



## The Star Rating System and Medicare Advantage Plans

ISSUE BRIEF  
NO. 854

LISA SPRAGUE, MBA, *Principal Policy Analyst*

MAY 5, 2015

*OVERVIEW — With nearly 30 percent of Medicare beneficiaries opting to enroll in Medicare Advantage (MA) plans instead of fee-for-service Medicare, it's safe to say the MA program is quite popular. The Centers for Medicare & Medicaid Services (CMS) administers a Star Ratings program for MA plans, which offers measures of quality and service among the plans that are used not only to help beneficiaries choose plans but also to award additional payments to plans that meet high standards. These additional payments, in turn, are used by plans to provide additional benefits to beneficiaries or to reduce cost sharing—added features that are likely to factor into beneficiaries' choice of MA plans. The Star Ratings program is also meant to drive improvements in the quality of plans, and this secondary effort seems to have been successful. Despite this success, issues with the Star Ratings system remain, including: how performance metrics are developed, chosen, and maintained; how differences among beneficiary populations (particularly with regard to the dually eligible and those receiving low-income subsidies) should be recognized; and the extent to which health plans can control the variables on which they are being measured. Because the Star Ratings approach has been extended to providers of health care as well—hospitals, nursing homes, and dialysis facilities—these issues are worth exploring as CMS fine-tunes its methods of measurement.*

The Medicare Advantage (MA) program gives Medicare beneficiaries the option to enroll in a private health plan rather than receiving benefits in the traditional fee-for-service (FFS) system. Virtually all beneficiaries have access to such plans, and one may enroll when newly eligible for Medicare or during an open enrollment period.<sup>1</sup> Beneficiaries new to Medicare may choose an MA plan if they are accustomed to managed care options, such as HMOs and PPOs, or beneficiaries may be drawn to the additional benefits and lower cost sharing that many MA plans provide. In 2014, 30 percent<sup>2</sup> of Medicare beneficiaries were enrolled in Medicare Advantage plans, up from 28 percent in 2013. The Medicare Trustees project modest growth in coming years.<sup>3</sup>

The Star Ratings system for MA plans, established in 2007, was envisioned as a tool for consumers to use in selecting a plan. The Centers for Medicare & Medicaid Services (CMS) cites research indicating that summary quality measures and the use of symbols, such as stars, are valuable to consumers in selecting plans and providers. MA plans are rated on defined quality measures: up to 33 are in effect for MA-only plans, and up to 44 are in effect for MA-PDP plans, which also offer prescription drug coverage. Star Ratings range from one to five stars. They are assigned on a contract rather than an organizational basis; that is, one insurer may have multiple contracts. (In turn, a contract may have multiple plan benefit packages.) The average rating per contract has increased over time, from 2.56 in 2012 to 3.92 in 2015.<sup>4</sup>

Among the issues involved in the design and administration of the Star Rating system are its two uses as a guide to consumers choosing among MA plans and as a factor in determining MA plan payments. This dual function means that CMS must be responsive both to beneficiaries who want transparent results relevant to their purchasing decisions and to health plans that have concerns related to differences in populations and their ability to influence the performance being measured.

Approximately 40 percent of MA-PDP contracts active in 2015 earned four stars or higher;<sup>5</sup> 11 of these earned five stars. As performance averages have edged higher, steps to discourage low-performing plan offerings

#### National Health Policy Forum

2131 K Street, NW  
Suite 500  
Washington, DC 20037

T 202/872-1390  
F 202/862-9837  
E [nhpf@gwu.edu](mailto:nhpf@gwu.edu)  
[www.nhpf.org](http://www.nhpf.org)

Judith Miller Jones, MA  
*Director*

Sally Coberly, PhD  
*Deputy Director*

Monique Martineau, MA  
*Director, Publications and  
Online Communications*

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at [www.nhpf.org](http://www.nhpf.org).

have also been adopted. Beginning in 2016, those that achieve less than a three-star rating for three consecutive years will be issued a notice of non-renewal of the contract for the following year.

The year-to-year increase in average star ratings, together with reduced incidence of low ratings, suggests that many plans have put considerable effort into improving performance on the range of measures. CMS noted in its fact sheet on 2015 Star Ratings that, of the 39 contracts that received low performance marks (2.5 stars or fewer) for 2014, 32 had since improved their performance or withdrawn or consolidated their contract.<sup>6</sup>

## HOW STAR RATINGS ARE CALCULATED

MA star ratings are based primarily on data collected on performance measures drawn from five sources:

1. HEDIS (Healthcare Effectiveness Data and Information Set), created by NCQA (National Committee for Quality Assurance), is a set of performance measures designed to assess a plan's clinical effectiveness, accessibility to members, and use of resources.<sup>7</sup>
2. CAHPS (Consumer Assessment of Healthcare Providers and Systems) is a survey developed under the aegis of the Agency for Healthcare Research and Quality and CMS to assess a patient's experience of care.<sup>8</sup>
3. HOS (Health Outcomes Survey) is a survey sponsored by CMS that gathers health status data from Medicare beneficiaries.
4. CMS administrative data support measures such as call center performance, volume of complaints, and beneficiary disenrollment.
5. Part D measures developed by the Pharmacy Quality Alliance are now included among the measure for MA-PDP plans.

