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Medicare Advantage star ratings: Basics and best practices

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Introduction

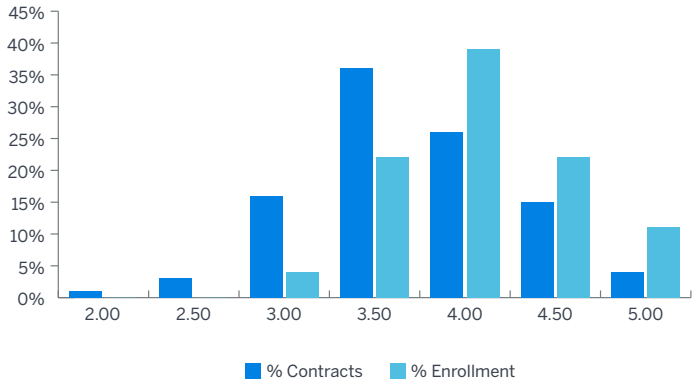
Since 2008, the Centers for Medicare and Medicaid Services (CMS) has developed and published annual performance ratings for Medicare Advantage (MA) only, prescription drug plan (PDP), and MA and Medicare Part D (MA-PD) contracts, referred to as star ratings. CMS intends star ratings, which range from 1.0 (low) to 5.0 (high), to grade Medicare plan quality. Initially, CMS published star ratings to help Medicare beneficiaries choose high-quality plans; however, since 2012, CMS has tied plan revenue and other incentives to star ratings as well.

The average 2018 star rating for MA-PD plans was 4.1. Nearly three-quarters of MA-PD members are enrolled in a plan with a star rating of 4.0 or higher. Since 2014, the average star rating has increased by 5% (from 3.9 to 4.1), and the share of Medicare beneficiaries enrolled in plans with star ratings of 4.0 or higher has grown by over two-fifths (from 52% to 73%).

Plans with more Medicare experience tend to have star ratings higher than plans with less experience. More than half (57%) of MA-PDs with more than 10 years of experience have star ratings of 4.0 or higher, whereas only 37% of plans with five to 10 years of experience reach that goal.

It is clear that CMS's star rating program helps drive members to higher-rated plans. Figure 1 shows that, for 2018, higher-rated contracts have more enrollment than lower-rated contracts.

FIGURE 1: 2018 MA-PD MEDICARE PLAN STAR RATINGS*



*384 MA-PD contracts included

This article provides an overview of CMS's methodology for calculating star ratings, introduces the financial and marketing implications of star ratings for Medicare plans, and summarizes best practices common to high-rated plans.

Star rating calculation and timing

In the following, we present a very simplified explanation of star rating calculation and timing.

For 2018 star ratings, CMS derived MA-PD star ratings from a maximum of 45 unique measures falling into five categories or domains (2018 star rating weights shown in parentheses):

1. Outcomes (3)
2. Intermediate outcomes (3)
3. Patient experience and complaints (1.5)
4. Access (1.5)
5. Process (1)

CMS assigns each measure to one of these five categories with the exception of two that are marked as Part C and Part D Quality Improvement Measures (weighted 5), which result from a comparison of a contract's current and prior year star ratings for certain measures. Star rating scores are calculated for each of the other measures using "cut points," which define raw measurement intervals that translate to each star rating (rounded to the whole star). Cut points for most measures change over time and are determined using "clustering" algorithms to establish the five most similar groupings of raw scores for each measure. Under the clustering approach there are no minimum performance levels corresponding to high ratings, which gives Medicare plans strong incentive to continually improve measurements each year to keep pace with its competitors.

CMS aggregates measure level MA-PD star ratings into three levels:

1. **Domain:** Nine groups, five Part C and four Part D, of similar measures assigned star ratings based on the non-weighted averages of the measure level star ratings (rounded to the whole star) for each group.
2. **Summary:** An overall Part C star rating assigned based on a weighted average of the star ratings for all Part C

measures (rounded to the half star); an overall Part D score is similarly assigned. The 2018 star rating weights for each measure category, shown in parentheses above, are used to calculate the weighted average summary star ratings.

3. **Overall:** An overall star rating assigned based on a weighted average of the star ratings for all Part C and Part D measures combined (rounded to the half star). The 2018 star rating weights for each measure category, shown in parentheses above, are used to calculate the weighted average overall star ratings.

