MILLIMAN RESEARCH REPORT

Medicare Advantage star ratings: Expectations for new organizations

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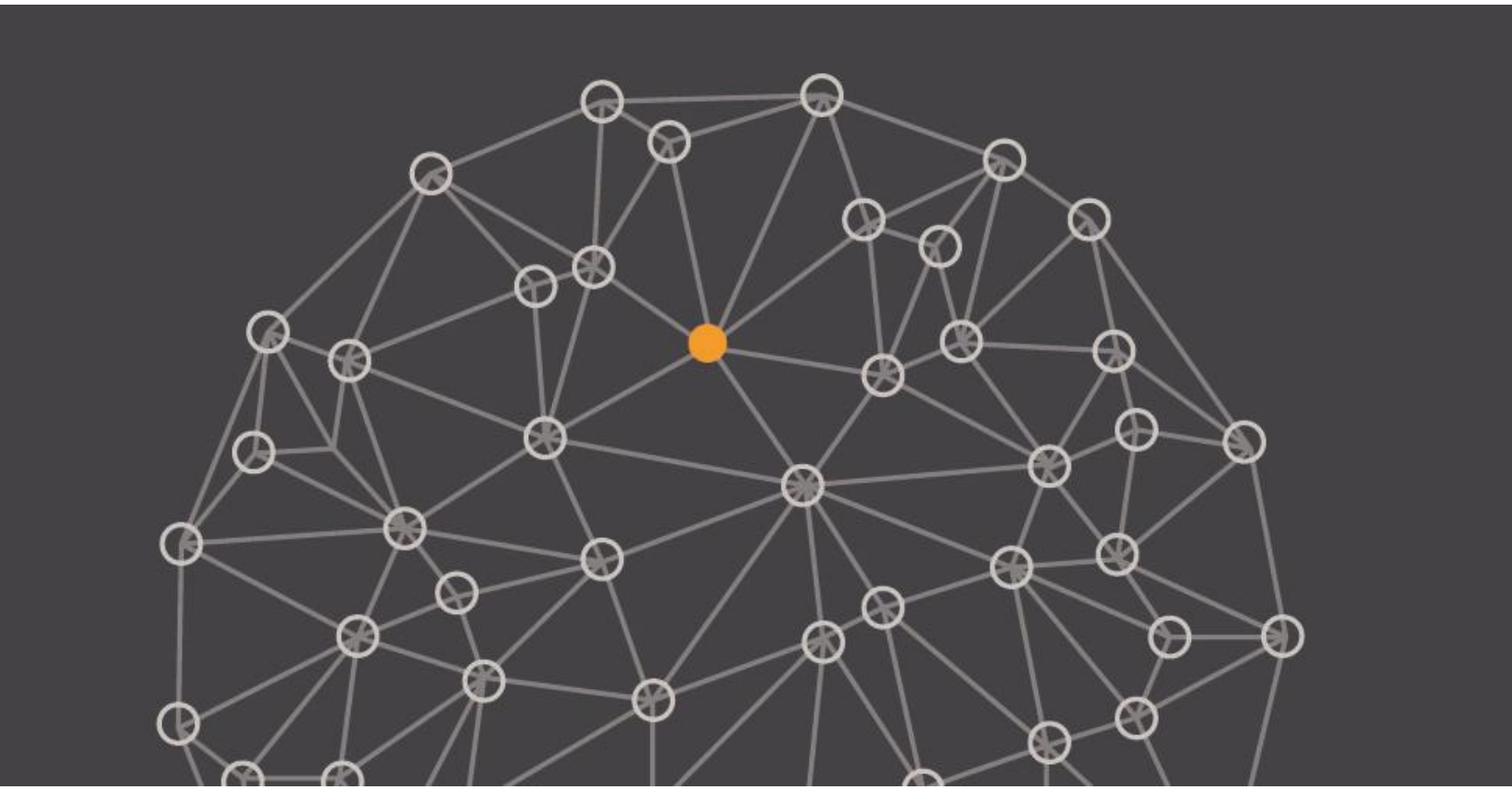
Kelly S. Backes, FSA, MAAA
Julia M. Friedman, FSA, MAAA
Dustin J. Grzeskowiak, FSA, MAAA
Elizabeth L. Phillips
Patricia A. Zenner, RN



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1. Executive Summary

Medicare Advantage organizations (MAOs) receive a significant portion of their revenue from the federal government. Successful MAOs maximize federal revenue to provide enhanced benefits and/or reduced premiums to their members, which ultimately improves marketability with the aim of increasing membership.

Organizations considering entering the Medicare Advantage (MA) market should be aware of the current star rating climate, as well as short- and long-term star rating and revenue considerations. Federal revenue is adjusted to reflect an MAO's level of quality and performance, as determined by a contract-specific star rating. A star rating of 4.0 and higher results in a quality bonus payment (QBP), which increases the federal revenue an MAO receives. As noted in Figure 1 below, contracts with a star rating of 4.0 or higher receive a 5% QBP, while those contracts designated as "New Contract" or "Low Enrollment" receive a 3.5% QBP.

A new MAO is assigned the "New Contract" star rating for its first three years of operations. In the fourth year, a contract-level star rating, ranging from 1.0 to 5.0, is calculated and assigned if the MAO has sufficient membership. A contract's star rating is generally based on its experience from three years prior.

We analyzed 2011 to 2018 star rating information released by the Centers for Medicare and Medicaid Services (CMS). We summarized star ratings of MAOs coming off the "New Contract" star rating by duration, which is defined as the number of years after a contract has come off the "New Contract" star rating. These results indicate the current level of star rating performance for new MAOs and the potential opportunity to increase star ratings above historical levels.

GENERAL STAR RATING RESULTS

The average 2011 to 2018 star rating for contracts coming off the "New Contract" star rating is 3.48 stars, which is based on 52 contracts. There are also 104 contracts assigned the "Low Enrollment" star rating in the first duration. For contracts with star ratings based on experience, this is 6% lower than the average 2018 star rating of 3.71 stars across all contracts. New MAOs increase their star ratings over time and the initial 6% gap is closed by about one-half within four years.

For those MAO's coming off of the "New Contract" star rating:

- The initial average star rating of 3.48 stars increased to 3.60 stars in the fourth year.
- The portion of contracts rated 3.5 stars and above increased from 56% in the first year to 63% in the fourth year. This is compared to 80% in 2018 for all contracts.
- The portion of contracts rated 4.0 stars and above increased from 37% in the first year to 40% in the fourth year. This is compared to 44% in 2018 for all contracts.
- The proportion of new contracts rated 2.5 stars and lower decreased from 17% in the first year to just 3% in the fourth year. This is compared to 4% in 2018 for all contracts. This improvement is caused by initially low-rated new contracts increasing their star ratings over time or exiting the market.

