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Medicare Star Ratings–What Plan Sponsors Need to Know

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On Oct. 12, the Centers for Medicare & Medicaid Services published its 2013 Medicare Health Plan Quality and Performance Ratings, also called ''Star Ratings'' or ''Plan Ratings.'' Star Ratings assist enrollees in choosing Medicare Advantage (''MA'') plans and Prescription Drug Plans (''PDPs'') during the annual enrollment period beginning in October and ending in December.

In the past, Star Ratings were used both as an informational tool for beneficiaries and as a way for CMS to help identify poor performing MA plans and PDPs. These ratings have become increasingly important since the enactment of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the ''Affordable Care Act'').[1] The Affordable Care Act requires that MA quality bonus payments be tied to Star Ratings—a requirement that has generated a fair amount of controversy.

CMS also has promulgated regulations and issued policy guidance that magnifies the importance of Star Ratings, including changes focused on beneficiary outreach, reimbursement, and acceptable marketing and enrollment activities.

I. Overview of Star Ratings System

CMS developed the Star Ratings system for Medicare Part C and Part D based on a comprehensive assessment of various health care metrics. Star ratings are published on the Medicare.gov website (http://www.medicare.gov) and may be accessed online using the ''Medicare Plan Finder'' tool. In a technical notes guidance document, CMS sets forth its Star Rating methodology, along with changes from year to year.[2]

MA plans and PDPs receive a Star Rating for certain categories called ''domains.'' Each domain is composed of various measures and each individual measure receives a Star Rating as well. For example, one measure is based on whether enrollees have had at least one primary care doctor visit in the last year.

The number of stars assigned to applicable measures and categories are aggregated, applied to various plans within a contract, and then CMS assigns a contract-level Star Rating, which is also called a ''summary score.'' CMS assigns stars based on the following scale:

1 Star	**Poor Performance**
2 Stars	**Below Average Performance**
3 Stars	**Average Performance**
4 Stars	**Above Average Performance**
5 Stars	**Excellent Performance**

For contract year 2013, CMS rates MA plans based on how they perform in five domains:

1. Staying Healthy: Screenings, Tests and Vaccines (10 measures);
2. Managing Chronic Long Term Conditions (13 measures);
3. Member Experience With Health Plan (6 measures);

[1] Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

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[2] *See* CMS, Medicare Health & Drug Plan Quality and Performance Ratings 2013 Part C & Part D Technical Notes (Draft, updated Oct. 2, 2012).

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4. Member Complaints, Problems Getting Services, and Improvements in the Health Plan's Performance (4 measures); and

5. Health Plan Customer Service (4 measures).

CMS rates PDPs on their performance in four domains:

1. Drug Plan Customer Services (5 measures);

2. Member Complaints, Problems Getting Services, and Improvement in the Drug Plan's Performance (4 measures);

3. Member Experience with the Drug Plan (3 measures); and

4. Patient Safety and Accuracy of Drug Pricing (6 measures).

MA plans that offer a prescription drug benefit under Medicare Part D (''MA-PDs'') are rated on both the MA and PDP domains/measures and receive one comprehensive Star Rating.

Star Ratings compile information from various sources including:

- The Healthcare Effectiveness Data and Information Set (''HEDIS'').
- The Consumer Assessment of Healthcare Providers and Systems (''CAHPS'') Survey.
- The Health Outcomes Survey (''HOS'').
- CMS administrative data, including but not limited to member satisfaction, appeals processes, audit results, and customer service.
- Prescription drug event (''PDE'') data submitted to the CMS by the drug plans (for Part D).

II. Star Ratings and Plan Reimbursement

Both Congress and CMS have taken actions to expand the use of Star Ratings in connection with MA plan and PDP reimbursement.

a. The Affordable Care Act and Quality Bonus Payments

The Affordable Care Act tied Star Ratings to MA reimbursement. The Affordable Care Act mandates that only plans with a quality rating of 4 stars or higher (based on the most recent data available) are eligible to receive quality bonus payments.[3] This is a significant shift in the use of Star Ratings, which prior to the Affordable Care Act were used to assist both enrollees (in plan selection) and CMS (in plan monitoring efforts), but did not impact plan payment.

b. CMS Demonstration Project

Following enactment of the Affordable Care Act, the Department of Health and Human Services, through CMS, created a demonstration project that delays application of the Affordable Care Act's bonus payment structure and extends quality bonus payments to the majority of MA plans (the ''Demonstration Project'').[4]

Unlike the Affordable Care Act's quality bonus payment structure, the Demonstration Project allows for the payment of quality bonuses to MA plans/contracts with 3 and 3.5 stars (in addition to those plans with 4, 4.5, and 5 stars, as the Affordable Care Act mandates).