CMS uses only the overall star rating to determine whether an MA-PD plan will receive additional revenue or other incentives. Because overall star ratings are determined based on a weighted average of measure level star ratings, higher-weighted measures affect the overall rating more than lower-weighted measures. For example, measures marked as Quality Improvement measures affect overall ratings five times as much as Process measures (weight of 5 versus weight of 1). New measures from any category received a weight of 1 for 2018 star ratings.

In Figure 2, we provide Breast Cancer Screening as an example of a 2018 star rating measure.

FIGURE 2: 2018 BREAST CANCER SCREENING MEASURE OVERVIEW

MEASURE NAME:	Breast Cancer Screening
DESCRIPTION:	Percentage of female plan members aged 52 to 74 who had a mammogram during the past two years.
DOMAIN NAME:	Staying Healthy: Screenings, Tests, and Vaccines
SUMMARY SCORE:	Part C
WEIGHT CATEGORY:	Process
CUT POINTS:	
1 STAR:	< 56%
2 STARS:	≥ 56% to < 70%
3 STARS:	≥ 70% to < 78%
4 STARS:	≥ 78% to < 84%
5 STARS:	≥ 84%

CMS calculates the star ratings using several data sources, with varying periods of data collection. For example, the 2018 star ratings, released in October 2017, are based on Healthcare Effectiveness Data and Information Set (HEDIS) data collected in calendar year 2016 and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data collected from March 2017 to June 2017. These star ratings will have marketing implications beginning in 2018's open enrollment period and financial implications beginning in 2019.

MA-PD plan implications

CMS leverages the star ratings program to help achieve one of its strategic goals—to improve the quality of care and general health status for Medicare beneficiaries. CMS publishes star ratings to measure the quality of MA-PD plans, help beneficiaries select the best plan for them, and financially reward high-quality plans.

Marketing: Some of the specific marketing-related impacts that a Medicare plan's star rating has are:

- CMS displays star ratings on the Medicare Plan Finder, where Medicare beneficiaries shop for plans, which can influence enrollment decisions. Medicare plans must also make their scores available to members and prospective members.
- CMS labels certain plans with a "Low Performing Icon" or a "High Performing Icon," depending on their star ratings, which can influence plan perception in the market.
- Plans with five-star ratings can enroll beneficiaries throughout the year instead of only during open enrollment or special election periods.

Financial: An MA-PD plan's Part C revenue depends on the relationship between the plan's bid amount and MA benchmark, as well as the plan's overall star rating. A plan's bid amount is the expected total cost for the plan to provide traditional Medicare benefits to a "standard" Medicare beneficiary. CMS publishes MA benchmark amounts for the plan's service area, which CMS generally intends to reflect actual traditional Medicare costs.

When a plan's bid amount is higher than the MA benchmark, the plan's Part C revenue equals the bid amount plus a member premium. When a plan's bid amount is lower than the MA benchmark, the plan's Part C revenue equals the bid amount plus a portion of the "savings" between the plan's bid and benchmark amounts, also known as an MA Rebate.

MA-PD plans must use revenue corresponding to the bid amount to pay for traditional Medicare benefits. They must use their MA Rebate revenues to pay for benefits they offer in addition to traditional Medicare benefits, also known as supplemental benefits (i.e., reduced Part B or Part D premiums, reduced member cost sharing, and/or benefit coverage beyond traditional Medicare).

Star ratings affect Part C revenue for MA-PDs in two ways:

1. Quality bonus payment (QBP): Plans receiving a QBP have their MA benchmark amounts increased by the QBP percentage, as determined by their overall star ratings. A higher MA benchmark amount means that the plan can either lower the required member premium or increase supplemental benefits.
2. Rebate percentage: A plan's MA Rebate is determined in part by its MA Rebate percentage, which is based on its overall star rating. A higher MA Rebate percentage increases supplemental benefits for plans with rebates.

Figure 3 shows the QBP and MA Rebate percentages by overall star rating for 2018.

FIGURE 3: 2018 QUALITY BONUS AND MA REBATE PERCENTAGES

OVERALL STAR RATING	QBP %	REBATE %
4.5 OR HIGHER	5.0%	70%
4.0	5.0%	65%
3.5	0.0%	65%
3.0 OR LOWER	0.0%	50%
NEW OR LOW ENROLLMENT	3.5%	65%

In Figure 4, we show the resulting MA Rebate for an example MA-PD plan with a $700 bid amount and a published MA benchmark amount of $800, given different overall star ratings.

