Carenet Health®

Activating the Business of Healthcare:
A Framework for Medicare Advantage Stars Success

Look closely at the habits of highly rated Medicare Advantage and Part D plans. They provide a framework for how to navigate the evolving stars standards and galvanize the business to achieve star rating success.

Carenet Health

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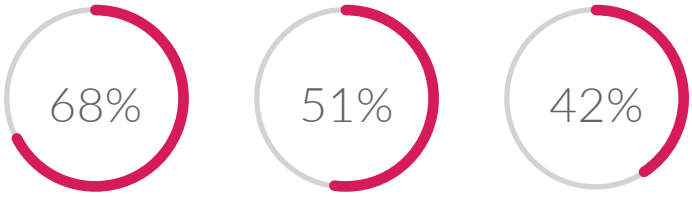
Introduction

Adaptability is a hallmark of successful Medicare Advantage plans. The latest star ratings put all plans on notice that they'll need to muster that trait as the Centers for Medicare and Medicaid Services (CMS) is sure to challenge them even more in the future.

Medicare Advantage Plan D Plans with Four or More Stars



As Oliver Wyman observed in their analysis of 2024 star ratings, there was a downward rating trend. The number of Medicare Advantage and Medicare Part D plans with four or more stars fell to 42% from 51% the year before and 68% in 2022.[1] For payers that means fewer will receive bonuses in their 2025 payments.

Analysts of Medicare businesses attributed some shifts to the end of pandemic-driven relaxation of some standards.[2] But other changes are afoot, Milliman noted, calling the release of 2024 ratings the opening bell in a "transformative phase of the program."[3]

In McKinsey's analysis, the Medicare Advantage program is "undergoing its biggest shifts in more than two decades."[4] Besides structural changes to star ratings, payers face the challenges of:

- An eligible member population skewing older with more (and most costly) healthcare needs.
- A slowdown in Medicare Advantage growth among new enrollees.
- Changes to risk adjustment formulas.
- The prospect of lower reimbursements with continued emphasis on pay for performance.

The star rating system is complex, with 40 weighted clinical and nonclinical measures, cut points and annual changes. It's easy for health plan leaders and "stars czars" to reach quickly for point solutions to address specific measures where their ratings were low.

In our experience, however, highly rated health plans approach their programs by stepping back before hurtling ahead to "fix" ratings for measures like "diabetes care — blood sugar controlled" or "members choosing to leave the plan."

Highly rated plans invest time in taking a critical look at all facets of star ratings and engage every department that contributes to member health and satisfaction by:

- Mapping their members' experiences with the health plan as patients with healthcare needs and members who need service and support, often at critical times.
- Evaluating their relationships with the healthcare providers who make up their networks. These doctors and other professionals profoundly impact patients' health and satisfaction.
- Anticipating and preparing for changes that CMS has signaled for the future.

The pressure is always on. Health plans must sustain performance in measures where they do well and address the measures where their ratings drag on their overall performance — and reimbursement.

In our experience working with 100 of the top U.S. payers, there are practices and approaches to stars that distinguish high-performing plans from others.

To borrow a phrase from a best-selling book of years ago, these are the **"habits of highly effective Medicare Advantage plans."**

Habit #1:

Listen to members and providers—then use the information to fine-tune engagement and support activities.

A conference speaker on member communications once reflected, "You don't just meet someone, say, 'Hi,' and not speak to them for eight months. They're not going to be your friend anymore."

Yet, this often can happen in member and provider relationships in Medicare Advantage and Part D plans such as when:

- Outreach communications are irregular, infrequent, or, worse, irrelevant to their situations or delivered in the way they least prefer.
- Care reminders such as, "You're due for an annual wellness exam," put the onus on members to make appointments and find transportation.
- Preauthorization policies and procedures require too much time of providers and their staff and appear to second-guess them.

But how do plans get to know and "become friends" with members and lift their services to meet the needs of their members and providers (who heavily influence member satisfaction and health outcomes)?

Highly rated plans have ongoing, year-spanning plans for nurturing their relationships with providers and members that include:

- **Asking, listening and applying how they want to be served.** Do they prefer phone calls, mail, email, portal messaging, text or voice messaging? Or different modes for different services (e.g., text prescription refill reminders; post plan documents to the portal)? Are there roadblocks to members getting needed care?
- **Measuring their satisfaction with benefits and programs.** Highly rated plans use multiple tools—surveys, meetings, events and other methods—to get honest feedback.
- **Identifying pain points and fixing them.** Does it take too long for call centers to pick up? Are representatives able to answer questions on the first inquiry? Are portals lacking needed functionality, or are they difficult to use?

