Improve Star Ratings by Transforming Member Feedback into Actionable Insights

Leverage the voice of the member to increase health plan quality

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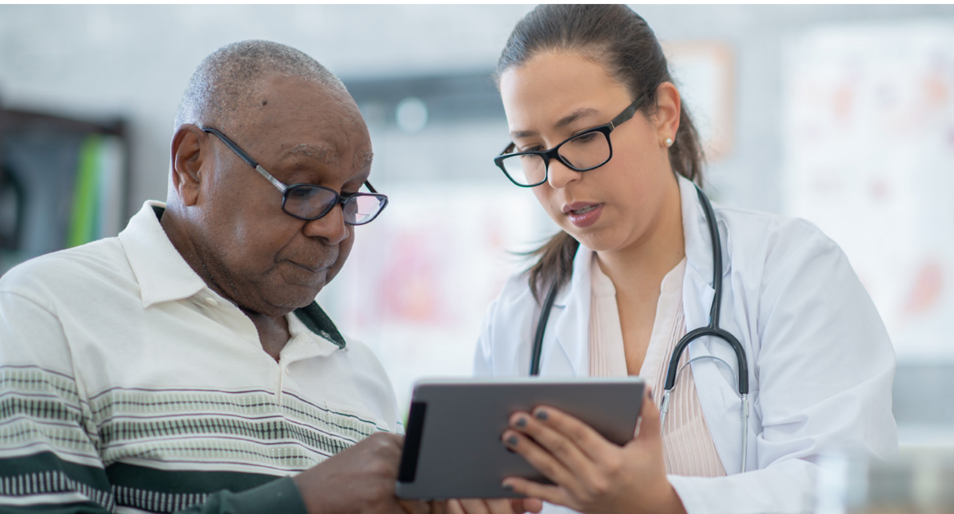
Introduction

By 2023, Medicare Advantage (MA) is expected to cover around 34 million people, an expected growth rate of 11% per year[1]. In addition to market growth, there's a considerable upside for health plans that provide superior member experiences. CMS made this change because they realized that when plans listen to the member's voice to enhance the overall member experience, outcomes improve.

Plans awarded MA Ratings of at least 4 Stars earn a significant bonus and higher rebates to use toward better benefits for their members. In other words, these plans have the resources to focus on driving member loyalty and retention while those who earn less than 4 Stars fall behind.



For those competing for membership in the MA space, achieving an overall **4 Star Rating or higher** – and the significant health plan revenue it drives – is a must. Thanks to a new methodology for calculating MA quality scores, achieving this rating is directly correlated to member experiences.

In this eBook, we'll explore:

01 The growing importance of the member experience as it relates to Star Ratings

02 Common characteristics of organizations that deliver positive experiences for their members

03 How to leverage member feedback and insights to drive actionable change across your organization

[1] Centers for Medicare & Medicaid Services

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Why member experience matters more now

CMS is placing more emphasis on member experience metrics than ever before. For the 2021 and 2022 Star Ratings, CMS increased the weight of the member experience measures from 1.5 to 2 and the member experience portion of the Star Ratings will rise from 2 to 4 beginning with the 2023 Star Ratings (Figure 1).

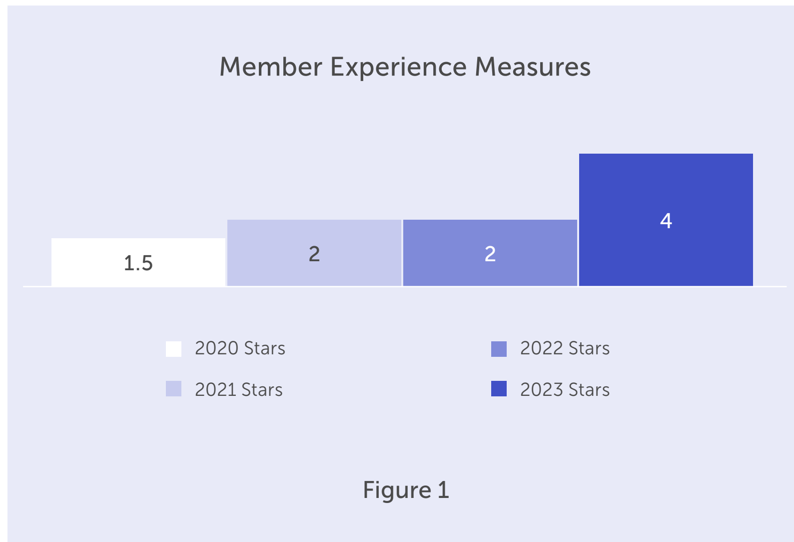

Figure 1

For that reason, plans can no longer think of member experience as an afterthought. Providing positive member experiences will be required in order to achieve a 4 Star Rating.