STAR RATINGS BY NETWORK TYPE

The 2011 to 2018 star ratings vary by HMO and PPO contracts. The average 3.75 star rating for PPO contracts (12 contracts) coming off the "New Contract" star rating is 8% higher than the average 3.46 overall star rating for HMO contracts (37 contracts).

The gap in the average star rating between health maintenance organization (HMO) and preferred provider organization (PPO) contracts is somewhat reversed over time, with the average star rating decreasing to 3.46 for PPO contracts and increasing to 3.65 for HMO contracts by the fourth year. This results in the average star rating for HMO contracts being 5% higher than the average star rating for PPO contracts in the long term.

Large nationwide MAOs, including PPOs, often focus significant effort early on in developing star rating improvement programs. HMO contracts are more likely to be sponsored by less experienced regional MAOs. This suggests new HMO contracts have an opportunity to achieve higher star ratings earlier, perhaps immediately after coming off the "New Contract" star rating, if they are actively engaged in star rating management early on and are early adopters of industry best practices.

STAR RATINGS BY MEMBERSHIP SIZE

The 2011 to 2018 star ratings vary by membership size. “Large"[1] contracts coming off the “New Contract” star rating achieved an average 3.69 stars, which is 9% higher than the average 3.39 stars for “Small"[2] contracts.

The average star rating for both membership size groups increased with additional years of experience. By the fourth durational year, the average star rating was 3.92 for Large contracts and 3.43 for Small contracts. The difference in star rating between Large and Small contracts increased to 14%.

The observed correlation between higher star ratings and larger membership reinforces the benefits of performing well in the CMS star rating program—higher star ratings generate more federal revenue, which in turn is passed through to the membership in the form of reduced premiums and/or increased benefits and improves marketability and membership.

KEY TAKEAWAY

Running an effective star rating management program is essential and must be implemented fully across the organization, including engaging vendors in the very early start-up stages, to maximize a contract’s star rating and therefore revenue attainment for new MAOs. Because there is a lag between the calculation of the star rating measures and the bid revenue year those star rating measures impact, it is a critical step to focus on a star rating management program immediately to ensure high star rating metrics. There should be continued tracking and subsequent improvement for each star rating metric, and both management and vendors should be educated on the goals and outcomes of each metric and the star rating program itself.

[1] Membership of 10,000 or more.

[2] Fewer than 10,000 members.

2. Introduction

The Medicare Advantage (MA) program is a government-sponsored program that offers an alternative to traditional fee-for-service (FFS) Medicare where benefits are provided to Medicare beneficiaries by privatized health insurance carriers. The cost of the program is funded in large part by the federal government, with the revenue received by private health insurance carriers based on laws, regulations, and an underlying bidding process established, regulated, and overseen by the Centers for Medicare and Medicaid Services (CMS). MAOs offer benefit plans as part of a contract with CMS when participating in the MA program. CMS monitors each contract's quality and performance by calculating star ratings for up to 48 measures[3] that fall within five broad categories: Outcomes, Intermediate Outcomes, Patient Experience, Access, and Process. These 48 star rating measures are aggregated into the following three star rating values:

1. Part C, which replaces traditional FFS Medicare Part A (hospital and long-term care services) and Part B (outpatient and professional services).
2. Part D, which provides prescription-drug coverage.
3. Overall, which is a combination of the Part C and Part D star ratings. CMS uses only the overall star rating when calculating an MAO's revenue.

An overall star rating is calculated and assigned at the contract level as a number from 1.0 (low) to 5.0 (high), in half-step increments. Contracts without sufficient membership are assigned the "Low Enrollment" star rating. Contracts for new MAOs are assigned the "New Contract" star rating for the first three years of operations,[4] with the possibility of having its fourth year star rating calculated based on its own experience, provided there is sufficient membership. For example, an MAO entering the market in 2016 will be assigned the "New Contract" star rating for 2016 through 2018 and will be eligible to receive its own star rating for 2019 if membership is sufficient—the MAO would receive notification of this star rating in the fall of 2018, which is applicable for the 2019 payment year. If there is not sufficient membership, the 2019 star rating would be set to the "Low Enrollment" star rating.

Contracts assigned higher star ratings receive more federal revenue and are able to charge lower premiums and/or offer richer supplemental benefits, both of which are key to attracting and retaining members. It is critical for contracts coming off the "New Contract" star rating to achieve 4.0 stars to retain a QBP. This means operating an active star rating management program in the initial start-up years given the approximate three-year lag between star rating data collection and revenue impact.

CMS benchmarks, which are intended to reflect the maximum amount of revenue CMS will pay an MAO to provide coverage for traditional FFS Medicare benefits, significantly impact the amount of revenue an MAO receives. The federal Part C revenue is determined as:

- The bid, which is the MAO's revenue requirement to provide coverage for traditional FFS Medicare benefits, plus
- The rebate, which is a portion of the difference (i.e., the rebate percentage) between the benchmark and the bid and is used to fund supplemental benefits.

Star ratings affect federal Part C revenue in two ways:[5]

- Quality bonus payment (QBP): Contracts with 4.0 stars and higher receive a 5% increase in their benchmark (10% in double bonus counties). Contracts assigned the "New Contract" or "Low Enrollment" star rating will receive a 3.5% increase in their benchmark (7% in double bonus counties). This increase in benchmark results in higher rebates and total federal Part C revenue.
- Rebate percentage: Contracts with higher star ratings will receive higher rebate percentages, resulting in higher rebates and total federal Part C revenue.

[3] Based on 2018 star ratings (34 Part C, 14 Part D).

[4] New contracts under an existing organization receive the average star rating of the existing contracts under the parent organization.

[5] CMS Office of the Actuary (February 1, 2018). Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter. Retrieved February 13, 2018, from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf.