Plans rated four stars or higher also typically take advantage of the skills and experience of data scientists in listening to their members and providers. Data analytics experts can sort through mountains of information from surveys, phone recordings, written complaints and other sources to:

- Understand preferences better based on channels members and providers use and are most effective in activating them to take action, such as arranging for a recommended cancer screening (member) or following up with patients newly diagnosed with diabetes in a timely manner (provider).
- Identify the times of day and days of the week when members and providers use different communication channels. With that information, plans can monitor those channels' performance and make decisions such as call center hours changes or portal maintenance schedules to be least disruptive.

Habit #2:

Rigorously explore, evaluate and map member and provider experiences before initiating ambitious program changes.

Highly successful plans recognize this: Every star measure matters. Taking a holistic view of programs designed to raise or sustain ratings helps ensure stability for plans while they navigate the ever-changing ratings terrain.

In other words, **successful plans recognize that there's no magic bullet to landing five stars**. They are comfortable with the fact that it's a constellation of factors that lead to success.

Because of that, they engage in activities to understand their members' and providers' experiences deeply and make changes to improve them.

Many plans use activities like journey mapping and root cause analysis to step back and evaluate the experiences their members and providers have. A journey map is a visual diagram of every member or provider touchpoint with a health plan. Journey mapping typically occurs with representatives from departments throughout the Medicare Advantage or Part D organization. Sometimes, plans will invite members or providers to participate, too.

There are so many touchpoints that members and providers have with a health plan that often the best course is to break down the exercise into service and care experiences, such as:

- Enrollment through onboarding (for providers, contracting through orientation).
- Chronic condition diagnosis and management.
- Acute condition diagnosis, treatment and recovery.

Journey mapping combined with data analytics can help uncover the root causes of low star ratings and illuminate opportunities for investing in transformative activities to improve engagement and satisfaction. In our experience, honest and open analysis of member and provider experience frequently uncovers friction points, such as:

- Difficulty getting appointments or finding providers in the plan's network.
- Delays in getting preventive, acute or chronic care.
- Confusion over follow-up care following hospitalization.
- Notification and management of annual formulary changes.

Member and provider data that align with star measures (e.g., hospital readmissions or medication adherence) is necessary to understanding experiences. Data can help focus a plan on areas that are likely leading to lower-than-desired ratings and help them move to brainstorming solutions. In this, we urge plans to use "blue-sky thinking," asking themselves what they'd do to address friction points or gaps if there were no resource constraints.

Together, these activities often lead to revelations for participants. At one health plan, participants were almost unanimous in their conviction that access to network providers was the issue having the largest effect on their ratings. Later, however, the group changed its priority: They needed to help providers address the hemorrhaging of staff due to the burden of work.

Taking time before jumping to solutions can prevent committing resources to ideas without thinking through their effects. Some plans have, for example, considered or started offering nutritious meal delivery to members with conditions such as diabetes, kidney disease and heart disease. Journey mapping, data evaluation and root cause analysis activities would introduce questions such as:

- Are members eating the food that's delivered?
- How do they rate the meal quality?
- Is there data to indicate that members who receive meals have better health outcomes?
- Are there alternatives to meal delivery that also might improve the nutrition and health habits of members?

Examining member and provider experience also provides an opportunity for scrutinizing programs in current or past use and making adjustments based on new information and data.

Habit #3:

Judiciously evaluate vendors to find out if and how they can help create an empathic ecosystem in support of members and providers.

Exploring the deepest corners of member and provider experience can be a messy but exhilarating experience, with diagrams and data scrawled on whiteboards around a room (physical or virtual). More "Aha!" moments happen when participants begin to connect their members' and providers' journeys and move their plans toward more cohesive and connected experiences for members and providers.

At this point, plans may begin to evaluate their resources and ability internally to take action to improve ratings

in star measures. They may consider the prospect of pulling in expertise and support from qualified vendors and even begin writing requests for proposals for services as wide and varied as nurse lines, telehealth companies, engagement specialists, palliative care and risk adjustment, to name a few.

Highly rated health plans do this cautiously. In our experience, vendors should have a deep understanding of the business of Medicare Advantage and Part D plans. They must have a range of clinical, analytical and customer experience talent to draw in and proven success supporting similar plans and customers.

Plans that "win" at stars also make stars an enterprise priority, not just the responsibility of a limited team that sends surveys and reviews charts.

Regular and vigorous engagement and collaboration are needed among all departments influencing stars, including quality, medical management, care management, utilization management, pharmacy, member and provider services, and provider relations — right up to the C-suite.

Habit #4:

Embrace the potential of technology to contribute to better health and star ratings.

According to the U.S. Government Accountability Office, the COVID-19 pandemic accelerated the rise and widespread acceptance of telehealth tenfold between 2019 and 2020.[5] Use has declined with the end of the public health emergency. Still, telehealth can influence many stars domain categories and ratings.