How do Star Rating measures work?

Star measures are each assigned a weight, based upon their measure weighting category.

The “patients' experience, complaints, and access measure", referred to throughout this eBook as “member experience” measures, were weighted 1.5 through the 2020 Star Rating period (Figure 2).

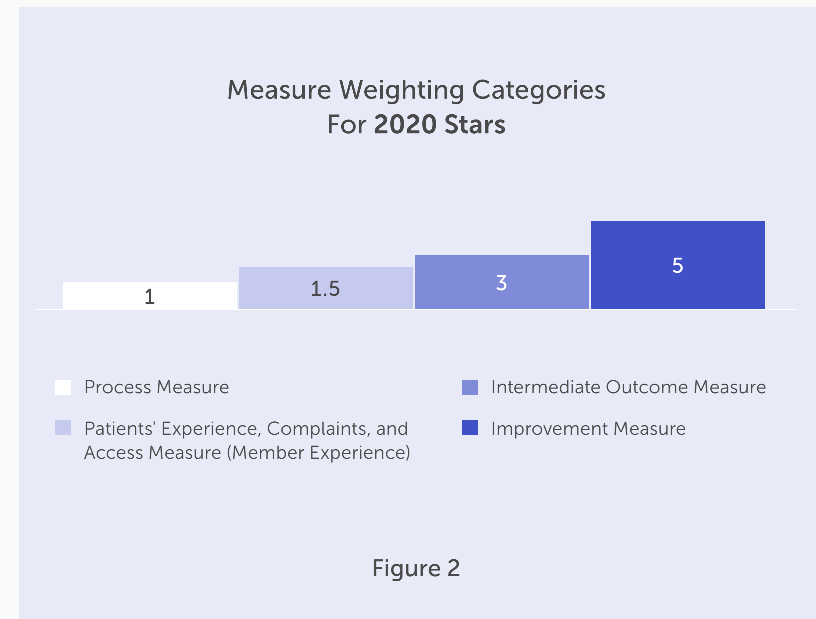

Figure 2

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Roughly half of member experience measures (Figure 3) come from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Getting needed care (CAHPS)	Getting appointments & care quickly (CAHPS)	Customer service (CAHPS)	Rating of health care quality (CAHPS)
Rating of health plan (CAHPS)	Care coordination (CAHPS)	Complaints about the health/drug plan (Part C) & (Part D)	Members choosing to leave the plan (Part C) & (Part D)
Plan makes timely decision about appeals (Part C)	Reviewing appeals decisions (Part C)	Call center-foreign language interpreter and TTY availability (Part C)	Call center-foreign language interpreter and TTY availability (Part D)
Rating of Drug Plan (CAHPS)	Getting needed prescription drugs (CAHPS)		

Figure 3

For the 2020 Star Ratings, the member experience measures comprised 31% of the entire weight of the Ratings, and these measures will increase to 58% for the 2023 Stars.

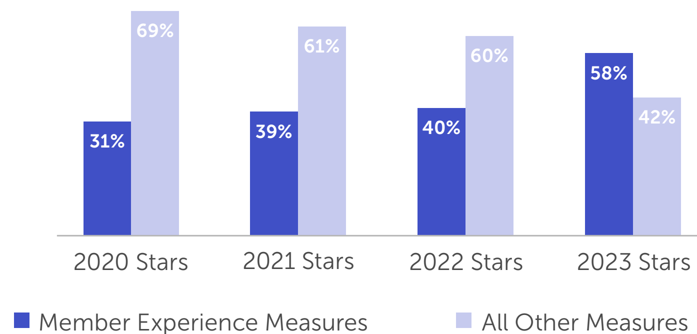

Figure 4

While patient experience is an inherently important dimension of healthcare quality, it is also the case that the preponderance of evidence shows that better patient experience is associated with better patient adherence to recommended treatment, better clinical processes, better hospital patient safety culture, better clinical outcomes, reduced unnecessary healthcare use, and fewer inpatient complications."

CMS, April 2018 Final Rule

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With this change, member experience measures become more impactful than measures assessing clinical outcome or patient safety. Additionally for the 2023 Stars Ratings, when the increase to a weight of 4 occurs, the CAHPS survey measures become – undeniably – the most important individual category, contributing more than 1/3 of Star Ratings on its own. In addition, the Administrative category, which comprises the remaining member experience measures, is just behind it. There is significant distance between the two of them and all remaining categories, as demonstrated in Figure 5.