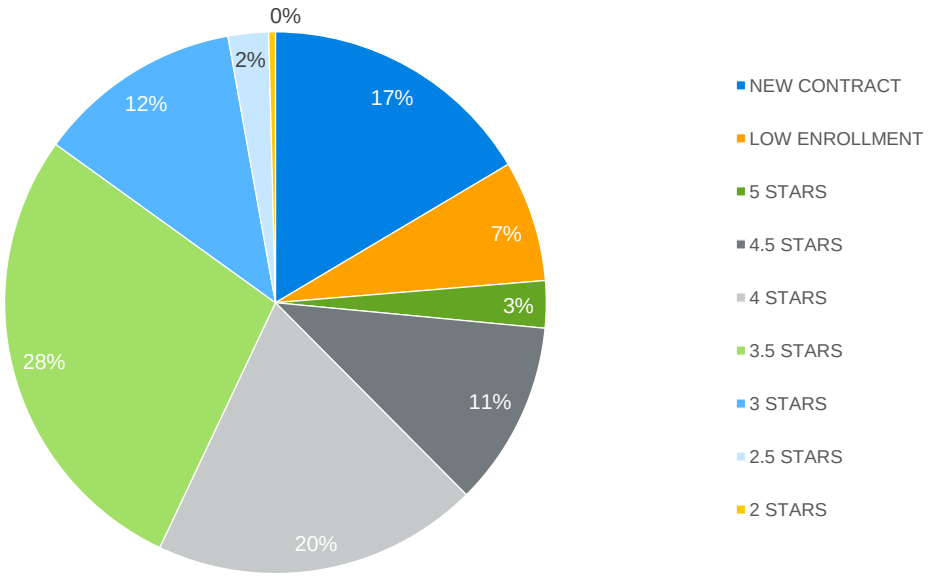
The 2019 QBP and rebate percentages by star rating are shown in Figure 1 below.[6]

FIGURE 1: 2019 QUALITY BONUS PAYMENT AND REBATE PERCENTAGES

STAR RATING	QBP	REBATE PERCENTAGE
4.5 OR HIGHER	5% (10% IN DOUBLE BONUS COUNTIES)	70%
4.0	5% (10% IN DOUBLE BONUS COUNTIES)	65%
3.5	0%	65%
3.0 OR LOWER	0%	50%
NEW CONTRACT OR LOW ENROLLMENT	3.5% (7% IN DOUBLE BONUS COUNTIES)	65%

The current distribution of individual MA contracts by 2018 star rating is shown in Figure 2.

FIGURE 2: 2018 OVERALL STAR RATING DISTRIBUTION



Based on a comparison of the 2018 and 2017 stars data:

- There are about 500 contracts in 2018. The number of total contracts in the market increased by 33 contracts from 2017 to 2018. The number of contracts receiving the "New Contract" star rating increased by 27 contracts from 2017 to 2018.
- Seventeen percent of contracts are considered a "New Contract" in 2018, which is an increase of 5% over 2017.
- Thirty-four percent of contracts achieved at least 4.0 stars and are eligible for a QBP in 2018, which is a decrease of 4% from 2017.
- Twenty-eight percent of contracts are receiving 3.5 stars and are just below the threshold to receive a QBP in 2018. This is an increase of 5% from 2017.

[6] The QBP may be reduced, such that the benchmark rate including any QBP is capped at pre-Affordable Care Act (pre-ACA) rate.

3. Results

The key to achieving a successful and marketable MA product is through obtaining and retaining profitable membership by maximizing revenue. One way to increase revenue is through achieving a 4.0+ star rating. Therefore, it is important to understand how long MAOs typically remain at the "Low Enrollment" star rating, and for a new MAO to project realistic membership and star rating expectations in its business plan.

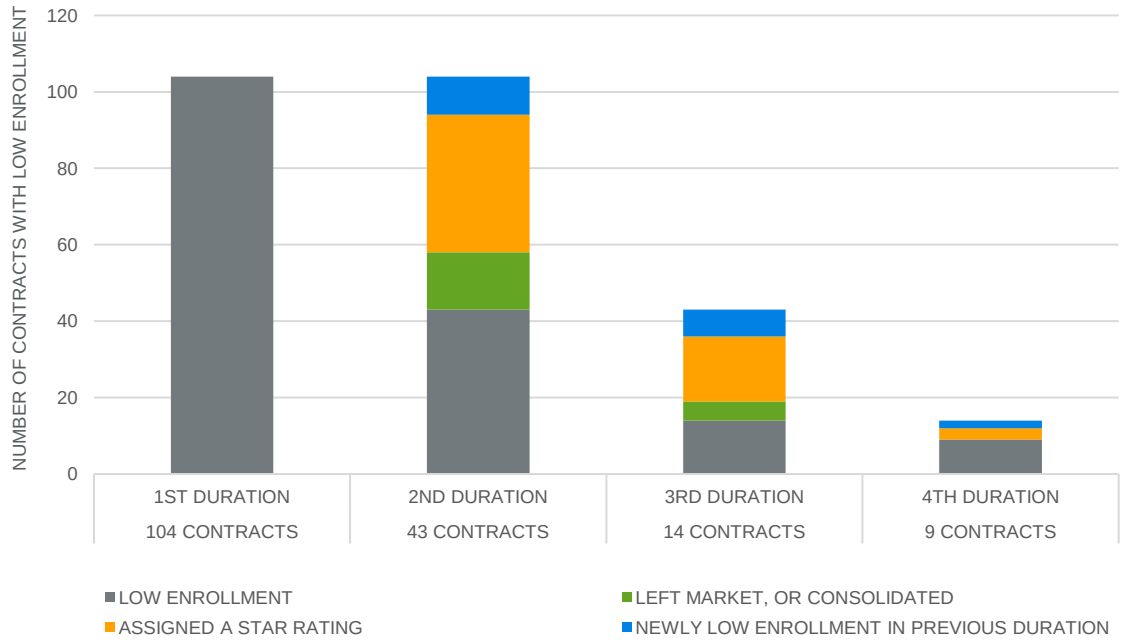
We analyzed 2011 to 2018 star rating experience to understand historical star rating patterns for MAOs coming off the "New Contract" star rating for each subsequent year. The results are shown in total and separately for various contract characteristics including network type and membership size. All analyses use the overall (combined Part C and Part D) star rating, with the exception of the results specific to Part C and Part D. Results are only shown for contracts with 2.5 and higher star ratings (that is, results do not include contracts with the "Low Enrollment" designation unless specifically indicated). Note that we define "duration" as the number of years after a contract has come off the "New Contract" star rating. Due to rounding, the percentages shown in the figures may not always sum exactly to 100%.

CONTRACTS RECEIVING THE "LOW ENROLLMENT" STAR RATING

A significant number of MAOs entering the market have insufficient membership to be assigned their own star ratings when coming off the "New Contract" star rating. The "Low Enrollment" designation is given to a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcomes Survey (HOS) data collections, because of a lack of sufficient enrollees to reliably measure the performance of the health plan. For example, HEDIS measures for contracts whose enrollment as of July 2016 were at least 500 but less than 1,000 will be included in the star ratings in 2018 when the contract-specific measure score reliability is equal to or greater than 0.7. If enrollment is lower than 500, or the HEDIS score is unreliable, these contracts are assigned the "Low Enrollment" star rating.

From 2011 to 2018, 104 of 158 contracts, or 66%, were assigned the "Low Enrollment" star rating after coming off the "New Contract" star rating. Figure 3 shows the subsequent star rating experience of these 104 contracts.