Each year, CMS reviews the measure sets, considering reliability, clinical recommendations, feedback from stakeholders, and data issues.<sup>9</sup> Measures are weighted to reflect CMS priorities in judging MA plans. Currently, process measures receive a weight of 1.0, as do new measures. Patient experience measures receive a weight of 1.5; outcomes and intermediate outcomes, a weight of 3. Quality improvement measures were raised from a weighting of 3 to 5 beginning in 2015. Information reported in 2015 reflects care delivered in 2014 and will be incorporated in 2016 Star Ratings, though data collection on some measures may involve a look-back period of longer than one year. Star Ratings are made public each October, just prior to the open enrollment period.

CMS calculates Star Rating scores for each measure. In addition, MA plans are given a summary Star Rating on the basis of their performance in five categories, or “domains”:

- Use of screenings, tests, and vaccines
- Management of chronic conditions
- Member experience with the plan (CAHPS)
- Member complaints and changes in the plan’s performance (assesses the number of member complaints, the number of members choosing to leave the plan, and improvement, if any, in the plan’s performance from year to year)
- Customer service/appeals (whether the plan makes timely decisions about appeals and how often an independent reviewer thought the appeal decision should be upheld)<sup>10</sup>

Scoring methodology continues to evolve. In years past, CMS defined threshold values—the scores a plan would need to achieve in order to be awarded four stars on certain measures—and communicated those values to plans before the measurement period. But subsequent CMS analysis has found that plans, on average, have more significant levels of improvement on measures without pre-determined thresholds.<sup>11</sup> As a result, CMS has announced it will eliminate all pre-defined thresholds from 2016 Star Ratings. Cut points—the lines of demarcation between numbers of stars—will continue to be calculated. These are designed to “minimize the distance between scores within a grouping [that is, a group with the same number of stars] and to maximize the distance between scores in different groupings.”<sup>12</sup>

Plans with performance that is both high-quality and stable over time have a reward factor (formerly known as an integration factor) applied to their rating. This can add up to 0.4 stars.

**CMS analysis has found that plans, on average, have more significant levels of improvement on measures without pre-determined thresholds.**

---

## STAR RATINGS AND CONSUMERS

Googling “find a Medicare Advantage plan” leads to Medicare’s Plan Finder at [Medicare.gov](http://www.Medicare.gov). By typing in a zip code and a medication list, a user can determine what MA and prescription drug plans are available for that location. Information presented includes estimated annual health and drug costs, monthly premium, deductibles and copays, out-of-pocket spending limit, drug information, and the plan’s summary Star Rating.

Another section of the website (not quite so easily found) explains what the ratings measure.<sup>13</sup>

How many consumers actually go through this process is difficult to estimate, as is the percentage of them who are influenced by the Star Ratings. One study targeting first-time Medicare enrollees found that a one-star increase in a plan's score was associated with a 9.5 percentage point increase in likelihood to enroll.<sup>14</sup> On the other hand, a Kaiser Family Foundation survey found that beneficiaries looking for an MA or drug plan looked at cost, access to providers, familiarity with the plan sponsor, and whether needed services or drugs would be covered, and did not give much weight to Star Ratings.<sup>15</sup>

## STAR RATINGS AND PLANS

MA Plans have a keen interest in the ratings they receive—and the methods used to define them—because star assignments can directly affect how much Medicare pays them, and in turn how much they can offer their enrollees. MA plans are paid a monthly capitated rate by CMS, which is intended to cover beneficiaries' Part A and Part B services. This amount reflects the relationship between a benchmark established by CMS and the amount bid by the plan. Plans that bid below the benchmark set by CMS for a beneficiary population retain a share of the savings, termed a "rebate," which must be used to provide additional benefits or reduced cost sharing to beneficiaries. The rebate percentage varies from 50 percent for plans with fewer than 3.5 stars to 70 percent for plans with 4.5 or more stars.<sup>16</sup> Plans with Star Ratings of 4 or higher earn a quality bonus payment (QBP).<sup>17</sup> While the amount may vary depending on the county involved, the predominant QBP is 5 percent.

Plans with a five-star rating have the additional advantage of accepting beneficiary enrollment at any time during the year, rather than only during the annual open enrollment period. That is, a beneficiary who enrolls in an MA plan during open enrollment may choose to exercise a one-time Special Enrollment Period opportunity later in the year in order to transfer to a five-star plan (provided that one is available in his or her service area).

