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## Medicare Advantage Star Ratings: Detaching Pay from Performance

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### EXECUTIVE SUMMARY

Rewarding quality health plans is an admirable goal for the Medicare Advantage program. Unfortunately, the current system of linking star ratings to bonus payments and rebate adjustments instituted by the Patient Protection and Affordable Care Act (and expanded by the CMS Quality Bonus Payment Demonstration) fails to achieve that goal, and depending on its specific implementation, may even be counterproductive.

Because criteria for evaluation are not published until after the period for which performance will be evaluated, there is no possibility that MA plans will be able to improve their performance to achieve the goals CMS intends to incentivize. Any adjustment plans will be able to make to their bids or plan offerings would have to be aimed at increasing enrollment in counties with the highest bonuses and rebates based on data from performance in *previous* years, possibly at the expense of improving their performance in the future.

The system rewards beneficiaries for choosing those plans favored by the selected CMS criteria, rather than the plans that best meet their needs. In effect patients whose preferences, health status, and even counties of residence, don't match the CMS model of a highly rated plan will be at a disadvantage. Simultaneously, the system will likely reduce the scope of choice available to MA-eligible beneficiaries, and reduce competition among MA plans.

Finally, the system rewards beneficiaries for living in counties with low poverty rates (since relatively wealthier counties tend to have more plans with higher ratings), thus adversely impacting poor beneficiaries even more than non-poor beneficiaries.

These impacts are inconsistent with the overall policy purpose. The goal of incentivizing quality health plans is legitimate and admirable; that goal will not be achieved by the rating structure currently being put into place.

The star bonus system could be improved by transforming it to a system in which criteria for performance were announced in advance, and bonuses were paid based on performance during the period in which it occurred. In addition, the system should not tilt the playing field against any particular beneficiaries' preferences. A star system with these characteristics would ensure that the program goal of incentivizing the achievement of high-quality plan offerings is achieved.

### Introduction

In 2008, the Centers for Medicare and Medicaid Services (CMS) established a rating system for Medicare Advantage (MA) plans on a 1-star to 5-star scale to assist beneficiaries in the selection of an MA plan. Beneficiaries may, if they wish, use these ratings in conjunction with information about benefits, copays, and available providers, to select the MA plan that best meets their needs.

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The Patient Protection and Affordable Care Act (PPACA) included a provision to use the star rating system as a crude “pay for performance” system. Payments to plans will be adjusted based on star ratings, both bonus payments to MA plans' bottom line and payments (i.e., “rebates”) are used to enhance benefits and/or reduce cost-sharing for beneficiaries. PPACA called for phasing in bonuses and larger rebates to plans with 4-star ratings or higher starting in 2012. In November 2010, CMS announced a “demonstration” program, by which the higher payments would extend to plans with 3-star ratings, and would be phased in faster. The question is, are the criteria for star ratings applied in a fashion that actually incentivizes quality performance, and if so does it do so in a way that benefits patients?

There are several reasons to believe this is unlikely. First, criteria for evaluation are announced after the period for which they are applied, and payments are made based on enrollment in a future time period – so MA plan contractors have no opportunity to adjust their plans to improve their performance in dimensions CMS prioritizes. Furthermore, the beneficiaries who experience the performance are not necessarily those whose payments will be affected by the ratings, because additional payments will be based on enrollment patterns in a future year, not enrollment in the year in which performance is evaluated. MA contractors will also have strong incentives to adjust their plans and bids in particular counties so as to maximize their bonuses and rebates. This could have the effect of disproportionately benefiting beneficiaries who live in certain counties based on historical data for those counties rather than current performance. Second, because of the rebate structure, instead of giving higher ratings to plans with more benefits, benefits will be increased for higher-rated plans. This means that beneficiaries with needs that differ from standard CMS criteria are likely to be penalized for selecting plans that are best for them. Beneficiaries will be incentivized to go into a subset of available plans, thus reducing competition and the scope of options available to all beneficiaries. Third, geographic variation in plan ratings, based in part on variation in FFS costs, will lead to lower benefits in certain regions – which happen to be, disproportionately, regions with higher poverty rates. So, benefits will be lower where patients are poorest.

