BETTER MEDICARE ALLIANCE

Improving Medicare Advantage Quality Measurement

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I. Overview

Medicare Advantage health plans are evaluated on a quality-based Star Rating System, which measures performance on a set of quality measures that span several domains, including patient experience and chronic care management. Medicare Advantage plans receive a composite quality star rating on a scale from one to five, with five indicating the highest quality rating. Four- and 5-star plans are eligible to receive additional quality bonus payments, which must be used to lower premiums and/or provide extra benefits to enrollees.

BMA POLICY RECOMMENDATIONS TO IMPROVE MEDICARE ADVANTAGE STAR RATING SYSTEM PERFORMANCE:

1. Develop transparent and prospective processes for star rating measures.
2. Lift the benchmark cap for high-quality plans.
3. Improve innovation and inclusion of new measures.
4. Align star ratings with the National Quality Strategy.
5. Remove compliance measures that do not clearly translate to quality.
6. Modify the Categorical Adjustment Index (CAI) to better account for social determinants of health.
7. Guarantee a transparent process when modifying the risk adjustment model.

II. Introduction

Medicare Advantage, also called Part C, is an option within Medicare that allows Medicare-eligible seniors and beneficiaries with disabilities to receive their benefits through a private plan of their choice, instead of receiving coverage through Fee-For-Service (FFS) Medicare. Medicare Advantage plans are approved and regulated by the Centers for Medicare & Medicaid Services (CMS). The Federal Government, through CMS, pays Medicare Advantage plans a fixed (or capitated) monthly amount per beneficiary to provide health benefits. CMS created the Five-Star Rating System in 2007 to measure and compare quality between Medicare Advantage health plans. Today, the program plays a critical role in ensuring public accountability and enhancing consumer choice by providing quality information on plans. Star ratings may lead to quality-based financial incentives and foster competition between plans to improve upon quality.

III. Overview of the Star Rating System

a. Program History

In 2007, CMS established the Star Rating System to provide accountability for quality and offer beneficiaries information to compare plans on quality in Medicare Advantage. CMS began by evaluating Medicare Advantage plans on their performance on prescription drug measures (Part D), and then in 2008, added health plan-specific measures (Part C measures).[1] Star ratings are applied at the contract level, as one plan can have many contracts with multiple variations of benefit packages.

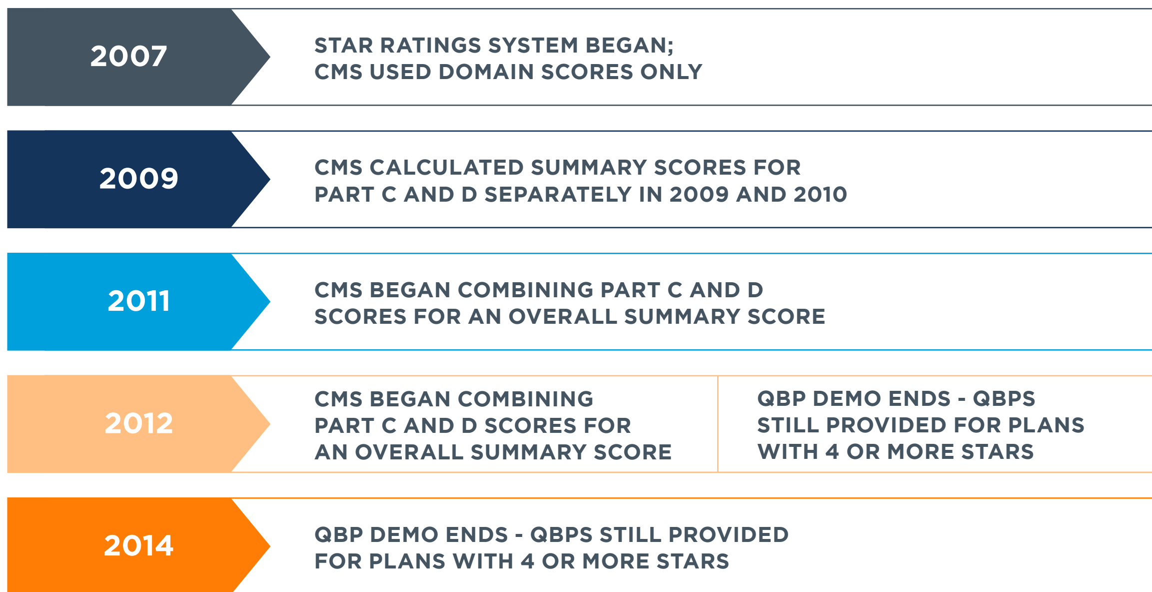
When the program launched, CMS rated each plan contract within individual quality categories, or domains, on a one- to five-star scale, with five stars representing the highest rating. In 2009, CMS moved to an aggregated system in which the scores within each category/domain were combined into overall Part C and Part D plan scores. In 2011, CMS created an overall combined score for Medicare Advantage contracts offering Part D
(MA-PD plans) based on their Part C and Part D summary scores.

The Affordable Care Act (ACA) created quality bonus payments (QBPs) for Medicare Advantage plans that achieve a certain quality level. Under a demonstration program from 2012 to 2014, CMS awarded QBPs to Medicare Advantage plans with at least three stars. In 2015, CMS ended the demonstration but continued awarding QBPs to plans with at least four stars. This approach to measuring quality is discussed in greater detail below.

Finally, CMS began allowing plans with five stars to enroll beneficiaries outside of the annual election period in 2012. Figure 1 shows the timeline of the Star Rating System.