The Demonstration Project is designed to test an alternative method for computing quality bonus payments and to determine whether plan performance will improve if bonuses are paid at various incremental Star Rating levels.

III. Criticism of Star Ratings System and CMS Demonstration Project

a. Controversy Surrounding Demonstration Project

The Demonstration Project has been the subject of congressional hearings and has led the Government Accountability Office (''GAO'') to issue a report that sets forth various concerns with respect to the legal basis and design of the Demonstration Project.[5]

The GAO report states that the structure of the Demonstration Project may not be effective to meet its stated purpose of testing whether a scaled bonus structure leads to faster quality improvement than the structure set forth in the Affordable Care Act.

Critics also have asserted that CMS created the Demonstration Project, at a cost of over $8 billion, as a means to temporarily offset the significant MA reimbursement reductions authorized by the Affordable Care Act.

In October, Republican leaders of the House Committee on Oversight and Reform and Subcommittee on Technology, Information Policy, Intergovernmental Relations and Procurement Reform issued a subpoena to HHS to compel production of various documents associated with the Demonstration Project (23 MCR 1242, 10/26/12).

Although HHS produced certain documents, leadership of the Committee on Oversight and Reform concluded that the document production was nonresponsive.[6] Despite this criticism and barring future actions to the contrary, the Demonstration Project is set to continue through 2014.

b. Concern that Star Ratings Do Not Capture the Most Important Aspects of Care

Various stakeholders have argued that Star Ratings do not capture the most important aspects of beneficiary medical treatment. This criticism is most prevalent with respect to special needs plans (''SNPs''), which are tailored to beneficiaries who have severe or disabling chronic conditions, are dually eligible for Medicare and Medicaid, and/or reside in institutions.

Critics assert that the Star Rating system relies heavily on measures related to preventive screening of risk factors that may not be appropriate in managing care for the SNP population. Certain measures, such as breast cancer screening, colorectal cancer screening, and glaucoma screening, may not be the most effective

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[3] 42 U.S.C. § 1395w–23(o).

[4] *See* CMS Fact Sheet, *Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration on Quality Bonus Payments* (Nov. 10, 2010), *available at* http://www.cms.gov/apps/docs/Fact-Sheet-2011-Landscape-for-MAe-and-Part-D-FINAL111010.pdf.

[5] GAO Report, Medicare Advantage, Quality Bonus Payment Demonstration Has Design Flaws and Raises Legal Concerns, GAO-12-964T (July 25, 2012) (23 MCR 844, 7/27/12).

[6] Letter from Darrell Issa to Kathleen Sebelius (Oct. 19, 2012).

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way to gauge the quality of health services provided to Medicare's most vulnerable beneficiaries enrolled in SNPs.

Removing some of these measures, or adding new measures geared towards individuals who have chronic conditions, are institutionalized, or are dually eligible for Medicare and Medicaid, could materially change the summary score of a plan sponsor's contracts that offer SNPs.

Public commenters have recommended that CMS create a separate Star Rating system for SNPs with measures that better reflect the quality of care offered by SNPs.[7] Specific recommendations include creating ''transitional star ratings'' until current ratings can be modified, and adding one-half stars to SNPs that obtain certain thresholds for SNP-related measures.[8]

Although CMS included three SNP-specific measures in the 2013 Plan Ratings, CMS has rejected the call to modify the Star Ratings system to better account for the beneficiary populations enrolled in SNPs:

> We have frequently considered the adoption of modifying the plan rating standards to account for unique differences in the characteristics of certain plan membership profiles. However, we have not yet found any statistical support for the special treatment of certain plans under the plan rating methodology. The 2011 Part C and D plan rating results, for example, provide no support for the argument that MA organizations offering SNPs face special challenges in achieving good star ratings. The plan rating results for all Part D contracts, when broken down into three categories by percentage of SNP enrollment per contract (SNP enrollment less than 50 percent, SNP enrollment greater than 50 percent, and SNP enrollment 100 percent of total contract enrollment) show that approximately 15 percent to 18 percent in each category receive less than 3 stars. The Part C results are slightly more mixed but still show that contracts with SNP enrollment receiving less than 3 stars are decidedly in the minority relative to their peers. Among the same enrollment percentage categories described for Part D, the percentage of Part C contracts with low star ratings ranged from approximately 15 percent to 29 percent. Interestingly, the rate of less than 3 star performers drops when SNP enrollment increases from 50 percent or more to exactly 100 percent. That is, contracts with only SNP members tend to have strong performance, equal to contracts with fewer than 50 percent SNP members. Therefore, we can easily conclude based on these data that having SNP members in a contract does not pull down summary plan rating results for either the Part C or Part D ratings.[9]

Many in the health care industry disagree with CMS's contention that SNPs do not adversely impact a contract's summary rating. They point to the fact that SNPs are held to the same standard as other MA plans despite the considerable differences in beneficiary population.