FIGURE 3: MIGRATION OF LOW ENROLLMENT CONTRACTS



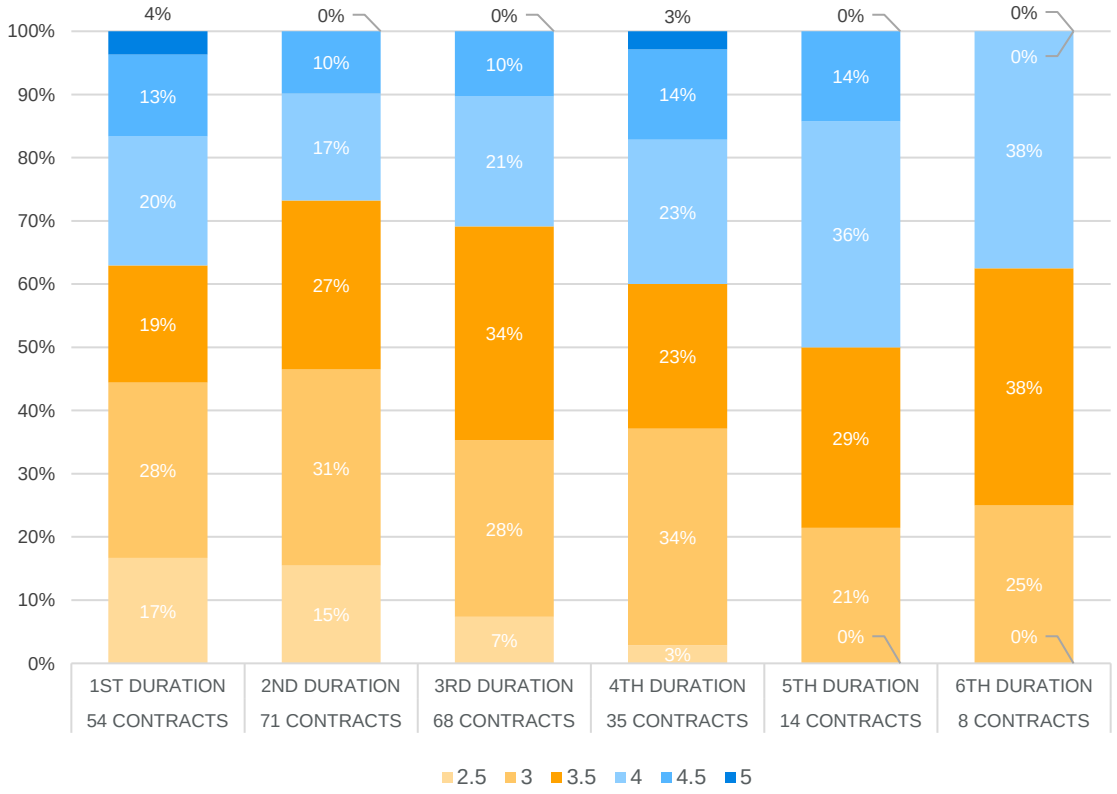
Only 41% of the contracts initially assigned the "Low Enrollment" star rating in the first duration retain the "Low Enrollment" star rating in the second duration. Thirty-five percent of contracts grew sufficient membership to be assigned a star rating based on their star rating metric results in the second duration.

Only 13% of the contracts initially assigned the "Low Enrollment" star rating in the first duration retain the "Low Enrollment" star rating in the third duration. It is uncommon for a contract to continue on as "Low Enrollment" for a number of years. This may be due in part to the regulations stating CMS may not enter into a contract with an MAO unless the MAO demonstrates it has the capability to enroll at least 5,000 individuals (required membership is lower for provider-sponsored organizations and MAOs offering benefits outside urbanized areas). Currently CMS waives this requirement in the first three years of the contract where the applicant is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract.

STAR RATINGS BY DURATION

The distribution of 2011 to 2018 star ratings by duration after coming off the "New Contract" star rating is shown in Figure 4.

FIGURE 4: OVERALL STAR RATINGS BY DURATION



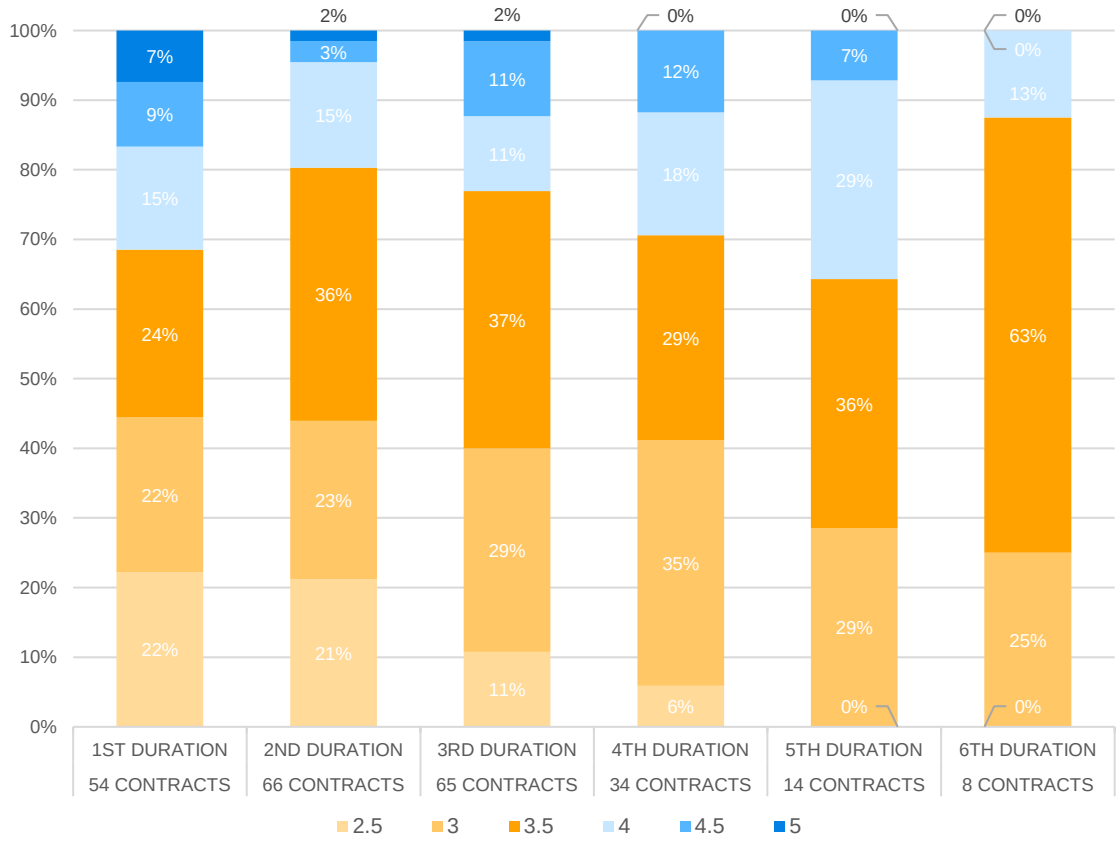
Very few contracts are able to achieve and maintain a 5.0 star rating over time. However, Figure 4 demonstrates that star ratings significantly improve as contracts mature. Thirty-seven percent of contracts receive a QBP (i.e., receive 4.0 stars and above) in the first duration—this jumps up to 50% of contracts in the fifth duration.