## Background

Medicare Advantage (MA) is the program that allows Medicare beneficiaries to enroll in a private-sector health plan as an alternative to the “traditional” fee-for-service (FFS) Medicare program. MA plans must provide all of the same benefits as the FFS Medicare program, and may also provide additional benefits. Medicare pays MA plans a fixed monthly amount per enrollee, based on a formula taking into account the enrollee's county of residence, health status, age, and the plan's “bid” submitted each year. Almost all Medicare beneficiaries are eligible to enroll, and they may choose any MA plan which operates in their county.<sup>1</sup> Beneficiaries continue to pay the same Part B premium as they would if they were in the FFS program. Some MA plans charge an additional premium, but most do not.

CMS gives each MA plan a “star rating,” indicating how that plan scores on a diverse set of criteria determined by CMS. Plans may be given a rating from “1-Star” to “5-Stars” in half-star increments, though in recent years no plan has scored lower than “2-Stars.”

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<sup>1</sup> Technically, MA plans have a “service area” and any eligible beneficiary who lives in that service area may enroll. Services areas are generally counties or groups of bordering counties, and payments to MA plans are based in part on the beneficiary's county of residence. All Medicare beneficiaries eligible for Part A and enrolled in Part B eligible for MA, with the exception of some patients with end-stage renal disease.

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Originally, the star rating system was intended to help Medicare beneficiaries decide which MA plan to choose (or whether to choose one at all). Of course, many other factors might also be of importance to beneficiaries in making this choice, such as whether their preferred physician was included in a plan, what optional benefits a plan includes, the structure of copays and deductibles, and whether the plan charged an additional premium. A beneficiary might use the star ratings as a major factor in the enrollment decision, might use it as a screening device for ruling out low-rated plans, might consider it as one factor in the decision process, or might ignore it entirely. In 2012, 51 percent of MA-eligible beneficiaries had the option of choosing a plan rated 4-star or higher,<sup>2</sup> but only 29 percent of MA enrollees enrolled in a plan rated 4-star or higher.<sup>3</sup> There are many reasons why the best plan for a particular beneficiary might not be the one with the highest star rating available; indeed, one of the reasons for having MA plans in the first place is that not all beneficiaries have the same needs and preferences.

With the passage of the PPACA, the star rating system is, for the first time, being used to calculate payments to MA plans as well – both payments that impact plans' profits, and payments that must be used to increase benefits. In other words, the star rating system will be used as a crude “pay for performance” system. In addition to the implicit pay for performance that MA plans can receive by attracting more enrollees with a quality health plan, MA plans will receive additional payments based on criteria developed by CMS. However, the criteria and the manner in which CMS plans to apply them, indicates that they will not be applied in a fashion that actually incentivizes quality performance, and benefits patients.

## Criteria, Performance, and Reward

In order for any type of performance incentive system to be effective, the party being incentivized must know or be able to determine the criteria upon which evaluation will be based. This is not possible in the star rating system as presently constituted – criteria are not announced until *after* the end of the period for which performance is evaluated. For example, CMS published criteria in October 2011 to be applied to plan performance between January 2010 and June 2011. There is simply no way that an MA plan can adjust its plan offerings, plan design, or performance in any way to improve its performance in the dimensions CMS chooses to evaluate.

The criteria that determine performance and star ratings are not all evaluated for the same time period. For example, the October 2011 criteria included cancer and cholesterol screenings for calendar year 2010, but flu vaccination for February through June 2011 (a period that excludes the peak flu vaccination season in the fall). “Improving bladder control” was measured for only five months (April through August 2010), and complaints about the health plan were measured from January through June of 2011. All in all, 36 different measures were computed using six separate, occasionally overlapping, time periods – the latest ending more than three months before the criteria were published.<sup>4</sup>

Furthermore, by the time the criteria were issued, not only was it too late for a plan to adjust its performance to improve its rating – it was too late to adjust plan design for the *following* year. MA plan details for the 2012 plan year had to be submitted by June 2011, three months before the criteria were published October 2011. (See Figure 1.)