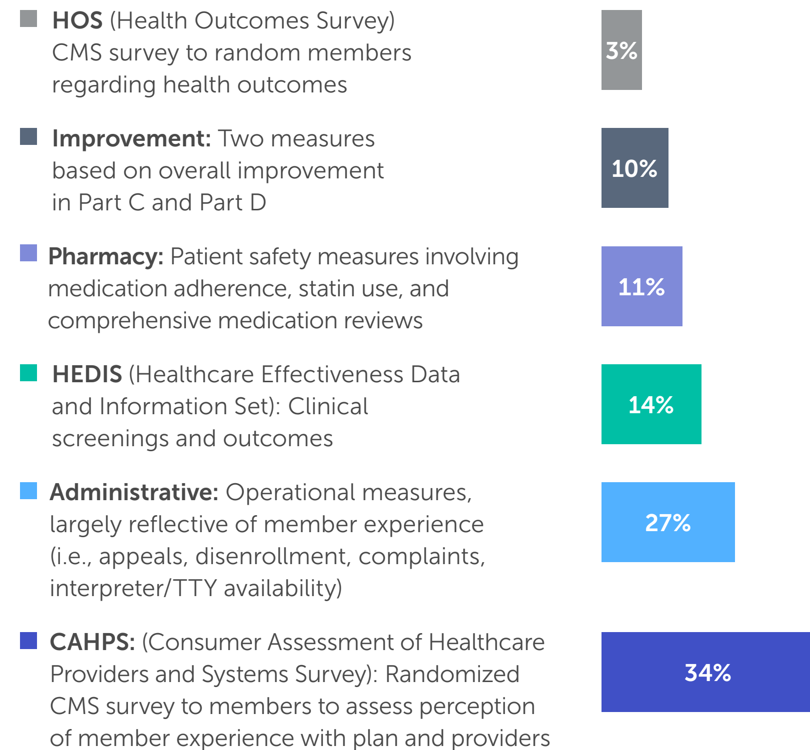

Figure 5

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7 steps to delivering a better member experience

Now that we've established the need to provide a positive member experience, let's look at how you can get there. Leading health care payers share several common characteristics outlined below, along with steps you can take to implement them in your organization.

1. **Create an Organization-Wide Culture of Quality**

   What it looks like: A relentless top-down commitment to the highest quality of work in every corner of the organization. Receive external recognition as a high-quality health plan focused on operational excellence. Flawlessly execute activities within the health plan's control.

   How you can develop it in your organization: Define what a culture of quality looks like in your organization and create a 3-5 year plan to operationalize. Solicit an executive sponsor and articulate the role that everyone plays in delivering a quality experience to members.

2. **Develop Member Experience Governance**

   What it looks like: An Executive Steering Committee informs the yearly goals by reviewing actionable data, recommending behaviors to move the organization to success, socializing the voice of the member throughout the organization, and ensuring the voice of the member informs every decision.

   How you can develop it in your organization: Launch a cross-functional committee of key stakeholders focused on the member experience. Lead each meeting with updated data – grievances, complaints, mock surveys, actual surveys, NPS, and disenrollment numbers. Play call recordings and read survey responses to the group. Recap occurrences that drove complaints. Co-create action plans to improve the member experience and use the meetings to manage those actions.

3. **Drive Member Service Excellence**

   What it looks like: Seasoned representatives trained in empathy and defined organizational behaviors to deliver high quality, compassionate experiences.

   How you can develop it in your organization: Develop training that aligns with the organization mission. This training should incorporate defined behaviors, emotional intelligence, and cultural sensitivity to increase empathy for the members served.

4. **Partner with High-Performing Vendors**

   What it looks like: Vendors are selected based on quality and held accountable by a robust vendor management team for achieving the highest quality while delivering a stellar member experience.

   How you can develop it in your organization: Incorporate service level agreements (SLAs) focused on the member experience for each member-touching vendor. Develop a vendor management team or equip your existing cross-functional owners with the tools and resources to effectively manage their vendors. Only engage vendors who are committed to developing an ongoing partnership.

5. **Provide Coordinated, Personal, and Relevant Member Engagement**

   What it looks like: Meet members where they are by honoring their preferred communication channels and their member's specific needs.

   How you can develop it in your organization: Invest in technology to track all member touches, ensuring members are not receiving overlapping outreaches. Record your members' channel of preference (email, text message, phone, or other) and communicate with them through that channel.