It appears many contracts may not have successfully implemented an active star rating management program early enough to sufficiently impact the first year after the "New Contract" star rating. This suggests there may be significant opportunity for new MAOs to improve these early efforts and reap the benefits in their revenue payments in the MAO's fourth year of operation.

PART C STAR RATINGS BY DURATION

The distribution of 2011 to 2018 Part C star ratings by duration is shown in Figure 5.

FIGURE 5: PART C STAR RATINGS BY DURATION

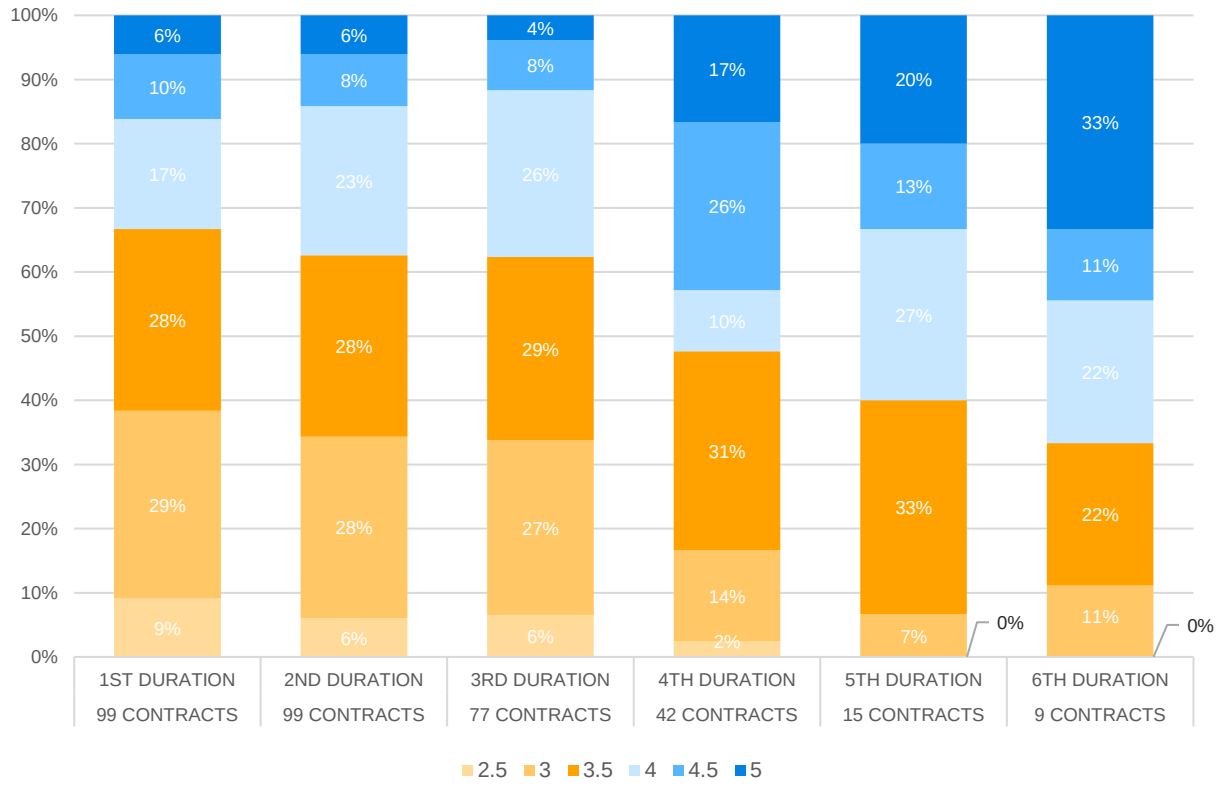


The Part C star rating results shown in Figure 5 are similar to the overall star rating results in Figure 4. A significant amount of star rating metrics are related to Part C, which heavily influences the overall star rating.

PART D STAR RATINGS BY DURATION

The distribution of 2011 to 2018 Part D star ratings by duration after coming off the "New Contract" star rating is shown in Figure 6.

FIGURE 6: PART D STAR RATINGS BY DURATION



More contracts have a Part D star rating assigned than those assigned a Part C star rating. Most of the Part D metrics have lower minimum membership thresholds than the Part C metrics. For this reason, and due to the smaller number of Part D metrics relative to Part C, an MAO generally receives a Part D star rating sooner than a Part C star rating.

Part D star ratings are higher, on average, than Part C star ratings at every duration.

The criteria for an MAO achieving a QBP is based on the overall star rating, which is calculated using a weighted average of the Part C and Part D measure star ratings. Because QBP achievement is based on the overall star rating, an MAO may target either Part C or Part D metrics for improvement, as long as the goal is an overall star rating of 4.0 stars or higher. Using star gaps and metric weights, MAOs may choose to target "low-hanging fruit" for short-term results in their stars management programs without regard to whether the metrics are Part C or Part D. Because achieving a high rating in some of the Part C metrics requires more long-term approaches, star rating management programs aim to achieve higher ratings in some of the more challenging Part C star rating measures over a longer period of time.

STAR RATINGS BY DURATION AND NETWORK TYPE

The distributions of 2011 to 2018 star ratings by duration and network type are shown in Figure 7 (PPO) and Figure 8 (HMO).