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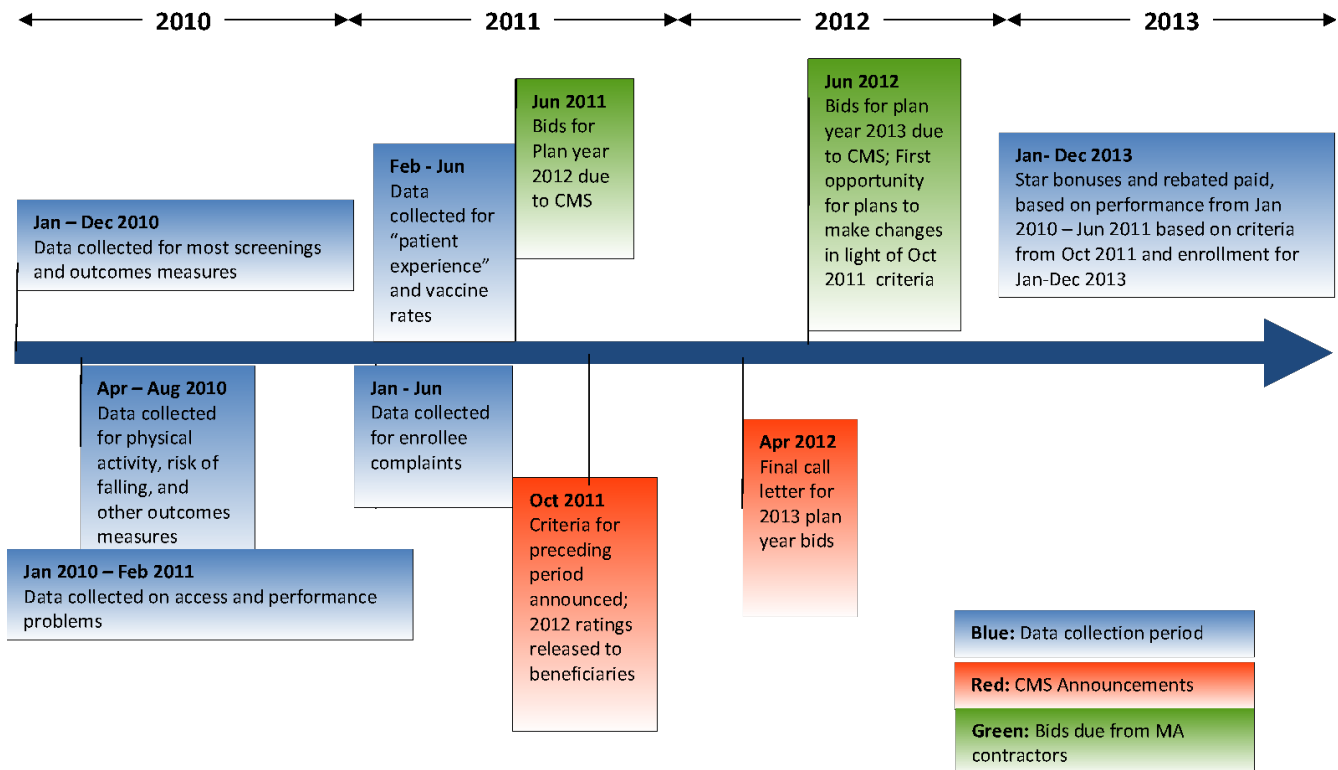
<sup>2</sup> Author's calculation based on CMS plan data.

<sup>3</sup> James C. Cosgrove, “Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings,” Government Accountability Office, GAO-12-409R, March 21, 2012.

<sup>4</sup> Center for Medicare and Medicaid Services, “Medicare Health & Drug Plan Quality and Performance Ratings 2012 Part C & Part D Technical Notes,” October 11, 2011.

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Figure 1: Star Rating Timeline



So, the actual ratings for each plan were calculated based on performance in 2010 and the first half of 2011, were published for beneficiaries to use when choosing a plan for 2012, and will be used to adjust payments for the 2013 plan year – and in each case, the plans may be significantly different from the years in which they were evaluated.

The inability to know how one is judged is harmful enough when the rating is being used as only one component of many in beneficiaries' choice of plans; it is even worse when being used as a basis of payment.