FIGURE 1:

Historical Timeline of the Medicare Advantage Star Rating System



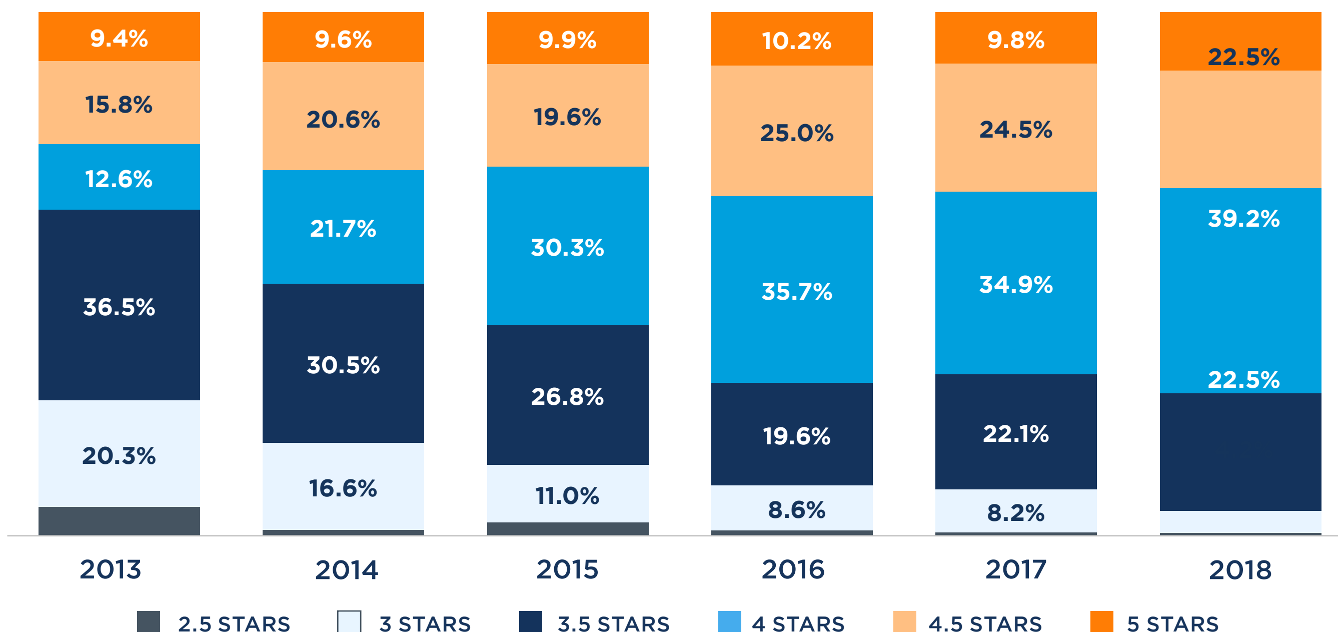
QBP: Quality Bonus Payment

b. Star Ratings Are Critical for Program Accountability and Beneficiary Choice

Enrollment in 4 and 5-star Medicare Advantage plans increased following the implementation of QBPs based on star ratings performance. Specifically, as shown in Figure 2, enrollment in plans with at least four stars has nearly quadrupled since 2009, increasing from 17 percent to approximately 73 percent of Medicare Advantage enrollees in 2018. Indeed, MA-PDs had an average rating of 4.06 for 2018, compared to 3.71 stars in 2013.

FIGURE 2

Distribution of MA-PD Enrollees by Star Rating*, 2013 – 2018



*Percentages are weighted by enrollment. These ratings summarize all Part C and Part D measures combined. The figure does not include contracts that were too new to be measured or did not have enough data to calculate a rating. Source: CMS. "Fact Sheet – 2018 Star ratings." October 2017; CMS enrollment files reflecting 2014-2018.

Enrollment has increased in high-performing plans due to several factors, including:

- Medicare Advantage plans have invested in quality improvement initiatives and increased their star ratings as a result; and
- A higher number of beneficiaries are choosing to enroll in high quality plans, because these plans must use bonus payments to lower premiums and/or provide additional benefits to enrollees.[2]

For example, while some studies suggest that star ratings are not used by beneficiaries to make enrollment choices, other studies have found a linkage between star ratings and Medicare Advantage enrollment.[3] An Avalere analysis found that the number of enrollees in 4.5-star plans increased by 30 percent during the 2016 Medicare Advantage open enrollment period. Meanwhile, enrollment in low-performing 2.5 and 3-star plans decreased.[4]

