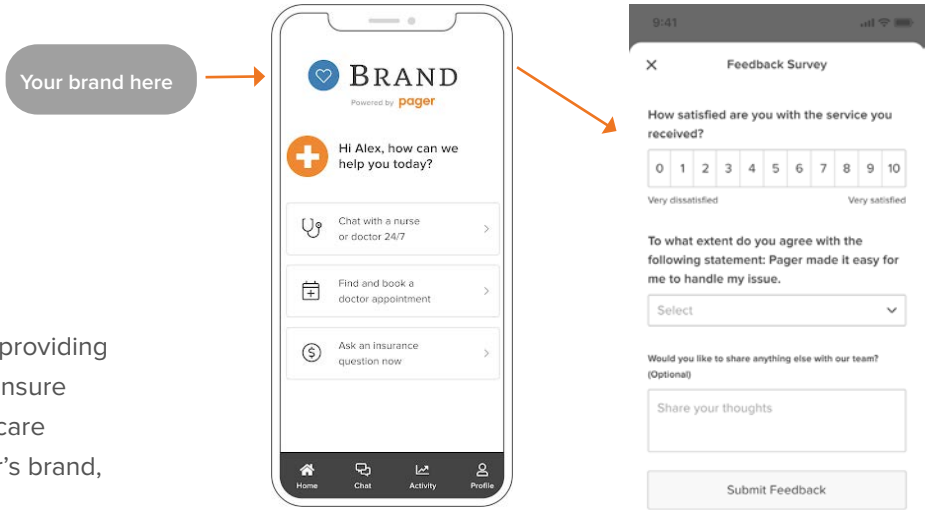
How Pager Can Help

Historically, health plans that don't own care delivery have been at a disadvantage in Star Ratings evaluations, because members aren't just evaluating health plan service – they're also evaluating their healthcare provider. When these providers aren't integrated within a health plan, it can be difficult to evaluate health plan performance separately from the care delivered by providers.

Pager helps health plans engage in care and care coordination by giving plans more control over the member's care journey, directly guiding members to the most appropriate and highest-performing providers in their network. Pager's technology wraps around the entire care experience, providing positive inbound and outbound touchpoints to improve member experience all along their care journey.

Ratings of plan and care quality

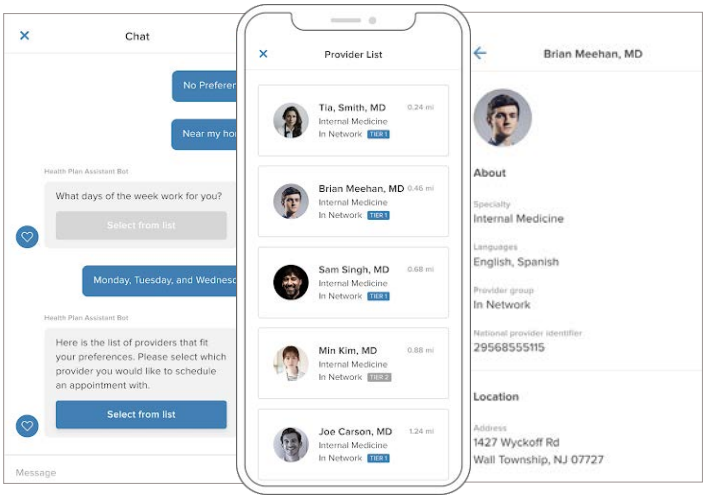
Pager offers a white-labeled solution, providing payers with flexibility on branding to ensure members associate their high-quality care experience for the year with the payer's brand, not an external point solution.



Measures	Sample CAHPS questions	Pager Strategy
C24: Rating of Healthcare Quality	• Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate your health plan?	• Pager is white labeled and embedded in your existing experience, meaning that the Pager experience is synonymous with the experience of your brand • Pager-led services within a health plan routinely average an NPS score of 80+ • Pager provides a simple, unified & guided user experience • Pager deploys a feedback survey at the end of each experience to regularly measure member satisfaction
C25: Rating of Health Plan	• Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	
D07: Rating of Drug Plan	• Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?	

Improving access to care and information

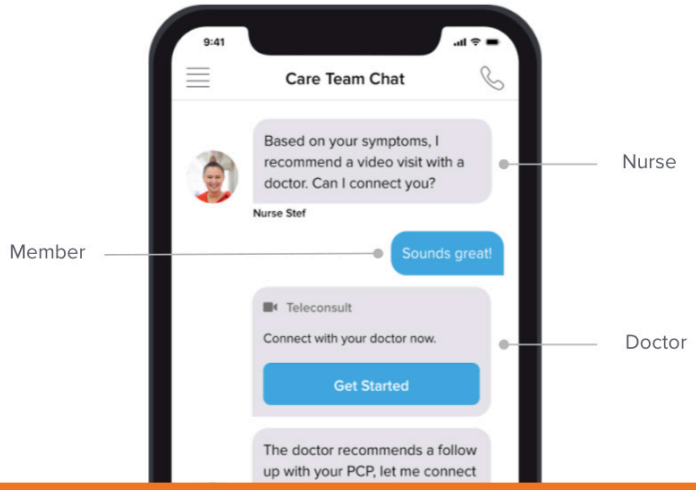
Pager provides a concierge-style provider search and scheduling feature for members to book appointments in real-time as requested. We also work with health plans to prioritize high-performing providers and drive increased member adherence to scheduled appointments.



