SOCIETY OF ACTUARIES®

Article from

Health Watch

June 2018
Issue 86

SOCIETY OF ACTUARIES®

Article from

Health Watch

June 2018
Issue 86

Medicare Advantage Star Ratings: Expectations for New Organizations

By Kelly S. Backes, Julia M. Friedman, Dustin J. Grzeskowiak, Elizabeth L. Phillips and Patricia A. Zenner

The Medicare Advantage (MA) program is a government-sponsored program that offers an alternative to traditional fee-for-service (FFS) Medicare where benefits are provided to Medicare beneficiaries by privatized health insurance carriers. The cost of the program is funded in large part by the federal government.

Successful Medicare Advantage organizations (MAOs) maximize federal revenue to provide enhanced benefits and/or reduced premiums to their members, which ultimately improves marketability, with the aim of increasing membership. One of the key levers to increasing revenue is achieving higher star ratings—contracts achieving 4.0 stars and above receive a quality bonus payment (QBP). Organizations considering entering the MA market should be aware of the current star rating climate, as well as short- and long-term star rating and revenue considerations. This article analyzes these considerations and demonstrates there may be opportunity for improvement beyond the current star rating levels for new organizations.

MEDICARE ADVANTAGE STAR RATING SYSTEM BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) monitors each contract's quality and performance by calculating star ratings for up to 48 measures[1] that fall within five broad categories: outcomes, intermediate outcomes, patient experience, access, and process. These 48 star rating measures are aggregated into the following three star rating values:

- Part C, which replaces traditional FFS Medicare Part A (hospital and long-term care services) and Part B (outpatient and professional services).
- Part D, which provides prescription-drug coverage.
- Overall, which is a combination of the Part C and Part D star ratings. CMS uses only the overall star rating when calculating an MAO's revenue.

An overall star rating is calculated and assigned at the contract level as a number from 1.0 (low) to 5.0 (high), in half-step increments. Contracts without sufficient membership are assigned the "Low Enrollment" star rating. Contracts for new MAOs are assigned the "New Contract" star rating for the first three years of operations,[2] with the possibility of having their fourth year star rating calculated based on their own experience, provided there is sufficient membership. For example, an MAO entering the market in 2016 will be assigned the "New Contract" star rating for 2016 through 2018 and will be eligible to receive its own star rating for 2019 if membership is sufficient—the MAO would receive notification of this star rating in the fall of 2017, which is applicable for the 2019 payment year. If there is not sufficient membership, the 2019 star rating would be set to the "Low Enrollment" star rating.

Contracts assigned higher star ratings receive more federal revenue and are able to charge lower premiums and/or offer richer supplemental benefits, both of which are key to attracting and retaining members. It is critical for contracts coming off the "New Contract" star rating to achieve 4.0 stars to retain a QBP. This means operating an active stars management program in the initial start-up years, given the approximate three-year lag between star rating data collection and revenue impact.

CMS benchmarks, which are intended to reflect the maximum amount of revenue CMS will pay an MAO to provide coverage for traditional FFS Medicare benefits, significantly impact the amount of revenue an MAO receives. The federal Part C revenue, as shown in Figure 1, is the sum of:

- The bid, which is the MAO's revenue requirement to provide coverage for traditional FFS Medicare benefits
- The rebate, which is a portion of the difference (i.e., the rebate percentage) between the benchmark and the bid, and is used to fund supplemental benefits

Star ratings affect federal Part C revenue in two ways:[3]

1. Quality bonus payment (QBP): Contracts with 4.0 stars and higher receive a 5% increase in their benchmarks (10% in double bonus counties). Contracts assigned the "New Contract" or "Low Enrollment" star rating will receive a 3.5% increase in their benchmarks (7% in double bonus counties). This increase in benchmark results in higher rebates and total federal Part C revenue.
2. Rebate percentage: Contracts with higher star ratings will receive higher rebate percentages, resulting in higher rebates and total federal Part C revenue.

The 2019 QBP and rebate percentages by star rating are shown in Table 1.[4]

The current distribution of individual MA contracts by 2018 star rating is shown in Figure 2.

There are about 500 contracts in 2018, an increase of 33 contracts from 2017 to 2018. Based on a comparison of 2018 and 2017 star rating data:

- 17% of contracts are considered a "New Contract" in 2018, which is an increase of 5% over 2017.
- 34% of contracts achieved at least 4.0 stars and are eligible for a QBP in 2018, which is a decrease of 4% from 2017.
- 28% of contracts received 3.5 stars and are just below the threshold to receive a QBP in 2018. This is an increase of 5% from 2017.