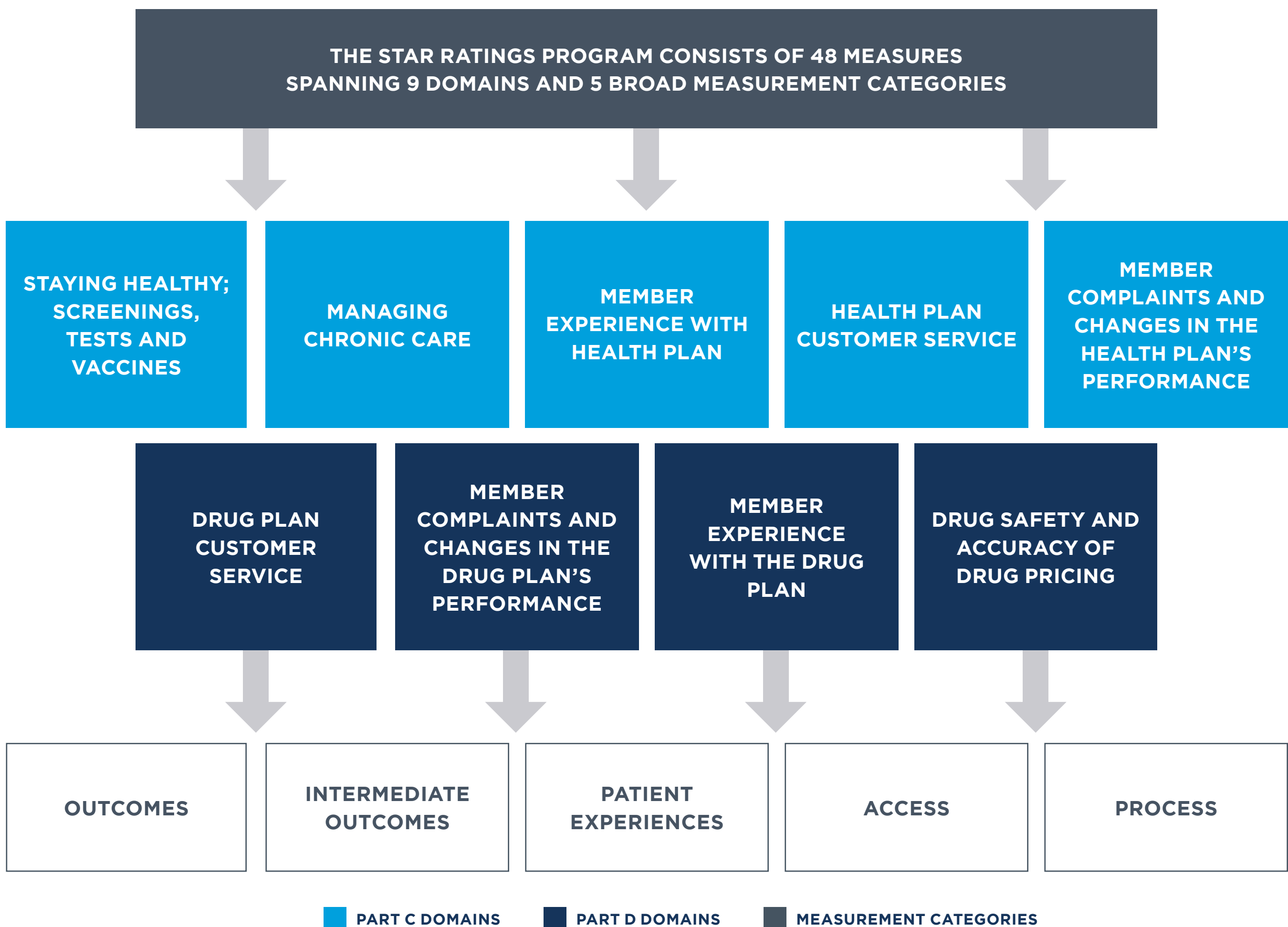
IV. Star Ratings Methodology

a. Calculation

CMS uses a complex methodology to calculate star ratings and determine which plans are eligible for QBPs. First, CMS compiles data for several different Part C and Part D measures, with some Part C and Part D measures deriving from the same data. The measures are then grouped into nine domains, as shown in Figure 3.

FIGURE 3

Domains and Measurement Categories in the Current Star Rating System



Source: CMS. 2018 Part C and D Star Ratings Technical Notes.

Second, for most measures, CMS establishes raw score thresholds – also called "cut-points" – that define the score a plan receives on a scale of 1 to 5. In prior years, CMS published predetermined cut-points needed to achieve a score equivalent to four stars for certain measures, but CMS halted this practice beginning with the 2016 star ratings. CMS noted that plans improved more on the measures without pre-determined cut-points than on those with pre-determined cut-points. As a result, CMS no longer publishes four-star cut-points in advance, but instead calculates the star ratings based on data from a prior year (i.e., 1 or 2 years prior). After assigning the score for the measure, CMS assigns a relative weight of 1, 1.5, 3, or 5 to each measure.

Finally, CMS assigns an overall score for the contract based on the weighted average of the Part C and D measure-level scores. Each Medicare Advantage contract receives a star rating from 1 to 5, at half-star increments. Figure 4 provides an example of how a plan's Star Rating is determined for a specific measure and how it contributes to the plan's overall Star Rating.[5] Plans must provide a star rating document to its members when they receive an enrollment form a summary of benefits. Plans' star ratings are also displayed on the Medicare Plan Finder, the government's online tool that allows consumers to search for plans and compare cost and coverage information.

FIGURE 4

How a Plan's Star Rating Is Determined: Calculation Example for "Plan A"

OVERALL PROCESS	EXAMPLE
INDIVIDUAL RAW SCORE CMS determines raw score for individual measure	Plan A Performed at 56% for measure C06 – "Monitoring Physical Acitvity"
CUTPOINTS CMS evaluates raw score against cutpoints established each year	Based on the cutpoints for 2018, Plan A is asigned **4 stars*** for measure C06
MEASURE WEIGHT CMS applies a weight 1.0 to 5.0 for each measure	Measure C06 is a process measure and has a weight of 1.0
AVERAGE RATINGS A plan's overall star rating is determined by how well they performed across all measures	The rating for measure C06 is combined with those of other measures to arrive at a final Star Rating for Plan A

*1 Star: <46%; 2 Stars: 46-49%; 3 Stars: 50-52%; 4 Stars: 53-57%; 5 Stars: 58%+
Source: CMS. 2018 Part C and D Star Ratings Technical Notes.

b. Measure Development

CMS manages an annual standardized process for the conceptualization, evaluation, and maintenance of star rating measures, outlined in CMS's "Measures Management System Blueprint."[6] CMS conducts lengthy reviews of the measures used in its quality initiatives. Based on clinical recommendations from expert panels, stakeholder feedback, and other issues identified during testing, CMS refines the measure specifications. The measure development process includes identifying measures of need, testing measures in a clinical setting, and ensuring the data collected is accurate and meaningful. CMS measures often undergo a stringent endorsement process spearheaded by the National Quality Forum (NQF) prior to program inclusion.

After CMS approves a measure, it is proposed for inclusion through the issuance of sub-regulatory guidance, such as the annual Call Letter or in memos released to plans through the Health Plan Management System (HPMS). This guidance has included changes to the weights assigned to each measure, the relative significance of the measure itself, and whether measures are included as part of the score or for display purposes only. Once finalized, measures are included in CMS' Technical Specifications document.

The process for measure inclusion into the star ratings does vary from that of other programs in which CMS uses recommendations set forth by the Measures Application Partnership (MAP). MAP is a multi-stakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs. In 2010, Congress recognized the benefit of an approach that encourages consensus building among diverse private and public-sector stakeholders. Importantly, MAP provides a coordinated look across federal programs at performance measures being considered.

CMS uses five main sources to determine the Star Rating measures: (1) CMS administrative data on plan quality and member satisfaction, (2) the Consumer Assessment of Healthcare Providers and Systems (CAHPS), (3) the Healthcare Effectiveness Data and Information Set (HEDIS), (4) the Health Outcomes Survey (HOS), and (5) the Pharmacy Quality Alliance (PQA). As shown in Figure 5, many of the measures used by CMS to determine the Star ratings are based on CMS data. CMS also has influence in the development of measures based on CAHPS, HEDIS, and HOS data.