[7] 75 Fed. Reg. 19685 (Apr. 15, 2010).
[8] *Id.*
[9] 77 Fed. Reg. 22114 (Apr. 12, 2012).

IV. Critical Star Rating Issues for MA Plan and PDP Sponsors

a. Star Ratings May Play a Considerable Role in a Plan's Future Viability

The impact of the Star Ratings system on plan quality bonus payments has received considerable attention. However, plan sponsors must recognize that over the past several years CMS has taken a variety of actions to expand the influence of the Star Ratings system on other important areas of plan operation, such as product expansion, enrollment, marketing, and contracting.

1. Effect of Star Ratings on Product Expansion

Star Ratings play an important role in CMS's Past Performance Review Methodology (the ''Past Performance Methodology'') for MA plan and PDP sponsors applying for service area expansions and/or new contracts.[10]

CMS applies the Past Performance Methodology to a 14-month performance review period (e.g., from Jan. 1, 2011, through Feb. 28, 2012, for contract year 2013 applications) and reviews 11 performance categories, including Star Ratings. CMS assigns ''negative point values'' to all categories where a plan sponsor's contract is considered a performance ''outlier'' based on receiving a summary score of fewer than 3 stars.

The Past Performance Methodology assigns two negative performance points to contracts that are considered Star Ratings outliers. CMS may reject applications for service area expansions and/or other new product offerings from MA contracts with four or more negative points, and PDP contracts with five or more negative points.

Therefore, contracts with fewer than 3 stars are either halfway (for MA) or close to halfway (for PDP or MA-PD) towards the negative performance point threshold that would prohibit expansion, with 10 performance categories left to be analyzed.

CMS applies the Past Performance Methodology to the legal organization level. If a legal entity has a contract with a summary score of 2.5 stars or fewer, it will receive two negative performance points. By applying this standard to the legal entity level and not the contract level, a legal entity could receive two negative performance points even if only one of the many contracts it sponsors receives fewer than 3 stars.

Plan sponsors must understand that one (or a few) poor performing contracts can prevent an entire legal entity from expanding its service areas or obtaining new contracts under the Past Performance Methodology. In addition, Star Ratings (if a contract is assessed fewer than 3 stars) can be one of the most important categories in the Past Performance Methodology that could preclude a plan's applications to expand service areas and/or product offerings.

2. Benefit of Excellent Star Ratings on Enrollment and Marketing

CMS has recently offered marketing advantages to MA plans with excellent Star Ratings. Beginning this year, at any time over the course of the year, Medicare

[10] Memorandum from Cynthia Tudor and Danielle Moon to All MA organizations, PDP Sponsors, and Cost Plans, *2013 Application Cycle Past Performance Review Methodology Update* (Dec. 2, 2011).

beneficiaries are able to enroll, through a ''special enrollment period,'' in MA plans that receive 5 stars.[11]

This provides 5 star MA plans with a considerable advantage over other plans that may enroll eligible beneficiaries only during the annual enrollment period that lasts approximately two months. In addition, a ''high performing icon'' appears on the Medicare Plan Finder website next to contracts with excellent Plan Ratings.[12]

This icon is assigned to MA contracts that achieve a 5 star Part C summary rating, PDP contracts with a 5 star Part D summary rating, and MA-PD contracts with a 5 star overall summary rating. This icon may influence enrollee plan choices as they research and review plan options on the Medicare Plan Finder website.

3. Potential Contract Terminations for Consistently Poor Performance

CMS may take contract actions against plan sponsors with poor Star Ratings. CMS has promulgated regulations that authorize the agency to terminate MA and PDP contracts that have received fewer than 3 stars for three consecutive years.[13]

This rule is significant because CMS expanded the scope of actions it can take against a plan sponsor's existing product offerings. Instead of simply denying applications for service area expansions/new contracts (as seen in the Past Performance Methodology), CMS has given itself the authority to terminate existing contracts based on Star Ratings.