FIGURE 7: PPO STAR RATINGS BY DURATION

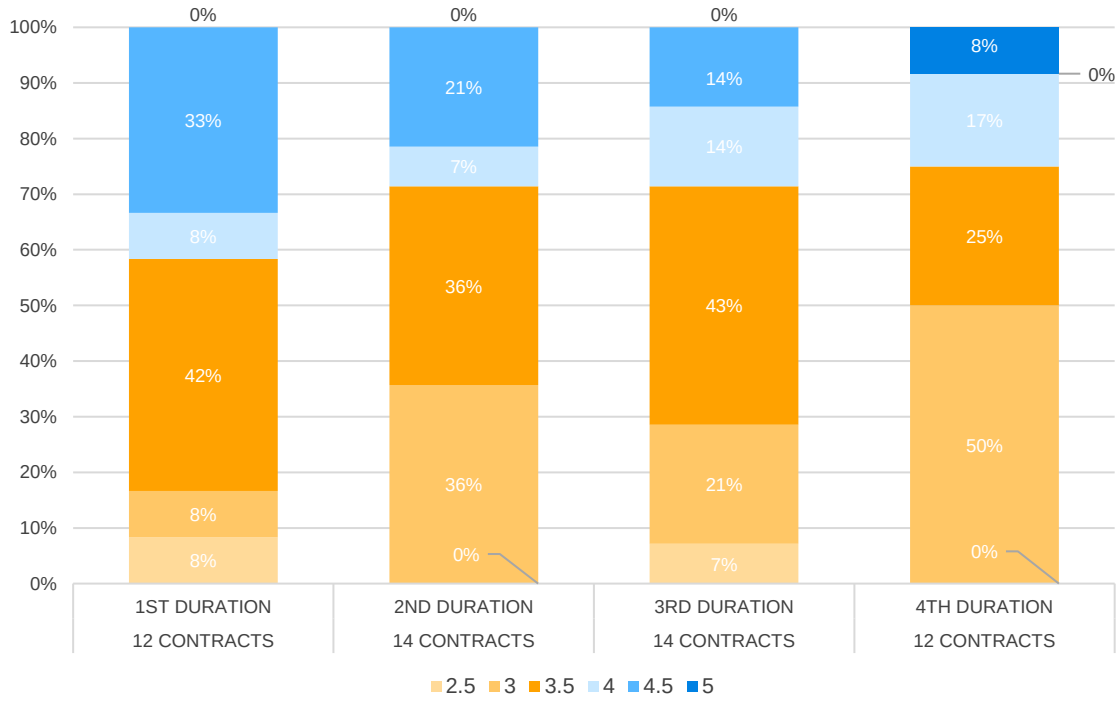
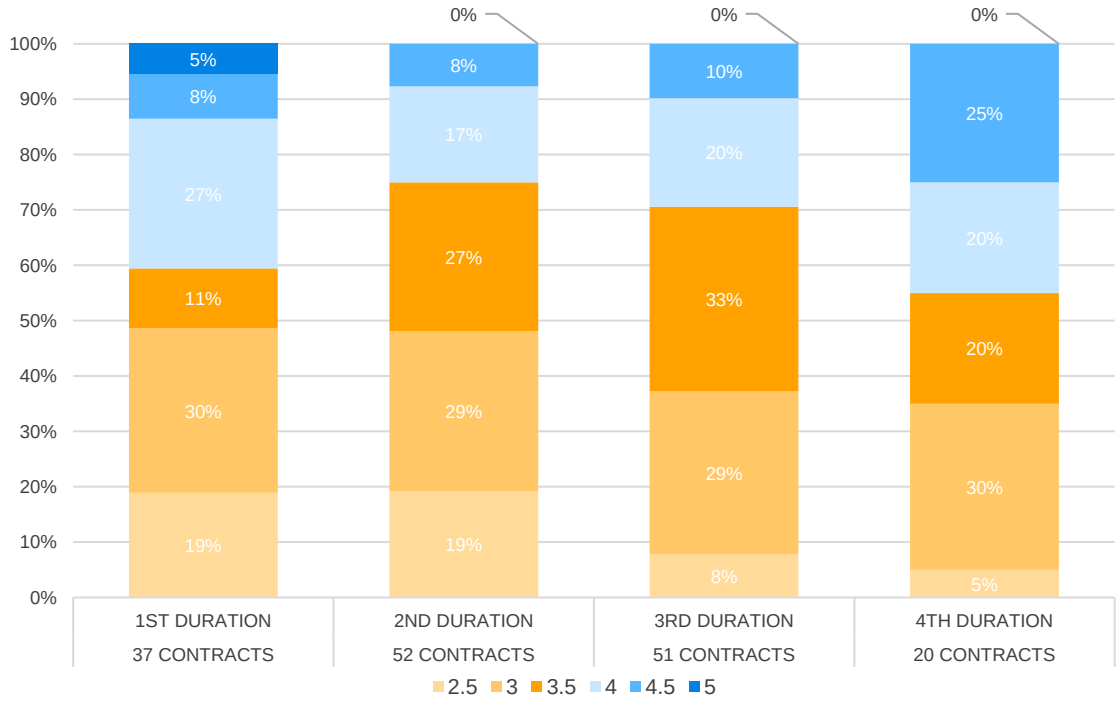


FIGURE 8: HMO STAR RATINGS BY DURATION



In the first three durations after coming off the "New Contract" star rating, HMO and PPO contracts have a similar distribution of contracts achieving 4.0 stars and higher. However, a much larger portion of PPO contracts initially achieve 3.5 stars compared to HMO contracts, which results in a higher average star rating in the first duration for PPO plans (3.75 stars) as compared to HMO plans (3.46 stars).

By the fourth duration, the average star rating for HMO contracts (3.65 stars) significantly increases and exceeds the average star rating for PPO contracts (3.46 stars). This significant durational improvement in HMO star ratings suggests there may be an opportunity to implement star management program initiatives earlier in the process, such that higher stars may be achieved earlier for HMO contracts.

STAR RATINGS BY DURATION AND MEMBERSHIP SIZE

The distributions of 2011 to 2018 star ratings by duration and membership size are shown in Figure 9 (Small contracts) and Figure 10 (Large contracts). Small contracts are defined as those with fewer than 10,000 members. Large contracts are defined as those with at least 10,000 members.