FIGURE 5

Number of Measures by Data Source in the Star Rating System for 2018

	Domains	CAHPS	HEDIS	HOS	CMS Data	Total # of Measures
Part C	Staying Healthy: Screnings, Tests and Vaccines	1	4	2		7
	Managing Chronic (Long-Term) Conditions		13		1	14
	Member Experience with Health Plan	6				6
	Member Complaints and Changes in the Health Plan's Performance				4	4
	Health Plan Customer Service				3	3
Part D	Drug Plan Customer Service				3	3
	Member Complaints and Changes in the Drug Plan's Performance				4	4
	Member Experience with the Drug Plan	2				2
	Drug Safety and Accuracy of Drug Pricing				5	5
Total Number of Measures		**9**	**17**	**2**	**20**	**48**

CAHPS: Consumer Assessment of Health Care Providers and Systems; HEDIS: Health care Effectiveness Data and Information Set; HOS: Health Outcomes Survey; CMS Data: includes any internal CMS data sources.
Source: CMS. 2018 Part C and D Star Ratings Technical Notes.

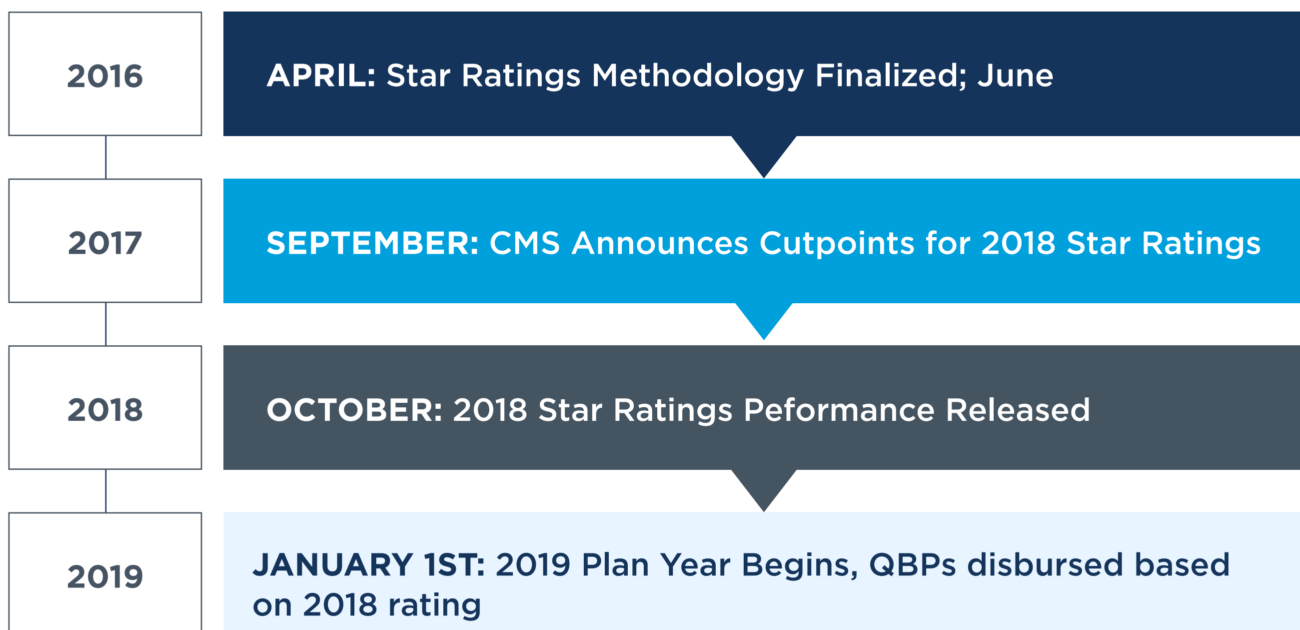
c. *Timeline*

There is a gap between when data are measured and when that data affects a plan's star rating. Current year Medicare Advantage plan payments are based on previous year's star ratings performance, yet the measure data itself can be from as many as two years earlier. In total, this process creates a three-year lag between the performance period for the data and the use of that data for payment.

For the following year, as shown in Figure 6, data collected in 2017 are based on 2016 events for most measures.[7] These data are used to determine the 2018 ratings. Because Medicare Advantage plans bids in June (e.g., June 2018 bids for 2019 benefit period), CMS uses the 2018 star ratings to determine eligibility for 2019 payment. The data lag can cause challenges, because quality improvement operations may not affect star ratings for several years. Furthermore,changes to particular measures can affect Medicare Advantage plans if they have made investments in that measure, including if CMS removes a measure from the star ratings, changes the weight of a measure, or if the cut-points for a measure shift more

FIGURE 6

Three-Year Lag between Performance and Payment Data



Note: Data Collected in 2017 is based on 2016 events. 2019 plan payments are made based on 2018 star ratings based on 2017 plan performance.

Source: CMS. Part C and D Star Ratings Technical Notes, 2016 - 2018.

d. Effect on Medicare Advantage

Star ratings affect Medicare Advantage in at least four ways, including:

- Allowing beneficiaries to evaluate relative plan quality and make informed choices based on performance, as described above;
- Changing the rate against which plans bid, called the benchmark;
- Increasing the resources Medicare Advantage plans must use to provide extra benefits, called rebates; and
- Removing Medicare Advantage plans from the program in cases of continuous low-quality performance.

Medicare Advantage plans bid to provide benefits to enrollees. This bid is then compared to a county - specific benchmark, which is established based on the average FFS Medicare spending in that county. If the bid is below the benchmark, a percentage of the difference is returned to the plan in the form of a rebate (and a % is returned to CMS). Plans must use rebates to: provide extra benefits, such as hearing, dental or vision; to reduce premiums; or to provide innovations in care delivery, like telemedicine or home care, to Medicare beneficiaries.

Bids from Medicare Advantage plans with at least a 4-star rating are compared to higher benchmarks than plans with fewer than four stars, increasing their potential to earn higher rebates and provide additional benefits. In addition, plans with higher star ratings receive QBPs, referenced earlier. These QBPs are delivered through adjustments to the rebate – higher quality plans receive a higher percentage of the difference between the bid and benchmark. The rebate percentage is 50 percent (3 stars or fewer), 65 percent (3.5 or 4 stars), or 70 percent (at least 4.5 stars). Like regular rebates, these bonuses must be used to provide additional benefits to enrollees.