Anecdotally, many plans report that CMS has been willing to work with them to address concerns they may have. As with any complex undertaking, concerns and differences of opinion remain. Some have to do with metrics and procedures; others are more structural.

### Administration and Procedures

Each year CMS communicates with plans (via a document known as the “call letter”) to convey information that MA plan sponsors need to take into consideration in preparing their bids for the next year, including changes to measures and processes. In recent years, CMS has also issued an “Enhancements to the Star Ratings” memo each fall, asking for comments on proposed Star Ratings changes. Some insurers have requested repeatedly that CMS present annual changes to MA in a formal notice with an associated comment period of up to 60 days. CMS maintains that its choice of using sub-regulatory guidance—providing written guidance in the form of letters or memoranda outside the formal rulemaking process—allows plans ample opportunity to comment and sufficient time to make adjustments. Insurers have also requested that CMS refrain from making changes retroactive or adopting measures on the basis of data that has already been collected because they feel this gives plans no opportunity to improve.

### Quality Measurement

Metrics used to calculate quality scores come in for some criticism each year. Those that have been through the consensus-based vetting process of NCQA or NQF are not typically controversial, though change may still be sought. In 2014, for example, CMS moved the breast cancer screening risk to “display” status, a kind of holding pen where measures are placed when they have experienced a significant change in methodology and are taken out of ratings calculations for a period of time. In 2016, this measure will return to the active list, reflecting NCQA’s changes to the age range (from 40-69 to 50-74), and the documentation time frame (from 24 to 27 months.)<sup>18</sup> An osteoporosis screening measure was similarly updated, adding an upper age limit, extending a look-back period to account for previous screenings, and tightening the list of acceptable modes of bone density testing. Certain measures, such as those relating to cholesterol screening and control (and following the lead of the American College of Cardiology and NCQA) were retired.

The 2016 call letter contemplates—and puts plans on notice of—potential new measures for 2017. One emerging category is care coordination. The letter states, “CMS believes that 5-star plans perform well on our Star Ratings measures because they understand how to effectively coordinate care for their enrollees. Our assumption about plans, however, is based largely on anecdote and discussions with high-performing plans. To date,

our ability to measure plans' care coordination efforts has largely been limited to the data we collect from CAHPS surveys."<sup>19</sup>

### Population and Risk Adjustment

Analysts (and plans themselves) have raised questions about how differences among beneficiary characteristics and demographics affect Star Ratings. What are the effects of geographically differing practice patterns, language and cultural factors, and population health status? To what extent should plans be held responsible for such factors? Or for other social determinants of health?

A variable that has garnered a great deal of attention, and prompted CMS to issue a Request for Information (RFI) in 2014, was the difference in Star Rating quality measurements for beneficiaries dually eligible for Medicare and Medicaid, versus those who are not, and the effect that the proportion of dual eligibles or low-income subsidy (LIS) enrollees has on plan ratings. CMS's RFI solicited analyses and research "that demonstrate that dual status **causes** lower MA and Part D quality measure scores."<sup>20</sup> CMS also conducted research of its own.

Observers have been divided on the issue. Some believe that plans serving a large number of dual/LIS beneficiaries are bound to be disadvantaged because of the socioeconomic factors that confound health care for these groups, and suggest that failure to adopt some form of case-mix adjustment may drive plans from the MA business, leaving vulnerable populations in the lurch. Some plans with a high proportion of dual/LIS beneficiaries say they have no intention of exiting, but would like the additional challenges they face in achieving good ratings recognized. Other analysts maintain that neutralizing lower quality scores via case-mix adjustment in effect legitimizes and perpetuates disparities.

In the call letter, CMS explains that its research found some differences (most of which are small) in measure-level performance among dual/LIS beneficiaries, but asserts that "evidence of an association between higher [d]ual enrollment (and higher LIS beneficiary enrollment) and lower Star Ratings does not prove causality."<sup>21</sup> More research, the letter says, is needed before permanent changes to the Star Rating system are made. CMS will continue to work with ASPE (Assistant Secretary for Planning and Evaluation), plan sponsors, measure developers, and other stakeholders to seek more scientific evidence before making changes.

Analysts (and plans themselves) have raised questions about how differences among beneficiary characteristics and demographics affect Star Ratings.