FIGURE 9: SMALL CONTRACT STAR RATINGS BY DURATION

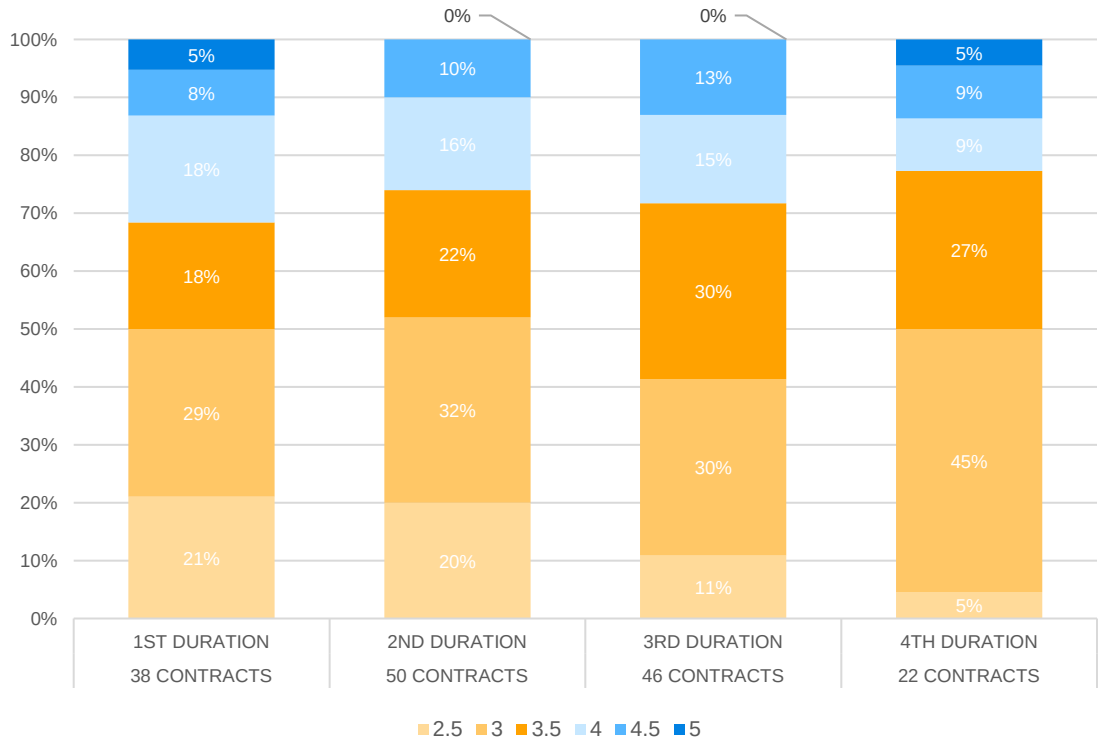
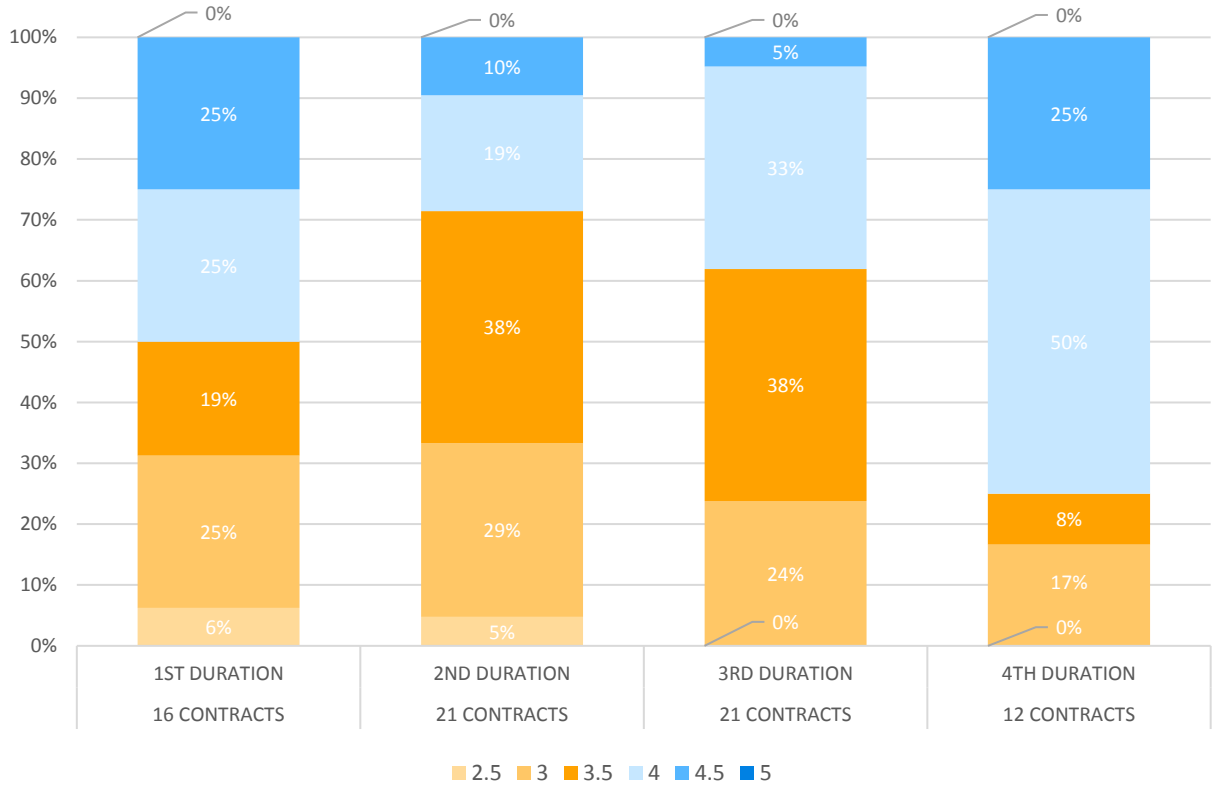


FIGURE 10: LARGE CONTRACT STAR RATINGS BY DURATION



Large contracts have a higher average star rating of 3.69 in the first duration compared to Small contracts with an average star rating of 3.39, or a 9% difference.

The average star ratings for both Large and Small contracts increases over time. By the fourth durational year, the average star rating for Large contracts was 3.92 stars and for Small contracts was 3.43 stars, or a 14% difference. The increase in the average star rating for Small contracts is caused by improvements in star ratings for contracts with overall results below 4.0 stars—the distribution of contracts at 4.0 stars and above remains constant with increasing duration. This suggests there may be additional opportunity within the Small contract category to increase star ratings even higher to achieve 4.0 stars and the QBP if these contractors are willing and able to invest in their star ratings programs.

The observed correlation between higher star ratings and larger membership reinforces the benefits of performing well in the CMS star rating program—higher star ratings generate more federal revenue, which in turn is passed through to beneficiaries in the form of reduced premiums and/or increased benefits and improves marketability and membership.

4. Methodology

We created a contract-level database containing year, star rating, membership, and plan characteristic information using the following data sources:

- 2011 to 2018 star rating information released by CMS[7]: We included all individual MA plans and excluded Employer Group Waiver Plans (EGWPs), Prescription Drug Plans (PDPs), Program of All-Inclusive Care for the Elderly (PACE) plans, Cost plans, Medicare-Medicaid Plans (MMPs), and Medical Savings Account (MSA) plans.
- 2011 to 2017 membership information released by CMS[8]: We used February membership for each year to correspond to the same year's star rating information. We used September 2017 membership information for the 2018 star ratings, as the February 2018 membership was not yet available. Note that any contracts that are new to the 2018 market did not have membership during September 2017 and are excluded from our analysis. Membership was used to quantify the size of a contract.