Figure 7 shows how star ratings impact plan payment and rebates. In the example, all plans bid $900. However, plans with 4 or more stars bid against higher benchmarks and receive higher rebate percentages, leading to higher payment from CMS and additional benefits

FIGURE 7

Star Ratings Program Payment and Rebates

3-STAR PLAN	3.5-STAR PLAN	4-STAR PLAN	4.5 & 5-STAR PLAN
Benchmark = $1,000	Benchmark = $1,000	Benchmark = $1,050	Benchmark = $1,050
Payment from CMS = $950	Payment from CMS = $965	Payment from CMS = $997.50	Payment from CMS = $1,005
Rebate Payment % = 50%	Rebate Payment % = 65%	Rebate Payment % = 65%	Rebate Payment % = 70%

PLAN BID REBATE AMOUNT

CMS: Centers for Medicare & Medicaid Services

Note: Numbers are for example purposes only.

Medicare Advantage organizations face grave consequences if they are unable to reach the 3-star threshold. Current regulations allow CMS to terminate a plan that fails to achieve a Part C and/or Part D summary 3-star rating for three consecutive years. This requirement to comply with standards of performance at the risk of plan termination makes quality scores a key priority for Medicare Advantage plans.

V. Comparing Star Ratings to the National Quality Strategy

As shown in Figure 3, the star ratings are based on measures across nine domains, which are specific to Medicare Advantage. As the concept of quality and value continue to grow, CMS has utilized the National Quality Strategy (NQS) as a framework for aligning measures accross systems and programs. The NQS was largely built on the Triple Aim, which was developed in 2008 to achieve the “simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.”[8]

In its most recent 2016 NQS update, CMS outlined several quality-focused goals and interventions for driving change on a large scale. These goals included: (1) making care safer by reducing harm caused in the delivery of care; (2) strengthening person and family engagement; (3) promoting effective communication and coordination of care; (4) promoting effective prevention and treatment of chronic disease; (5) working with communities to institute best practices; and (6) making care affordable.

According to CMS, the star ratings are intended to align with the NQS by measuring outcomes, patient experience, access, and processes.[9] Certainly, the Star Sating System has elements that are aligned with the NQS. However, as discussed below, some of the star rating measures (e.g., compliance or operational measures) do not fit squarely into NQS domains.

VI. Medicare Advantage Star Rating System Policy Issues

The Star Rating System has demonstrated benefits to both patients and the health care marketplace at large. Specifically, star ratings allow beneficiaries to make choices based on how well plans are performing. As beneficiaries increasingly enroll in plans with higher star ratings, the star rating measures help drive Medicare Advantage plan priorities. Given the impact star ratings may have on patient care, there are opportunities to improve the program to ensure quality measures reflect patient priorities. Quality should reflect Medicare beneficiaries' preferences, needs, and values.[10]

The analysis that follows assesses the current composition of star rating measures, considers current strengths of the program, and identifies potential areas for future policy action.

a. Strengths of the Current Star Rating Measures

The current composition of Star Rating measures includes several strengths, as described below.

More than One-Half of the Star Rating Measures are based on Independent, Trusted Sources

One of the positive features of the Star ratings is that most of the measures are either NQF-endorsed or from established quality entities such as the National Committee for Quality Assurance (NCQA). Measures endorsed by the NQF have gone through a rigorous development process, which includes criteria such as 1) importance to measure, 2) scientifically acceptable – that is, it produces reliable and valid results on the quality of care, 3) relevant and useable, and 4) can be collected. In addition, the NQF process obtains input from payers and providers alike.[11]

The Star Ratings Include Health Outcome and Patient Experience Measures

Star ratings capture a variety of components of quality by including domains aligned with the Triple Aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Measures relate to health outcomes and reflect

patient needs through the use of measures from NCQA-accredited patient surveys, such as the CAHPS, HEDIS, and HOS. Patient experience is a critical component of quality. As shown in Figure 5, beneficiary experience with the Medicare Advantage plan constitutes six Part C measures and two-Part D measures.

Outcomes Measures Are Weighted More Heavily than Process Measures

CMS prioritizes outcome measures over process measures. Outcome measures are weighted three times more than process measures. This weighting aligns with the priorities of the Triple Aim and the NQS domains by placing emphasis on health outcomes. A process measure tracks whether a service was provided, but does not indicate what happens after the service occurs. In contrast, outcome measures track the impact of a service on the patient. There are currently three "outcome" measures and six "intermediate outcome" measures, which encourages the move toward achieving specific higher-level outcomes.

b. Areas for Potential Policy Action

While there are strengths associated with the current measures used to drive the star ratings, Better Medicare Alliance recommends the following improvements to ensure star ratings accurately measure plan performance:

1. Develop transparent and prospective processes for star rating measures.
2. Lift the benchmark cap for high-quality plans.
3. Improve innovation and inclusion of new measures.
4. Align star ratings with the National Quality Strategy.
5. Remove compliance measures that do not clearly translate to quality.
6. Modify the Categorical Adjustment Index to better account for social determinants of health
7. Guarantee a transparent process when modifying the risk adjustment model.

1. Develop Transparent and Prospective Processes for Measures

Transparent and predictable star rating measures allow adequate time for plans and providers to plan, prepare, and implement system changes to successfully meet new measures and improve care for beneficiaries. As such, CMS should communicate any and all changes as early as possible to enable plans and providers to optimally perform on star rating measures. To the extent possible, CMS should provide more tools to gauge star ratings in advance of publication as a quality improvement opportunity. As part of this effort, CMS should ensure greater stability in the star ratings program by announcing new star rating measures and cut-points prospectively.

CMS does not announce new measures or cut-points prospectively. This, in addition to large fluctuations in measure cut-points, creates uncertainty in setting quality improvement goals. In addition, this lack of predictability makes it harder for Medicare Advantage plans to integrate performance goals into value-based provider contracts. Changes to the star ratings without notice also compromise the stability of the measurement and accountability system, as Medicare Advantage plans have relied on these benchmarks to set goals and track achievement with star rating scores. CMS should avoid unnecessary changes to measures, share information regarding any changes to the star ratings as early as possible, and provide adequate time for plans to implement any changes.