In the preamble to its April 2012 final rule, CMS explained:

> We have established that 3 stars reflects an average level of performance and is the lowest acceptable rating for plan sponsors. Sponsors that fail for three consecutive years to achieve at least a 3-star rating have demonstrated that they have substantially failed to meet the requirements of the Part C and D programs and failed to take timely and effective corrective action. Therefore, we are adopting the authority to terminate the contracts of Part C and D sponsors that fail to achieve at least a 3-star plan rating for 3 consecutive years.[14]

This rule does not apply retroactively; therefore, the earliest that CMS can terminate a contract as a result of poor Plan Ratings is contract year 2015. However, for contracts that presently have received fewer than 3 stars during the past three consecutive years, CMS assigns a ''low performing icon'' to appear on the Medicare Plan Finder website.[15] This symbol may deter prospective beneficiaries from enrolling in these plans.

4. Reductions in Star Ratings While Under Sanction

When CMS issues marketing and/or enrollment sanctions, the contract's Plan Rating is automatically reduced to 2.5 stars regardless of how it performs with respect to the individual measures that are used to calculate a contract's summary score.[16] With this automatic reduction, plan sponsors receive the double penalty of both not being able to market to and/or enroll new beneficiaries along with all of the adverse consequences discussed above that accompany contracts that score below 3 stars.

Because plan sponsors are held accountable for the actions of their first tier, downstream, and related entities, they should implement comprehensive policies and procedures, internal audit mechanisms, and compliance programs geared toward assuring the quality of the services provided by first tier, downstream, and related entities.

b. Strategies to Improve and Maintain Star Ratings

Plan sponsors should create a strategy to improve/maintain their ratings with particular attention placed on the inputs that go into Star Ratings. Such strategies should include adjusting contracting activities with first tier, downstream, and related entities to address the quality measures used to calculate Star Ratings.

Many of the measures that go into the Star Ratings calculations are based on activities that plan sponsors delegate to participating providers and downstream contractors. Because plan sponsors are held accountable for the actions of their first tier, downstream, and related entities, they should implement comprehensive policies and procedures, internal audit mechanisms, and compliance programs geared toward assuring the quality of the services provided by first tier, downstream, and related entities.

Plan sponsors should also consider offering training sessions to ensure that first tier, downstream, and related entities offer quality care that is reflected in the inputs used to calculate Star Ratings. It is important for all parties to understand how meeting and exceeding certain Star Ratings thresholds can put plan sponsors in a better position to maintain and improve the quality of beneficiaries' care, market to new beneficiaries, expand product offerings, and receive greater payments from CMS.

V. The Future of Star Ratings

CMS has signaled that Star Ratings are likely here to stay and all signs point to the expanded use of these ratings for various aspects of the MA and PDP programs.

As a result, in the coming years, CMS will: (i) continue to demand a strong level of quality and performance; (ii) expand the focus on improving beneficiary outcomes and experience; (iii) adopt new measures de-

[11] *See* Memorandum from Michael Crochunis to Medicare Advantage Organizations, *Establishing a Special Election Period (SEP) to Enroll in 5-Star Medicare Advantage Plans in Plan Year 2012*, Nov. 19, 2010.

[12] CMS, Medicare Health & Drug Plan Quality and Performance Ratings 2013 Part C & Part D Technical Notes (Draft, updated Oct. 2, 2012), p. 10.

[13] 42 C.F.R. § 422.510(a)(14); 42 C.F.R. § 423.509(a)(13).

[14] 77 Fed. Reg. 22074-75 (Apr. 12, 2012).

[15] CMS, Medicare Health & Drug Plan Quality and Performance Ratings 2013 Part C & Part D Technical Notes (Draft, updated Oct. 2, 2012), p. 10-11.

[16] *Id*. at 11.

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veloped by consensus-based organizations to create a more robust measurement system; and (iv) consider alternative methods to evaluate a plan's improvement.[17]

[17] Presentation by Cynthia G. Tudor, Vikki Oates, and Elizabeth Goldstein, *A Discussion on Medicare Part C & D Plan Ratings*, CMS 2012 Medicare Advantage & Prescription Drug Plan Fall Enrollment, Marketing and Compliance Conference (Sept. 5, 2012).

MA plan and PDP sponsors should take note of how the Star Ratings have evolved and monitor future guidance. By focusing on quality metrics that are included as components of the Star Rating methodology, plan sponsors can potentially reap the rewards of expanded enrollment, enhanced reimbursement, and improved member health care outcomes.