Furthermore, the fact that bonus payments are not only delayed, but based on benchmarks and enrollment for a different year than the performance being rewarded provides an opportunity for MA plan offerers to alter their plan offerings in one year to maximum bonuses collected based on past, rather than current, performance. A plan that qualifies for a high star rating based on 2010 performance could adjust its bids, service areas, and marketing strategy for the 2013 plan year (bids due in June 2012) to maximize its bonus. Benchmarks can vary for each of the more than 3,000 counties and county-like jurisdictions, and over 200 of these jurisdictions are eligible for double MA bonuses based on demographic factors.<sup>5</sup> Offerers of MA plans will have a strong incentive to adjust their bids, and possibly their services areas or marketing plans, in such a way as to increase enrollment in counties with the highest bonuses and rebates – based on data from performance in *previous* years. In effect, CMS will be giving

<sup>5</sup> The MA bonus is doubles in a “qualifying county,” which is defined as a jurisdiction that meets three criteria: (1) It is part of a metropolitan statistical area that has total population above 250,000; (2) at least 25 percent of eligible beneficiaries are enrolled in MA; and (3) average spending on behalf of FFS beneficiaries in that jurisdiction is less than the national average for FFS spending.

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incentives to plan offers to alter their bids for reasons other than to improve performance or benefit patients – the exact opposite of what a well-design pay for performance system is supposed to do.

CMS further disconnects plan offerings from their star ratings by giving the same star rating to all MA plans covered under the same contract (each MA contract includes several different plans). A plan responsible for a contract's high (or low) star rating based on performance in 2010 or 2011 might not even exist in 2013 or 2014, but the other plans in that same contract will be paid or denied bonuses based on the prior performance of the plan that no longer exists.<sup>6</sup>

Additionally, because the criteria are set after data becomes available, there may be opportunity for CMS decision-makers to select criteria in such a way as to reward favored plans, and there will be an incentive for plans to engage in attempts to influence the criteria based on results that have already occurred. Either of these would undermine the incentive to perform well, and replace it with an incentive to expend resources attempting to match criteria to performance already achieved.

Furthermore, by setting criteria when performance data is known, the star system could be used as a back-door budgeting tool to reduce overall payments to MA plans by setting goals that plans are already known, based on available performance data, to be extremely unrealistic. There is some indication this is already happening. For example, the average rate of all-cause readmission within 30 days is 19.6 percent for FFS patients, and a significantly better 15 percent for MA patients. Yet CMS issued criteria in October 2011 requiring this rate to be no more than 5 percent for credit at the 5-star level – a standard any plan with significant membership is highly unlikely to meet in the foreseeable future.

In fact, the importance of a measure to patients' actual health care seems to be a secondary concern. One of the primary determinants of health care quality is access to primary care. In a time when more and more primary care physicians are dropping out of the Medicare FFS program due to low payment rates, most MA plans score well on this measure – so CMS is dropping it from the 2013 star rating criteria.<sup>7</sup> If one assumes that CMS is not deliberately trying to reduce performance in this critical area, the only other purpose for dropping this measure would be to reduce MA program payments.

Taken to the extreme, CMS could develop criteria that would, based on data already available, limit bonuses or even guarantee that no plan – regardless of quality – receives a high enough rating to get a bonus. CMS could thereby substantially reduce overall MA program payments by fiat, regardless of actual performance of MA plans.

## **Who Gets the Reward?**

The extra payments to plans with high ratings will be delivered in two components. One is a direct bonus payment, which goes directly to the operator of the MA plan to use at it wishes. If the rating system adequately measured plan performance, this would be a straightforward pay for performance incentive – better performance would lead to higher net revenue.

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<sup>6</sup> James C. Cosgrove, *op. cit.*

<sup>7</sup> Center for Medicare and Medicaid Services, “Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,” April 2, 2012, p. 82.

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The second component is an increase in the “rebate,” which is the component of the payment which the MA plan must “return” to enrollees in the form of either an actual rebate of a portion of the Part B premiums, additional benefits, lower copayments or deductibles, or some combination of these. In this case, the reward for operating a quality MA plan would go not to the operator of the plan, but to those who enroll in the plan. It is therefore not a reward for performance; it is a reward for beneficiaries for enrolling in a plan that scores well according to CMS criteria.

It should go without saying that individual patients have different needs, and therefore the best plan for one patient might not be the best plan for another. Indeed, this is one of the main reasons for having the Medicare Advantage plan in the first place – each Medicare beneficiary can choose the plan that best meets his or her needs, and three-fourths of MA enrollees choose plans with ratings of 3-star or lower. Clearly, the “criteria” that determine the best plan for any particular beneficiary will differ from that of other beneficiaries – and from the criteria CMS uses in computing the star ratings.

In other words, the best plan according to the star rating system would not be the best plan for every patient. Some beneficiaries may highly value a particular type of benefit, or may find that their preferred physician is available in some MA plan or plans, but not others (and perhaps not in FFS either). Therefore, for some beneficiaries the best plan will *not* be the highest-rated plan according to the CMS star rating criteria.