In addition, given that one of the main sources of data CMS uses to determine star rating measures is CAHPS, the consumer survey should be more transparent. CMS releases detailed data for all the other star ratings data sources. Therefore, CMS should ensure the methodology for the survey is clear. CMS should also be responsive to concerns surrounding bias in the data. For example, beneficiaries surveyed at different times of the year may give different responses. CMS should better consider the transparency, fairness, and accuracy of the CAHPS.

2. Lift the Benchmark Cap for High Quality Plans

The Star Rating System has been effective at driving improvements in quality. However, due to a policy known as the benchmark cap created by the Patient Protection and Affordable Care Act of 2010 (ACA). Medicare Advantage capitated payments to plans are capped at the pre-ACA level (plus growth updates). This policy is a cost-control measure to prevent benchmarks, which play a key role in determining Medicare Advantage plan payment, from exceeding their pre-ACA levels. However, the result is that high-quality Medicare Advantage plans with 4+ Stars that would normally be eligible for a QBP, do not receive the quality incentive if they operate in a county affected by the benchmark cap. This means beneficiaries in these counties do not receive additional benefits from enhanced rebates. Across the country, beneficiaries in over 40% of counties are negatively impacted by this policy.[12] Congress should remove the benchmark cap for 4-star or higher plans to ensure all beneficiaries benefit from enrollment in high-quality plans.

3. Improve Innovation and Inclusion of New Measures

The basic structure of the Star Rating System has been largely intact since 2008. However, in recent years, payers and providers have come together to consider which measures are most meaningful for a Medicare and/or commercial population. Through the Core Quality Measure Collaborative, CMS worked with the NQF, health plan stakeholders, national physician organizations, employers, and consumers to identify core performance measures.[13] However, many of these measures have not yet been included in the Medicare Advantage program. CMS has an opportunity to update Medicare Advantage by leveraging the work done by the Core Quality Measures Collaborative, further promoting the alignment of quality measures across public programs.

Additionally, addressing measurement gaps within the star ratings can result in a more comprehensive quality ratings system. For example, there are a limited number of measures associated with mental health and substance abuse. Measuring mental health accurately can be challenging, but an expansion of these measures would serve to acknowledge the direct impact of effective behavioral and mental health care on plan performance.

4. Align Star Ratings with the National Quality Strategy

Given the goal of improving performance at the plan, system, and provider levels, CMS should continue ongoing efforts to adopt the domains of the National Quality Strategy within Medicare Advantage, as CMS has done with other quality reporting programs. This exercise will also allow CMS to remove measures where excellent performance already exists, as well as measures where improvement can be difficult to achieve. Alignment, stability, and consistency with the NQS, Triple Aim, or another approach to quality would better enable plans and providers to meet quality goals.

5. Remove Compliance Measures That Do Not Clearly Translate to Quality

Compliance measures, although useful in determining whether a plan is performing certain functions, may not be appropriate to include in the star ratings, given that they may be less relevant to patient care. In fact, the relationship between compliance measures and the actual quality of care provided to patients is sometimes unclear. For example, the star ratings structural measure, “Beneficiary Access and Performance Problems,” (see Figure 8) under the Part C Domain Member Complaints and Changes in the Health Plan’s Performance, indicates the extent to which CMS found compliance violations through audits or other compliance activities. However, CMS has a series of penalties at its disposal to sanction plans for compliance violations. By including compliance in the star ratings, CMS is “double-dipping” compliance issues in its evaluation and action toward plans. In addition, not all Medicare Advantage plans are audited each year, which could place audited plans at a disadvantage. Furthermore, neither the NQS nor the Triple Aim includes any discussion of compliance issues.

Comparing Medicare Advantage star rating measures to measures associated with other Medicare programs also underscores this point. For example, as shown in Figure 8, a comparison of the quality measures used to evaluate Medicare Advantage plans and the Medicare Shared Savings Program shows compliance and process measures in Medicare Advantage are outliers. While compliance could be an indicator of patient experience (e.g., by assessing how well beneficiaries can obtain care), patient experience is more directly captured through current stars performance measures (i.e., CAHPS).

FIGURE 8

Some Star Rating Measures Do Not Align with Other Medicare Programs

MA Star Ratings Program
Patient Experiences
Getting Needed Care
Getting Appointments and Care Quickly
Customer Service
Care Coordination
Rating of Health Care Quality
Rating of Health Plan
Managing Chronic (Long-Term) Conditions
Care for Older Adults - Functional Status Assessment
Care for Older Adults - Medication Review
Medication Reconciliation Post-Discharge
Reducing the Risk of Falling
Plan All-Cause Readmissions
Special Needs Plan (SNP) Care Management
Care for Older Adults - Pain Assessment
Osteoporosis Management in Women Who Had a Fracture
Diabetes Care - Kidney Disease Monitoring
Rheumatoid Arthritis Management
Diabetes Care - Blood Sugar Controlled
Diabetes Care - Eye Exam
Controlling Blood Preassure
Improving Bladder Control
Staying Health: Screenings, Tests, and Vaccines
Improving or Maintaining Physical Health
Monitoring Physical Activity
Improving or Maintaining Mental Health
Breast Cancer Screening
Colorectal Cancer Screening
Annual Flu Vaccine Measure
Adult: BMI Assessment
Member Complaints and Changes in Health Plan's Performance
Complaints About the Health Plan
Members Choosing to Leave the Plan
Beneficiary Access and Peformance Problems
Helath Plan Quality Improvment
Health Plan Customer Service
Plan Makes Timelye Decisions About Appeals
Reviewing Appeals Decisions
Call Center - Foreign Language Interpreter/TTY Availability