Forward-thinking plans understand that telehealth extends beyond its use for a doctor, nurse or physician assistant video visit. The Medicare-eligible population is skewing ever older and making up a larger share of the total population.[6]

of Medicare members prefer to manage their health digitally

of Medicare members have used their plan's digital benefits

We need to turn to telehealth in new and creative ways. Our research also shows that Medicare plans have an adoption challenge among their members, 86% of whom said using technology is important to manage their health, only 16% had used their plan's on-demand digital healthcare benefits.

Primary care practices are already aligning with home health agencies to meet more of the healthcare needs of Medicare members — for monitoring vital signs and medication adherence, as well as check-ins and consults — in their homes.[7] Medicare plans may find it productive (and advantageous to star rating improvement) to partner with their network providers by supplying equipment and clinical resources for remote patient monitoring.

Another exciting but still emerging opportunity is virtual and augmented reality in healthcare professional training and member education. Consider, for example, how immersive virtual experiences could help members with chronic diseases understand their conditions and learn about treatment options and the importance of ongoing care.

Artificial intelligence (AI) and automation will also take on larger roles in the future. Many AI applications already are being used or tested in healthcare, such as to help providers summarize visit notes or analyze patient data for patterns that may indicate risks of future health issues, emergency room visits or hospitalizations.

Health plans also use AI to improve their speed and accuracy in responding to member questions through virtual assistants available through a screen or phone call.

Turning to Medicare stars, AI applications can use member data and inputs, such as human or digital messages with member services, to identify sources of discontent that could lead to low scores on the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is used in star ratings.

Proactively identifying members who could be "detractors" on a CAHPS survey and understanding their experiences and emotions can help plans identify areas for improvement.

Habit #5:

Prepare for new measurements, specifically of health equity.

CMS has finalized a rule to add a health equity index (HEI) to the 2027 star ratings, which will be based on plan performance in 2024 and 2025. The ratings will compare outcomes for members with and without social risk factors. Members with risk factors are defined as those who have disabilities, who qualify for low-income subsidy (LIS) or who are dually eligible for Medicare and Medicaid.

Adding the HEI to star ratings puts a new onus on Medicare Advantage and Part D plans. Forward-looking plans already identify at-risk members and evaluate how their outcomes compare to the rest of the plan's population. From there, the plans are positioned

to develop strategies for closing gaps in care and improving satisfaction scores among members with social risk factors.

We expect there will be more scrutiny of provider-to-member ratios across populations with social risk factors in the future. Plans that wish to sustain strong star ratings or improve their ratings are already devising and implementing multifaceted plans that include all or some of the following:

- Forming new provider partnerships and contracts to increase diversity within the network and improve access for members with social risk factors.
- Adding or expanding virtual providers.
- Increasing in-home and at-home services to keep members well and safe.
- Improving cultural competency among their plan's member-facing staff and network providers.

Habit #6:

Operate from a position of strength and commitment to members and providers.

Some of the nation's largest health plans, such as UnitedHealthcare and Humana, operate some of the highest-rated Medicare Advantage plans. Their success stems partly from their size and scale, particularly their ownership of physician practices and other services such as telehealth providers, pharmacy benefit managers and chronic condition management services.

Every plan of every size can use staff and strategic partnerships with outside firms to create ecosystems that improve its chances of star success. McKinsey suggests some of the tactics they can use, including:[8]

- Member engagement activities that connect experiences across channels.
- Targeting care delivery options suited to the needs and demographics of their membership.
- Investing in technology to increase efficiency — such as chatbots and customer analytics — and lower administrative costs.

Not only do national carriers run five-star plans; regional health plans do too.[9] Observers, take note. Smaller plans can make up for what they lack in size with canniness and cultures that foster collaboration, dedication to member health and strong provider partnerships.

In conclusion, be fearless and bold.

Medicare Advantage plans are complex and inherently tough to manage. Leaders must balance investment initiatives and market opportunities with their ability to manage healthcare and administrative costs and, in many cases, turn a profit and answer to shareholders.

Every year presents new situations and challenges, including:

- New and revised stars standards.
- Unforeseen and unpredictable public health events and emergencies.
- Provider contract renewal negotiations and network changes.
- New (and usually expensive) drugs coming to market, along with formulary revisions.

McKinsey and others have noted that the recent Medicare rate reductions will put further pressure on plans.[10]

But we say: **It's not a time to be timid.** It's a time to reach into the depths of your organization to bring out the best in it.

Successful Medicare Advantage and Part D plans recognize the fluidity of their business. They're energized by it. They respond by using the habits we've listed here, along with nimbleness and a commitment to challenge past practices to achieve better member outcomes in the future.

About Carenet Health

Carenet Health activates the successful business of healthcare for payers, providers and health services companies. Our performance-based health action platform leverages the power of our more than 400 licensed clinicians and 1,600 care navigators, customer analytics, and AI and machine learning capabilities. Over two decades, we have supported the business transformation of more than 100 of the top payers and 500 providers by helping them contain costs and seize opportunities for growth in a dynamic healthcare system.

For more information, please visit carenethealth.com.

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