6. **Offer High-Quality Products**

   What it looks like: Thoughtful plan designs that remove member barriers to care and incent healthy actions. Invest in products that make it easier for members to manage their health in more effective ways and improve their quality of life.

   How you can develop it in your organization: Ensure your plan designs eliminate any barriers to care. Remove cost-share for preventive screenings. Add supplemental benefits that resonate with your membership.

7. **Engage Provider Partners and Work Only with Engaged Provider Partners**

   What it looks like: Collaborative engagement with provider partners driven by data sharing, market-competitive incentives, performance feedback, plan-provided support, and co-created strategies.

   How you can develop it in your organization: Monetize gap closures and equip your provider partners with dashboards that clearly track incentives. Discuss the importance of Stars and the member experience during joint operating committees. Co-create gap closure solutions with your providers.

How a voice of the member program can increase stars

As part of your member experience governance, you'll want to turn your CAHPS and other surveys into a Voice of the Member Program. Don't just capture data. Use it to generate actionable insights, deliver them to the most appropriate department, and hold that department accountable for taking action. Then, close the loop when action has been taken to reduce the member pain point.

Let's show how acting on member insights can directly impact the member experience and the CAHPS survey scores.

Measure: Care Coordination

Question from the CAHPS Survey: IIn 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?

Before Acting Upon the Insights from the Voice of the Member

Listen to the Voice of the Member →	Capture Signals, Triage, and Route for Immediate Resolution →	Act Upon the Insights from the Voice of the Member
Plan A conducts an IVR-based mock survey to a random sample of members annually asking a series of CAHPS-like questions, including this question.	• Plan A captures each member's response. • On a monthly basis, the responses are aggregated and presented to the Star Ratings Executive Steering Committee.	• If enough members respond unfavorably for a certain provide, the Network Management team will add it to the agenda for the next meeting with that provider. • There is no follow-up to ensure the discussion happened.

After Acting Upon the Insights from the Voice of the Member

Listen to the Voice of the Member →	Capture Signals, Triage, and Route for Immediate Resolution →	Act Upon the Insights from the Voice of the Member
• Each time it receives a claim for a blood test, x-ray, or other test on one of its members, Plan A conducts an SMS survey two weeks later asking the member if someone from the doctor's office followed up with the results. • If member indicates "No", Plan A responds, apologizing for the delay and an offer to reach out to the doctor to remind them to follow-up with the member.	• Plan A captures each member's response and immediately routes any members answering "No" to the appropriate team. • Plan A receives this member's response and sends it, along with the name and relevant information for the provider, to the Network Management team.	• The Network Management team reaches out to the provider's office to let them know this member has still not received their test results, inquire as to the reason for the long delay, and advise the provider's office to follow-up with the member immediately. • For the issue to be closed out, the department receiving the route must indicate that the action has been taken.

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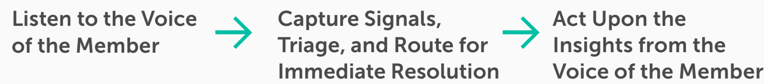
Measure: Getting Appointments and Care Quickly

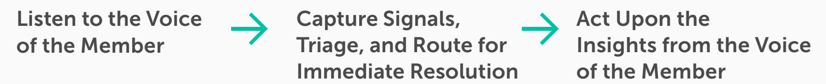
Question from the CAHPS Survey: In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?

Before Acting Upon the Insights from the Voice of the Member



Listen to the Voice of the Member	Capture Signals, Triage, and Route for Immediate Resolution	Act Upon the Insights from the Voice of the Member
Plan A conducts an IVR-based mock survey to a random sample of members annually asking a series of CAHPS-like questions, including questions about their general satisfaction with their health plan and provider. However, there are no questions regarding how often the member got an appointment for a check-up or routine care as soon as they needed.	No signals are captured regarding this question.	No significant actions are taken. There is no relevant information captured from the annual mock survey regarding this specific question.

After Acting Upon the Insights from the Voice of the Member



Listen to the Voice of the Member	Capture Signals, Triage, and Route for Immediate Resolution	Act Upon the Insights from the Voice of the Member
• Each time it receives a claim for an Annual Wellness Visit, Plan A conducts an SMS survey asking the member if she was able to get the appointment as soon as she needed. • If member indicates "No", Plan A invites clarification as to why. • Member responded with a "No" and added "it always takes several weeks to see my doctor for a wellness appointment".	• Plan A captures each member's answer to the question and any clarifying selections or free-text responses. • Plan A immediately routes any members answering "No" to the appropriate team. • Plan A receives this member's response and sends it, along with the name and relevant information for the provider, to the Network Management team.	• The Network Management team reaches out to the provider's office to let them know about the member's response, inquire as to the reason for the long delay, and add it as an agenda item at the next Joint Operating Committee meeting between Plan A and the provider. • For the issue to be closed out, the department receiving the route must indicate that the action has been taken.