Our data set contains about 810 unique contracts offered from 2011 through 2018. About 430 contracts are continuing to be offered for 2018 relative to 2017 and roughly 380 contracts were offered in prior years and are no longer offered in 2018. There are about 70 new contracts (14% of total contracts) for 2018; however, these contracts include cross-walked contracts that may have existed in 2017 but were assigned a new contract number in 2018. We did not account for cross-walking in our analysis, as our goal is to analyze a contract's star rating after coming off the "New Contract" star rating and not how the star rating changes due to contract consolidation.

We used our data set to review star ratings by duration for those contracts identified as "New Contract." That is, we looked at how a star rating changed for a particular contract one year after coming off "New Contract" (first duration), two years after coming off "New Contract" (second duration), etc. We conducted separate analyses by plan characteristics including network type (HMO/PPO) and membership size.

[7] Part C and Part D Performance Data, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

[8] CMS (June 12, 2012), Monthly MA Enrollment by State/County/Contract, Retrieved February 12, 2018, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html.

5. Best practices

Achieving star rating success requires a long lead time. An MAO's star rating impacting its revenue in its fourth year of operations will be based on actual plan measures from data collected as early as the first year of operations. As part of start-up operations, and prior to enrolling members, an MAO should begin star rating planning. This planning may include education and gap assessment, strategic and tactical considerations, and business plan projections.

EDUCATION AND GAP ASSESSMENT

One of the first steps in planning should be to identify all subcontractors delegated to manage key administrative aspects and to determine how their services may affect star ratings. Contractors are very important to early star rating success for most new MAOs.

Educational sessions should be provided to all MAO staff and subcontractors to familiarize them with the CMS star rating program and metrics and to prepare them for the star rating gap assessment. The educational materials provided to subcontractors should be tailored to the services delegated. Vendors with years of MA expertise may often have staff who do not fully understand their roles and impact on star ratings.

A star rating gap assessment should be conducted entailing a "current/proposed state" evaluation. The purpose of the assessment is to identify gaps, risks, and opportunities and to formulate recommendations to move toward a best practice star rating strategy. Internal and delegated operations' leaders should work interactively in describing the star rating metrics, discuss current operations, and ask questions to understand the enhancements required to achieve a higher star rating. Each functional area having a potential impact on the star rating results should be visited. Individual interviews should be conducted with key staff regarding current and planned operations, opportunities, and challenges.

STRATEGIC AND TACTICAL PLAN

Potential strategic and tactical approaches should be discussed to close the gaps identified in the assessment. Viable options for a three-year implementation plan should be determined. We have found it very effective for MAOs to separately address each of the following nine areas in their implementation plans, even though there may be some overlap among operational departments:

1. Corporate leadership
2. Engaging providers
3. Engaging members
4. Readmissions
5. Customer service
6. HEDIS
7. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and HOS
8. Appeals and grievances
9. Prescription drug

For each of the nine areas, we recommend MAOs base their star rating strategic and tactical plans on identified gaps. The plan should be updated as needed based on what is working, what is not working, and changing priorities. Plan-specific tasks, including identification of the responsible party, start and end dates, and interdependencies, should be identified as part of the implementation. The current star rating performance should be reviewed and reported on regularly. All staff and vendors should be held accountable, not just the star rating leader. MAOs should celebrate the wins, and continually work to fix the barriers. The CMS star rating program is ever-changing, and MAOs should constantly work to improve their star ratings.

BUSINESS PLAN IMPLICATIONS

An MAO should consider impacts of future star ratings on its initial business plan. A typical business plan includes projections of plan experience, including revenue projections, for the first five years of a start-up organization. In this situation, a new MAO can assume that its revenue for the first three years will be based on the "New Contract" star rating. The star rating for the fourth and fifth year are unknown. An MAO will need to assess the reasonableness of achieving a higher star rating for these years. In any case, an MAO needs to ensure that its star rating initiatives will

achieve the star rating it assumes in its business plan, or it will risk actual revenue (and potentially membership) being lower than projected.

Example: Corporate Leadership Best Practices

We provide an example of Corporate Leadership best practices most MAOs need to implement as first year start-up priorities. Subcontractors should be included in all stars strategy and tactics, leveraging subcontractor strengths and resolving subcontractor deficiencies.

Structure: Establish an organizational and committee structure and policies for continuous oversight of stars performance. Identify / hire staff to oversee the stars planning, implementation, measurement, and evaluation efforts. Develop performance measurement and gap reporting at the star metric level. Design operational metrics including benchmarks, goals, and reporting around each star measure for each department and subcontractor. Regularly report experience compared to benchmark to leadership.

Mission, Goals, and Incentives: Link star goals to the MAO's mission and include in the strategic plan. Ensure formal adoption of goals at the corporate / organizational levels, including subcontractors. Require staff to develop individual goals supporting the stars effort, incorporating into performance reviews. Establish an ongoing reward / recognition program for staff and subcontractors demonstrating behaviors supporting stars.

Training and Education: Provide formal training on the stars strategy and tactical priorities to all staff and subcontractors. Include stars training in new employee and subcontractor orientation. Communicate with staff / subcontractors regularly to keep stars "top of mind."

Demonstrate Commitment: Ensure senior management regularly verbalizes / reinforces stars as an organizational / subcontractor priority. Develop mechanisms to solicit innovative ideas from staff / subcontractors and to publically announce, reward, and celebrate successes. Develop mechanisms to collect staff / subcontractors feedback on barriers to achieving star excellence. Create an environment to modify processes as needed.

Communication: Develop and implement a plan to communicate and reinforce star decisions, philosophies, goals, priorities, and progress throughout the organization and with subcontractors. Develop a plan to regularly review staff / subcontractor performance to ensure participation and understanding of the stars goals.

FINAL THOUGHTS

Successful MAOs target profitability and membership growth. The key to both of these goals is to optimize revenue. While there are a few levers to increase revenue, one of the most direct ways is to achieve a QBP through attainment of a 4.0 and greater overall star rating. Managing an effective star rating management program is essential and must be implemented fully across the organization and with vendors in the very early start-up stages to ensure the best possible star rating and revenue attainment for new MAOs.

6. Qualifications, caveats, and limitations

Kelly Backes, Julia Friedman, and Dustin Grzeskowiak are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this report and attachments are complete and accurate and have been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this report related to the Medicare Advantage program.

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The validity of certain comparisons provided in this report may be limited, particularly where the number of contracts, enrollment, and/or credibility in data segments is low. Additionally, future star rating performance for any one organization will vary from the historical experience provided in this report.

In completing this analysis we relied on information from CMS, which we accepted without audit. However, we did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.

CONTACT

Kelly S. Backes
kelly.backes@milliman.com

Julia M. Friedman
julia.friedman@milliman.com

Dustin J. Grzeskowiak
dustin.grzeskowiak@milliman.com

Elizabeth L. Phillips
libby.phillips@milliman.com

Patricia A. Zenner
pat.zenner@milliman.com