The nature of the MA Rebate formula and varying QBP and MA Rebate percentages by overall star rating result in large relative rebate changes among different star ratings. Per the example, the impact of dropping from a 3.5 overall star rating to a 3.0 is a 23% reduction in MA Rebate revenue, which would necessitate significant benefit reductions or member premium increases for the plan. The impact of dropping from a 4.0 overall star rating to a 3.5 is even more severe, resulting in a 29% reduction in MA Rebate revenue.

Medicare plan star rating best practices

While there is no single list of star rating best practices that will be effective for all Medicare organizations, we have observed several practices common to high-rated plans.

Strong implementation foundation: Five-star plans are typically characterized by a "culture of quality," which extends beyond their dedicated star ratings operations. Senior management makes star ratings a priority and receives support from a multidepartmental team accountable for developing and implementing a comprehensive star ratings strategy. The team documents and updates an annual star ratings program description that includes objectives, goals, data sources, resource assignments, and a description of the annual evaluation process. A detailed annual work plan accompanies the program description and lists targets, accountabilities, and frequency of management updates.

Organized change plan: The star ratings team develops and tracks progress using an organized change plan developed after conducting a comprehensive operational assessment. The assessment identifies for each star ratings measure the primary point of control, e.g., provider, health plan, pharmacy benefit management (PBM), for achieving the goal. The change plan prioritizes efforts based on the ability for the effort to change star ratings (e.g., ease of change, measure weight, gap to get to next star level), and includes timing (effort start and expected impact timing), interdependencies, and responsibilities.

Train, educate, and communicate: The star ratings team and those assigned responsibilities in the change plan must become star ratings experts. Team members must understand star ratings measure components, cut points, calculations, and data sources. Management, staff, vendors, and providers must be educated on the measures and their impact on results. A communication plan developed to dictate the who, what, when, and how of communications will be disseminated to all of the stakeholders, including the public.

FIGURE 4: EXAMPLE: MA REBATE CALCULATIONS

OVERALL STAR RATING	FORMULA	3.0 STARS OR LOWER	3.5 STARS	NEW/LOW ENROLLMENT	4.0 STARS	4.5 STARS OR HIGHER
BID AMOUNT	A			$700		
QBP PERCENTAGE	B	0.0%		3.5%	5.0%	
MA BENCHMARK	C = $800 X (1 + B)	$800		$828	$840	
SAVINGS	D = C - A	$100		$128	$140	
REBATE PERCENTAGE	E	50%		65%		70%
MA REBATE	F = D X E	$50	$65	$83	$91	$98

Data-driven processes: At the core of a best practice star ratings strategy is data analytics leveraged for the annual review, prioritization, and ongoing monitoring of star ratings performance and change plans. Member selection, vendor and provider prioritization, and root cause analysis should all be informed by a comprehensive data strategy. Overall star ratings result from a complex calculation involving multiple data points and sources. Best practice plans leverage this data to inform their star ratings tactics in real time.

Manage vendor and provider relationships: Most health plans have one or more vendors that contribute to star ratings—PBMs, HEDIS vendors, vendors conducting chart reviews, and other vendors delegated operational responsibilities. Best practice plans proactively manage their vendor relationships through delegation oversight, collaboration, contractual performance measures, and incentives. Best practice plans also manage their "star ratings relationships" with their practitioners and laboratories using these same tools.

Member outreach: At the center of each star rating measure are the health plan's members and the care that they receive through the plan. Best practice plans know which members have care gaps and actively work to close those gaps to deliver high-quality care and drive member satisfaction, which star ratings will reflect.

Integrate and coordinate with other priorities and initiatives: There are numerous opportunities for health plans to integrate their star ratings plans with other core operations. For example, care management should incorporate star ratings measures into their assessments; risk-adjustment-focused chart reviews and health risk appraisals should incorporate star ratings measures in their reviews; and information technology (IT) systems improvements, e.g., data collection and integration, electronic medical record (EMR) access, should incorporate star ratings measures in their objectives. Best practice plans take a holistic approach to star ratings improvement, and integrate their star ratings strategy into their other key operational efforts.

Conclusion

Becoming a star ratings leader requires a much deeper understanding of CMS's methodology for calculating star ratings than provided in this article. It also requires determining which best practices and priorities will be most effective within the organizational environment.

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