



Research

Primer: The Medicare Advantage Star Rating System

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Introduction

For years, policymakers and health insurers have looked for ways to simultaneously reduce federal health care expenditures and ensure better quality care for patients. For both hospital services (Part A) and physician services (Part B), the Centers for Medicare and Medicaid Services (CMS) has implemented multiple programs to track providers' performance on various metrics and adjust payments accordingly—similar to efforts being imposed by private insurers. For Medicare Advantage (MA or Part C), CMS operates the Star Rating System. This system provides a relative quality score to Medicare Advantage Organizations (MAOs) on a 5-star scale based on their plans' performance on selected criteria, and is now used to determine whether or not an MAO will receive bonus payments and/or rebates for their enrollees.

How Stars are Calculated

The 5-star rating system was first implemented by CMS for MA plans in 2008 serving as a tool to inform beneficiaries as to the quality of the various plan options and assist them in the plan selection process. Ratings are set at the MAO contract level—not the plan level—meaning all plans under the same contract receive the same score. Stars are assigned to each contract for each individual measure being evaluated, based on relative performance compared to the other contracts. The overall summary score for each contract is then calculated by averaging the star ratings for each individual measure for a contract.

Performance is not weighted by plan enrollment; a contract performing well with many enrollees does not receive any extra credit for providing high-quality care to more people than a contract with lower enrollment. Further, for the majority of measures in the Stars Rating program, performance is not adjusted for patient characteristics or socioeconomic status. There are a few lower-weighted Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, which measure patient satisfaction with the care they received that include some adjustments for age, education, mental and physical health, income, and state of residence.^[1] However, adjustments are not made for the higher-weighted Healthcare Effectiveness Data and Information Set (HEDIS) or the Health Outcomes Survey (HOS) clinical measures which more closely and objectively measure the quality of health care provided through reviews of patient medical charts and insurance claims, and which are more likely to be impacted by those adjustment factors.

Since 2011, CMS has set thresholds (based on historical trends) which must be attained to achieve 4-star status for roughly half of the measures. However, they are eliminating the thresholds beginning in 2016 as CMS no longer believes the target indicators are needed and that the thresholds increase the risk of rating misclassification. Analysis by CMS has shown that greater improvement is typically achieved for measures which do not have predetermined thresholds than those that do. While this may be because the incentive to improve any further is significantly diminished once the threshold for receiving the bonus payment is achieved,

it may also result from underlying differences between measures which have been given thresholds and which have not, as they are not randomly selected.[2]

In 2014 and 2015, measures were based on five broad categories, with weights varying based on the category's level of importance as determined by CMS[3]:

Metric Category	Weight
Improvement	5[4]
Outcomes	3
Intermediate Outcomes	3
Patient Experience	1.5
Access	1.5
Process	1