Medicare Shared Savings Program
Patient Experiences
Access to Specialists
Getting Timely Care, Appointments, and Information
How Well Your Providers Communicate
Patients' Rating of Provider
Health Promotion and Education
Shared Decision Making
Stewardship of Patient Resources
Health Status/Function Status
Care Coordination/Patient Safety
Medication Reconciliation Post-Discharge
Falls: Screening for Future Fall Risk
Skilled Nursing Facility 30-Day All-Cause Readmission Measure
Risk Standardized, All Condition Readmission
All-Cause Unplanned Admissions for Patients w/Diabetes
All-Cause Unplanned Admissions for Patients w/Heart Failure
All-Cause Unplanned Admissions for Patients w/Multiple Chronic Conditions
Ambulatory Sensitive Condition Acute Composite Preventitve Quality Indicator
Use of Imaging Studies for Low Back Pain
Use of Certified EHR Technology
Clinical Care for At-Risk Population
Diabetes Mellitus: Hemoglobin A1c Poor Control
Diabetes: Eye Exam
Controlling High Blood Pressure
Depression Remission at Twelve Months
Ischemic Vascular Disease (IVD): Use of Aspirin of Another Antithrombotic
Preventive Health
Breast Cancer Screening
Colorectal Cancer Screening
Influenza Immunization
Body Mass Index (BMI) Screening and Follow Up
Pneumonia Vaccination Status for Older Adults
Tobacco Use: Screening and Cessation Intervention
Screening for Clinical Depressino and Follow-up Plan
Stain Therapy for the Prevention and Treatment of Cardiovascular Disease

6. Modify the Categorical Adjustment Index to Best Account for Social Determinants of Health

In recent years, stakeholders have expressed concerns that the Star Rating System does not accurately reflect the quality of care delivered by plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees. Notably, Inovalon investigated the effect of high enrollment of dual-eligible beneficiaries on Medicare Advantage plans' star ratings and found that lower performance scores for dual-eligible enrollees do not appear to be associated with the care quality provided by the plan. Instead, the study found that 70 percent or more of the observed disparities in outcomes between dual-eligible and non-dual-eligible enrollees were attributable to differences in clinical, sociodemographic, and community resource factors associated with higher risk of a worse outcome, inherent in the duals population.

Because dual-eligible and low-income enrollees can greatly benefit from the care coordination, disease management, preventive health, and other services Medicare Advantage plans provide enrollees, it is critical that star ratings do not undermine plans' incentives to enroll these beneficiaries. To address these concerns, in 2016 CMS implemented an interim adjustment to overall and summary scores for dual-eligible, low-income, and disabled beneficiaries for certain star rating measures. The Categorical Adjustment Index (CAI) has had minimal impact on Medicare Advantage star ratings, with more than 96 percent of plans receiving no star rating adjustment in the first two years of its use. The limited impact is the result of the design of the CAI, which, contributes less than 20 percent to the overall star rating and does not fully address disparities related to all social risk factors.

CMS will continue to apply the CAI in 2018 while it works with various federal agencies and stakeholders to develop a longer-term solution, which will require the collection of better data on social risk factors. Many existing data sources provide information averaged across multiple, disparate neighborhoods, resulting in a relatively imprecise assignment of characteristics to individuals. Studies using these data have consistently demonstrated no impact of social risk factors due to their aggregate nature. In contrast, an Inovalon study using social risk factor data available at the 9-digit ZIP code level found a clear relationship between social risk factors like income, education, and home ownership, and quality outcomes.[14] Numerous studies have shown the link between near neighborhood characteristics, health behaviors, and outcomes.

Addressing the complex health and social needs of dual-eligible and low-income beneficiaries is an important policy discussion that affects the Star Rating System, as well as other aspects of the payment and delivery of care in Medicare Advantage. As CMS explores ways to strengthen Medicare Advantage's role in addressing the social determinants of health to improve outcomes for Medicare Advantage enrollees, the following solutions should be considered:

1. Including more measures that demonstrate a disparity in outcomes between dual-eligible and non-dual-eligible beneficiaries in the CAI adjustment.

2. Risk-adjust measures for additional social factors. Two recent reports from the Office of the Assistant Secretary for Planning and Evaluation and the National Academies of Medicine found that beneficiaries with social risk factors had worse outcomes on many of the quality measures.[15, 16] Both reports recommended that the measures used in the current Medicare Advantage program should continue to be examined to determine if adjustment for social risk factors is appropriate.
3. Securing access to an accurate source of social risk factor data. In 2015, the NQF initiated a two-year trial period to assess the impact of adjusting relevant quality measures for socioeconomic status (SES) and other demographic factors. That pilot ended April 2017, but preliminary NQF assessment is that "using available SES data, many measures with clear conceptual basis for SES adjustment have not demonstrated a large effect of SES on outcomes after consideration of clinical factors. More robust data at the patient and community level are needed to support risk adjustment."[17]

7. Better Integrate Patients and Providers in the Measure Development Process

The role of patient groups in the current measure development process is not clear. CMS invites comments on the star ratings both when it proposes changes and when it publishes the annual Call Letter. Yet, patient groups lack specifics as to the extent to which the patient perspective has been considered, because CMS does not publish all of the comments to the annual Call Letter.

CMS should consider implementing a more patient-centered process for developing and evaluating star rating measures. As noted earlier, the patient perspective is a key component for effectively measuring quality. Many of the measures developed by CMS are based on clinical outcomes, without capturing true aspects of a patients' experience. Capturing patient experience, and what a patient would view as high-quality, is especially critical for star ratings as more enrollees look to the ratings to select their Medicare Advantage plans. CMS should consider a more holistic approach to quality by asking patient groups for input. CMS could consider holding public working sessions with such patient groups to obtain patient feedback and incorporate the feedback into their measure development processes.

Likewise, the development of new measures should include more input from providers. Providers offer valuable insight regarding the real-life applicability of the measures and how quality care is delivered to patients. Providers are uniquely positioned to identify specifically what works in health care, what is actionable and most meaningful, and where there are barriers to quality improvement. Clear summaries detailing how proposed policy changes could impact patients and providers would be beneficial to stakeholders.

VII. Conclusion

As Medicare Advantage continues to grow, CMS should ensure the Star Rating System reflects the most current approach to quality and care delivery. This includes actionable and meaningful assessment measures of health outcomes, patient satisfaction, and incentives for high-value care delivery.