Figure 1
Federal Part C Revenue for Medicare Advantage

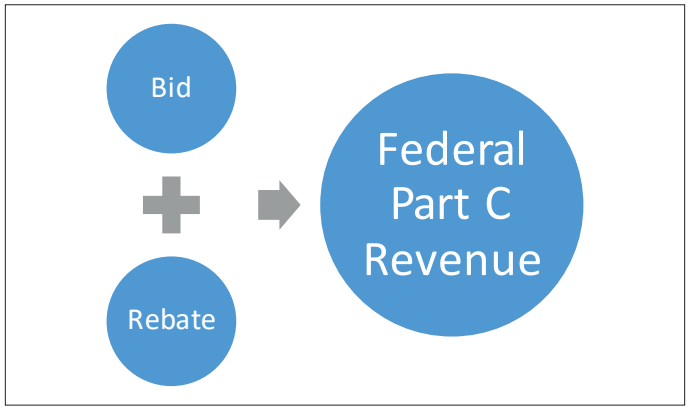


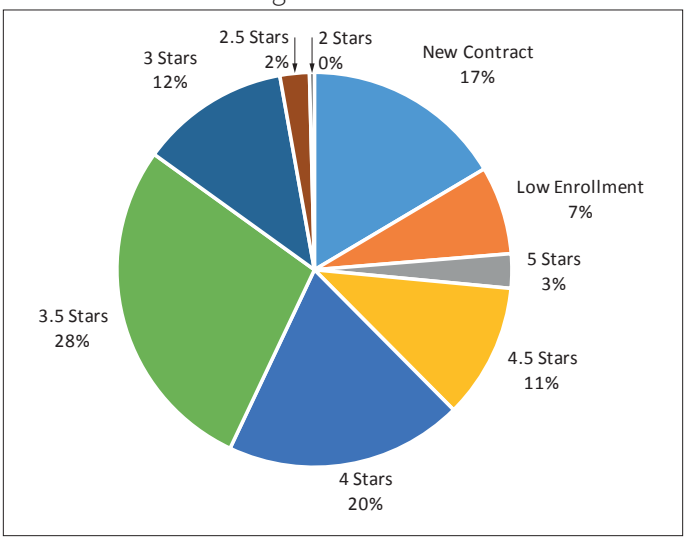
Table 1
2019 Quality Bonus Payment and Rebate Percentages

Star Rating	QBP	Rebate Percentage
4.5 or higher	5% (10% in double bonus counties)	70%
4.0	5% (10% in double bonus counties)	65%
3.5	0%	65%
3.0 or lower	0%	50%
New contract or low enrollment	3.5% (7% in double bonus counties)	65%

METHODOLOGY

We analyzed 2011 to 2018 star rating information released by CMS. We summarized star ratings of MAOs coming off the "New Contract" star rating by duration, which is defined as the number of years after a contract has come off the "New Contract" star rating. These results indicate the current level of star rating performance for new MAOs and the potential opportunity to increase star ratings above historical levels.

Figure 2
2018 Overall Star Rating Distribution



We created a contract-level database containing year, star rating, membership, and plan characteristic information using the following data sources:

- **2011 to 2018 star rating information released by CMS.**[5] We included all individual MA plans and excluded Employer Group Waiver Plans (EGWPs), Prescription Drug Plans (PDPs), Program of All-Inclusive Care for the Elderly (PACE) plans, Cost plans, Medicare-Medicaid Plans (MMPs), and Medical Savings Account (MSA) plans.

- **2011 to 2017 membership information released by CMS.**[6] We used February membership for each year to correspond to the same year's star rating information. We used September 2017 membership information for the 2018 star ratings, as the February 2018 membership was not yet available. Note that any contracts that are new to the 2018 market did not have membership during September 2017 and are excluded from our analysis. Membership was used to quantify the size of a contract.

GENERAL STAR RATING RESULTS

The average 2011 to 2018 star rating for contracts coming off the "New Contract" star rating is 3.48 stars, which is based on 52 contracts. There are also 104 contracts assigned the "Low Enrollment" star rating in the first duration. For contracts with star ratings based on experience, this is 6% lower than the average 2018 star rating of 3.71 stars across all contracts. New MAOs increase their star ratings over time, and the initial 6% gap is closed by about one-half within four years.

For those MAOs coming off of the "New Contract" star rating:

- The initial average star rating of 3.48 stars increased to 3.60 stars in the fourth year.

- The portion of contracts rated 3.5 stars and above increased from 56% in the first year to 63% in the fourth year. This is compared to 80% in 2018 for all contracts.

- The portion of contracts rated 4.0 stars and above increased from 37% in the first year to 40% in the fourth year. This is compared to 44% in 2018 for all contracts.

- The proportion of new contracts rated 2.5 stars and lower decreased from 17% in the first year to just 3% in the fourth year. This is compared to 4% in 2018 for all contracts. This improvement is caused by initially low-rated new contracts increasing their star ratings over time or exiting the market.