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Measure: Getting Needed Prescription Drugs

Question from the CAHPS Survey: In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Before Acting Upon the Insights from the Voice of the Member

Listen to the Voice of the Member →	Capture Signals, Triage, and Route for Immediate Resolution →	Act Upon the Insights from the Voice of the Member
Plan A conducts an IVR-based mock survey to a random sample of members annually asking a series of CAHPS-like questions, including questions about their general satisfaction with their drug plan. There are no questions specific to mail-order.	Occasional grievances and/or complaints surface regarding pain points with the mail-order program, but they are not widely socialized with cross-functional leaders.	No actions are taken regarding the mail-order benefit. There is no relevant information captured from the annual mock survey, and any relevant data from the grievances and complaints is not widely circulated or acted upon.

After Acting Upon the Insights from the Voice of the Member

Listen to the Voice of the Member →	Capture Signals, Triage, and Route for Immediate Resolution →	Act Upon the Insights from the Voice of the Member
• Each time one of its members orders medication via mail-order for the first time, Plan A conducts an SMS survey asking the member how easy it was to use their prescription drug plan to fill the prescription by mail. • The survey is timely and relevant, as the member just had the experience that the survey is based on. • If member's rating is low, Plan A invites clarification as to why. • Member responded with a "2" and added "it took me 3 calls to find someone to explain how to use the mail-order, and there was no information on the website".	• Plan A captures each member's rating of the question and any clarifying selections or free-text responses. • Plan A immediately routes any low-scoring members to the appropriate team to resolve the issue or improve the process going forward. • Plan A receives this member's response and sends to the Pharmacy team.	• To prevent this issue from recurring, the Pharmacy team works with the following teams: - the Marketing/Web team to make mail-order instructions more prominent on the website - the Marketing team to design a "Mail-Order 101" brochure to send to members - the Customer Service team to enhance knowledge content and understanding of mail-order benefits and processes • For the issue to be closed out, the department receiving the route must indicate that the action has been taken.

It's a new world

Creating positive member experiences is more important than ever – and now more important than anything else – for Medicare Advantage plans. Measures assessing the member experience account for more than half of Star Ratings. When interactions are not positive, those experiences are significant drivers of disenrollment and complaints. For strong growth and high satisfaction that drives retention and improves quality outcomes, health plans must foster positive experiences.

It requires strategic planning and flawless execution to develop those experiences. You can deploy countless strategies for improvement, but all must be informed by the voice of the member. Health plans must connect the dots between the member's voice, actionable insights, steps to mitigate the pain, and who needs to do it. Most importantly, the signals must reach the appropriate person or team, with clear understanding of what needs to be done.

How Medallia customer experience empowers action on voice of member programs

Medallia customer experience can connect the dots to provide better member experiences by empowering teams to make that change. Medallia enables healthcare leaders to connect and engage members, families, and care teams to strengthen relationships, improve care, and drive better outcomes. The platform embeds rich and intuitive listening tools seamlessly throughout the entire healthcare journey to instantaneously collect, analyze, and surface real-time signals.

By breaking down silos across the organization to create a unified view of feedback and experience data, the entire organization is empowered to take the right action at the right time to address friction in the member journey, influence member behavior, and turn negative experiences into positive ones.

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Toni Land, MBA, BSN, CPXP and Head of Clinical Healthcare Experience at Medallia, has spent more than 30 years in healthcare across a number of settings ranging from nursing, home care, medical practice, performance improvement, and management. Prior to joining Medallia, she was Chief Patient Experience & Quality Officer at the Medical Center Health System and Director of Patient Experience at Prisma Health.

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About Medallia

Medallia is the pioneer and market leader in Experience Management. Medallia's award-winning SaaS platform, the Medallia Experience Cloud, leads the market in the understanding and management of experience for customers, employees and citizens. Medallia captures experience signals created on daily journeys in person, digital and IoT interactions and applies proprietary AI technology to reveal personalized and predictive insights that can drive action with tremendous business results. Using Medallia Experience Cloud, customers can reduce churn, turn detractors into promoters and buyers and create in-the-moment cross-sell and up-sell opportunities, providing clear and potent returns on investment. www.medallia.com

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