Measures	Sample CAHPS questions	Pager Strategy
C21: Getting Needed Care	**In the last 6 months...** • How often was it easy to get the care, tests, or treatments you needed? • How often did you get an appointment to see a specialist as soon as you needed?	**Pager connects patients to care via:** • Clinical automation and AI to quickly evaluate symptoms • Seamless handoffs across care providers • Chat and video for all care provider roles • Bringing in care coordinators for concierge scheduling where necessary
C22: Getting Needed Appointments and Care Quickly	**In the last 6 months...** • When you needed care right away, how often did you get care as soon as you needed? • When you needed care right away, how often did you get an appointment at a doctor's office/ clinic as soon as you needed? • How often did you see the person you came to see within 15 minutes of your appointment time?	**Pager helps patients get care quicker through:** • >30 second first touch response time • Leveraging 4:1 chat concurrency so each agent can provide services to multiple patients • Providing concierge service to guide patients to high-performing providers and setting appointments
C23: Customer Service	**In the last 6 months...** • How often did your health plan's customer service give you the information or help you needed? • How often did your health plan's customer service treat you with courtesy and respect? • How often were the forms from your health plan easy to fill out?	**Pager improves the customer service experience with:** • CRM platform integrations for care and customer service in one experience • Option to bring any role at a payer onto the Pager platform to provide customer service and collaborate with care teams

Care coordination

Pager 360 connects members with doctors, nurses, and their entire care team via chat & video, thus transforming the way people access, navigate and coordinate care.



Measures	Sample CAHPS questions	Pager Strategy
C26: Care Coordination	**In the last 6 months...** • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did you and your personal doctor talk about all the prescription medicines you were taking? • How often did your personal doctor seem informed and up-to-date about the care you got from specialists?	**Pager's Aftercare Program:** • Demonstrates an 87% consult completion rate in Pager's Aftercare Program where our our agents proactively close member's gaps in care • Includes agents who provide support on next best actions, discharge instructions, lab results and more, within a pre-scheduled 24-48 hours followup time • 54% of members, who typically already saw a provider, had additional health-related questions answered through Pager's Aftercare Program **Pager's multi-agent care coordination allows for:** • Multiple team members to provide care within a single patient interaction **Pager's integrations allow for:** • Pager can integrate with a payer's EHR to ensure all member data is consolidated in one place for their PCPs to review all care received

What does this mean for health plans?

Healthcare can no longer be a one-time transaction between a patient and their provider, or a member and their health plan. Previous methods of engaging members have been largely through traditional marketing and have led to member abrasion, with members inundated with emails, telephone calls, fliers, mailers, text messages, a litany of disparate third party apps, and other contacts for routine and special healthcare services.

By offering a continuous digital connection, plans can encourage members to reach out when they are seeking care – and can offer a singular location for members to access a variety of services.

With bonus payments tied to Star Ratings, in addition to other benefits like year-round enrollment and marketing opportunities, plans are incentivized to achieve higher Star Ratings as a way to see increased enrollment, and ultimately, revenue.

Health plans have a timely opportunity to unify the member care and service experience for seniors to enhance their position in Star Ratings ahead of their competitors. With the increasing importance of Star Ratings – and specifically member experience measures – health plans must re-evaluate their strategy of closing gaps to a more holistic view of the member experience and their entire care journey. If they do this, in addition to Star Ratings improvement, health plans can also hope to see growth in membership and lower membership attrition.

Creating a consumer-centric, digital member experience

Health plans must think of their members as true consumers and begin to deliver a positive consumer experience accordingly. 96% of Americans own a cellphone of some kind, and 81% own a smartphone. With a computer in their pockets, consumers are expecting a digital-first experience like the one they experience for their retail shopping or their banking.

What's more, Baby Boomers have become increasingly tech savvy, and soon, Gen X will age into Medicare as well. With technological advancements in most other industries, and a population increasingly comfortable using new technologies, a digital experience will become table stakes. A consumer-centric, unified, easy-to-use digital experience will set health plans apart from the pack.

These digital experiences must be cohesive and easy to access. By meeting members where they are via virtual tools, and by leveraging AI, machine learning and analytics to

Members aren't just evaluating health plan service – they're also evaluating their healthcare provider. When these healthcare providers aren't integrated within a health plan, it can be difficult to evaluate health plan performance separately from the care delivered by providers.

ensure touchpoints are delivered when and where a member wants and needs them, plans can create an experience that builds trust and confidence with their members.