To achieve these goals, CMS should consider more closely evaluating the role of patients and providers in developing measures, work to align other quality programs with the Medicare Advantage Star Rating System, and increase overall program transparency. CMS should continue to improve quality measures in the Star Rating System to better measure outcomes, and incentivize value based care, while balancing the need for certainty and stability. Changes in measures should allow for stakeholder review and adjust. To recognize time needed to properly implement new measures at the plan provider level. Finally, CMS should work to align quality measures across public programs to seamlessly integrate incentive structures, ease clinician burden, and increase overall system transparency.

Today's star ratings, detailed in the appendix, affect nearly 20 million beneficiaries, 500 plans, and tens of thousands of providers, subcontractors and community partners. Each of these stakeholder groups needs consideration in the stars rating process. Some star rating measures evaluate patient experience and outcomes, yet opportunities exist to delete duplicate measures and add measures that assess patient-reported outcomes, patient experience, and the long-term satisfaction of patients. In addition, many other CMS programs now include measures that assess clinical outcomes (i.e. Hospital Readmissions Reduction Program, Merit-Based Incentive Payment System). The Star Rating System in Medicare Advantage would benefit from a more evidence-based, outcome-centered approach. The goal should be fewer, more targeted measured that drive-value and enhance consumer engagement.

Building on the strengths in the current Star Rating System, CMS can make improvements. By making key structural changes and continuing to partner with stakeholders, CMS can forge a more quality based Star Rating System that aligns with the goal of addressing the needs of today's beneficiaries, while looking to technology and innovation to meet the needs of millions of future beneficiaries. Medicare Advantage payment systems and flexibility offers a significant leadership role in the movement towards high-value, high-quality care, greater patient engagement and improvements in outcomes and cost savings.

VIII. Appendix

Table 1: 2018 List of Star Rating System Measures

Domain Name	Measure Number	Measure Name	Measure Weight
Staying Health: Screenings, Tests, and Vaccines	C01	Medication Reconciliation Post-Discharge	1.0
	C02	Plan All-Cause Readmissions	3.0
	C03	Getting Needed Care	1.5
	C04	Getting Appointments and Care Quickly	1.5
	C05	Customer Service	1.5
	C06	Rating of Health Care Quality	1.5
	C07	Rating of Health Plan	1.5
Managing Chronic (Long-Term) Conditions	C08	Care Coordination	1.5
	C09	Complaints About the Health Plan	1.5
	C10	Members Choosing to Leave the Plan	1.5
	C11	Beneficiary Access and Performance Problems	1.5
	C12	Health Plan Quality Improvement	5.0
	C13	Plan Makes Timely Decisions About Appeals	1.5
	C14	Reviewing Appeals Decisions	1.5
	C15	Call Center – Foreign Language Interpreter/TTY Availability	1.5
	C16	Controlling Blood Pressure	3.0
	C17	Rheumatoid Arthritis Management	1.0
	C18	Reducing Risk of Falling	1.0
	C19	Improving Bladder Control	1.0
	C20	Medication Reconciliation Post-Discharge	1.0
	C21	Plan All-Cause Readmissions	3.0
Member Experience with Health Plan (Patient Experience)	C22	Getting Needed Care	1.5
	C23	Getting Appointments and Care Quickly	1.5
	C24	Customer Service	1.5
	C25	Rating of Health Care Quality	1.5
	C26	Rating of Health Plan	1.5
	C27	Care Coordination	1.5
Health Plan Customer Service	C28	Complaints About the Health Plan	1.5
	C29	Members Choosing to Leave the Plan	1.5
	C30	Beneficiary Access and Performance Problems	1.5
	C31	Health Plan Quality Improvement	5.0
Drug Plan Customer Service	C32	Plan Makes Timely Decisions About Appeals	1.5
	C33	Reviewing Appeals Decisions	1.5
	C34	Call Center – Foreign Language Interpreter/TTY Availability	1.5

Domain Name	Measure Number	Measure Name	Measure Weight
Drug Plan Customer Service	D01	Call Center – Foreign Language Interpreter and TTY Availability	1.5
	D02	Appeals Auto–Forward	1.5
	D03	Appeals Upheld	1.5
Member Complaints and Changes in the Drug Plan's Performance	D04	Complaints about the Drug Plan	1.5
	D05	Members Choosing to Leave the Plan	1.5
	D06	Beneficiary Access and Performance Problems	1.5
	D07	Drug Plan Quality Improvement	5.0
Member Experience w/ Drug Plan	D08	Rating of Drug Plan	1.5
	D09	Getting Needed Prescription Drugs	1.5
Drug Safety and Accuracy of Drug Pricing	D10	MPF Price Accuracy	1.0
	D11	Medication Adherence for Diabetes Medications	3.0
	D12	Medication Adherence for Hypertension (RAS antagonists)	3.0
	D14	Medication Adherence for Cholesterol (Statins)	3.0
	D15	MTM Program Completion Rate for CMR	1.0

[1] "Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Changes." Regulations.gov. N.p., n.d. Web. 27 July 2016.

[2] Li, Pengxiang, and Jalpa A. Doshi. "Impact of Medicare Advantage Prescription Drug Plan Star ratings on Enrollment before and after Implementation of Quality-Related Bonus Payments in 2012." Ed. Ji-Hyun Lee. PLoS ONE 11.5 (2016): e0154357. PMC. 29 Sept. 2017. Web.

[3] Li P, Doshi JA (2016) Impact of Medicare Advantage Prescription Drug Plan Star ratings on Enrollment before and after Implementation of Quality-Related Bonus Payments in 2012. PLoS ONE 11(5) (2016): n/ pag. Web.

[4] "More than 70 Percent of Medicare Advantage Enrollees in Plans with Four or More Stars", Avalere Health, LLC n.d. Web. 8 Sept. 2016. Web.

[5] The sample calculation is for simple illustrative purposes only and so it does not include i-factors.

[6] CMS, Quality Measurement Development and Management Overview. n.d. Web. 08 Sept. 2016. Web.

[7] Of the 47 measures, 33 are based on 2014 data and 12 are based on 2015 data. The other two measures, the performance improvement measures, are derived based on changes in the star rating measures.

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[17] Options for Recognizing and Accommodating Social Risk Factors, Helen Burstin, MD, MPH, Chief Scientific Officer, National Quality Forum, presented at SNP Alliance Fall Leadership Meeting, Washington DC, October 2016.