---

## RATINGS EXPANSIONS AND OUTLOOK

CMS has announced plans to adopt star rating systems for all of the [Medicare.gov](http://www.Medicare.gov) Compare websites. In addition to MA and Part D plans, ratings are available for nursing homes and a limited number of large physician group practices. Ratings for dialysis facilities, hospitals, and home health agencies made their debut in 2015. While Star Ratings for plans have gradually achieved widespread acceptance, some of the other rating systems are still being debated. CMS resolved to recalculate stars for nursing homes following considerable publicity about these facilities' ability to "game" their self-reported numbers.<sup>22</sup> The dialysis facility rating system has drawn criticism from industry and patient groups for some of its metrics and for the decision to "grade on the curve," which opponents say forces a percentage of facilities into one- and two-star categories even if their performance differs little from higher-scoring facilities.<sup>23</sup>

To date, Star Ratings have focused on the quality component of the value equation. Legislative change would be required to allow CMS to consider cost in their ratings of plans. Some analysts suggest that, in Medicare's overall drive toward paying for value, cost needs to be an explicit consideration. Others say that beneficiaries can see a cost component in the form of richer benefits or lower cost sharing in high-quality plans.

Still other observers raise questions about whether health plans remain an appropriate focus of performance measurement, given that both quality and cost ultimately reflect clinician behavior and beneficiary characteristics. For now, plans are the accountable entities and continue to put significant effort into making their stars shine. It is up to them to drive measurement and accountability to the provider level as they may be willing and able.

## ENDNOTES

1. MedPAC reports that 0.4 percent do not. "The Medicare Advantage program: Status report," ch. 13 in Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 324, [www.medpac.gov/documents/reports/mar14\\_ch13.pdf](http://www.medpac.gov/documents/reports/mar14_ch13.pdf).
2. Kaiser Family Foundation, "Medicare Advantage Fact Sheet," May 1, 2014, <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.
3. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 2014, p. 162, [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf).



4. Centers for Medicare & Medicaid Services (CMS), “Fact Sheet – 2015 Star Ratings,” p. 1, in “2015 Part C & D Medicare Star Ratings Data” ZIP file, [www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html).
5. CMS, “Fact Sheet – 2015 Star Ratings,” p. 1.
6. CMS, “Fact Sheet – 2015 Star Ratings,” p. 3.
7. Resource use measures are not among those selected for inclusion in star ratings.
8. Lisa Sprague, “Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys: Assessing Patient Experience,” National Health Policy Forum, The Basics, December 18, 2014, [www.nhpf.org/library/details.cfm/2976](http://www.nhpf.org/library/details.cfm/2976).
9. CMS, “Fact Sheet – 2015 Star Ratings,” p. 1.
10. For further detail, see CMS, “Medicare 2015 Part C & D Technical Notes,” updated October 3, 2014, [http://cdn5.medicarehelp.org/wp-content/uploads/2014/10/2015\\_Tech\\_Notes\\_2014\\_10\\_03.pdf](http://cdn5.medicarehelp.org/wp-content/uploads/2014/10/2015_Tech_Notes_2014_10_03.pdf).
11. CMS, “Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,” April 6, 2015, p. 87, [www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf](http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf).
12. CMS, announcement and call letter, p. 84.
13. Medicare.gov, “Star Ratings,” [www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx](http://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx).
14. Rachel O. Reid *et al.*, “Association Between Medicare Advantage Plan Star Ratings and Enrollment,” *Journal of the American Medical Association*, 309, no. 3 (January 16, 2013): p. 267, <http://jama.jamanetwork.com/article.aspx?articleid=1557733>.
15. Gretchen Jacobson *et al.*, “How are Seniors Choosing and Changing Health Insurance Plans? Findings from Focus Groups with Medicare Beneficiaries” Kaiser Family Foundation, May 2014, <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changing-health-insurance-plans.pdf>.
16. Centers for Medicare & Medicaid Services, “Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter,” February 20, 2015, p. 15, [www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf](http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf).
17. For the years 2012 to 2014, CMS implemented a demonstration that took the place of the quality bonus prescribed for plans earning four or more stars by the Patient Protection and Affordable Care Act of 2010 (ACA). Under the demonstration, plans with three or more stars were eligible for a quality bonus. The demonstration was repeatedly criticized by the U.S. Government Accountability Office (GAO) for its research design and expense. See for example GAO testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, “Medicare Private Health Plans: Selected Current Issues,” September 21, 2012, GAO-12-1045T, [www.gao.gov/assets/650/648677.pdf](http://www.gao.gov/assets/650/648677.pdf).

18. CMS, announcement and call letter, p. 89.
19. CMS, announcement and call letter, p. 109.
20. CMS, “Request for Information – Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible Versus Non-Dual-Eligible Enrollees,” [www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Request-for-Information-About-the-Impact-of-Dual-Eligibles-on-Plan-Performance.pdf](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Request-for-Information-About-the-Impact-of-Dual-Eligibles-on-Plan-Performance.pdf).
21. CMS, announcement and call letter, p. 102.
22. Katie Thomas, “Medicare Star Ratings Allow Nursing Homes to Game the System,” *New York Times*, August 24, 2014, [www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html](http://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html).
23. See, for example, the American Kidney Foundation’s summary at <https://www.kidney.org/The-Dialysis-Facility-Compare-Star-Program>.