In order to build a true relationship with members that encourages them to turn to your plan to access care and support, personalization is key. This personalization can be difficult when a member's only experience with their healthcare is via disparate customer service phone calls and brick and mortar doctor's office visits. By offering a continuous digital connection, plans can encourage members to reach out when they are seeking care – and can offer a singular location for members to access the variety of services they need and expect from their health plan.

Pager connects health plan members to their entire clinical and service team, allowing them to communicate, collaborate, share information, and make better decisions in a secure place for messaging and tools. We excel in providing members a concierge-like service, and our own NPS of 80+ reflects that we continue to meet member demands during both COVID-19 and routine visits.

The time is now for health plans to double-down on their strategies for improving member experience, especially if they want to become or remain high-performing, 5-Star plans. Contact us and learn how Pager can support your team with the tools and services to help drive the best healthcare experience for your members. +

About the Authors

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About Pager

Pager is a virtual care collaboration platform that provides whole person healthcare in a trusted, convenient, connected care experience, like having a "doctor in the family." Pager helps people make better healthcare decisions by enabling better access and reducing costs, making care simple and easy to understand throughout the entire care journey. Through a combination of hi-tech AI automation and hi-touch concierge services, Pager offers an integrated, full-service experience including triage, telemedicine, e-prescriptions, appointment scheduling, after-care follow-up, care advocacy, and customer service. Pager's omni-channel communications platform connects the fragmented healthcare ecosystem by aggregating a care team of nurses, doctors, pharmacists, coordinators, advocates, and more in one place. Pager partners with leading payers, providers, and employers representing more than 15 million people across the United States and Latin America.

Staff your member experience with Pager's nurse navigators, care coordinators, and virtual care doctors

Care Coordinators

Our in-house coordinators are experts at guiding and navigating complex care issues.

Nurse Navigators

Our in-house nurse team is staffed by Registered Nurses who operate at the top of their license to help members navigate care.

Doctors

We work with some of the largest provider groups in the US to ensure 24/7 member availability to telehealth services.

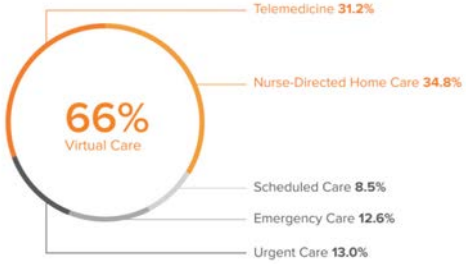
Specialists

Our clinical leadership can identify gaps in care where immediate access to specialists could make an impact on your population.

"I chatted with Nurse Frances to see what she thought about my excessive headaches and she recommended going to the emergency room immediately. Turns out I had meningitis."

Appropriate care resolutions

Patients are routed to the most appropriate site of care. In 66% of cases, virtual care is the appropriate response, leading to $190 in cost savings per encounter by diverting away from ER and urgent care clinics.



Care service principles

Quality care

We treat our patients like family and provide the safest, highest-quality clinical care

Superior experience

A robust, integrated service offering leads to high first-touch resolution

Building trust

Member trust and satisfaction leads to repeat utilization

Personalized service

Critical data points with the right balance of human-centricity and automation

Improving member satisfaction and cost of care

80+

Market-leading Net Promoter Score

12 sec

Time to first response

16 minutes

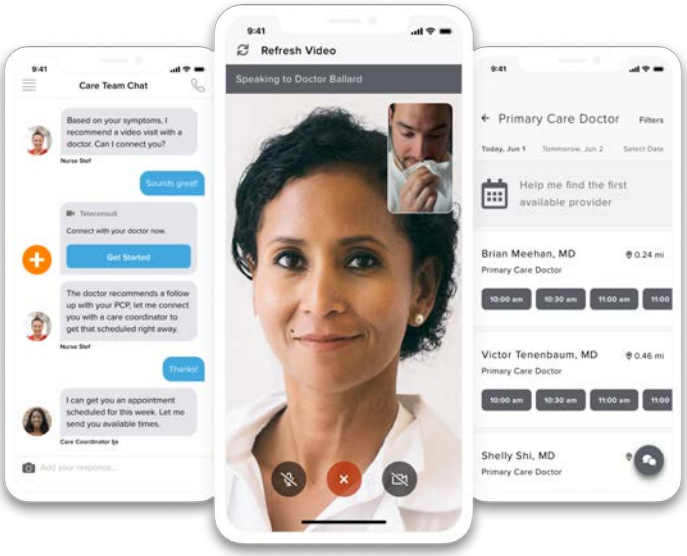
Average patient engagement in chats with nurses

$190

Average cost savings per encounter by avoiding ER and urgent care clinics

Solutions for a high-touch, high-tech consumer experience

Bring patients and their care team together in a single chat to make smarter & faster decisions



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