STAR RATINGS BY NETWORK TYPE

The 2011 to 2018 star ratings vary by health maintenance organization (HMO) and preferred provider organization (PPO) contracts. The average 3.75 star rating for PPO contracts (12 contracts) coming off the "New Contract" star rating is 8% higher than the average 3.46 overall star rating for HMO contracts (37 contracts).

The gap in the average star rating between HMO and PPO contracts is somewhat reversed over time, with the average star rating decreasing to 3.46 for PPO contracts and increasing to 3.65 for HMO contracts by the fourth year. This results in the average star rating for HMO contracts being 5% higher than the average star rating for PPO contracts in the long term.

Large nationwide MAOs, including PPOs, often focus significant effort early on in developing star rating improvement programs. HMO contracts are more likely to be sponsored by less experienced regional MAOs. This suggests new HMO contracts have an opportunity to achieve higher star ratings earlier, perhaps immediately after coming off the "New Contract" star rating, if they are actively engaged in star rating management early on and are early adopters of industry best practices.

STAR RATINGS BY MEMBERSHIP SIZE

The 2011 to 2018 star ratings vary by membership size. "Large"[7] contracts coming off the "New Contract" star rating achieved an average 3.69 stars, which is 9% higher than the average 3.39 stars for "Small"[8] contracts.

The average star rating for both membership size groups increased with additional years of experience. By the fourth durational year, the average star rating was 3.92 for Large contracts and 3.43 for Small contracts. The difference in star rating between Large and Small contracts increased to 14%.

The observed correlation between higher star ratings and larger membership reinforces the benefits of performing well in the CMS star rating program—higher star ratings generate more federal revenue, which in turn is passed through to the membership in the form of reduced premiums and/or increased benefits, which improves marketability and membership.

BEST PRACTICES AND KEY TAKEAWAYS

Running an effective star rating management program is essential and must be implemented fully across the organization, including engaging vendors in the very early start-up stages, to maximize a contract's star rating and therefore revenue attainment. Some best practices include:

- **Education.** Identify all subcontractors delegated to manage key administrative aspects and ensure they, as well as MAO staff, are familiar with the CMS star rating program and the metrics they are responsible for.

- **Gap assessment.** The assessment should identify gaps, risks, and opportunities to assist in formulating recommendations to move toward a best practice star rating strategy.

- **Strategic and tactical plans.** Potential strategic and tactical approaches should be discussed to close the gaps identified in the assessment, and viable options for a three-year implementation plan should be determined. This includes separately addressing each of the following areas:

  - Corporate leadership
  - Engaging providers
  - Engaging members
  - Readmissions
  - Customer service
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and Health Outcomes Survey (HOS)
  - Appeals and grievances
  - Prescription drugs

- **Business plan implications.** MAOs should consider impacts of future star ratings on their business plans and the reasonableness of achieving higher star ratings in the fourth and fifth years of operation.

Successful MAOs target profitability and membership growth. The key to both of these goals is to optimize revenue. While there are a few levers to increase revenue, one of the most direct ways is to achieve a QBP through attainment of 4.0 and greater overall star ratings. Managing an effective star rating management program is essential and must be implemented fully across the organization and with vendors in the very early start-up stages to ensure the best possible star rating and revenue attainment for new MAOs. ■

Please note the opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman. Kelly S. Backes, Julia M. Friedman and Dustin J. Grzeskowiak are members of the American Academy of Actuaries and meet the qualification standards of the Academy for sharing the information in this article. They relied on information from CMS, which was accepted without audit. However, they did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.

Kelly S. Backes, FSA, MAAA, is a consulting actuary at Milliman Inc. She can be reached at *kelly.backes@milliman.com*.

Julia M. Friedman, FSA, MAAA, is an actuary at Milliman Inc. She can be reached at *julia.friedman@milliman.com*.

Dustin J. Grzeskowiak, FSA, MAAA, is an actuary at Milliman Inc. He can be reached at *dustin.grzeskowiak@milliman.com*.

Elizabeth L. Phillips is an actuarial analyst at Milliman Inc. She can be reached at *libby.phillips@milliman.com*.

Patricia A. Zenner, RN, is a health care management consultant at Milliman Inc. She can be reached at *pat.zenner@milliman.com*.

ENDNOTES

1 Based on 2018 star ratings (34 Part C, 14 Part D).

2 New contracts under an existing organization receive the average star rating of the existing contracts under the parent organization.

3 CMS Office of the Actuary (February 1, 2018). Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter, Retrieved February 12, 2018, from *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf*.

4 The QBP may be reduced, such that the benchmark rate including any QBP is capped at the pre-ACA rate.

5 Part C and Part D Performance Data, *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html*.

6 CMS (June 12, 2012), Monthly MA Enrollment by State/County/Contract, Retrieved February 12, 2018, from *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html*.

7 Membership of 10,000 or more.

8 Less than 10,000 members.