When the star ratings were used only for the purpose of informing beneficiaries, this was not a problem. Beneficiaries were free to take into account whatever factors they wished, including personal preferences, their own health status, and – if they desired – the CMS star rating. They were also free to weight these factors anyway they liked, and could decide that factors related to their own personal situation took precedence over CMS' measure of overall plan quality, or the reverse.

Once the star ratings are used to increase plan benefits – via higher rebates – the beneficiaries' situation changes. Someone who prefers, for whatever reason, a plan with a lower star rating will receive *lower* overall benefits than someone who prefers a plan with a higher star rating. For example, a beneficiary whose preferred physician(s) are available only through MA plans with lower ratings will “pay” for that preference in the form of reduced benefits, higher copayments and deductibles, and possibly a higher premium than would be the case if that same beneficiary's physicians were available in a higher-rated plan.

For the same reason, beneficiaries whose preferences happen to be similar to the CMS criteria will be rewarded for having those preferences. Also, beneficiaries without strong idiosyncratic preferences will be encouraged to choose higher-rated plans not just by the rating itself, but by the fact that those plans will have more money to work with and therefore offer higher benefits and/or lower payments.

From a policy standpoint, this outcome is highly undesirable. This method of linking star ratings to payments does not reward performance. It does, however, undermine the notion of beneficiary choice that is the basic assumption behind Medicare Advantage in the first place, by penalizing beneficiaries simply for having preferences or health status that don't match the criteria formulated by others. Furthermore, by herding relatively neutral beneficiaries into fewer, CMS-favored plans, the result will be less diversity among plan designs, less competition, and less choice. It is unclear what benefit, if any, would offset these substantial disadvantages.

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## Adverse Impact on the Poor

Because rebates, and thus net benefits, will be higher in plans with higher ratings, beneficiaries without access to higher-rated plans will necessarily receive lower benefits than those with such access. This factor is important because beneficiaries can choose only from plans offered in their county, and not all counties will have highly rated plans. This disparity in benefits will disproportionately affect those least able to make up for it with other resources – because higher-rated plans are less likely to be available in counties with higher poverty rates.

Overall, MA plans rated 4-star or higher are available (for 2012) in 32.9 percent of all counties, and to 50.9 percent of MA-eligible beneficiaries. But for counties with poverty rates of 25 percent or higher (roughly, the poorest 9.3 percent of counties), only 13.4 percent have at least one 4-star or higher plan. Of the other counties, 34.9 percent have at least one 4-star or higher plan. In other words, a non-poor county is 2.6 times more likely to have bonus-eligible plans available than a poor county. The number of 4-star or higher plan choices follows a similar pattern. The map in Figure 2 shows the variation in the percentage of beneficiaries in each state with access to a 4-star or higher MA plan in the 2012 contract year. Note that 15 states plus Puerto Rico have no 4-star or higher plans at all; in 8 states plus DC every beneficiary has at least one 4-star-or-higher option. The rest of the states fell somewhere in between.

On a population basis, the difference is less dramatic, but still present: 52.2 percent of the non-poor, but only 48.2 percent of the poor, will have access to at least one 4-star or higher plan. (Because of the large sample size involved, this difference is statistically significant at any reasonable significance level; the  $p$ -value is less than  $10^{-20}$ .) This assumes the poverty rate among beneficiaries is the same as the poverty rate for the general population in the county. To the extent that MA-eligible beneficiaries have higher poverty rates than the general population, the difference would be greater.

The result is that rewarding patients for living in counties with highly-rated plans adversely impacts poor beneficiaries, and adversely impacts both beneficiaries and providers in poorer counties. Furthermore, this adverse effect is not balanced by any desirable policy outcome – it is a downside with no corresponding upside.

## Conclusion

Rewarding quality health plans is an admirable goal for the Medicare Advantage program. Unfortunately, the current system of linking star ratings to bonus payments and rebate adjustments instituted by the Patient Protection and Affordable Care Act (and expanded by the CMS Quality Bonus Payment Demonstration) fails to achieve that goal, and depending on its specific implementation, may even be counterproductive

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**Figure 2: Percentage of Beneficiaries in Each State with Access to a 4-Star or Higher MA Plan in 2012**

